SOMERSET NHS FOUNDATION TRUST/
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

PUBLIC BOARD MEETINGS HELD IN COMMON

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

Microsoft Teams meeting

Join on your computer, mobile app or room device

Click here to join the meeting

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

Yours sincerely

COLIN DRUMMOND
CHAIRMAN SFT

MARTYN SCRIVENS
CHAIRMAN YDH

A G E N D A

9.00	**1.**	**WELCOME AND APOLOGIES FOR ABSENCE**	**Joint**	
	2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND GOVERNORS**	**Joint**	
	3.	**TO APPROVE THE MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 7 FEBRUARY 2023**	**SFT**	**Enclosure A**
	4.	**TO APPROVE THE MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 7 FEBRUARY 2023**	**YDH**	**Enclosure B**
	5.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**	**Joint**	**Enclosure C**
	6.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**	**Joint**	**Enclosure D**

	7.	**TO NOTE THE CHAIRMEN'S REMARKS** • **Non-Executive Directors lead roles**	**Joint**	**Verbal** **Enclosure E**
9.15	**8.**	**TO RECEIVE THE CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**	**Joint**	**Enclosure F**
OBJECTIVE 2: to provide the best possible care and support to people				
9.35	**9.**	**PATIENT STORY AND CLINICAL TOPIC ON END OF LIFE SERVICES**	**Joint**	**Presentation**
10.05	**10.**	**TO RECEIVE THE ASSURANCE REPORT OF THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETINGS HELD ON 25 JANUARY 2023**	**Joint**	**Enclosure G**
OBJECTIVE 8 – To develop a high performing organisation delivering the vision of the Trust				
10.15	**11.**	**TO RECEIVE THE PERFORMANCE REPORTS** • **YDH** • **SFT**	 **YDH** **SFT**	 **Enclosure H** **Enclosure I**
10.35	**12.**	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**	**Joint**	**Verbal**
10.50		**Coffee Break**		
11.05	**13.**	**TO APPROVE THE RISK MANAGEMENT STRATEGY**	**Joint**	**Enclosure J**
OBJECTIVE 6 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture				
11.25	**14.**	**TO RECEIVE THE SIX MONTHLY FREEDOM TO SPEAK UP PROGRESS REPORT**	**Joint**	**Enclosure K**
11.40	**15.**	**TO RECEIVE THE SIX MONTHLY STAFFING ESTABLISHMENT REPORT**	**Joint**	**Enclosure L**
11.55	**16.**	**TO RECEIVE THE STAFF SURVEY 2022 REPORT**	**Joint**	**Presentation**
12.10	**17.**	**ASSURANCE REPORT FROM THE WORKFORCE/ PEOPLE COMMITTEE MEETINGS HELD ON 30 JANUARY 2023**	**Joint**	**Enclosure M**

OBJECTIVE 7: To live within our means and use our resources wisely				
12.50	**18.**	**TO RECEIVE THE FINANCE REPORTS** • **YDH** • **SFT**		**Enclosure N** **Enclosure O**
12.35	**19.**	**TO APPROVE THE CAPITAL PROGRAMME FOR 2023/24**		**Enclosure P**
12.55	**20.**	**TO RECEIVE A VERBAL REPORT FROM THE FINANCIAL RESILIENCE COMMERCIAL COMMITTEE/FINANCE COMMITTEE MEETING HELD ON 24 FEBRUARY 2023**	**Joint**	**Verbal**
ALL OBJECTIVES				
13.00	**21.**	**TO APPROVE CHANGES TO THE CONSTITUTION** • **YDH** • **SFT**	**Joint**	**Enclosure Q** **Enclosure R**
FOR INFORMATION				
13.20	**22.**	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**	**Joint**	
	23.	**ANY OTHER BUSINESS**	**Joint**	
	24.	**RISKS IDENTIFIED**	**Joint**	
	25.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**		
	26.	**ITEMS TO BE DISCUSSED AT THE CONFIDENTIAL BOARD MEETINGS** The items presented to the Confidential Board are items which are in draft format; are in pre submission stage; are related to specific patients or colleagues; are commercially sensitive (e.g contracts); are for strategic discussion; are otherwise required to be presented to the Confidential Board, e.g. due to regulatory requirements (approval of annual accounts and Quality Accounts); or the publicity on which would be prejudicial to the public interest. Every effort will be made to present items to the Public Board meeting.		
	27.	**WITHDRAWAL OF PRESS AND PUBLIC** To move that representatives of the press and other members of the public be excluded from the remainder of		

		the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	
13.25	**28.**	**DATE FOR NEXT MEETING** 9 May 2023	

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

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST MEETING HELD ON MEETINGS HELD ON 7 FEBRUARY 2023 BY MS TEAMS

PRESENT

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

IN ATTENDANCE

Graham Hughes	Non-Executive Director, YDH
Paul Mapson	Non-Executive Director, YDH
Meridith Kane	Medical Director for Acute Hospitals
Fiona Reid	Director of Communications
Ben Edgar-Attwell	Deputy Director of Corporate Services
Lynn Borthwick	midwife (for item 15 only)
Katarina Harrison-Tvarozkova	Consultant Obstetrics and Gynaecology (for item 15 only)
Kayleigh Sharp	(for item 15 only)
Laura Walker	Head of Patient Safety and Learning (for item 22 only)
Janet Fallon	Guardian of Safe Working – SFT (for item 26 only)
John McFarlane	Guardian of Safe Working - YDH (for item 26 only)
James Esleyer	observing
Neil Powell	Inspector, Care Quality Commission

Ian Hawkins	Lead Governor, SFT/Governor, YDH
Kate Butler	Deputy Lead Governor, SFT
Cllr Adam Dance	Governor, YDH
Virginia Membrey	Governor, YDH
Cllr Steve Ashton	Governor, SFT
Tim Slattery	Governor, SFT
Erica Adams	Governor, SFT
Ria Zandvliet	Secretary to the Trust (minute taker)

1.	**APOLOGIES**
1.1	Apologies were received from Jan Hull (Non-Executive Director/Deputy Chairman).
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Colin Drummond will be chairing this public Board meeting.
1.3	The Chairman welcomed all Board members, governors, colleagues and other attendees to the meeting and confirmed that both the SFT and YDH meetings were quorate.
2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS**
2.1	No questions from members of the public or governors had been received.
3.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 8 NOVEMBER 2022**
3.1	Kate Fallon proposed, Stephen Harrison seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 8 November 2022 as a correct record.
4.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 8 NOVEMBER 2022**
4.1	The approval of the minutes is reflected in the YDH minutes.
5.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 6 DECEMBER 2022**
5.1	Stephen Harrison proposed, Barbara Gregory seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 6 December 2022 as a correct record.
6.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 6 DECEMBER 2022**

6.1	The approval of the minutes is reflected in the YDH minutes.
7.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 20 JANUARY 2023**
7.1	Kate Fallon proposed, Stephen Harrison seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 20 January 2023 as a correct record.
8.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 20 JANUARY 2023**
8.1	The approval of the minutes is reflected in the YDH minutes.
9.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**
9.1	The Board received the action log and noted the completed actions.
	Minehead League of Friends
9.2	The Director of Corporate Services advised that he had responded to the questions submitted to the Board and, at the request of the League of Friends, Norma Coombes, Senior Matron, had attended their January 2023 meeting to answer any questions. The Minehead Minor Injury Unit was currently experiencing significant operational pressures and a long term same day urgent care strategy will be welcomed. It was noted that we are arranging, with the League of Friends, a meeting including Jonathan Higman, Chief Executive of the Integrated Care Board, in relation to the progress made on the same day urgent care review.
	Ambulance stack
9.3	Martyn Scrivens queried what progress had been made in relation to taking specific patients, e.g. patients who had fallen at home, out of the ambulance stack and what impact this had made. The Chief Executive advised that it had been difficult to set the service up at scale and a meeting had been arranged at lunch time on 7 February 2023 to look at the resources required to support ambulance services.
9.4	The Chief Operating Officer (Mental Health, Families and Neighbourhoods) provided an update on progress made to date and it was noted that 19 urgent community responses had been diverted from the ambulance stack to community services during January 2023. This number was lower than expected but he was optimistic that more progress will be made after the meeting today.
	Community Hospital review
9.5	Discussions had previously taken place about a review of the future role of community hospitals and it was queried what progress had been made. The Chief Executive advised that the need for clarity about the future model of community inpatient care had been raised with the ICB and, although they had acknowledged this need for clarity, a timeframe for agreeing the future model had not as yet been confirmed. It was agreed to further discuss the community

	hospital model at a future Board development day. **Action: Ria Zandvliet to include this on the Board development day programme.**
9.6	**Patient Safety Board** Barbara Gregory, as patient safety lead, highlighted the recent Patient Safety Board meeting and advised that feedback on the issues raised at the meeting had been presented to the January 2023 Quality and Governance Assurance Committee meeting. The issues raised will be included in the Committee's assurance report to the March 2023 Board meeting.
10.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**
10.1	The Board received the Register of Directors' interest. The Board noted the following changes to the register: • Peter Lewis – to remove "Director, Yeovil Property Operating Company Limited"
10.2	Kate Fallon declared an interest in relation to the SFT Guardian of Safe working for post graduate doctors agenda item as her daughter produced and presented the report.
11.	**CHAIRMEN'S REMARKS**
11.1	The Chairman advised that the last few months had been particularly challenging for all colleagues and, on behalf of the Board, thanked them for their continued hard work. The Chairman also commended the executive team on their management of the impact of the industrial actions.
11.2	He advised that the trusts had been forced into challenging situations and they tried to do their best to take patients out of the ambulance stack; and ensure that escalation and boarding beds were available. These additional pressures and functioning in crisis mode will however not be sustainable in the longer term.
11.3	**Board Committee Membership** The Chairman presented the overview of Non-Executive Director Board Committee membership which was received by the Board. The Chairman advised that Committee membership was in line with the Committees' Terms of References for the post merger organisation and thanked all Non-Executive Directors for their ongoing hard work and for being flexible about Committee membership.
12.	**CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**
12.1	The Chief Executive presented the report which was received by the Board. He advised that the report set out a number of significant and positive developments and specifically highlighted the consultation on the options for acute hospital-based stroke services in Somerset; the levelling up funding for the establishment

	of a training academy for health and social care and the benefits of the training academy; and the recent positive media coverage.
12.2	The Chief Operating Officer (Hospital Services) provided an update on the ongoing significant operational pressures and actions being taken and highlighted: • The escalation position - MPH - all acute escalation beds had been opened at the beginning of January 2023 and additional pre-emptive boarding arrangements had been set up to be able to manage the pressures. The escalation and boarding arrangements were eased in the middle of the month but, in view of the increased operational pressures, had subsequently been reinstated. Musgrove Park Hospital (MPH) was currently managing 74 escalation beds, which included nine pre-emptive boarding beds. These escalation beds will need to remain in place in view of the delays in discharges and resulting long length of stays. - YDH – 38 escalation beds had been opened at YDH with a further ten pre-emptive boarding beds. • Delayed discharges - MPH - 128 patients with a length of stay of over 21 days which was particularly high compared to pre Covid-19 standards. 120 of these patients were medically fit for discharge but were awaiting intermediate care, bedded care or other care packages. - YDH – the number of delayed discharges (87) was proportionally higher than at MPH as social care capacity in the South Somerset area was particularly challenging. • The ambulance handover position – the trusts took the view that as much risk as possible should be held in urgent care services so that ambulance handover times can be kept to a minimum, but this approach increased the pressures in urgent care services. • The infection control position - MPH currently had 36 inpatients with Covid-19 or flu and 33 inpatients with a respiratory infection and, in terms of infection control, these groups of patients will need to be managed in a different way. - YDH – the number of patients with Covid-19 (20) or flu (13) was proportionally higher at YDH than at MPH. • Staff sickness had increased and this was mainly due to Covid-19 or flu infections amongst staff.
12.3	The Chief Operating Officer (Hospital Services) advised that there were currently 103 patients waiting for supported discharge pathways and it had been agreed with social care partners and the Integrated Care Board (ICB) to reduce this number to 75 or below by 10 February 2023.

12.4	The Board discussed the report and commented/noted that: • Pre-emptive boarding beds were used for low risk patients only. The term "boarding beds" was used for instances where a patient was admitted to a ward whilst awaiting for a bed to become available. It was noted that all boarding areas in acute and community hospitals had been assessed by the health and safety team, fire officer and senior clinicians to ensure that these areas were safe. A decision to use boarding beds was only taken in exceptional circumstances but instances where boarding beds had to be used had increased over the last few weeks. • A significant amount of leadership support was provided in relation to the care of patients and support to colleagues. Colleagues had expressed their concerns about the escalation and boarding approach and we recognise that the use of escalation and boarding beds should be limited to the absolute minimum and not become normalised. Colleagues will continue to be encouraged to raise their concerns either through their line manager, incident reporting process or through the Freedom to Speak Up Guardians. It was recognised that the pressures had an impact on colleagues and all Board members were encouraged to speak to colleagues and listen to their concerns. • It was queried whether comparative performance data was available. The Chief Nurse advised that regular contact was made with trusts in the South West region and all trusts were under similar pressures. There was variation in terms of the approach taken in relation to the management of patients arriving by ambulance and the Trust's approach of taking the risk into hospitals to avoid holding patients in the ambulance had resulted in higher escalation and boarding requirements. The difference in approach therefore made it more difficult to compare performance on a like for like basis. It will be key to focus on bed occupancy, including boarding beds, against the core bed capacity as this will provide more accurate data. • The Chief Operating Officer (Hospital Services) advised that the level of acute pre-emptive boarding beds was not out of line with other trusts in the South West area. The level of escalation beds, including the doubling up of beds in the Jubilee building, was high and, although it was recognised that this was due to the risk approach to be able to keep ambulance handover times to a minimum and manage patients within the emergency department, these pressures had continued for considerable time. • The approach taken by the trusts was the right approach and was to the benefit of patients. There was a risk that the good ambulance handover times performance gave the impression at a regulatory level that Somerset was not experiencing the same challenges as in other areas. It was queried whether regulators were aware of the different risk approach. The Chief Executive advised that there was a real risk that Somerset performance data was seen as better than it actually was but every opportunity was taken to communicate the approach taken by the trusts and the impact on performance data to regulators. He felt that just looking

	at numbers did not provide a clear picture and comparative information will need to better reflect the different approaches. • Funding had been provided to the Local Authority to improve discharge pathways and it was queried whether this funding was being used effectively. The NHS was currently carrying the costs for patients without criteria to reside and these costs were higher than the costs of intermediate care, bedded care or social care packages. It was queried whether social care funding had been raised as a limiting factor in addressing the social care challenges. The Chief Executive advised that discussions had taken place with the Local Authority about their plans for 2023/24, including the financial aspects, and a meeting had been set up for the end of February 2023 to discuss the plans in more detail and this will include how to ensure that the additional social care funding will be used most effectively. Going forward, it will be important to move away from referring to health or social care funding as the overarching focus should be on what is best for the population of Somerset. • A recent announcement was made about 5,000 new beds and funding but it was stressed that expectations for Somerset should be carefully managed as there was no space left on the acute estates to set up more modular units and, in addition, it was not clear whether the funding was ”new funding”. The challenges and pressures were significant and modular units on their own would not solve the patient flow and workforce capacity challenges. The Chief Executive commented that it was not felt that more acute beds were required and the focus should be on ensuring that patients were in the right bed for their needs. Additional beds will not solve the longer term challenges and workforce will not be available to staff any additional beds. Additional beds were put in at YDH but this was as part of the redevelopment of the YDH site.
	Industrial Action
12.5	The Chief Nurse provided an update on the industrial actions and it was noted that the RCN will be holding a second two day action at SFT. The two day action made planning more difficult and it was important to bear in mind that the dispute was between nurses and the government and not with the trusts. It was noted that a legal framework for the safe withdrawal of labour was in place and the Chief of People and Organisational Development was working closely with the Strike Committee to plan the safe withdrawal of labour and the level of derogation.
12.6	The Chief Nurse advised that there was significant support for the strike action. The strike would have an impact on patients due to the large number of cancellations and a further impact on colleagues not involved in the strike. Planning for the strike action was progressing well.
12.7	It was queried whether the ambulance strikes had impacted on the trusts and it was noted that the impact had been minimal.

13.	**Q3 2022/23 BOARD ASSURANCE FRAMEWORKS**
13.1	The Director of Corporate Services presented the updated Q3 2022/23 Board Assurance Frameworks (BAF) for SFT and YDH which were received by the Board. The BAFs had been discussed by the Audit Committee, Executive Team and relevant sub Committees since the November 2022 Board meeting.
13.2	The Director of Corporate Services advised that the overall assessment In terms of level of risk was consistent across both organisations and the highest risks identified within the Assurance Frameworks continued to relate to: • the impact of pressures and capacity shortfalls in social care and intermediate care (objectives 2, 3 and 8) • insufficient capacity to meet demand (objectives 7 and 8) • infrastructure investment and ageing estate (objectives 2 and 8) • the impact of pressures in primary care (objectives 2, 3 and 5) • workforce recruitment and retention (objectives 3 and 6) • the impact of the pandemic (objective 5) • delivery of financial plans (objectives 7 and 8).
13.3	The Director of Corporate Services advised that four of the highest strategic risks had increased and the BAFs clearly showed the pressures and challenges across both trusts and in the wider health system. He highlighted the key areas of progress and areas of concern for objectives one and eight which were reserved to the Board.
13.4	The Board discussed the report and commented/noted that: • mapping of the risks on the BAF and the Corporate Risk Registers had been undertaken to ensure that the risks across both the BAF and corporate risk registers were aligned. • An update on the dementia strategy had been presented to a recent Quality and Governance Assurance Committee meeting and it was suggested including a patient story/clinical topic on dementia and delirium at a future Board meeting. • Some of the out of hospital schemes were under performing, including the Hospital at Home scheme, and this was linked to the work in relation to the ambulance stack. The Chief Operating Officer (Mental Health, Families and Neighbourhoods) commented that the Hospital at Home scheme was a vital part of the out of hospital strategy going forward. The limited amount of progress made was linked to the ability to take patients from the ambulance

stack. There was no strong history of what the out of hospital service should look like but the aim was for 2/3 of the service capacity to focus on admission avoidance and 1/3 on facilitating early discharge. Good progress was being made recruiting to the team but the remote monitoring equipment will not arrive until March 2023 and this equipment will be essential to the success of the service. In spite of the challenges and the slow start, every effort will be made to make this service a success and embed this new way of working. It was noted that capacity will continue to be built up over the summer and it was expected that the service will be fully functioning by the autumn.

There were a number of out of hospital pathways and alternatives to admissions already in place or being developed and it was queried whether the referral processes into the different services will be simplified as all services shared the same patient base. The Chief Operating Officer (Mental Health, Families and Neighbourhoods) agreed that there had been a number of initiatives for community services, each with their own requirements and specification and where possible the initiatives have been joined up. The Hospital at Home initiative was an extension of the Rapid Response Service but with a locality base and a single point of contact with the primary link call centre. A single point of contact was however not in place for the discharge pathways and, following a deep dive into these pathways, it was recognised that the pathways will need to be simplified and a review of the pathways and options to simplify processes was currently being caried out.

- The number of amber and red rated strategic objectives was felt to be a concern especially at the end of the year and it was felt that the amber rating indicated that the issues were not understood or being resolved. The Director of Corporate Services advised that the amber rating indicated that plans were in place to deliver the strategic objective but that the plans will not be fully implemented in the current financial year. Barbara Gregory reiterated that she would have expected there to be no amber or red rated strategic objectives at this time of the year. The Chief Executive responded that the key risks related to capacity, patient flow and demand and these will need to be mitigated at system level as actions were not solely in the trusts' control. It was, however, important to ensure that these levels of risk were not normalised.

- Strategic objective 1 – improving the health and wellbeing of the population. Although progress was being made, this progress was not fully visible, especially the aspects involving the Integrated Care Board (ICB) and social care services and it was therefore suggested dedicating time at a future Board Development Day to explore this objective and system actions in more detail. The Chief Executive advised that progress was being made implementing processes which will make a difference to the wellbeing of the population but it will take some time for the benefits to become visible through improvements in outcomes. The Chief Executive acknowledged that some delays had been experienced due to changes in organisational form both at the ICB and Local Authority. The Chief Executive agreed to provide a detailed update at a future Board Development Day. **Action: Chief Executive**.

	• It was highlighted that some of the objectives had been rated green whilst a number of related risks on the corporate risk register had been rated red, e.g. workforce related risks. The Chief Executive advised that considerable strategic workforce planning was taking place and this was reflected in the green rating for strategic objective six.
13.5	The Chairman thanked the Board members for the detailed discussion and highlighted: the need for clear communications about the public health agenda; the increased involvement of the third sector due to the reduction in NHS and social care resources; the challenges faced by primary care services; and the high number of patients with no criteria to reside. The majority of these issues were outside of the control of the trusts but impacted on all services provided by the trusts.
13.6	The Board noted the Board Assurance Frameworks, the level of risks and the actions taken to mitigate the risks.
14.	**Q3 2022/23 CORPORATE RISK REGISTER PROGRESS REPORTS**
14.1	The Director of Corporate Services presented the Q3 2022/23 Corporate Risk Register progress report which was received by the Board.
14.2	The Director of Corporate Services highlighted: • The common areas of risks identified across both trusts. • The total of 65 risks on the combined risk register – 44 SFT and 21 YDH risks – 21 of which scored 20 and above, with the majority of these risks relating to SFT. This evidenced a continued increase in the numbers of high level risks on the corporate risk register in the last six months. Details of these risks and the new risks were noted. • 11 new risks had been added since the last report and the risk rating of five risks had increased.
14.3	The Board discussed the report and commented/noted that: • The number of high risks reflected the extreme pressures on services and on colleagues. • It will not be possible to mitigate all risks and a decision will need to be made as to which risks to tolerate. It was suggested categorising the risks into risks which can be tolerated and risks will need to be prioritised in terms of mitigation. The Director of Corporate Services agreed that it will not be possible to mitigate all risks in the current year and discussions as to which risks to tolerate in the short term will take place at the next Quality and Governance Assurance Committee meetings. • Significant work was taking place but the level of risks felt uncomfortable. Not all risks were in the direct control of the trusts as some of the risks

	were linked to national strategic issues. It was suggested that it will be helpful to distinguish between risks which were in control of the trusts and risks which could not be controlled. • It was noted that the risk management strategy will be presented to the March 2023 Board for approval and the strategy will set out general risk appetite and tolerance principles. • Discussions will be taking place with the ICB about the management of system wide risks.
14.4	The Board thanked the Director of Corporate Services for his, and the team's ongoing focus on risk management.
15.	**PATIENT STORY AND CLINICAL TOPIC ON THE TWIN CLINIC**
15.1	The Chief Nurse introduced the Lynn Borthwick (midwife); Katarina Harrison-Tvarozkova (Consultant Obstetrics and Gynaecology) and Kayleigh Sharp (mum of twins).
15.2	Katarina Harrison-Tvarozkova advised that she had been appointed to her current role at Musgrove Park Hospital in 2021 and had set up the twin clinic to be able to make a difference to the outcome of twin pregnancies. She advised that Kayleigh Sharp had been one of the first mums to use the new service and had been invited to talk about her experience using the service.
15.3	Kayleigh Sharp provided feedback on the care she and her twins received whilst under the care of the twin clinic and highlighted the excellent support received. She further highlighted the difficulties she had faced during her pregnancy and the positive impact the care provided at the twin clinic had on her wellbeing. She was able to ask questions; all aspects of her care were well explained; and she was well supported. Kayleigh was confident that without the twin clinic she would not have had such a positive outcome. She further highlighted the contact she had been able to make with other twin parents and her ongoing contact with the service.
15.4	Katarina Harrison-Tvarozkova and the Chairman thanked Kayleigh for her feedback. Kayleigh Sharp left the meeting.
15.5	Katarina Harrison-Tvarozkova and Lynn Borthwick provided details of the work of the twin clinic and highlighted: • the excellent support provided by midwifes. • the reasons for multiple pregnancies; overview of multiple pregnancies and baby deaths over the last few years. • Guidance and standards – Savings Babies Lives Version 2 – Ockenden Report; the MBRRACE-UK Saving Lives Improving Mothers' Care recommendations; the NICE guidelines on twin and triplet pregnancies.

	• The type and level of care provided prior to implementation of the twin clinic. • The establishment of the twin clinic and the changes to the service – including the implementation of the NICE guidelines. • The improvements made to twin pregnancy outcomes following the establishment of the twin clinic. • the next steps: the QI project and the benefits of signing up to and using the QI project; the twins trust maternity project which was aimed at reducing still births, neonatal admissions, deaths and increasing natural births. • The positive impact on Musgrove Park Hospital (MPH) including the significant financial savings; the zero still births and neonatal deaths; and the reduction in neonatal admissions.
15.6	The Board discussed the presentation and commented/noted that: • The twin clinic was currently only available at MPH and it was noted that contact had been made with clinicians at Yeovil District Hospital (YDH) about extending this service to YDH. Two options could be considered - using the same team across both YDH and MPH or train the YDH team on the twin clinical model. • The Chief Medical Officer supported the roll out of the service to YDH and advised that it will be helpful to discuss this further with the YDH clinicians at an away day in the near future. • The service was solely focussed on twin pregnancies and other high risk pregnancies were managed by specific obstetric specialists, e.g. diabetes, long term conditions. However it was felt that further improvements to services provided to high risk pregnancies could be made.
15.7	The Board thanked Katarina Harrison-Tvarozkova and Lynn Borthwick for their excellent work and improvements to outcomes for mums and twins.
15.8	Katarina Harrison-Tvarozkova and Lynn Borthwick left the meeting.
16.	**ASSURANCE REPORT OF THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 23 NOVEMBER 2022**
16.1	Graham Hughes presented the report which was received by the Board. He highlighted the areas of assurance received and the areas to be reported to the Board. These areas related to:

	• The Health and Safety Executive Improvement Notice relating to the use of safer medical sharps in theatres – the Committee had received assurance about the progress made in implementing the action plan at its January 2023 meeting. • The update on the Homicide reports including the Duty of Candour audit and review. • The deteriorating patients internal audit findings. • The strategic objectives risk tolerance levels.
16.2	Details of these areas were set out in the report and were noted.
16.3	The Board discussed the report and commented/noted that: • The Health and Safety Executive (HSE) Improvement Notice – a further visit by the HSE was expected on 1 March 2023 and feedback from this visit will be provided to the March 2023 Board meeting. • Draft Independent Homicide Report – the publication of the final report was now not expected until May 2023. • Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services – a review of the recommendations set out in the letter from Claire Murdoch had been completed and an action plan had been published on the trust's website.
16.4	The Chairman thanked Graham Hughes for the update and thanked the Committee for its assurances.
17.	There was no item 17 on the agenda.
18.	**CARE QUALITY COMMISSION (CQC) INSPECTION REPORT**
18.1	The Director of Corporate Services presented the report which was received by the Board. The Director of Corporate Services advised that the CQC had inspected three core service areas: the mental health acute wards for adults of working age and psychiatric intensive care unit; the specialist community mental health services for children and young people; and the community end of life care services. The CQC further inspected the well-led key lines of enquiry for the trust overall. The findings were very positive with the community mental health services for children and young people receiving an "outstanding" rating. The remaining services received an overall "good "rating.
18.2	The Board discussed the report and commented/noted that: • The community mental health for children and young people's team was particularly complimented on the significant improvements made since the

	last CQC inspection. • Due to the low number of core services inspected, the positive findings will not result in an improvement in the overall "good" rating for the trust. • The overall caring domain for the trust had been rated as "outstanding" and this was an excellent result. • the overall safe domain had been rated as "requires improvement". The CQC acknowledged that although improvements had been made in two of the three services inspected, due to the limited number of services inspected, the overall rating could not be changed. • three "must do" actions had been identified relating to the mental health acute wards for adults of working age and psychiatric intensive care unit. The immediate actions in relation to the environment had already been implemented but this was also part of the longer term plans to move St Andrews in Wells to the new Rowan Ward in Yeovil. The remaining must do actions related to risks assessments and training of staff. An action plan will be prepared and monitored through the Integrated Quality Assurance Board (IQAB) and Quality and Governance Assurance Committee meetings. • Well led review – the work carried out in relation to inclusion and equality was acknowledged but further work will be required in relation to providing support for colleagues from minority groups to progress across the organisation.
18.3	The Board welcomed the report and the Chairman thanked all colleagues for their hard work.
19.	**QUALITY AND PERFORMANCE REPORTS** **Group Board Overview Quadrant – YDH** **Quality and Performance Report – SFT**
19.1	The Chief Finance Officer presented the reports which were received by the Board. She provided an overview of the key performance challenges across both trusts which covered: acute referral to treatment (RTT) times; diagnostics; cancer services; urgent care – A&E 4 hour performance; ambulance handover times; community physical health services waiting times and activity; mental health waiting times and activity; children and young people's eating disorders; out of area placements; infection control; slips, trips and falls; mandatory training; sickness absence; turnover rates; career conversations.
19.2	The Board discussed the report and commented/noted that: • As at 31 December 2022, two YDH and three SFT patients had been waiting over 104 weeks but overall good progress was being made reducing waiting times.

	• The ongoing pressures on a large number of services. The pressure in urgent care services particularly impacted on ambulance handover times. • Referrals into mental health services continue to be higher than the pre Covid-19 period and this continued to impact on performance. • Children and Young People's Eating Disorders – performance was excellent with no breaches in urgent or routine standards in December 2022. • Colorectal cancer referrals had increased by 50% and it was queried whether this increase was linked to a lack of primary care capacity. It was noted that the increase was felt to be due to an increase in awareness about colorectal cancer as a result of recent high profile cases. Although the level of demand had increased, the percentage of positive cancer diagnosis had not increased. The colorectal cancer pathway had been identified as a topic to be further explored at a future Quality and Governance Assurance Committee meeting as it will be important to ensure that plans are in place to respond to the increase in demand. • Stroke services – it was queried what impact the outcome of the stroke consultation will have on SSNAP performance and whether the SSNAP scores will be combined into a single score after the merger. It was noted that the SSNAP scores will continue to be reported on a site by site basis but the consultation outcome will impact on the models provided. • The ED performance in December 2022 indicated challenges in primary care and 111 services and this will need to be kept under close review. The Chief Executive advised that the increase in ED attendance was a mixture of an increase in respiratory illness and children with streptococcus A as well as challenges accessing primary care services. Attendance by head of population in Yeovil was comparatively high and discussions were taking place with the ICB to explore the reasons for the higher attendance in more detail. • It was queried whether evidence was available that a delay in achieving the two week threshold for cancer diagnosis was not impacting on outcomes compared to patients being diagnosed through other referral pathways. The Chief Operating Officer (Hospital Services) advised that the two week target was important in terms of patient experience and the performance issues will be explored at the Quality and Governance Assurance Committee. The 62 day cancer target covered all referral routes and performance can be monitored by referral route. However, irrespective of the referral route, the focus was on ensuring that patients were diagnosed as soon as possible. • Mental health performance was excellent and was meeting expected standards. Although overall acute services performance compared well with other trusts – the highest in the South West over the last few weeks - a number of performance targets were not being met and every effort was

	being made to ensure that the population of Somerset received the best possible service. The Board received assurance that performance metrics were reviewed on a weekly basis. • The number of patients treated out of area had increased and the details of the 14 placements had been scrutinised in detail at the Mental Health Act Committee meeting. Alexander Priest, Chairman of the Mental Health Act Committee, advised that the Committee was satisfied that all placements had been appropriate and that plans were in place to return as many patients as possible to Somerset. Performance will be further reviewed at the March 2023 Committee meeting. • It was queried why there had been a higher contracted full time equivalent (fte) rate at YDH compared to SFT. The Chief Executive advised that an analysis had been undertaken and this showed that the level of increase across both trusts was similar. Further analysis will need to be undertaken to understand the reasons for this increase as the increase did not seem to have impacted on the vacancy rate. • the figure for the average 21+ days length of stay included patients without criteria to reside who were waiting for intermediate care, bedded care, or social care packages to become available.
19.3	The Board acknowledged the areas of good performance and recognised the challenges and the actions being taken to address them.
20.	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**
20.1	The Director of Strategy and Digital Development advised that an update had also been included in the Chief Executive report. He provided the following additional update: • the external review conducted by NHS England was being concluded with final interviews scheduled for 8 February 2023 and a Board to Board meeting scheduled for 23 February 2023. • NHS England will be approving the merger risk rating at its Board meeting to be held on 15 March 2023. Subject to the risk rating, the trust boards will be asked to approve the merger and the Councils of Governors will be asked to approve a recommendation that the Boards have carried out a robust due diligence process. The Boards and Council of Governors meetings have been scheduled for 20 March 2023. • An overview of day one specific actions will be presented to the Confidential Board meeting and these actions mainly focussed on legal, regulatory and technical aspects which will have to be in place by the date of the merger. • Post merger reporting to the Board will focus on progress in relation to the implementation of the clinical integration plans.

20.2	The Board discussed the update and commented/noted that: • The merger and progress made had been widely communicated but feedback from members of the public on the merger itself had been limited. Further communications will be issued prior to the merger. The limited feedback received was mainly focussed on what the merger meant for services in the different geographies rather than on the merger itself. • The Council of Governors will want to be assured about appropriate public engagement and it will be important to set out what actions have been taken. The Director of Strategy and Digital Development advised that the engagement process had been shared with the governor' led Membership and Communications Group but the details will be shared with all governors. • the single leadership team had enabled the waiting times challenges as well as the challenges resulting from the pandemic to be addressed more effectively on a system wide basis and the success of bringing both trusts together should be celebrated. • Although significant media work had taken place, it was recognised that there were some gaps in relation to system wide communications and relationships with stakeholders and options to close these gaps will be further explored with the ICB. • It was important to recognise that the merger will be a merger of SFT as an acute, community and mental health trust and YDH as an acute trust and that the merger will create unique opportunities. It will be helpful to not only focus communications on the integration of acute services but to describe the wider clinical vision the trusts were aiming to achieve.
20.3	The Board noted the merger update.
21.	**LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT**
21.1	Laura Walker joined the meeting for this agenda item. She advised that the reports for both trusts were being aligned and that work was taking place to align processes to ensure robust and consistent systems across both trusts.
21.2	**YDH** The discussion of this item is reflected in the YDH minutes.
21.3	**SFT** Laura Walker presented the report which demonstrated the processes for learning from deaths and how this learning was shared and improvements made.

21.4	The Board received the report and the issues identified as part of the investigations; the lessons learned, areas of improvement and actions taken were noted.
21.5	The Board discussed the report and commented/noted that: • Both the HSMR and SHMI figures were above the expected range and the coding backlog had impacted on the figures. In addition, the impact of end of life coding on the HSMR figures had been explored in detail at previous Board meetings and were well understood. A further analysis of the figures was being undertaken to ensure that the increase in figures was solely due to the coding issues. • No thematic issues had been identified as part of the reviews conducted both by Medical Examiners and the wider team.
21.6	**Joint** The Chief Medical Officer provided an overview of the SHMI and SHMR processes and highlighted: • The different data sources on which the SHMI and HMSR figures were based, with YDH using Dr Foster and SFT using HED, a benchmarking solution developed by University Hospitals Birmingham NHS Foundation Trust. The national system is managed by NHS Digital and their latest data was September 2022. The national SHMI figures for both trusts based on the September 2022 data was within the expected range. • The HSMR data acted as an alarm bell with any negative deviations investigated. • A high HSMR had been reported for SFT for some time and there was a clear understanding that this was due to the coding of end of life services. • The SFT hospital based SHMI was within expected range with exception of Frome community hospital and the reasons had previously been discussed. Whilst a number of community hospitals had triggered deep dives, no thematic themes had been identified. • The YDH HSMR figure was low due to the end of life coding and the Chief Medical Director provided an overview of the palliative coding figures at both YDH and SFT over the last year. Merry Kane advised that the reduction was also due to a post Covid-19 normalisation of the figures. • The HSMR and SHMI figures will continue to be reported separately for each acute site post merger.
21.7	The Board thanked Laura Walker for the excellent reports.

22.	**GUARDIAN OF SAFE WORKING FOR JUNIOR DOCTORS REPORT**
22.1	John McFarlane, Guardian of Safe Working YDH, and Janet Fallon, Guardian of Safe Working SFT, joined the meeting for this agenda item.
22.2	**YDH** The discussion of this item is reflected in the YDH minutes.
22.3	**SFT** Janet Fallon presented the report, which was received by the Board. The Board discussed the report and commented/noted that: • The report provided evidence that the working hours for trainee doctors at SFT remained safe and that the process was working well. • The report showed an upward trend in exception reporting with a total of 174 exceptions reported. The upward trend reflected the pressures faced by trainee doctors working in acute areas of the Trust, with the majority of the exceptions originating from medical specialties. Most exceptions related to the workload on the Acute Medical Unit and general medical on-call shifts. • Eight immediate safety concerns had been raised, five of which related to work in medical specialties. The concerns included incidents relating to medical on-call weekend cover shifts; concerns about safe levels of minimum staffing on the wards; and the impact of managing acutely unwell patients. A working group had been set up to review and address the medical on-call issues and a change had been made to the hospital out of hours weekend arrangements. No further safety concerns had been received following the implementation of the change in cover arrangements. • There had been an increase in the number of missed educational opportunities and this had been raised with the Academy. • Rota management remained challenging and complex and innovation and improvement in rota design and implementation will be required to meet acceptable standards as outlined in the contract and the BMA Good Rostering Guide. It was noted that rota management had been raised previously and it was queried why the rota issues had not as yet been resolved. The Chief of People and Organisational Development advised that work was taking place to bring both rota management teams together and, as part of this work, areas of good practice will be identified and implemented. Stacy Barron-Fitzsimmons will be part of the service group senior team and will be able to support this process.

	External rota management systems were available but will come at high costs and all options will need to be considered to ensure that the rota management system will be as robust as possible and meet the needs of the trusts. • Both trusts had used bank and agency medical staff. The table in the report showed that certain services routinely used bank staff whilst other services routinely used agency staff. It was queried what the reasons for this different approach was. Janet Fallon advised that the emergency department and acute medicine were the highest users of agency staff. The emergency department had set up a bank of locally employed doctors willing to work shifts on an ad-hoc basis. However, in spite of this bank, additional agency cover was required. Other services did not have access to a pool of locally employed doctors and could therefore only use agency staff. Locum cover was often not available at short notice and work will need to take place, especially in medicines, to increase the number of locally employed doctors willing to support shifts. It was noted that YDH had more access to locally employed doctors. John McFarlane however replied that there was an issue in relation to their rate of pay and this had been raised at the recent Hospital Leadership Group meeting. He highlighted details of the negotiations with a local middle grade doctor to cover shifts and felt that a pay review will need to be undertaken to ensure that more shifts can be covered by locally employed doctors as this will reduce the need for more expensive agency cover.
22.4	The Chief Medical Officer thanked John McFarlane and Janet Fallon for their excellent work and engagement with junior doctors. Their senior leadership and reporting to the Board were very important. He advised that the reports are presented to the Senior Operational Management Group/Hospital Leadership Group at each respective trust prior to being presented to the Board but he stressed the importance of ensuring that the reports were also shared with the triumvirate teams as they will be able to provide support in terms of addressing the issues identified. In addition, this extra layer will strengthen the assurance process to the Board.
22.5	The Board accepted the recommendations set out in the report.
22.6	The Chairman thanked Janet Fallon and John McFarlane for their excellent report.
22.7	The Chief Medical Officer advised that Janet Fallon will be stepping down from her role as Guardian of Safe Working and he thanked her for her excellent quality of work and for driving forward fundamental changes at Musgrove Park Hospital. The Board also thanked Janet Fallon for her excellent work. Janet Fallon thanked the Board for its support to her over the last 3.5 years. She advised that her interaction with the Board and senior management team had been positive aspects of her role.

22.8	Janet Fallon and John McFarlane left the meeting.
23.	**ASSURANCE REPORT OF THE PEOPLE AND WORKFORCE COMMITTEE MEETINGS HELD ON 14 NOVEMBER 2022**
23.1	Stephen Harrison presented the report which was received by the Board.
23.2	Stephen Harrison highlighted the areas for follow which related to: sickness absence and turnover; review of the Board Assurance Framework; workforce risks; update on the Violence and Aggression Programme and Freedom to Speak; and health and wellbeing internal audit follow up. The Committee did not identify any significant risks or issues to be reported to the Board.
23.3	Stephen Harrison advised that the last meeting of the Committees took place on 30 January 2023 and the meeting received a helpful presentation on nursing recruitment and retention. It was felt that it will be helpful to share the details with the Board and it was agreed to include this item on the agenda of a future Board Development Day. **Action: Secretary to the Trust.**
23.4	The Board discussed the report and commented/noted that: • It was noted that the ICB's People Committee inaugural meeting will take place on 10 February 2023. Both the Chief Executive and Chief of People and Organisational Development have been invited to the Committee meetings and the Chief of People and Organisational Development will be attending the inaugural meeting. The Chairman highlighted the need to avoid duplication of the work already taking place by the trusts' well established People/Workforce Committees. • It was agreed that workforce risks will need to be assessed on a system wide basis and the trusts' Committees will need to work closely with the ICB Committee in relation to workforce planning. • Considerable workforce planning was taking place across the trusts but there did not seem to be a clear scrutiny of the primary care workforce. The quarterly reports from Symphony had highlighted the challenges recruiting GPs and the impact of the lack of a standardised pay structure for independent GPs on the ability to recruit GPs, and the primary care workforce will need to become one of the key areas of focus for the ICB People Committee. The Chief of People and Organisational Development advised that there will be other workforce related areas to be taken forward by the ICB and these will be discussed at the meeting. • Sube Banerjee, as Executive Dean and Professor of Dementia at the Faculty of Health at University of Plymouth, commented that to date it had been difficult to convince medical students to train as a GP due to negative attitudes about a career in primary care services. Students will need to continue to be encouraged to become a GP and the positive aspects of a career in primary care will continue to be raised.

	• It was noted that Kate Fallon will be taking over as Chairman of the People Committee from 1 April 2023.
23.5	The Chairman complimented Graham Hughes and Stephen Harrison for their ongoing leadership of the Committees and focus on workforce and wellbeing.
24.	**FINANCE REPORTS**
	Finance Report – YDH
24.1	The discussion of this item is reflected in the YDH minutes.
	Finance Report - SFT
24.2	The Chief Finance Officer presented the financial report which was received by the Board. She highlighted the financial position: • An in-month surplus of £409,000 which was in line with the plan for the month. A year to date deficit of £2.955 million which was £863,000 adverse to plan. • Agency spend for the year to date was £22.8 million which was £6.4 million above the same period in 2021/22. • A cumulative £8.4 million cost improvement plan delivery against an end of year forecast of £12.8 million. • An underspend against the capital programme due to slippage of some of the schemes. Spend continued to fall behind plan although the reprofiling of central funding for the Surgical Centre had recently been confirmed by NHSE. This removed the risk of a significant underspend on this scheme in year and pressure in subsequent years. Further schemes had been identified to ensure the capital resources were fully utilised by year end. • Risks going forward included the funding of the escalation capacity; the gap in efficiency schemes; and staffing challenges.
25.	**VERBAL REPORT FROM THE FINANCIAL RESILIENCE COMMERCIAL COMMITTEE/FINANCE COMMITTEE MEETING HELD IN COMMON ON 30 JANUARY 2023**
25.1	Kate Fallon, Chairman of the joint Committee, provided feedback from the meeting held in common on 30 January 2023 and advised that key discussions had focussed on the capital programme; the 2023/24 planning update; and the Somerset TogethEHR Outline Business Case.
25.2	She congratulated the finance teams on their excellent efforts, especially over the last few months, as the late publication of the planning guidance for 2023/24 will have impacted on their ability to prepare financial plans for 2023/24.
25.3	Kate Fallon advised that the performance and finance directorate meetings were working well. She further advised that the Committees will be scrutinising agency expenditure more intensively and a sub group had been set up to look at resource

	based workforce planning for the future. It was recognised that this will be a challenging and complex exercise.
25.4	Barbara Gregory highlighted recent regulatory comments on the level of scrutiny of financial data at Board meetings. She felt that detailed scrutiny at the Financial Resilience and Commercial/Finance Committee meetings was appropriate as the membership of the Financial Resilience and Commercial/Finance Committee included a number of Non-Executive Directors with a financial background. The committees were able to provide the Board with assurance that appropriate scrutiny had taken place.
25.5	The Chairman commented that all Board members had an open invitation to attend the Committee meetings and, when required, all Non-Executive Directors will attend for specific agenda items. The Committee meetings will enable detailed discussions to take place, whilst the time for detailed discussions at Board meetings was more limited. Kate Fallon agreed that the Committee meetings were the best forum for detailed discussions.
25.6	The Chairman and Martyn Scrivens agreed that there was significant financial experience and knowledge amongst Non-Executive Directors on the Committees and that the Board received significant assurance from the Committees.
26.	**ASSURANCE REPORTS FROM THE AUDIT COMMITTEE MEETINGS HELD ON 17 JANUARY 2023** **YDH and SFT Audit Committee meetings held in common**
26.1	Barbara Gregory, Chair of the SFT Audit Committee, presented the report which was received by the Board.
26.2	Paul Mapson highlighted the risks to be reported to the Board which related to: • The number of amber and red rated strategic risks. • The high number of workforce related risks. • The gaps in agency invoice checking controls. • The late submission of colleague termination forms to payroll.
26.3	Paul Mapson advised that the strategic and workforce risks had already been discussed as part of the Board Assurance Framework and Corporate Risk Register discussions. The details of the risks above were set out in the report.
26.4	Barbara Gregory particularly highlighted that internal audit recommendations were followed up as quickly as possible and auditors were complimentary about the actions and quality of actions being taken.
27.	**ASSURANCE REPORT OF THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 13 DECEMBER 2022**

27.1	Alexander Priest, Chair of the Mental Health Act Committee, presented the report which was received by the Board.
27.2	Alexander Priest highlighted the following risks to be reported to the Board: • Mental health bed pressures and delayed discharges. • Timing for assessment under the MHA taking into consideration bed availability. • The need for a review into the mitigations for the admission of patients with sexual safety issues onto a mixed PICU.
27.3	The Chairman thanked the Committee for its excellent work.
28.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
28.1	There were no follow up questions from the Public or Governors.
29.	**ANY OTHER BUSINESS**
29.1	The Chairman advised that this was Matthew Bryant's last formal public Board meeting prior to him moving into a Chief Executive role in Dorset. The Chairman advised that Matthew had been a fantastic colleague and has made tremendous contributions during his time at Taunton and Somerset NHS Foundation Trust (TST) and, following the merger in 2020, at Somerset NHS Foundation Trust (SFT). On behalf of the Board, Colin Drummond wished Matthew every success in his new role.
29.2	Matthew Bryant said that it had been a privilege working with colleagues in TST, SFT and at Yeovil District Hospital NHS Foundation Trust and to be a member of the Board of both SFT and YDH. He had enjoyed working with all colleagues and felt that the Board as a whole had been able to make a difference to colleagues and the population of Somerset. He advised that the post merger vision was the right vision.
30.	**RISKS IDENTIFIED**
30.1	The Board did not identify any new significant risks which had not as yet been included on the risk register but reiterated the increase in risks overall and the workforce risks in particular.
31.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
31.1	The Board agreed that the meeting had been very productive; well chaired and well balanced with focussed discussions.
32.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
32.1	

	The Chairman highlighted the items for discussion at the confidential Board meeting and set out the reasons for including these items on the Confidential Board agenda.
33.	**WITHDRAWAL OF PRESS AND PUBLIC**
33.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
34.	**DATE FOR NEXT MEETING**
34.1	7 March 2023

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

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST BOARD MEETING HELD ON 7 FEBRUARY 2023 BY MS TEAMS

PRESENT

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

IN ATTENDANCE

Colin Drummond	Chairman - SFT
Barbara Gregory	Non-Executive Director – SFT
Kate Fallon	Non-Executive Director - SFT
Stephen Harrison	Non-Executive Director – SFT
Sube Banerjee	Non-Executive Director - SFT
Meridith Kane	Medical Director for Acute Hospitals
Fiona Reid	Director of Communications
Ben Edgar-Attwell	Deputy Director of Corporate Services
Lynn Borthwick	midwife (for item 15 only)
Katarina Harrison-Tvarozkova	Consultant Obstetrics and Gynaecology (for item 15 only)
Kayleigh Sharp	Mumu of twins (for item 15 only)
Laura Walker	Head of Patient Safety and Learning, SFT (for item 22 only)
Janet Fallon	Guardian of Safe Working – SFT (for item 26 only)
John McFarlane	Guardian of Safe Working - YDH (for item 26 only)
James Esleyer	observing
Neil Powell	Inspector, Care Quality Commission

Ian Hawkins	Lead Governor, SFT/Governor, YDH
Kate Butler	Deputy Lead Governor, SFT
Cllr Adam Dance	Governor, YDH
Virginia Membrey	Governor, YDH
Cllr Steve Ashton	Governor, SFT
Tim Slattery	Governor, SFT
Erica Adams	Governor, SFT
Ria Zandvliet	Secretary to the Trust (minute taker)

1.	**APOLOGIES**
1.1	Apologies were received from Jan Hull (Non-Executive Director/Deputy Chairman).
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Colin Drummond will be chairing this public Board meeting.
1.3	Coli Drummond welcomed all Board members, governors, colleagues and other attendees to the meeting and confirmed that both the SFT and YDH meetings were quorate.
2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS**
2.1	No questions from members of the public or governors had been received.
3.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 8 NOVEMBER 2022**
3.1	The approval of the minutes is reflected in the SFT minutes.
4.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 8 NOVEMBER 2022**
4.1	Graham Hughes proposed, Alexander Priest seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 8 November 2022 as a correct record.
5.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 6 DECEMBER 2022**
5.1	The approval of the minutes is reflected in the SFT minutes.

6.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 6 DECEMBER 2022**
6.1	Martyn Scrivens proposed, Graham Hughes seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 6 December 2022 as a correct record.
7.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 20 JANUARY 2023**
7.1	The approval of the minutes is reflected in the SFT minutes.
8.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 20 JANUARY 2023**
8.1	Martyn Scrivens proposed, Alexander Priest seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 20 January 2023 as a correct record.
9.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**
9.1	The Board received the action log and noted the completed actions.
	Minehead League of Friends
9.2	The Director of Corporate Services advised that he had responded to the questions submitted to the Board and, at the request of the League of Friends, Norma Coombes, Senior Matron, had attended their January 2023 meeting to answer any questions. The Minehead Minor Injury Unit was currently experiencing significant operational pressures and a long term same day urgent care strategy will be welcomed. It was noted that we are arranging, with the League of Friends, a meeting including Jonathan Higman, Chief Executive of the Integrated Care Board, in relation to the progress made on the same day urgent care review.
	Ambulance stack
9.3	Martyn Scrivens queried what progress had been made in relation to taking specific patients, e.g. patients who had fallen at home, out of the ambulance stack and what impact this had made. The Chief Executive advised that it had been difficult to set the service up at scale and a meeting had been arranged at lunch time on 7 February 2023 to look at the resources required to support ambulance services.
9.4	The Chief Operating Officer (Mental Health, Families and Neighbourhoods) provided an update on progress made to date and it was noted that 19 urgent community responses had been diverted from the ambulance stack to community services during January 2023. This number was lower than expected but he was optimistic that more progress will be made after the meeting today.

	Community Hospital review
9.5	Discussions had previously taken place about a review of the future role of community hospitals and it was queried what progress had been made. The Chief Executive advised that the need for clarity about the future model of community inpatient care had been raised with the ICB and, although they had acknowledged this need for clarity, a timeframe for agreeing the future model had not as yet been confirmed. It was agreed to further discuss the community hospital model at a future Board development day. **Action: Ria Zandvliet to include this on the Board development day programme.**
	Patient Safety Board
9.6	Barbara Gregory, as patient safety lead, highlighted the recent Patient Safety Board meeting and advised that feedback on the issues raised at the meeting had been presented to the January 2023 Quality and Governance Assurance Committee meeting. The issues raised will be included in the Committee's assurance report to the March 2023 Board meeting.
10.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**
10.1	The Board received the Register of Directors' interest. The Board noted the following changes to the register: • Peter Lewis – to remove "Director, Yeovil Property Operating Company Limited" • Graham Hughes – to remove "Volunteer Advisor at Citizens Advice"
11.	**CHAIRMEN'S REMARKS**
11.1	Colin Drummond advised that the last few months had been particularly challenging for all colleagues and, on behalf of the Board, thanked them for their continued hard work. Colin Drummond also commended the executive team on their management of the impact of the industrial actions.
11.2	He advised that the trusts had been forced into challenging situations and they tried to do their best to take patients out of the ambulance stack; and ensure that escalation and boarding beds were available. These additional pressures and functioning in crisis mode will however not be sustainable in the longer term.
	Board Committee Membership
11.3	Colin Drummond presented the overview of Non-Executive Director Board Committee membership which was received by the Board. Colin Drummond advised that Committee membership was in line with the Committees' Terms of References for the post merger organisation and thanked all Non-Executive Directors for their ongoing hard work and for being flexible about Committee membership.

12.	**CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**
12.1	The Chief Executive presented the report which was received by the Board. He advised that the report set out a number of significant and positive developments and specifically highlighted the consultation on the options for acute hospital-based stroke services in Somerset; the levelling up funding for the establishment of a training academy for health and social care and the benefits of the training academy; and the recent positive media coverage.
12.2	The Chief Operating Officer (Hospital Services) provided an update on the ongoing significant operational pressures and actions being taken and highlighted: • The escalation position - MPH - all acute escalation beds had been opened at the beginning of January 2023 and additional pre-emptive boarding arrangements had been set up to be able to manage the pressures. The escalation and boarding arrangements were eased in the middle of the month but, in view of the increased operational pressures, had subsequently been reinstated. Musgrove Park Hospital (MPH) was currently managing 74 escalation beds, which included nine pre-emptive boarding beds. These escalation beds will need to remain in place in view of the delays in discharges and resulting long length of stays. - YDH – 38 escalation beds had been opened at YDH with a further ten pre-emptive boarding beds. • Delayed discharges - MPH - 128 patients with a length of stay of over 21 days which was particularly high compared to pre Covid-19 standards. 120 of these patients were medically fit for discharge but were awaiting intermediate care, bedded care or other care packages. - YDH – the number of delayed discharges (87) was proportionally higher than at MPH as social care capacity in the South Somerset area was particularly challenging. • The ambulance handover position – the trusts took the view that as much risk as possible should be held in urgent care services so that ambulance handover times can be kept to a minimum, but this approach increased the pressures in urgent care services. • The infection control position - MPH currently had 36 inpatients with Covid-19 or flu and 33 inpatients with a respiratory infection and, in terms of infection control, these groups of patients will need to be managed in a different way. - YDH – the number of patients with Covid-19 (20) or flu (13) was proportionally higher at YDH than at MPH. • Staff sickness had increased and this was mainly due to Covid-19 or flu infections amongst staff.

12.3	The Chief Operating Officer (Hospital Services) advised that there were currently 103 patients waiting for supported discharge pathways and it had been agreed with social care partners and the Integrated Care Board (ICB) to reduce this number to 75 or below by 10 February 2023.
12.4	The Board discussed the report and commented/noted that: • Pre-emptive boarding beds were used for low risk patients only. The term "boarding beds" was used for instances where a patient was admitted to a ward whilst awaiting for a bed to become available. It was noted that all boarding areas in acute and community hospitals had been assessed by the health and safety team, fire officer and senior clinicians to ensure that these areas were safe. A decision to use boarding beds was only taken in exceptional circumstances but instances where boarding beds had to be used had increased over the last few weeks. • A significant amount of leadership support was provided in relation to the care of patients and support to colleagues. Colleagues had expressed their concerns about the escalation and boarding approach and we recognise that the use of escalation and boarding beds should be limited to the absolute minimum and not become normalised. Colleagues will continue to be encouraged to raise their concerns either through their line manager, incident reporting process or through the Freedom to Speak Up Guardians. It was recognised that the pressures had an impact on colleagues and all Board members were encouraged to speak to colleagues and listen to their concerns. • It was queried whether comparative performance data was available. The Chief Nurse advised that regular contact was made with trusts in the South West region and all trusts were under similar pressures. There was variation in terms of the approach taken in relation to the management of patients arriving by ambulance and the Trust's approach of taking the risk into hospitals to avoid holding patients in the ambulance had resulted in higher escalation and boarding requirements. The difference in approach therefore made it more difficult to compare performance on a like for like basis. It will be key to focus on bed occupancy, including boarding beds, against the core bed capacity as this will provide more accurate data. • The Chief Operating Officer (Hospital Services) advised that the level of acute pre-emptive boarding beds was not out of line with other trusts in the South West area. The level of escalation beds, including the doubling up of beds in the Jubilee building, was high and, although it was recognised that this was due to the risk approach to be able to keep ambulance handover times to a minimum and manage patients within the emergency department, these pressures had continued for considerable time. • The approach taken by the trusts was the right approach and was to the benefit of patients. There was a risk that the good ambulance handover times performance gave the impression at a regulatory level that Somerset was not experiencing the same challenges as in other areas. It was

	queried whether regulators were aware of the different risk approach. The Chief Executive advised that there was a real risk that Somerset performance data was seen as better than it actually was but every opportunity was taken to communicate the approach taken by the trusts and the impact on performance data to regulators. He felt that just looking at numbers did not provide a clear picture and comparative information will need to better reflect the different approaches. • Funding had been provided to the Local Authority to improve discharge pathways and it was queried whether this funding was being used effectively. The NHS was currently carrying the costs for patients without criteria to reside and these costs were higher than the costs of intermediate care, bedded care or social care packages. It was queried whether social care funding had been raised as a limiting factor in addressing the social care challenges. The Chief Executive advised that discussions had taken place with the Local Authority about their plans for 2023/24, including the financial aspects, and a meeting had been set up for the end of February 2023 to discuss the plans in more detail and this will include how to ensure that the additional social care funding will be used most effectively. Going forward, it will be important to move away from referring to health or social care funding as the overarching focus should be on what is best for the population of Somerset. • A recent announcement was made about 5,000 new beds and funding but it was stressed that expectations for Somerset should be carefully managed as there was no space left on the acute estates to set up more modular units and, in addition, it was not clear whether the funding was ”new funding”. The challenges and pressures were significant and modular units on their own would not solve the patient flow and workforce capacity challenges. The Chief Executive commented that it was not felt that more acute beds were required and the focus should be on ensuring that patients were in the right bed for their needs. Additional beds will not solve the longer term challenges and workforce will not be available to staff any additional beds. Additional beds were put in at YDH but this was as part of the redevelopment of the YDH site. **Industrial Action**
12.5	The Chief Nurse provided an update on the industrial actions and it was noted that the RCN will be holding a second two day action at SFT. The two day action made planning more difficult and it was important to bear in mind that the dispute was between nurses and the government and not with the trusts. It was noted that a legal framework for the safe withdrawal of labour was in place and the Chief of People and Organisational Development was working closely with the Strike Committee to plan the safe withdrawal of labour and the level of derogation.
12.6	The Chief Nurse advised that there was significant support for the strike action. The strike would have an impact on patients due to the large number of cancellations and a further impact on colleagues not involved in the strike. Planning for the strike action was progressing well.

12.7	It was queried whether the ambulance strikes had impacted on the trusts and it was noted that the impact had been minimal.
13.	**Q3 2022/23 BOARD ASSURANCE FRAMEWORKS**
13.1	The Director of Corporate Services presented the updated Q3 2022/23 Board Assurance Frameworks (BAF) for SFT and YDH which were received by the Board. The BAFs had been discussed by the Audit Committee, Executive Team and relevant sub Committees since the November 2022 Board meeting.
13.2	The Director of Corporate Services advised that the overall assessment In terms of level of risk was consistent across both organisations and the highest risks identified within the Assurance Frameworks continued to relate to: • the impact of pressures and capacity shortfalls in social care and intermediate care (objectives 2, 3 and 8) • insufficient capacity to meet demand (objectives 7 and 8) • infrastructure investment and ageing estate (objectives 2 and 8) • the impact of pressures in primary care (objectives 2, 3 and 5) • workforce recruitment and retention (objectives 3 and 6) • the impact of the pandemic (objective 5) • delivery of financial plans (objectives 7 and 8).
13.3	The Director of Corporate Services advised that four of the highest strategic risks had increased and the BAFs clearly showed the pressures and challenges across both trusts and in the wider health system. He highlighted the key areas of progress and areas of concern for objectives one and eight which were reserved to the Board.
13.4	The Board discussed the report and commented/noted that: • mapping of the risks on the BAF and the Corporate Risk Registers had been undertaken to ensure that the risks across both the BAF and corporate risk registers were aligned. • An update on the dementia strategy had been presented to a recent Quality and Governance Assurance Committee meeting and it was suggested including a patient story/clinical topic on dementia and delirium at a future Board meeting. • Some of the out of hospital schemes were under performing, including the Hospital at Home scheme, and this was linked to the work in relation to the ambulance stack. The Chief Operating Officer (Mental Health, Families and

Neighbourhoods) commented that the Hospital at Home scheme was a vital part of the out of hospital strategy going forward. The limited amount of progress made was linked to the ability to take patients from the ambulance stack. There was no strong history of what the out of hospital service should look like but the aim was for 2/3 of the service capacity to focus on admission avoidance and 1/3 on facilitating early discharge. Good progress was being made recruiting to the team but the remote monitoring equipment will not arrive until March 2023 and this equipment will be essential to the success of the service. In spite of the challenges and the slow start, every effort will be made to make this service a success and embed this new way of working. It was noted that capacity will continue to be built up over the summer and it was expected that the service will be fully functioning by the autumn.

There were a number of out of hospital pathways and alternatives to admissions already in place or being developed and it was queried whether the referral processes into the different services will be simplified as all services shared the same patient base. The Chief Operating Officer (Mental Health, Families and Neighbourhoods) agreed that there had been a number of initiatives for community services, each with their own requirements and specification and where possible the initiatives have been joined up. The Hospital at Home initiative was an extension of the Rapid Response Service but with a locality base and a single point of contact with the primary link call centre. A single point of contact was however not in place for the discharge pathways and, following a deep dive into these pathways, it was recognised that the pathways will need to be simplified and a review of the pathways and options to simplify processes was currently being caried out.

- The number of amber and red rated strategic objectives was felt to be a concern especially at the end of the year and it was felt that the amber rating indicated that the issues were not understood or being resolved. The Director of Corporate Services advised that the amber rating indicated that plans were in place to deliver the strategic objective but that the plans will not be fully implemented in the current financial year. Barbara Gregory reiterated that she would have expected there to be no amber or red rated strategic objectives at this time of the year. The Chief Executive responded that the key risks related to capacity, patient flow and demand and these will need to be mitigated at system level as actions were not solely in the trusts' control. It was, however, important to ensure that these levels of risk were not normalised.

- Strategic objective 1 – improving the health and wellbeing of the population. Although progress was being made, this progress was not fully visible, especially the aspects involving the Integrated Care Board (ICB) and social care services and it was therefore suggested dedicating time at a future Board Development Day to explore this objective and system actions in more detail. The Chief Executive advised that progress was being made implementing processes which will make a difference to the wellbeing of the population but it will take some time for the benefits to become visible through improvements in outcomes. The Chief Executive acknowledged that some delays had been experienced due to changes in organisational form both at

	the ICB and Local Authority. The Chief Executive agreed to provide a detailed update at a future Board Development Day. **Action: Chief Executive**. • It was highlighted that some of the objectives had been rated green whilst a number of related risks on the corporate risk register had been rated red, e.g. workforce related risks. The Chief Executive advised that considerable strategic workforce planning was taking place and this was reflected in the green rating for strategic objective six.
13.5	Colin Drummond thanked the Board members for the detailed discussion and highlighted: the need for clear communications about the public health agenda; the increased involvement of the third sector due to the reduction in NHS and social care resources; the challenges faced by primary care services; and the high number of patients with no criteria to reside. The majority of these issues were outside of the control of the trusts but impacted on all services provided by the trusts.
13.6	The Board noted the Board Assurance Frameworks, the level of risks and the actions taken to mitigate the risks.
14.	**Q3 2022/23 CORPORATE RISK REGISTER PROGRESS REPORTS**
14.1	The Director of Corporate Services presented the Q3 2022/23 Corporate Risk Register progress report which was received by the Board.
14.2	The Director of Corporate Services highlighted: • The common areas of risks identified across both trusts. • The total of 65 risks on the combined risk register – 44 SFT and 21 YDH risks – 21 of which scored 20 and above, with the majority of these risks relating to SFT. This evidenced a continued increase in the numbers of high level risks on the corporate risk register in the last six months. Details of these risks and the new risks were noted. • 11 new risks had been added since the last report and the risk rating of five risks had increased.
14.3	The Board discussed the report and commented/noted that: • The number of high risks reflected the extreme pressures on services and on colleagues. • It will not be possible to mitigate all risks and a decision will need to be made as to which risks to tolerate. It was suggested categorising the risks into risks which can be tolerated and risks will need to be prioritised in terms of mitigation. The Director of Corporate Services agreed that it will not be possible to mitigate all risks in the current year and discussions as

	to which risks to tolerate in the short term will take place at the next Quality and Governance Assurance Committee meetings. • Significant work was taking place but the level of risks felt uncomfortable. Not all risks were in the direct control of the trusts as some of the risks were linked to national strategic issues. It was suggested that it will be helpful to distinguish between risks which were in control of the trusts and risks which could not be controlled. • It was noted that the risk management strategy will be presented to the March 2023 Board for approval and the strategy will set out general risk appetite and tolerance principles. • Discussions will be taking place with the ICB about the management of system wide risks.
14.4	The Board thanked the Director of Corporate Services for his, and the team's ongoing focus on risk management.
15.	**PATIENT STORY AND CLINICAL TOPIC ON THE TWIN CLINIC**
15.1	The Chief Nurse introduced the Lynn Borthwick (midwife); Katarina Harrison-Tvarozkova (Consultant Obstetrics and Gynaecology) and Kayleigh Sharp (mum of twins).
15.2	Katarina Harrison-Tvarozkova advised that she had been appointed to her current role at Musgrove Park Hospital in 2021 and had set up the twin clinic to be able to make a difference to the outcome of twin pregnancies. She advised that Kayleigh Sharp had been one of the first mums to use the new service and had been invited to talk about her experience using the service.
15.3	Kayleigh Sharp provided feedback on the care she and her twins received whilst under the care of the twin clinic and highlighted the excellent support received. She further highlighted the difficulties she had faced during her pregnancy and the positive impact the care provided at the twin clinic had on her wellbeing. She was able to ask questions; all aspects of her care were well explained; and she was well supported. Kayleigh was confident that without the twin clinic she would not have had such a positive outcome. She further highlighted the contact she had been able to make with other twin parents and her ongoing contact with the service.
15.4	Katarina Harrison-Tvarozkova and Colin Drummond thanked Kayleigh for her feedback. Kayleigh Sharp left the meeting.
15.5	Katarina Harrison-Tvarozkova and Lynn Borthwick provided details of the work of the twin clinic and highlighted: • the excellent support provided by midwifes.

	• the reasons for multiple pregnancies; overview of multiple pregnancies and baby deaths over the last few years. • Guidance and standards – Savings Babies Lives Version 2 – Ockenden Report; the MBRRACE-UK Saving Lives Improving Mothers' Care recommendations; the NICE guidelines on twin and triplet pregnancies. • The type and level of care provided prior to implementation of the twin clinic. • The establishment of the twin clinic and the changes to the service – including the implementation of the NICE guidelines. • The improvements made to twin pregnancy outcomes following the establishment of the twin clinic. • the next steps: the QI project and the benefits of signing up to and using the QI project; the twins trust maternity project which was aimed at reducing still births, neonatal admissions, deaths and increasing natural births. • The positive impact on Musgrove Park Hospital (MPH) including the significant financial savings; the zero still births and neonatal deaths; and the reduction in neonatal admissions.
15.6	The Board discussed the presentation and commented/noted that: • The twin clinic was currently only available at MPH and it was noted that contact had been made with clinicians at Yeovil District Hospital (YDH) about extending this service to YDH. Two options could be considered - using the same team across both YDH and MPH or train the YDH team on the twin clinical model. • The Chief Medical Officer supported the roll out of the service to YDH and advised that it will be helpful to discuss this further with the YDH clinicians at an away day in the near future. • The service was solely focussed on twin pregnancies and other high risk pregnancies were managed by specific obstetric specialists, e.g. diabetes, long term conditions. However it was felt that further improvements to services provided to high risk pregnancies could be made.
15.7	The Board thanked Katarina Harrison-Tvarozkova and Lynn Borthwick for their excellent work and improvements to outcomes for mums and twins.
15.8	Katarina Harrison-Tvarozkova and Lynn Borthwick left the meeting.

16.	**ASSURANCE REPORT OF THE QUALITY AND PERFORMANCE/ GOVERNANCE AND QUALITY ASSURANCE COMMITTEE MEETING HELD ON 23 NOVEMBER 2022**
16.1	Graham Hughes presented the report which was received by the Board. He highlighted the areas of assurance received and the areas to be reported to the Board. These areas related to: • The Health and Safety Executive Improvement Notice relating to the use of safer medical sharps in theatres – the Committee had received assurance about the progress made in implementing the action plan at its January 2023 meeting. • The update on the Homicide reports including the Duty of Candour audit and review. • The deteriorating patients internal audit findings. • The strategic objectives risk tolerance levels.
16.2	Details of these areas were set out in the report and were noted.
16.3	The Board discussed the report and commented/noted that: • The Health and Safety Executive (HSE) Improvement Notice – a further visit by the HSE was expected on 1 March 2023 and feedback from this visit will be provided to the March 2023 Board meeting. • Draft Independent Homicide Report – the publication of the final report was now not expected until May 2023. • Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services – a review of the recommendations set out in the letter from Claire Murdoch had been completed and an action plan had been published on the trust's website.
16.4	Colin Drummond thanked Graham Hughes for the update and thanked the Committee for its assurances.
17.	There was no item 17 on the agenda.
18.	**CARE QUALITY COMMISSION (CQC) INSPECTION REPORT**
18.1	The discussion of this item is included in the SFT minutes.

19.	**QUALITY AND PERFORMANCE REPORTS** **Group Board Overview Quadrant – YDH** **Quality and Performance Report – SFT**
19.1	The Chief Finance Officer presented the reports which were received by the Board. She provided an overview of the key performance challenges across both trusts which covered: acute referral to treatment (RTT) times; diagnostics; cancer services; urgent care – A&E 4 hour performance; ambulance handover times; community physical health services waiting times and activity; mental health waiting times and activity; children and young people's eating disorders; out of area placements; infection control; slips, trips and falls; mandatory training; sickness absence; turnover rates; career conversations.
19.2	The Board discussed the report and commented/noted that: • As at 31 December 2022, two YDH and three SFT patients had been waiting over 104 weeks but overall good progress was being made reducing waiting times. • The ongoing pressures on a large number of services. The pressure in urgent care services particularly impacted on ambulance handover times. • Referrals into mental health services continue to be higher than the pre Covid-19 period and this continued to impact on performance. • Children and Young People's Eating Disorders – performance was excellent with no breaches in urgent or routine standards in December 2022. • Colorectal cancer referrals had increased by 50% and it was queried whether this increase was linked to a lack of primary care capacity. It was noted that the increase was felt to be due to an increase in awareness about colorectal cancer as a result of recent high profile cases. Although the level of demand had increased, the percentage of positive cancer diagnosis had not increased. The colorectal cancer pathway had been identified as a topic to be further explored at a future Quality and Governance Assurance Committee meeting as it will be important to ensure that plans are in place to respond to the increase in demand. • Stroke services – it was queried what impact the outcome of the stroke consultation will have on SSNAP performance and whether the SSNAP scores will be combined into a single score after the merger. It was noted that the SSNAP scores will continue to be reported on a site by site basis but the consultation outcome will impact on the models provided. • The ED performance in December 2022 indicated challenges in primary care and 111 services and this will need to be kept under close review. The Chief Executive advised that the increase in ED attendance was a mixture of an increase in respiratory illness and children with streptococcus A as well as challenges accessing primary care services. Attendance by

	head of population in Yeovil was comparatively high and discussions were taking place with the ICB to explore the reasons for the higher attendance in more detail. • It was queried whether evidence was available that a delay in achieving the two week threshold for cancer diagnosis was not impacting on outcomes compared to patients being diagnosed through other referral pathways. The Chief Operating Officer (Hospital Services) advised that the two week target was important in terms of patient experience and the performance issues will be explored at the Quality and Governance Assurance Committee. The 62 day cancer target covered all referral routes and performance can be monitored by referral route. However, irrespective of the referral route, the focus was on ensuring that patients were diagnosed as soon as possible. • Mental health performance was excellent and was meeting expected standards. Although overall acute services performance compared well with other trusts – the highest in the South West over the last few weeks - a number of performance targets were not being met and every effort was being made to ensure that the population of Somerset received the best possible service. The Board received assurance that performance metrics were reviewed on a weekly basis. • The number of patients treated out of area had increased and the details of the 14 placements had been scrutinised in detail at the Mental Health Act Committee meeting. Alexander Priest, Chairman of the Mental Health Act Committee, advised that the Committee was satisfied that all placements had been appropriate and that plans were in place to return as many patients as possible to Somerset. Performance will be further reviewed at the March 2023 Committee meeting. • It was queried why there had been a higher contracted full time equivalent (fte) rate at YDH compared to SFT. The Chief Executive advised that an analysis had been undertaken and this showed that the level of increase across both trusts was similar. Further analysis will need to be undertaken to understand the reasons for this increase as the increase did not seem to have impacted on the vacancy rate. • the figure for the average 21+ days length of stay included patients without criteria to reside who were waiting for intermediate care, bedded care, or social care packages to become available.
19.3	The Board acknowledged the areas of good performance and recognised the challenges and the actions being taken to address them.

20.	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**
20.1	The Director of Strategy and Digital Development advised that an update had also been included in the Chief Executive report. He provided the following additional update: • the external review conducted by NHS England was being concluded with final interviews scheduled for 8 February 2023 and a Board to Board meeting scheduled for 23 February 2023. • NHS England will be approving the merger risk rating at its Board meeting to be held on 15 March 2023. Subject to the risk rating, the trust boards will be asked to approve the merger and the Councils of Governors will be asked to approve a recommendation that the Boards have carried out a robust due diligence process. The Boards and Council of Governors meetings have been scheduled for 20 March 2023. • An overview of day one specific actions will be presented to the Confidential Board meeting and these actions mainly focussed on legal, regulatory and technical aspects which will have to be in place by the date of the merger. • Post merger reporting to the Board will focus on progress in relation to the implementation of the clinical integration plans.
20.2	The Board discussed the update and commented/noted that: • The merger and progress made had been widely communicated but feedback from members of the public on the merger itself had been limited. Further communications will be issued prior to the merger. The limited feedback received was mainly focussed on what the merger meant for services in the different geographies rather than on the merger itself. • The Council of Governors will want to be assured about appropriate public engagement and it will be important to set out what actions have been taken. The Director of Strategy and Digital Development advised that the engagement process had been shared with the governor' led Membership and Communications Group but the details will be shared with all governors. • the single leadership team had enabled the waiting times challenges as well as the challenges resulting from the pandemic to be addressed more effectively on a system wide basis and the success of bringing both trusts together should be celebrated. • Although significant media work had taken place, it was recognised that there were some gaps in relation to system wide communications and relationships with stakeholders and options to close these gaps will be further explored with the ICB.

	• It was important to recognise that the merger will be a merger of SFT as an acute, community and mental health trust and YDH as an acute trust and that the merger will create unique opportunities. It will be helpful to not only focus communications on the integration of acute services but to describe the wider clinical vision the trusts were aiming to achieve.
20.3	The Board noted the merger update.
21.	**LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT**
21.1	Laura Walker joined the meeting for this agenda item. She advised that the reports for both trusts were being aligned and that work was taking place to align processes to ensure robust and consistent systems across both trusts.
	YDH
21.2	Laura Walker presented the report and advised that the report reflected the ongoing progress with Medical Examiners identifying cases requiring further investigation through Mortality Reviews or Clinical Investigation and the difficulties experienced when demand exceeds capacity to complete Mortality Reviews.
21.3	The Board received the report and the issues identified as part of the investigations; the lessons learned, areas of improvement and actions taken were noted.
21.4	The Board discussed the report and commented/noted that:
	• There had been an increase in the number of reviews undertaken by the Medical Examiners and this provided the Board with an increased level of assurance.
	• Learning relating to the completion of treatment escalation plans had been identified. A training programme was being implemented and good progress was already being made.
	• The HSMR figures remain within an expected range.
	• No thematic issues had been identified as part of the reviews conducted both by Medical Examiners and the wider team.
	SFT
21.5	The discussion of this item is included in the SFT minutes.
	Joint
21.6	The Chief Medical Officer provided an overview of the SHMI and SHMR processes and highlighted:

	• The different data sources on which the SHMI and HMSR figures were based, with YDH using Dr Foster and SFT using HED, a benchmarking solution developed by University Hospitals Birmingham NHS Foundation Trust. The national system is managed by NHS Digital and their latest data was September 2022. The national SHMI figures for both trusts based on the September 2022 data was within the expected range. • The HSMR data acted as an alarm bell with any negative deviations investigated. • A high HSMR had been reported for SFT for some time and there was a clear understanding that this was due to the coding of end of life services. • The SFT hospital based SHMI was within expected range with exception of Frome community hospital and the reasons had previously been discussed. Whilst a number of community hospitals had triggered deep dives, no thematic themes had been identified. • The YDH HSMR figure was low due to the end of life coding and the Chief Medical Director provided an overview of the palliative coding figures at both YDH and SFT over the last year. Merry Kane advised that the reduction was also due to a post Covid-19 normalisation of the figures. • The HSMR and SHMI figures will continue to be reported separately for each acute site post merger.
21.7	The Board thanked Laura Walker for the excellent reports.
22.	**GUARDIAN OF SAFE WORKING FOR JUNIOR DOCTORS REPORT**
22.1	John McFarlane, Guardian of Safe Working YDH, and Janet Fallon, Guardian of Safe Working SFT, joined the meeting for this agenda item.
22.2	**YDH** John McFarlane presented the report which was received by the Board.
22.3	The Board discussed the report and commented/noted that: • 95 exception reports had been received with the majority relating to the number of hours worked. In the majority of these instances, overtime payments had been made. • The report provided evidence that the working hours for trainee doctors at YDH remained safe. • Ten immediate safety concern had been raised relating to the workload of junior doctors – four of which had been put in error. The rota team had

	been able to bring in additional locums but there remained rota gaps. Contingency plans have now been put in place but have not as yet been required. • The number of exception reports had almost doubled compared to the average number of exception reports and this was due to the volume of admissions and pressures on discharging patients. • The Foundation Programme Director has sent out a letter to all junior doctors to advise them of impending redeployment for periods of 48 to 72 hours if required due to pressures in other services. The letter has given junior doctor assurance that their concerns are being listened to and acted upon.
22.4	Colin Drummond thanked John McFarlane for his excellent management of the Guardian of Safe Working process.
	SFT
22.5	The discussion of this item is included in the SFT minutes.
	Joint
22.6	The Chief Medical Officer thanked John McFarlane and Janet Fallon for their excellent work and engagement with junior doctors. Their senior leadership and reporting to the Board were very important. He advised that the reports are presented to the Senior Operational Management Group/Hospital Leadership Group at each respective trust prior to being presented to the Board but he stressed the importance of ensuring that the reports were also shared with the triumvirate teams as they will be able to provide support in terms of addressing the issues identified. In addition, this extra layer will strengthen the assurance process to the Board.
22.7	The Board accepted the recommendations set out in the report.
22.8	Colin Drummond thanked Janet Fallon and John McFarlane for their excellent report.
22.9	The Chief Medical Officer advised that Janet Fallon will be stepping down from her role as Guardian of Safe Working and he thanked her for her excellent quality of work and for driving forward fundamental changes at Musgrove Park Hospital. The Board also thanked Janet Fallon for her excellent work. Janet Fallon thanked the Board for its support to her over the last 3.5 years. She advised that her interaction with the Board and senior management team had been positive aspects of her role.
22.10	Janet Fallon and John McFarlane left the meeting.

23.	**ASSURANCE REPORT OF THE PEOPLE AND WORKFORCE COMMITTEE MEETINGS HELD ON 14 NOVEMBER 2022**
23.1	Stephen Harrison presented the report which was received by the Board.
23.2	Stephen Harrison highlighted the areas for follow which related to: sickness absence and turnover; review of the Board Assurance Framework; workforce risks; update on the Violence and Aggression Programme and Freedom to Speak; and health and wellbeing internal audit follow up. The Committee did not identify any significant risks or issues to be reported to the Board.
23.3	Stephen Harrison advised that the last meeting of the Committees took place on 30 January 2023 and the meeting received a helpful presentation on nursing recruitment and retention. It was felt that it will be helpful to share the details with the Board and it was agreed to include this item on the agenda of a future Board Development Day. **Action: Secretary to the Trust.**
23.4	The Board discussed the report and commented/noted that: • It was noted that the ICB's People Committee inaugural meeting will take place on 10 February 2023. Both the Chief Executive and Chief of People and Organisational Development have been invited to the Committee meetings and the Chief of People and Organisational Development will be attending the inaugural meeting. Colin Drummond highlighted the need to avoid duplication of the work already taking place by the trusts' well established People/Workforce Committees. • It was agreed that workforce risks will need to be assessed on a system wide basis and the trusts' Committees will need to work closely with the ICB Committee in relation to workforce planning. • Considerable workforce planning was taking place across the trusts but there did not seem to be a clear scrutiny of the primary care workforce. The quarterly reports from Symphony had highlighted the challenges recruiting GPs and the impact of the lack of a standardised pay structure for independent GPs on the ability to recruit GPs, and the primary care workforce will need to become one of the key areas of focus for the ICB People Committee. The Chief of People and Organisational Development advised that there will be other workforce related areas to be taken forward by the ICB and these will be discussed at the meeting. • Sube Banerjee, as Executive Dean and Professor of Dementia at the Faculty of Health at University of Plymouth, commented that to date it had been difficult to convince medical students to train as a GP due to negative attitudes about a career in primary care services. Students will need to continue to be encouraged to become a GP and the positive aspects of a career in primary care will continue to be raised. • It was noted that Kate Fallon will be taking over as Chairman of the People Committee from 1 April 2023.

23.5	Colin Drummond complimented Graham Hughes and Stephen Harrison for their ongoing leadership of the Committees and focus on workforce and wellbeing.
24.	**FINANCE REPORTS**
	Finance Report – YDH
24.1	The Chief Finance Officer presented the financial report which was received by the Board. She highlighted the financial position: • An in-month surplus of £234,000 in line with the plan. The year to date was a negative variance of £133,000 in line with the plan. • Agency spend remained higher than plan and this was driven both by SHS locum and trust agency expenditure due to an increase in non elective activity and sickness absence. • A £3.924 million cost improvement plan delivery against £3.078 million planned efficiencies, of which 21% had been achieved recurrently. • An underspend against the capital programme. The programme will be revised after agreement by NHS England to reprofile funding for the theatre schemes. • The year to date position included £2.289 million pay award funding above plan and an additional £1.405 million reimbursement of Covid-19 costs (testing) incurred outside of the system funding envelope.
	Finance Report - SFT
24.2	The discussion of this item is included in the SFT minutes.
25.	**VERBAL REPORT FROM THE FINANCIAL RESILIENCE COMMERCIAL COMMITTEE/FINANCE COMMITTEE MEETING HELD IN COMMON ON 30 JANUARY 2023**
25.1	Kate Fallon, Chairman of the joint Committee, provided feedback from the meeting held in common on 30 January 2023 and advised that key discussions had focussed on the capital programme; the 2023/24 planning update; and the Somerset TogethEHR Outline Business Case.
25.2	She congratulated the finance teams on their excellent efforts, especially over the last few months, as the late publication of the planning guidance for 2023/24 will have impacted on their ability to prepare financial plans for 2023/24.
25.3	Kate Fallon advised that the performance and finance directorate meetings were working well. She further advised that the Committees will be scrutinising agency expenditure more intensively and a sub group had been set up to look at resource based workforce planning for the future. It was recognised that this will be a challenging and complex exercise.

25.4	Barbara Gregory highlighted recent regulatory comments on the level of scrutiny of financial data at Board meetings. She felt that detailed scrutiny at the Financial Resilience and Commercial/Finance Committee meetings was appropriate as the membership of the Financial Resilience and Commercial/Finance Committee included a number of Non-Executive Directors with a financial background. The committees were able to provide the Board with assurance that appropriate scrutiny had taken place.
25.5	Colin Drummond commented that all Board members had an open invitation to attend the Committee meetings and, when required, all Non-Executive Directors will attend for specific agenda items. The Committee meetings will enable detailed discussions to take place, whilst the time for detailed discussions at Board meetings was more limited. Kate Fallon agreed that the Committee meetings were the best forum for detailed discussions.
25.6	Colin Drummond and Martyn Scrivens agreed that there was significant financial experience and knowledge amongst Non-Executive Directors on the Committees and that the Board received significant assurance from the Committees.
26.	**ASSURANCE REPORTS FROM THE AUDIT COMMITTEE MEETINGS HELD ON 17 JANUARY 2023** **YDH and SFT Audit Committee meetings held in common**
26.1	Barbara Gregory, Chair of the SFT Audit Committee, presented the report which was received by the Board.
26.2	Paul Mapson highlighted the risks to be reported to the Board which related to: • The number of amber and red rated strategic risks. • The high number of workforce related risks. • The gaps in agency invoice checking controls. • The late submission of colleague termination forms to payroll.
26.3	Paul Mapson advised that the strategic and workforce risks had already been discussed as part of the Board Assurance Framework and Corporate Risk Register discussions. The details of the risks above were set out in the report.
26.4	Barbara Gregory particularly highlighted that internal audit recommendations were followed up as quickly as possible and auditors were complimentary about the actions and quality of actions being taken.
27.	**ASSURANCE REPORT OF THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 13 DECEMBER 2022**
27.1	Alexander Priest, Chair of the Mental Health Act Committee, presented the report which was received by the Board.

27.2	Alexander Priest highlighted the following risks to be reported to the Board: • Mental health bed pressures and delayed discharges. • Timing for assessment under the MHA taking into consideration bed availability. • The need for a review into the mitigations for the admission of patients with sexual safety issues onto a mixed PICU.
27.3	Colin Drummond thanked the Committee for its excellent work.
28.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
28.1	There were no follow up questions from the Public or Governors.
29.	**ANY OTHER BUSINESS**
29.1	Colin Drummond advised that this was Matthew Bryant's last formal public Board meeting prior to him moving into a Chief Executive role in Dorset. Colin Drummond advised that Matthew had been a fantastic colleague and has made tremendous contributions during his time at Taunton and Somerset NHS Foundation Trust (TST) and, following the merger in 2020, at Somerset NHS Foundation Trust (SFT). On behalf of the Board, Colin Drummond wished Matthew every success in his new role.
29.2	Matthew Bryant said that it had been a privilege working with colleagues in TST, SFT and at Yeovil District Hospital NHS Foundation Trust and to be a member of the Board of both SFT and YDH. He had enjoyed working with all colleagues and felt that the Board as a whole had been able to make a difference to colleagues and the population of Somerset. He advised that the post merger vision was the right vision.
30.	**RISKS IDENTIFIED**
30.1	The Board did not identify any new significant risks which had not as yet been included on the risk register but reiterated the increase in risks overall and the workforce risks in particular.
31.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
31.1	The Board agreed that the meeting had been very productive; well chaired and well balanced with focussed discussions.
32.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
32.1	Colin Drummond highlighted the items for discussion at the confidential Board meeting and set out the reasons for including these items on the Confidential Board agenda.

33.	**WITHDRAWAL OF PRESS AND PUBLIC**
33.1	The Board moved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
34.	**DATE FOR NEXT MEETING**
34.1	7 March 2023

SOMERSET NHS FOUNDATION TRUST/YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON ON 7 FEBRUARY 2023

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
ACTIONS FROM THE MEETINGS HELD ON 6 NOVEMBER 2022				
14. Corporate Risk Register Progress Reports	To consider including a quadrant diagram to distinguish between the different type of risks in the 2023/24 corporate risk register.	Phil Brice	April	This will be considered for the 2023/24 Corporate Risk Register.
ACTIONS FROM THE MEETINGS HELD ON 7 FEBRUARY 2023				
9. Future Community Hospitals model of care	To include a discussion on the future model of community hospital care on the schedule for a future Board Development Day.	Ria Zandvliet	February 2023	This item has been included on the Board development programme.
13. Board Assurance Framework	To give an update on the work in relation to strategic objective 1 – improving the health and wellbeing of the population – and the actions taken by ICB and Local Authority to a future Board Development Day.	Peter Lewis	To be confirmed	The item has been included on the Board development programme.

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

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

Executive Summary and Reason for presentation to Committee/Board	The Registers of Interests are presented to the Board at every meeting and reflect the interests of Board members as at 28 February 2023.
Recommendation	The Board is asked to: • note the Register of Interests; • declare any changes to the Register of Interests; • declare any conflict of interests in relation to the agenda items.

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

☐ Obj 1 Improve health and wellbeing of population

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

☐ Obj 3 Strengthen care and support in local communities

☐ Obj 4 Reduce inequalities

☐ Obj 5 Respond well to complex needs

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

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

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

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

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

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

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

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

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

REGISTERS OF DIRECTORS' INTERESTS

JOINT EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Chief Executive, Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust • Member of the NHS Confederation Community Network Board • Management Board Member, Yeovil Strategic Estates (YEP) Partner Board • Director, YEP Project Co. Limited
Phil Brice Director of Corporate Services	• Sister works for Somerset NHS Foundation Trust • Non-Executive Director of the Shepton Mallet Health Partnership • Director of Corporate Services, Yeovil District Hospital NHS Foundation Trust • Non-Executive Director of SSL
Isobel Clements Chief of People and Organisational Development	• Chief of People and Organisational Development, Yeovil District Hospital NHS Foundation Trust
Andy Heron Chief Operating Officer (Neighbourhoods, Mental health and Families)	• Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services) • Director of the Shepton Mallet Health Partnership • Chief Operating Officer (Neighbourhoods, Mental health and Families), Yeovil District Hospital NHS Foundation Trust • Executive Director for SHS
Pippa Moger Chief Finance Officer	• Stepdaughter works for Yeovil District Hospital NHS Foundation Trust • Son works for Somerset NHS Foundation Trust • Director of the Shepton Mallet Health Partnership • Director of YEP Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Chief Finance Officer, Yeovil District Hospital NHS Foundation Trust • Non-Executive Director for SSL

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

Somerset NHS Foundation Trust Non-Executive Directors	
Colin Drummond Chairman	• Honorary Vice President of Calvert Trust Exmoor (outdoor holidays for people with disabilities) – current • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators – Master
Jan Hull Non-Executive Director (Deputy Chairman)	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit • Non-Executive Director Yeovil District Hospital NHS Foundation Trust
Dr Kate Fallon Non-Executive Director (Senior Independent Director)	• Daughter is a Consultant at Somerset NHS Foundation Trust • Symphony Health Services Board member • Daughter has been appointed as the Guardian of Safe Working Hours for Junior Doctors • Non-Executive Director Symphony Health Services
Stephen Harrison	• Trustee, YMCA Brunel Group • Trustee, Lawrence Centre, Wells

Non-Executive Director	• Governor, Wookey Primary School
Barbara Gregory Non-Executive Director	• RESEC Research into Elderly and Specialist Care Trustee. • Deloitte Associate – with effect from 6 February 2018. • Chair of the CNL (Chairs, Non Executive and Lay members) Faculty of HFMA • Director of AGRF
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset • Non-Executive Director Yeovil District Hospital NHS Foundation Trust
Sube Banerjee Non-Executive Director	• Executive Dean, Faculty of Health, University of Plymouth • Hon Consultant in Psychiatry, Plymouth University Hospitals NHS Trust (unremunerated) • Visiting Professor, Brighton and Sussex Medical School (unremunerated) • Trustee and Patron, Alzheimer's Society (unremunerated) • Editor-in-chief, The International Journal of Geriatric Psychiatry • Director Cognitive Agility Ltd (personal consulting to governments and industry) • Association Member BUPA (unremunerated) • Trustee and Executive Board Member Medical Schools Council (unremunerated) • Board member University of Plymouth Enterprise Limited (unremunerated)
Martyn Scrivens Non-Executive Director	• Chairman Yeovil District Hospital NHS Foundation Trust • Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust • Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022) ▪ Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: – Ardonagh Holdco Limited (Jersey) – Ardonagh New Midco 1 Limited (Jersey) – Ardonagh Group Holdings Limited (UK) – Ardonagh New Midco 3 Limited (Jersey) – Ardonagh Midco 1 Limited (Jersey) – Ardonagh Midco 2 plc (UK)

	– Ardonagh Midco 3 plc (UK) – Ardonagh Finco plc (UK)
Yeovil District Hospital NHS Foundation Trust Non-Executive Directors	
Martyn Scrivens Chairman Non-Executive Director	• Non-Executive Director Somerset NHS Foundation Trust • Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust • Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022) • Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: – Ardonagh Holdco Limited (Jersey) – Ardonagh New Midco 1 Limited (Jersey) – Ardonagh Group Holdings Limited (UK) – Ardonagh New Midco 3 Limited (Jersey) – Ardonagh Midco 1 Limited (Jersey) – Ardonagh Midco 2 plc (UK) – Ardonagh Midco 3 plc (UK) – Ardonagh Finco plc (UK) •
Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	• Advisor to Swansea Bay University Health Board • Advisor to NHS Devon Health System
Jan Hull Non-Executive Director	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit • Non-Executive Director Somerset NHS Foundation Trust
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset • Non-Executive Director Somerset NHS Foundation Trust

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Non-Executive Director lead roles
SPONSORING EXEC:	Colin Drummond, Chairman SFT
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Colin Drummond, Chairman SFT
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	Non-Executive Director lead roles have been reviewed in the light of "The Enhancing Board Oversight: A new approach to non-executive director champion roles" report and in the light of the merger. An overview of Non-Executive Director lead roles is set out in the attached report.
Recommendation	The Board is asked to note the Non-Executive Directors lead roles with effect from 1 April 2023.

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

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

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

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

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

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

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

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

NON-EXECUTIVE DIRECTOR LEAD ROLES

1. INTRODUCTION

1.1. "The Enhancing Board Oversight: A new approach to non-executive director champion roles" guidance was published by NHS England/Improvement and this guidance sets out a new recommended approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures.

1.2. The lead roles have been reviewed in the light of the guidance and the merger and below an overview of required lead roles and the Non-Executive Director lead for each of the roles.

2. NON-EXECUTIVE DIRECTOR LEAD ROLES

2.1. Below an overview of the lead roles to be retained at Non-Executive Director level and the lead Non-Executive Director identified for each of the roles:

Security Management	Barbara Gregory
Freedom to Speak Up	Kate Fallon
Wellbeing Guardian	Graham Hughes
Maternity	Alexander Priest

2.2. The overview of Board Committee membership and Committee Chairs was presented to the February 2023 Board meeting. In addition to that overview, Barbara Gregory will be taking over as Chair of the Organ Donation Committee with effect from 1 April 2023.

3. RECOMMENDATION

3.1. The Board is asked to note the Non-Executive Directors lead roles with effect from 1 April 2023.

CHAIRMAN

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

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

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

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

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

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

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☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1. UPDATE ON INDUSTRIAL ACTIONS

Royal College of Nursing (RCN)

1.1. The RCN have paused the planned industrial action for 1 to 3 March 2023 following an announcement that the Department of Health and Social Care and the Royal College of Nursing have agreed to enter a process of intensive talks.

British Medical Association (BMA) ballot outcome

1.2. The BMA have communicated the successful ballot of junior doctors and are preparing for a full 72-hour walkout, starting on Monday 13 March 2023 until the morning of Thursday 16 March 2023.

1.3. We are continuing to work closely with trade unions and colleagues to understand the potential impact of the planned strike action and the plans that we may need to put in place.

Other planned strike actions

1.4. Below is an overview of the planned strike action that is currently confirmed which we anticipate will have a direct impact on our trusts. Other industrial action is planned during this period but the impact on delivery of our core services is not currently assessed as significant.

2 March	National education union	All schools in London, South East and South West
6 March	GMB ambulance strikes	
15 March	National education union	All schools in England
16 March	National education union	All schools in England
13 March to 16 March	BMA (Doctors in Training)	SFTand YDH

2. MUSGROVE PARK HOSPITAL AND YEOVIL DISTRICT HOSPITAL TO GET SURGICAL ROBOTS

2.1. Our team of surgeons are set to begin using robotic surgery for the first time in Somerset – thanks to a £1.5 million commitment from the Musgrove Park Hospital League of Friends.

2.2. Over the last five years, the hospital's League of Friends has provided more than £4 million for various funding initiatives. This includes recent funding for equipment – not just large items, but smaller item too – that can make a real difference to patients and colleagues, such as chairs, resuscitators, dementia kits, water coolers, and training aids. None of this would have been possible without a number of legacies over the last couple of years, as well as donations by individuals and organisations.

2.3. As a result of the investment from the League of Friends we have been able to secure an additional £1.5m of capital funding from NHS England to provide the same surgical robot at Yeovil District Hospital.

2.4. The money will buy two da Vinci Xi surgical system, which will enable our surgeons to perform more intricate, less invasive surgery. It means that robotic surgery could now be used in a number of different disciplines within our acute hospitals.

3. PATIENTS IN SOMERSET TO BENEFIT FROM £15M FUNDING BOOST FOR ADDITIONAL THEATRE AND NEW WARD AT YEOVIL HOSPITAL

3.1. The £15m Government investment for developing Yeovil Hospital's site will play a key part in reducing waiting times for patients across Somerset.

3.2. With plans already underway, the building work is split into two parts. The first will see Yeovil Hospital's main theatre receive a significant refurbishment, including increasing space in the recovery area, as well as an extension that will add a fifth theatre to the existing four, increasing the number of operations that can be performed each year in the county.

3.3. The second part of the project will be the addition of a new 20-bed ward. This will be made up of single, en-suite rooms and is set to be a dedicated orthopaedic ward with physio space for early rehabilitation to take place, supporting patients to get home as soon as possible after their operation.

4. MATERNITY NOTES MOVE TO SINGLE DIGITAL PLATFORM IN SOMERSET

4.1. Maternity colleagues across Yeovil Hospital and Somerset NHS FT will be getting to grips with new digital platform 'BadgerNet' which launched on Wednesday 22 February 2023.

4.2. The new single maternity record will replace all paper patient notes and current electronic systems for maternity clinicians to use as the main pregnancy record across Somerset. The system will not only ensure clinicians and midwives can record information in the same way across the county, wherever they are delivering care, be that in a hospital, birthing centre or in the community, but it will also fully replace the hand-held notes that are traditionally carried around throughout pregnancy. Alongside the clinician's access to the Badgernet platform is the launch of the new 'BadgerNotes'

app which fully replaces the paper notes for those in our care throughout their pregnancy journey.

4.3. BadgerNotes also carries useful information and enables midwives to provide appointment reminders and share updates directly to those in their care. An additional bonus is that BadgerNet and BadgerNotes are already well-established in a number of other trusts including our neighbouring county of Dorset.

4.4. This move is just one example of teams working together to integrate services at Yeovil Hospital and Somerset NHS Foundation Trust as we move towards a single merged trust, enabling our teams to smoothly deliver consistent and equal care for patients across the county.

5. NEW VICTORIA PARK HEALTH AND WELLBEING HUB OPENS IN BRIDGWATER

5.1. People from Bridgwater and the surrounding area are benefiting from a new health and wellbeing hub that has opened in the town this winter.

5.2. The exciting new development, which is located in the former Victoria Park medical centre building, provides a range of services for people of all ages, from pre-natal to end of life care.

5.3. The hub is run by our trust, in partnership with the Bridgwater Bay Primary Care Network – which is where GP practices work together with community, mental health, social care, pharmacy, hospital and voluntary services in the local are to meet the needs of individual patients.

5.4. The idea of the hub is to provide equal access to health advice and support for all patients to empower them to manage their own long term conditions. The hub operates an open door arrangement where members of the public can drop in if they need any help with their general wellbeing, as well as offering a range of pre-booked appointments

5.5. The new Victoria Park Health and Wellbeing Hub is not a GP health centre and won't provide urgent or acute care. Our advice to patients who need that level of help is that they should speak to their GP, visit their nearest minor injuries unit, or call NHS 111 if they're unsure what to do.

6. NEW SERVICE IDENTIFIES AND MANAGES PATIENTS LIVING WITH FRAILTY WHO ATTEND A&E

6.1. Older people living with frailty are getting extra support if they need care at our emergency department (A&E) at Musgrove Park Hospital thanks to an existing service at the hospital being repurposed to focus on patients with frailty.

6.2. For many years, an older person's assessment and liaison (OPAL) team has been helping older people who present to our emergency department to get

the right care and treatment. With the introduction of a new Acute Frailty Unit at the hospital in early 2022, the four-strong team of acute frailty practitioners have refocused their efforts on identifying those older patients presenting to hospital with frailty.

6.3. It is part of a series of intensive support services that we are putting in place, alongside our partners across the wider healthcare system in Somerset, to help keep people in their own home setting or avoid a long stay in hospital.

6.4. As part of the re-launch of the service, the acute frailty practitioners are assigned as named clinicians for patients at the hospital's emergency department for the first time ever. This is a new part of the role where the acute frailty practitioners hold responsibility for the patient's care and assessment, which could involve a transfer to the hospital's acute frailty unit or discharging them home or to an alternative care setting if safe and appropriate to do so. The service is also being extended back to seven days a week, 8am to 6pm, so patients can be assessed by our frailty team if they arrive at the emergency department over the weekend.

6.5. Our acute frailty practitioner colleagues are no longer wearing a uniform so that the service is aligned with our geriatrician team, but you'll be able to spot Amy, Carol, Karen and Katie by their bright yellow lanyards – which are very much loved by patients!

7. CHIEF OPERATING OFFICER

7.1. Following the departure of Matthew Bryant (Chief Operating Officer for Acute Services), Andy Heron (currently our Chief Operating Officer for Neighbourhoods, Mental Health and Families) will become our single Chief Operating Officer with effect from 27 February 2023. Andy will be supported by the leadership teams within the following service groups:

- Children, Young People and Families Services Group
- Clinical Support and Cancer Services Group
- Medical Services Group
- Mental Health and Learning Difficulties Service Group
- Neighbourhood Services Group
- Surgical Services Group

and the Director of Elective Care. We are also looking at further strengthening the operational leadership arrangements. In the meantime, Alison Ficarotta will be providing some additional support on an interim basis.

8. INCLUSIVE CULTURE

8.1. February 2023 was Kindness, Civility and Inclusion Month, and a series of blogs on the 'What, Why and How' of kindness, civility and inclusion have been published. We hope that these blogs will provide an opportunity to check in with ourselves, and each other.

8.2. The first blog reflects on what kindness and civility means and challenging our own bias and perspective. A recording of the blog titled “What role does kindness play in helping us become more inclusive?” is available on the following link inclusion blog 1.

8.3. The second blog looks at the “Why” behind kindness, civility and inclusion. A recording of the blog is available on the following link Inclusion 2 - Version 2 - YouTube.

8.4. The third and final blog looks at the “How” behind kindness, civility and inclusion. A recording of the blog is available on the following link Inclusion 3 - Version 2 - YouTube

9. LGBTQ+ HISTORY MONTH: OUR ACHIEVEMENTS

9.1. For LGBTQ+ History Month this February, our joint colleague network has been celebrating all they have achieved so far and shared inspirational LGTBQ+ figures in healthcare.

9.2. Our colleague networks are key to promoting and supporting diversity, inclusivity, and empowering colleagues to be themselves at work – and key to the networks, are their members. In honour of LGBTQ+ History month, our LGBTQ+ network members have contributed their own personal reflection on what the month meant to them, and how far society has progressed in recent history.

10. MEDIA COVERAGE

The Times ‘behind the scenes’ feature

10.1. We recently welcomed the health correspondent and photographer from the Times newspaper to capture some of the stories of our teams and partners working together across 48 hours in healthcare in Somerset. The feature focused on how we are responding to the challenges of caring for an aging population. The feature was published in print and online on Saturday 4 February 2023. How NHS Somerset is revolutionising the way we care for our elderly | News | The Times

10.2. They spent two days visiting primary and secondary care, and adult social domiciliary care to gain an insight into some of the pressures we are facing, and to hear about a number of the initiatives we have put in place to help improve patience experience and relieve pressures across our services.

10.3. The feature has been well received and has also generated further interest online and with local media.

11. AWARDS

Going for Gold

11.1. Congratulations and very well done to our first group of colleagues to complete their Gold Quality Improvement (QI) training programme.

11.2. Colleagues' commitment, enthusiasm and dedication to the year-long course has been fantastic. Their QI skills and projects are already making a difference: improving care experience and health outcomes, increasing colleague satisfaction and lowering costs. Hayley Peters, Chief Nurse, and David Shannon, director of Strategy and Digital Development, proudly presented gold QI colleagues with their course completion certificates and watched their project presentations.

11.3. Colleagues provided the following feedback:

- The Gold QI course offers a great opportunity to learn and apply the 7 steps of QI methodology to a project in your area.
- I had a number of barriers with my project but having access to an improvement mentor provided invaluable support.
- My project is far from complete but the Gold QI training and improvement methodology has provided a way of thinking that I will take forward and would encourage others to do so the same.

Congratulations to the Paediatric Cardiology service

11.4. Congratulations to our paediatric cardiology service that has received recognition for their work to prepare young people with complex heart conditions to manage their condition throughout their lives by winning best abstract at a national conference.

11.5. The team has achieved this by setting up dedicated 'transition clinics', held twice a year for young people who are approaching the age of 14 to 18 years and will soon have their care transferred and managed by adult cardiology team.

Congratulations to our Community and Mental Health cleaning team

11.6. Congratulations to our community and mental health cleaning team who won the "Healthcare Cleaning Team of the Year" award at the national MyCleaning Awards, in collaboration with NHS England. This national award is in recognition of the incredible amount of work they have done over the past couple of years to keep on top of changes and updates to processes.

11.7. Our cleaning teams have responded magnificently to the demands that the pandemic, new national standards of cleanliness and the challenge that extreme pressure on our services have brought.

12. NATIONAL DEVELOPMENTS

NHS England and Department of Health and Social Care's Delivery Plan for Recovering Urgent and Emergency Care Services (UEC)

12.1. NHS England and the Department for Health and Social Care have published their Delivery Plan for Recovering Urgent and Emergency Care Services.

12.2. The document sets out how trusts and systems should work to deliver headline improvements in UEC performance, reducing average category two ambulance call times and waiting times at A&E over the next two years.

12.3. The levers to achieve this are primarily focused on improving patient flow, reducing bed occupancy and limiting delayed discharges.

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held in common on 25 January 2023
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Assurance Committee
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Boardtr	The attached report sets out the items discussed at the Quality and Governance Assurance Committee meeting held on 25 January 2023. The Committee received assurance in relation to: • Implementation of the deteriorating patients audit action plan. • The progress in relation to the implementation of the recommendations set out in the Health and Safety Executive (HSE) Improvement Notice. • The appointment of a new Head of Medical Physics and the interim secondment arrangements put in place. • The alignment of the Corporate Risk Registers and the discussions in relation to the system risk management processes. • Compliance with year 4 of the SFT and YDH Maternity Incentive Schemes. • The re-instatement of the normal infection prevention and control isolation and cohorting practices.

	• The planning for the industrial actions. • The findings from the SFT Care Quality Commission inspection report. • The findings from the Quality and Financial Governance Review. The Committee identified the following areas of concern or for follow up: • The number of high rated risks on the corporate risk register and the impact on patients and colleague wellbeing. • The current operational pressures. The Committee identified the following area to be reported to the Board: • The recommendation to for the Chief Executive to sign off Year 4 MIS declarations for SFT and YDH. • The discussion in relation to the operational pressures, harm/moral injury and risks.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Assurance Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETINGS HELD IN COMMON ON 25 JANUARY 2023

1. PURPOSE

1.1. The report sets out the items discussed at the formal meetings held on 25 January 2023, along with the assurance received by the Committees and any areas of concern identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

Deteriorating patients audit action plan

2.1 The Committees noted that an executive-led group had been set up to review the internal audit action plan. The Committees received an update on the actions being taken and noted that a three month pilot had been set up which will enable deteriorating patient details to be seen on a whiteboard behind the nurses' station. If successful, this pilot will be rolled out across the trusts.

2.2 The Committees noted that the implementation of the internal audit recommendations will be overseen by the Deteriorating Patient Group.

2.3 The Committees agreed that it will be important to get the process right and that due to the transformational change required, this may require more time than anticipated.

Health and Safety Executive (HSE) Improvement Notice - YDH

2.4 The Committees noted that the deadline for the implementation of the recommendations set out in the Improvement Notice had been extended by one month. The Committees received assurance that good progress was being made to achieve compliance.

Radiation Protection Advisor

2.5 The Committees noted that a new Head of Medical Physics was being recruited and that interim secondment arrangements had been agreed to ensure that support to the team was available.

Corporate Risk Register

2.6 The Committees noted that work was underway to align the risk registers from 1 April 2023. The single register will give a better overview of the risks as there were currently a large number of duplicate risks across both trusts.

2.7 The Committees noted that discussions were taking place with the ICB about how the trusts can support the system risk management processes.

Maternity Services – SFT and YDH Maternity Incentive Scheme (MIS)

2.8 The Committees received an update on compliance with the MIS Year 4 actions and noted that full compliance with all ten safety actions for both SFT and YDH will be declared.

2.9 The Committees recognised the significant challenges and noted how these challenges had been addressed.

2.10 The Committees further received an update on the Q3 positions and the preparations for Year 5 of the MIS.

2.11 The Committees formally signed off the Year 4 compliance statements for both SFT and YDH and:

- Accepted the content of the briefing as adequate assurance of an evidential basis for meeting the requirements of the scheme in full.

- Made a recommendation on behalf of Trust Board that the requirements of the scheme have been met and to give permission to the Chief Executive to sign the Board declaration form.

2.12 The Committees will continue to receive relevant reports where required by the scheme and will retain oversight of the maternity incentive scheme actions.

2.13 The Committees thanked Sallyann King and the wider team for this excellent achievement and recognised the significant efforts and time dedicated to the implementation of the maternity incentive scheme. The Committees further recognised the high levels of engagement and support of a range of colleagues in both trusts.

Infection Prevention and Control

2.14 The Committees received an update on the changes in infection prevention and control restrictions during the period of high flu and Covid-19 positive patients and noted that normal infection prevention and control isolation and cohorting practices had been reinstated.

Industrial Action

2.15 The Committees received an update on the planning for the industrial actions taken by the RCN and ambulance staff and noted the mitigating actions put in place to ensure the safety of patients and colleagues.

2.16 The Committees agreed that the mitigation actions and planning for the strike actions provided significant assurance.

2.17 The Committees noted that further nursing, as well as junior doctor, strikes were being scheduled and mitigating actions will be planned as soon as the dates for the strikes have been confirmed.

SFT Care Quality Commission (CQC) Inspection Report

2.18 The Committees noted that the CQC inspection report had been published on 20 January 2023 and that SFT had been rated "good" overall. Due to the low number of sites inspected, the improvements in individual ratings will not change the overall ratings for the Trust which were:

- Requires Improvement for Safe.
- Good for Responsive, Effective and Well Led
- Outstanding for Caring

2.19 The Committees noted the findings of the inspection, including the must do actions, and particularly complimented the children and young people mental health services for the significant improvements made to achieve an 'outstanding' overall rating.

2.20 The CQC report was presented to the February 2023 Board meeting and the findings have been shared and discussed with the Board.

Quality and Financial Governance Review

2.21 The Committees received the feedback letter from NHS England and noted that no material concerns had been identified.

2.22 The Committees noted that six recommendations had been made and that work was already taking place to implement actions to address the recommendations.

2.23 The Committees further noted the positive feedback in relation to the Committees' approach to formal and planning meetings and that this approach was felt to be an effective model.

3. AREAS OF CONCERN OR FOLLOW UP

Corporate Risk Register

3.1. The Committees received the up-to-date combined Corporate Risk Register report and noted that there were currently 65 risks on the risk registers – 44 on the SFT risk register and 21 on the YDH risk register – with 21 risks scoring 20 or 25. The Committees noted the details of the risks and recognised that although progress in mitigating risks had been made, the management of the risks remained challenging due to the operational pressures.

3.2. The Committees expressed their concerns about the large number of high rated risks, particularly in the urgent and acute care services, and agreed that this was an uncomfortable position which inevitably will impact on colleague morale and wellbeing and levels of patient care.

Current operational pressures

3.3. The Committees received an update on the escalation positions across both trusts and noted that the increase in operational pressures as a result of additional activity, flu, Covid-19, and bank holidays, had

resulted in a “business continuity” level of escalation being declared in January 2023. This level of escalation had now been reduced but the Committees agreed that this demonstrated the significant level of operational pressures.

3.4. The Committees further received an update on the review of the internal bed capacity and noted the number of escalation and pre-emptive boarding beds both in acute services and in community hospitals.

3.5. The Committees noted the risks and mitigations put in place to create safe escalation beds and areas. The Committees recognised the impact of the pressures on colleagues and patients. The Committees were informed that a colleague at YDH had raised discomfort with the escalation arrangements and standards of care with the Care Quality Commission and a response setting out the arrangements put in place to mitigate risks will be submitted to the Care Quality Commission.

3.6. The Committees received an update on the emergency department attendance levels and noted that the levels had consistently been higher than pre Covid-19.

3.7. In terms of colleague metrics, the Committees noted that sickness absence levels continued to be high and agreed that this was a reflection of the ongoing operational pressures. The Committees further noted the issue regarding retention levels at YDH.

3.8. The Committees discussed the potential for the operational pressures to impact on the longer term strategic aims and noted the development of a new Quality Strategy Framework and the work with the ICB to establish system wide quality standards. The Committees were advised that the strategic aspects and risks will continue to be discussed as part of the Board Assurance Framework discussions.

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 recommendation to for the Chief Executive to sign off Year 4 MIS declarations for SFT and YDH.
- The discussion in relation to the operational pressures, harm/moral injury and risks.

5. BOARD ASSURANCE FRAMEWORK (BAF)

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

- Objective 2 – positive assurance related to the MIS but negative assurance in terms of the operational pressures and current position and the level of risk the Trusts are holding generally in terms of the levels of care we can safety provide.

- The CQC report and NHSE feedback apply across all the objectives to an extent and will also apply to Objective 8 which is reserved to the Board.

- The Must Dos in the CQC report related to MH services provide negative assurance around Objectives 2 and 4.

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

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Quality and Performance Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Nathan Wray, Senior Information Analyst
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Report sets out performance across a range of quality and performance measures and the reasons for any significant changes or trends. Covid-19 continues to have a significant impact on a range of access standards, whilst restoration work is being undertaken to reduce the number of patients waiting and to shorten waiting times. As referrals recover to pre-Covid-19 levels this will also have an impact on services and numbers waiting. Urgent and emergency patients continue to be prioritised, to receive the treatments they need.
Recommendation	The Board is asked to discuss and note the report.

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

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

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

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

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Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
No recommendations are being made, other than to ask the Board to discuss and note the report.

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

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

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

YDH | Operating Performance Overview

January 23

CONTENTS

Mortality Rates

Safe

January 23

Latest HSMR Nov-2021 to Oct-2022	Weekend Mortality Relative Risk	Number of Trustwide Deaths	Crude Mortality Rate (Deaths / Discharges)
0.897	**0.925**	**104**	**2.74%**

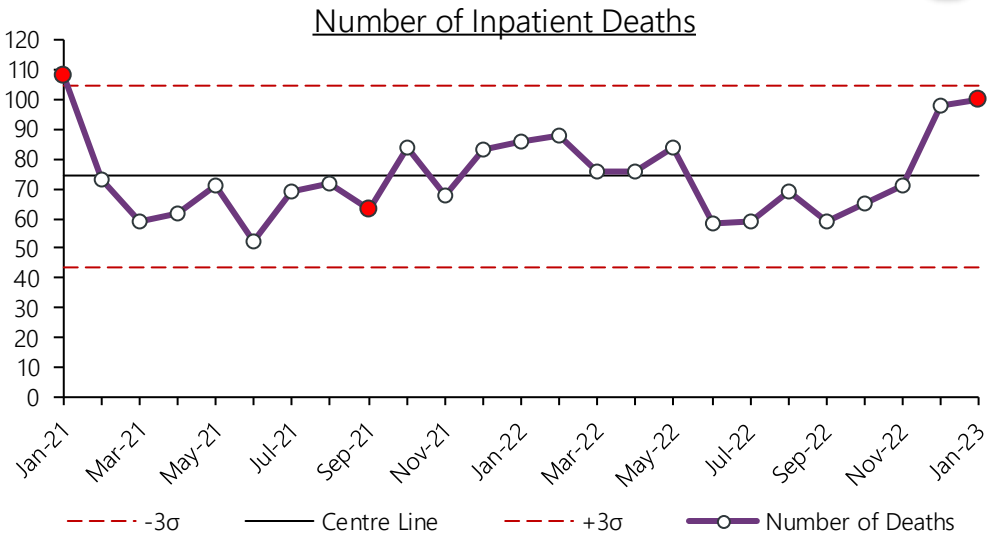
January 20

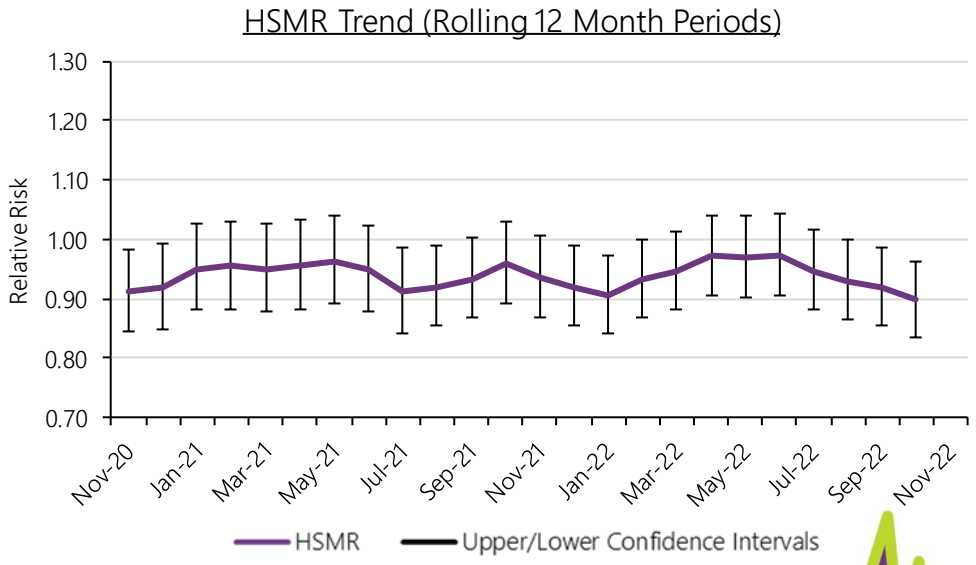
HSMR Nov-19 to Oct-20	Weekend Mortality Relative Risk	Number of Trustwide Deaths	Crude Mortality Rate (Deaths / Discharges)
0.867	**0.901**	**78**	**1.78%**

RAG status: Achieved

The trust's HSMR was 89.7 in for the 12 month period up to October 2022. The Trust continues to perform better than the National Average.

Further information is available in the quarterly mortality report.





Patient Falls and Pressure Ulcers

Safe

January 23

Patient Falls	Patient Falls Causing Harm	Patient Falls rate per 1000 bed days	Pressure Ulcers
79	**2**	**6.69**	**14**

January 20

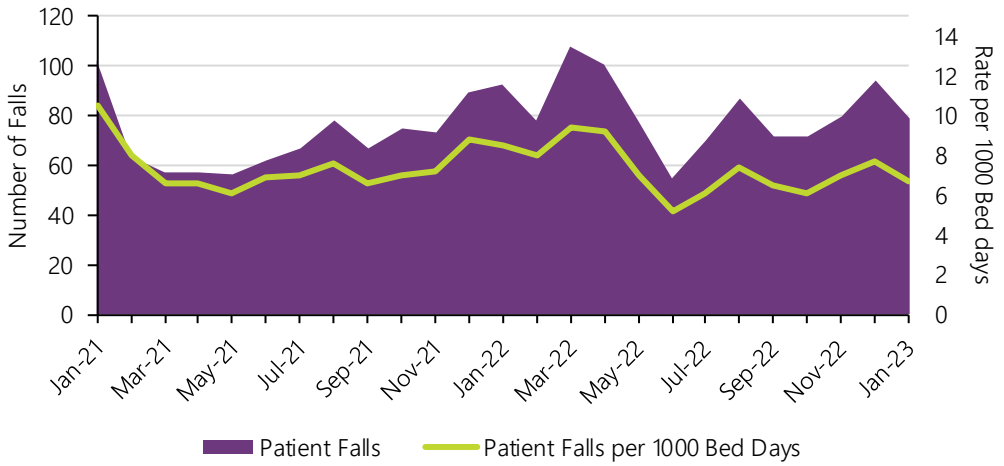
Patient Falls	Patient Falls Causing Harm	Patient Falls rate per 1000 bed days	Pressure Ulcers
69	**0**	**6.31**	**7**

Additional notes	Count	Diff	% Diff
• Patient Falls YTD:	**788**	**121**	**+18.14%**
• Patient Falls YTD 19/20:	667		
• Pressure Ulcers YTD:	**97**	**55**	**+130.95%**
• Pressure Ulcers YTD 19/20:	42		
• Pressure Ulcers 6M Avg:	**9.7**	**5.5**	**+132.00%**
• Pressure Ulcers 6M Avg	4.2		

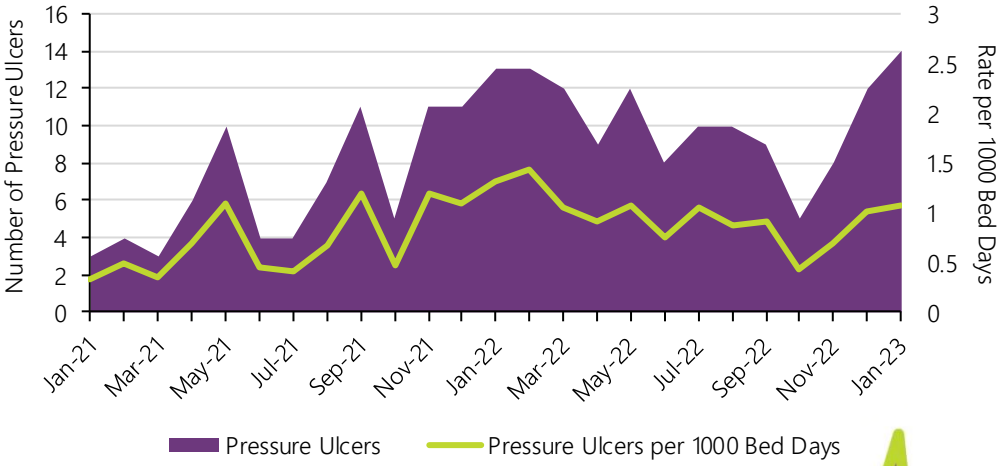
RAG status: Failed, close to achievement

Four key areas have been identified in the reviews: Documentation, Assessment, Training, Revalidation of Pressure Ulcer Category. Work is being undertaken with the Tissue Viability team and through the monthly Pressure Ulcer Steering Group.

Patient Falls



Pressure Ulcers +2



Yeovil Hospital Healthcare

Infection Control

Safe

January 23

MRSA Bacteremia	C.Diff (Lapses in Care)	YTD C.Diff (Lapses in Care)	YTD C.Diff
0	0	0	7

E.Coli	P.Aeruginosa	Klebsiella spp.	Positive Covid-19 Cases
2	0	0	89

Additional notes

- The Trust's Threshold for C/Diff cases this year is 15

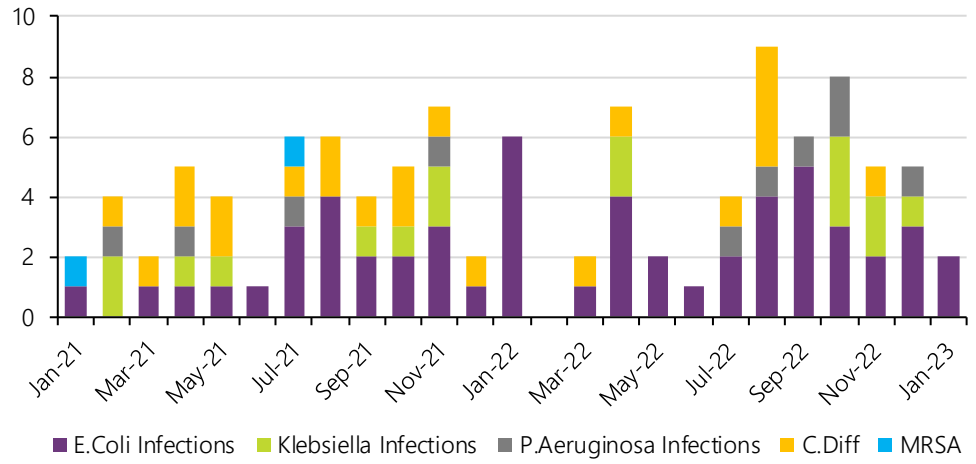
July 2022 Trust infection rate per 100,000 bed days;
E.Coli - 46.58, P.Aeruginosa - 9.32, Klebsiella - 9.32

May 2022 National infection rate per 100,000 bed days;
E.Coli - 30.59, P.Aeruginosa - 5.74, Klebsiella - 12.54
(All rates shown above are for hospital onset infections only)

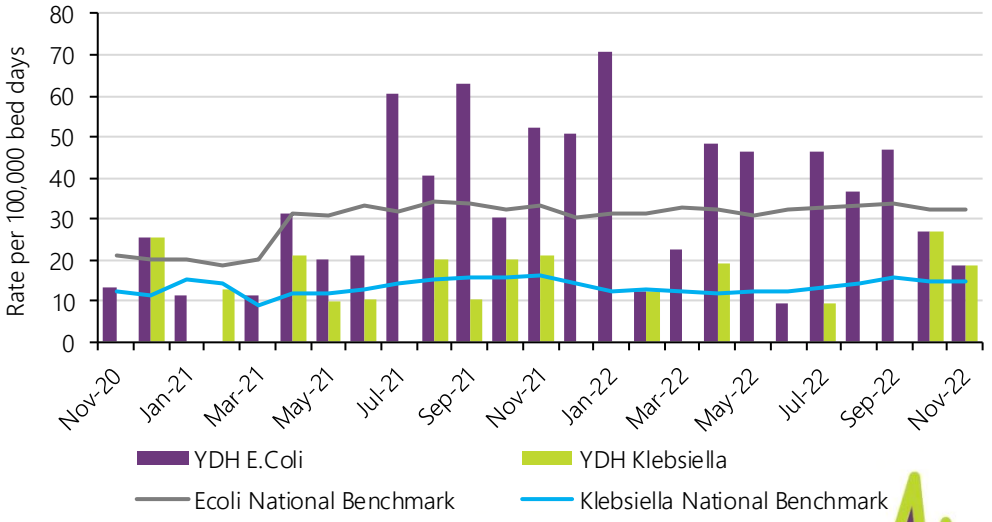
RAG status: Achieved

Targets Met.
There has been 7 reported C.Diff cases this financial year. The trust's C.Diff threshold for 22/23 is 15. Further information is available in the quarterly quality report.

Bloodstream and C.Diff Infections



YDH Hospital Onset BSI Infection rate per 100,000 bed days



Stroke Services

Effective

January 23

SSNAP Report - Jul-22 to Sep-22

YDH SSNAP Level	YDH SSNAP Score	90% Stay on Stroke Unit	12hr CT Scan
D	51.3	60.00%	96.67%
Targets			
B	**70**	**83.3%**	**83%**

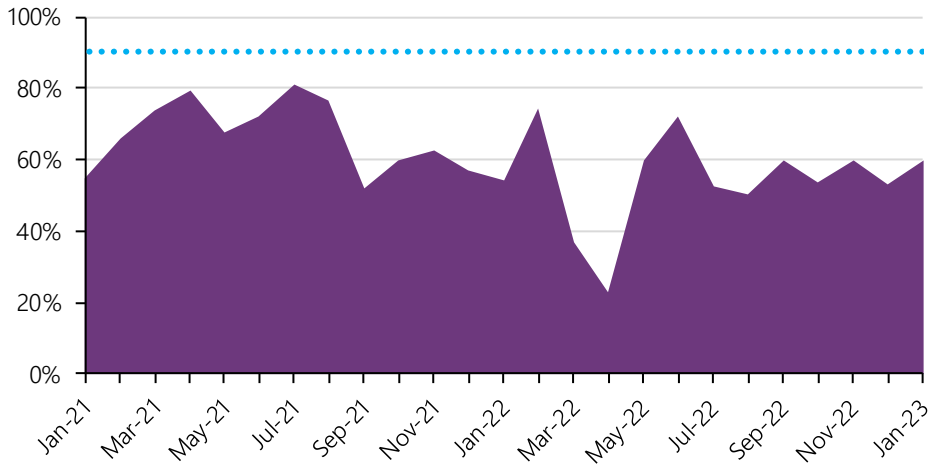
Additional notes

Stroke Performance national benchmarks from 20/21 Stroke Audit:
4hr Direct Admission = 55.10%
12hr CT Scan = 95.70%
90% Stay = 80.80%
Thombolysed = 10.70%
Consultant 24hr Review = 84.90%

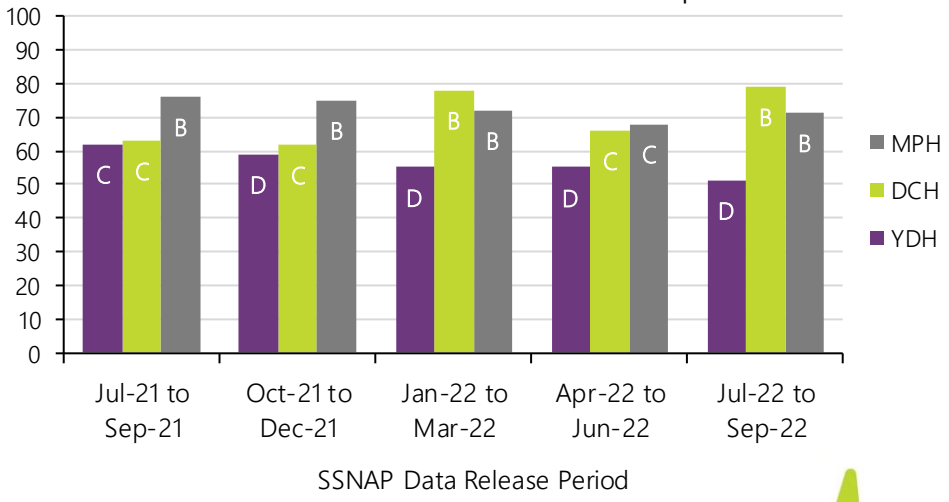
RAG status: Failed

Targets Failed. Reason:
The 90% Stay Stroke performance has been affected by a large number of patients not being directly admitted to the stroke unit, primarily due to hospital capacity pressures. High numbers of patients have been unable to secure a discharge due to pressures of Community Services such as Stroke Rehab Units and Packages of Care in Somerset and Dorset, impacting the numbers of available beds for new admissions. There is an anticipated drop in the next SSNAP rating due to this. This is also affecting other targets.

90% Stroke Unit Stay Achievement



SSNAP Levels/Scores - Peer Trust Comparison



Admissions and LOS

Responsive

January 23

Elective Admissions	Non-Elective Admissions	Average Elective LOS	Average Non - Elective LOS
1,747	**2,044**	**2.92**	**5.83**

January 20

Elective Admissions	Non-Elective Admissions	Average Elective LOS	Average Non - Elective LOS
2,012	**2,365**	**1.83**	**4.29**

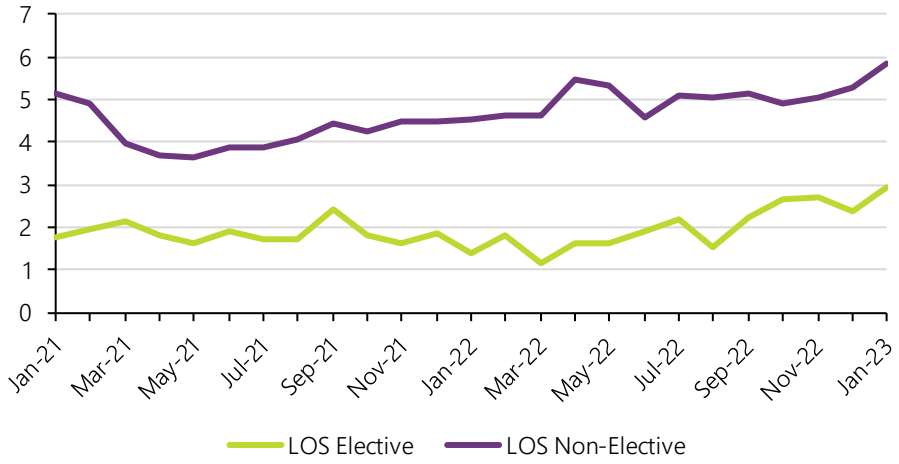
Additional notes	Count	Diff	% Diff
• Elective Admissions YTD:	**18,668**	**-1,557**	**-7.70%**
• Elective Admissions YTD 19/20:	20,225		
• Non-Elective Admissions YTD:	**21,215**	**-1,016**	**-4.57%**
• Non-Elective Admissions YTD 19/20:	22,231		
• Average Elective LOS vs 19/20 diff:		**+1.1**	**+59.54%**
• Average Non-Elective LOS vs 19/20		**+1.5**	**+35.98%**

RAG status: Failed, close to achievement

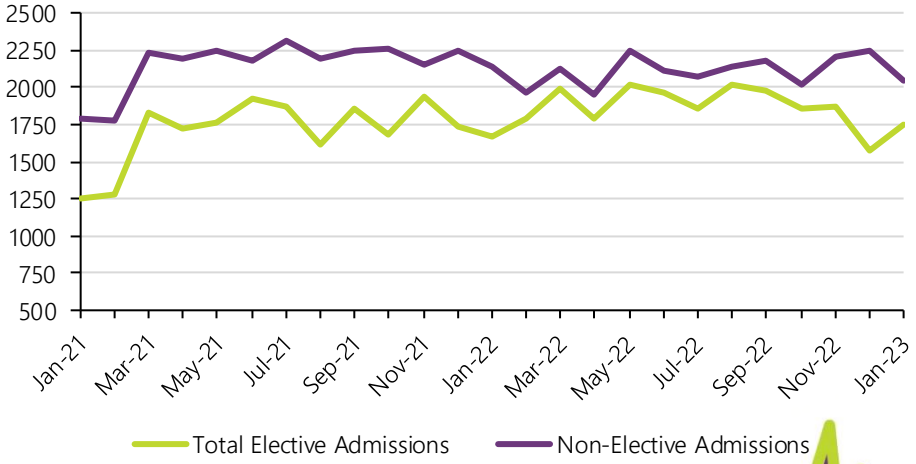
Targets Failed. Reason:

Elective and non-elective admissions are in line with pre covid levels. The increase in non-elective length of stay is reflective of an increase in patient acuity as well as an increase in patients delayed with no reason to reside.

Average Length of Stay (Days)



Admissions



Readmissions

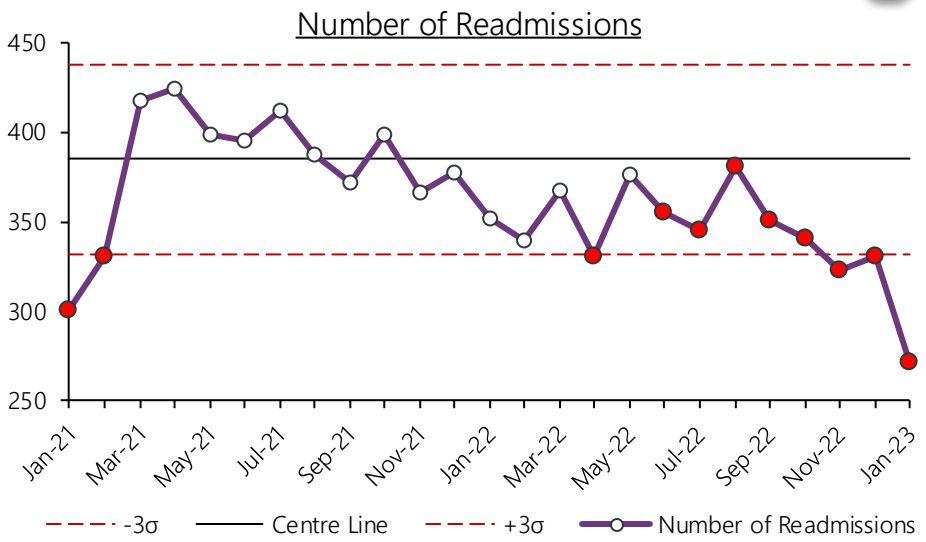
Responsive

January 23

Number of readmissions	Readmission Rate (Exc 0 day LOS)	Related Readmission Rate	Unrelated Readmission Rate
271	**6.65%**	**3.11%**	**4.04%**

January 20

Number of readmissions	Readmission Rate (Exc 0 day LOS)	Related Readmission Rate	Unrelated Readmission Rate
818	**17.25%**	**9.39%**	**9.30%**

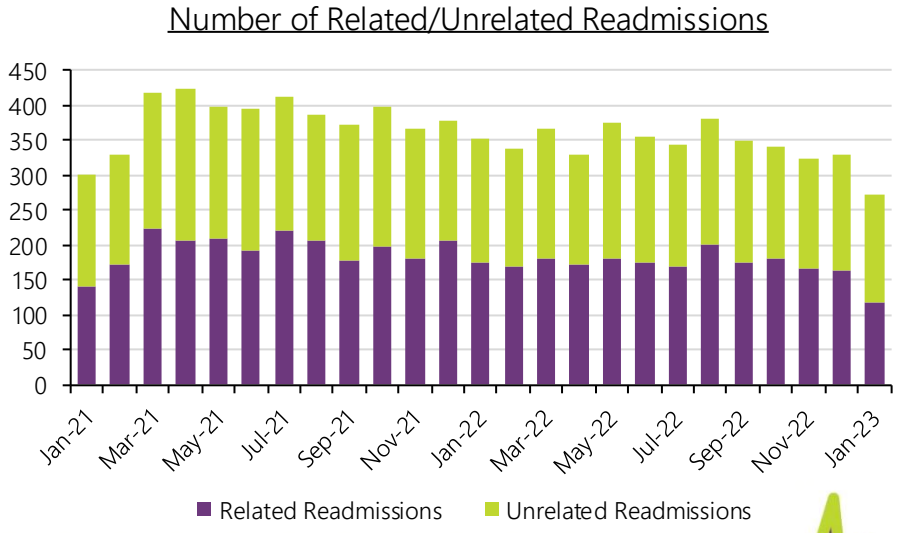


Additional notes	Count	Diff	% Diff
• Readmissions YTD: • Readmissions YTD 19/20:	**3,403** 8,214	**-4,811**	**-58.57%**
• Related Readmissions • Related Readmission 19/20:	**118** 411	**-293**	**-71.29%**
• Readmissions Rate (All) • Readmissions Rate (All) 19/20:	**8.00%** 17.72%	**-9.72%**	**--**

RAG status: Achieved

Targets Met.

Readmissions have remained within the expected range.



Criteria to Reside

Effective

January 23

Total Beddays with no criteria to reside	Beddays with no criteria to reside (Aged 65+)	Average Stranded Patients (21+ Days LOS)
2,785	**2,620**	**79.8**

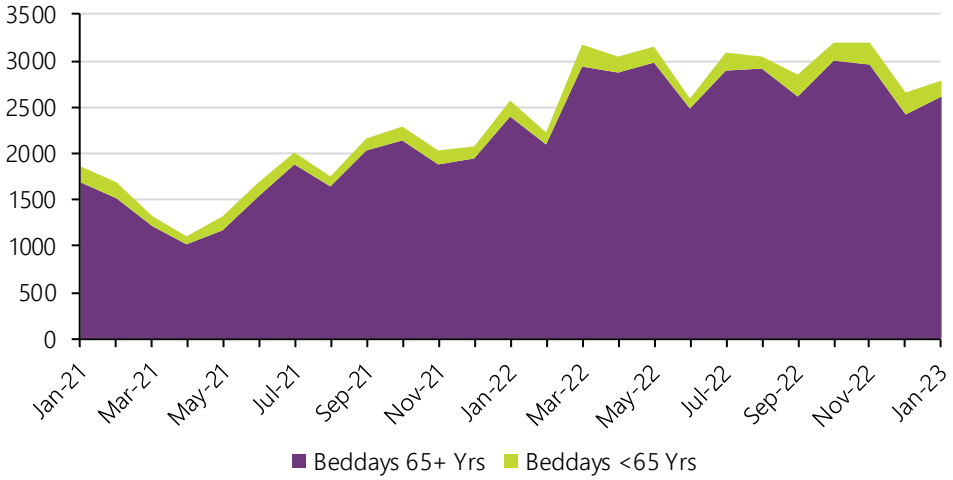
January 20

Total Beddays with no criteria to reside	Beddays with no criteria to reside (Aged 65+)	Average Stranded Patients (21+ Days LOS)
1,425	**1,312**	**32.5**

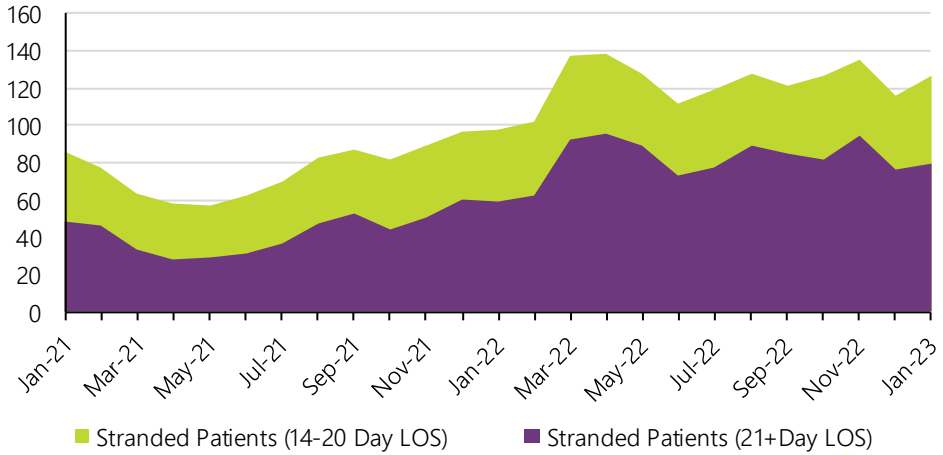
RAG status: Failed

Targets Failed. Reason:
The levels of patients with no criteria to reside is remains high although levels of patients with a length of stay of >21 days has stabilised in later months.

Beddays that do not meet the 'criteria to reside'



Average number of daily Stranded Patients



Cancelled Operations

January 23

On the Day Non-Clinical Reasons	YTD On the Day Non-Clinical Reasons	Rebooked within 28 Day Target	Urgent Cancellations
3	**114**	**100.00%**	**3**

January 20

On the Day Non-Clinical Reasons	YTD On the Day Non-Clinical Reasons	Rebooked within 28 Day Target	Urgent Cancellations
10	**69**	**100.00%**	**2**

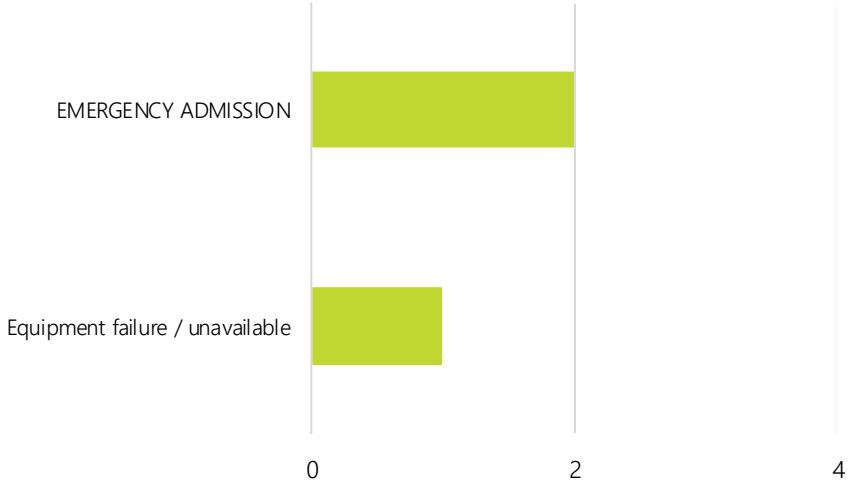
Additional notes

Note: For any elective operation cancelled by the trust on the day of the operation/admission, an offer of a new date must be within 28 days of the cancelled operation date.

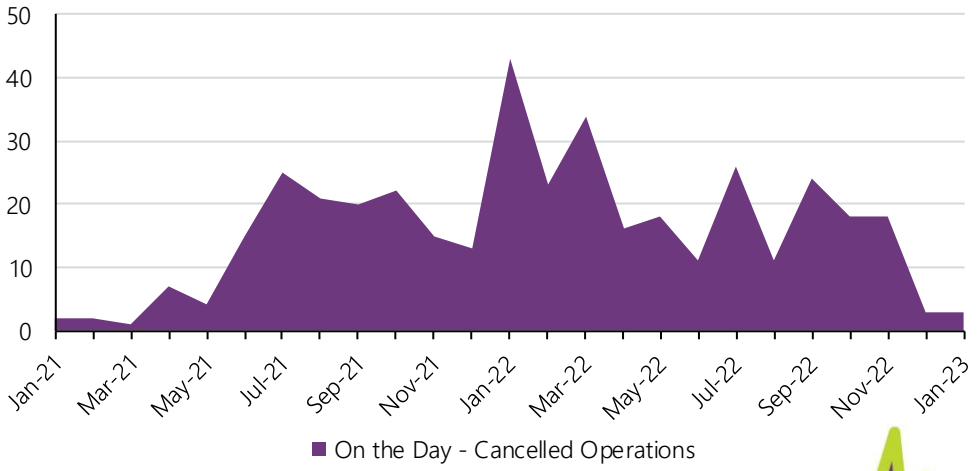
RAG Status: Failed, close to achievement

Targets Failed. Reason:
The main reason for cancellations was due to emergency admission and equipment failure.

Hospital non Clinical On the Day Cancellation of Elective Operations Jan-23



Number of Cancelled Operations



Diagnostic Waits

Responsive

January 23

Overall Diagnostic 6 Week Waits

61.59%

(Target 99.0%)

Additional notes

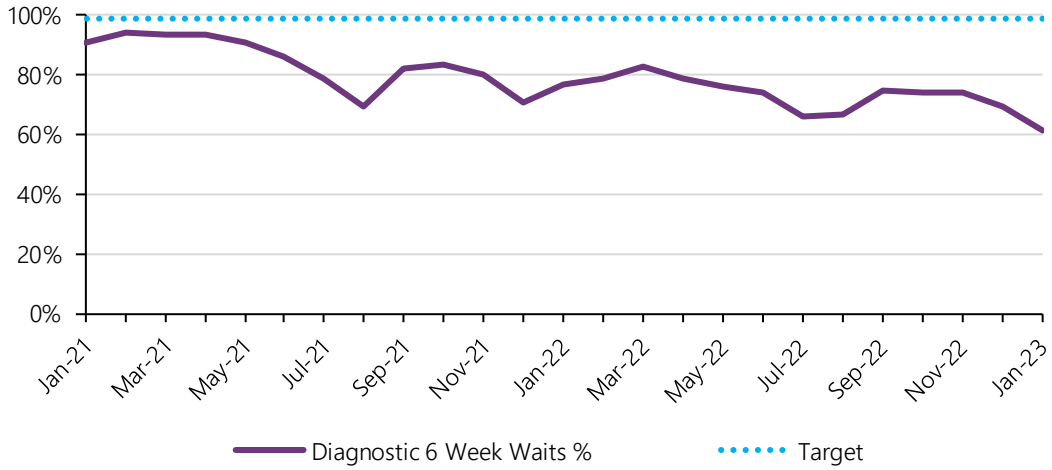
The area with the lowest diagnostics performance was:

Physiological Measurement	**38.48%**

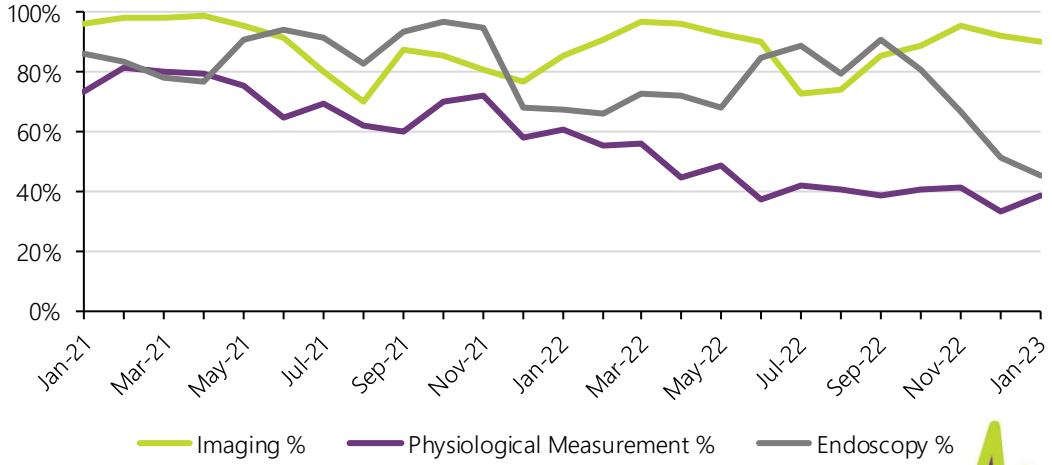
RAG status: Failed

Targets Failed. Reason:
There continues to be capacity issues with Echocardiology and Audiology Services but weekly reviews of the waiting lists continue to ensure patients are seen as soon as possible and in priority order. The Ultrasound waiting list size has increased due to an increase in bookings, extra lists have been put in place in response.

Diagnostic 6 Week Waits %



Diagnostic Waits by Type of Test



RTT Performance

Responsive

January 23

18 Week Incomplete Pathways	> 52 Week Waits	> 104 Week Waits
67.92%	**497**	**0**
Target - 92%		Dec 2022 Trajectory - 8

January 20

18 Week Incomplete Pathways	> 52 Week Waits	> 104 Week Waits
88.69%	**0**	**0**

Additional Notes:

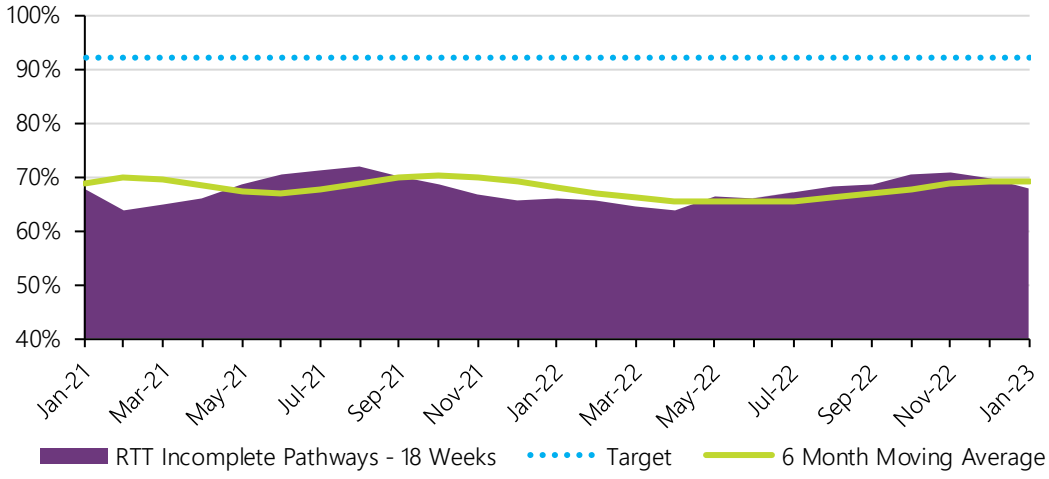
Specialties with the Lowest RTT Performance this month:

T&O - **43.60%**
ENT - **52.09%**

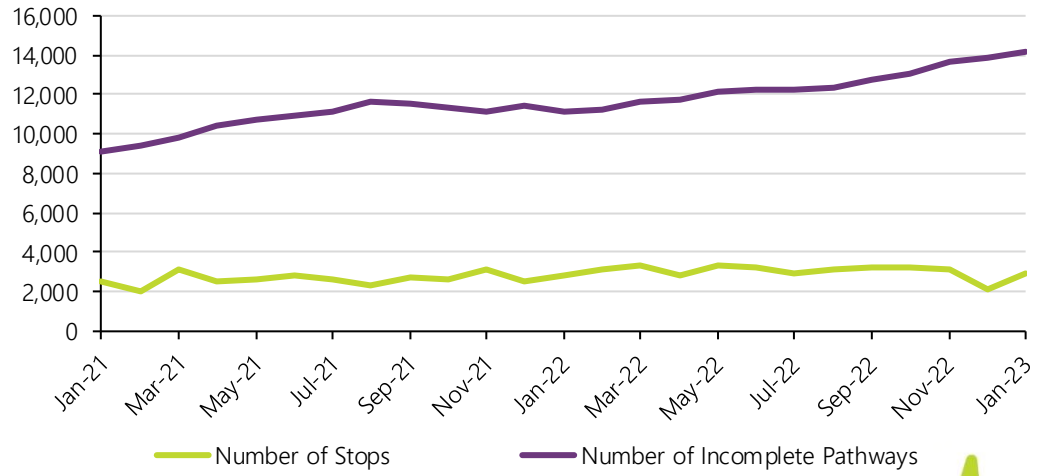
RAG status: Failed

ENT non-admitted pathways and T&O, and gynaecology admitted pathways continue to be areas of focus. RTT Performance continues to improve and the Trust is achieving target levels of 104 week waiters.

RTT Incomplete Pathways - 18 Weeks



RTT Incomplete Pathways with All Stops



RTT Pathways

January 23

Incomplete Pathways	Pathways > 18 Weeks	Pathways > 40 Weeks	Pathways > 78 Weeks
14194	**4554**	**1105**	**51**

January 20

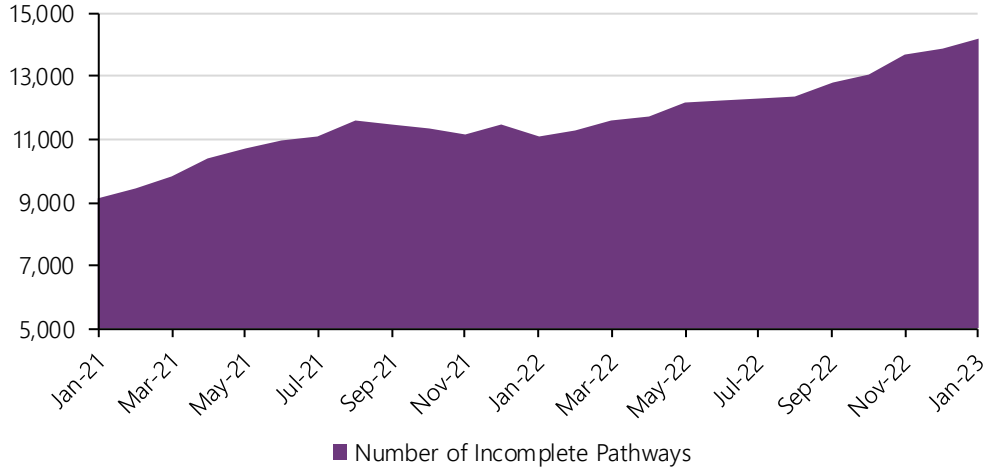
Incomplete Pathways	Pathways > 18 Weeks	Pathways > 40 Weeks	Pathways > 78 Weeks
9967	**1127**	**12**	**0**

Additional notes	Diff	% Diff
Number of Incomplete Pathways	**4227**	**42.41%**

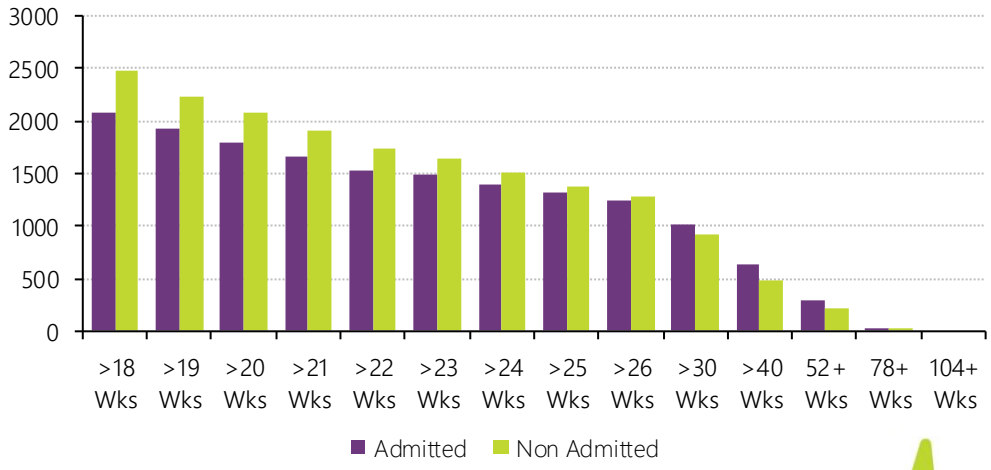
RAG status: Failed, close to achievement

Targets Failed. Reason:
Total RTT Waiting List size continues to exceed pre covid levels, with four times the number of 18 week breaches. Patients on the waiting list are reviewed and prioritised with the focus on urgent, cancer and our longest wait patients.

RTT Incomplete Pathways (total waiting list size)



RTT Incomplete Pathways - Aging



Cancer Performance

Responsive

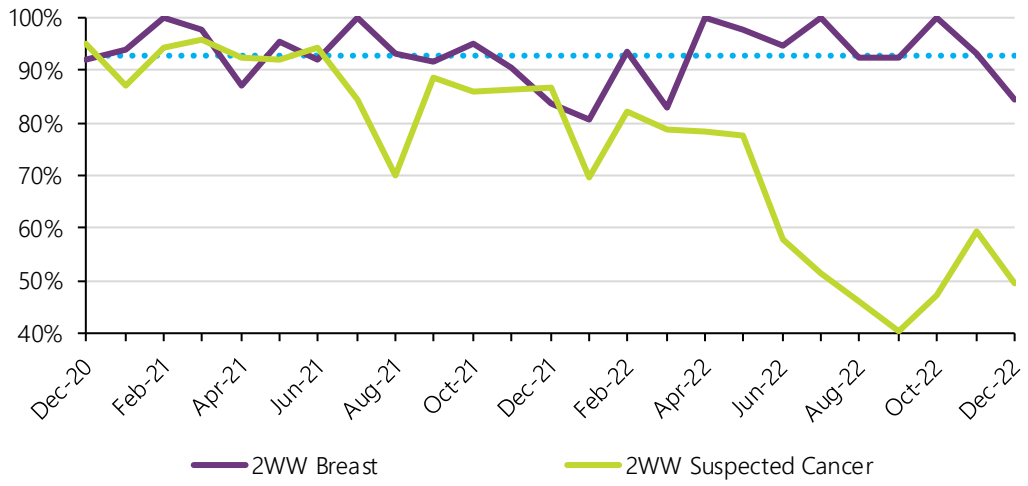
December 22

28 Day Diagnosis: 2 Week Suspected Cancer	28 Day Diagnosis: Exhibited Breast Cancer Symptoms
69.68%	**100.00%**
(National Target - 75.00%)	(National Target - 75.00%)
2 Week Suspected Cancer	2 Week Exhibited Breast Cancer Symptoms
49.66%	**84.62%**
(National Target - 93.00%)	(National Target - 93.00%)
31 Day Treatment First	62 Day Treatment Standard
87.76%	**51.35%**
(National Target - 96.00%)	(National Target - 85.00%)

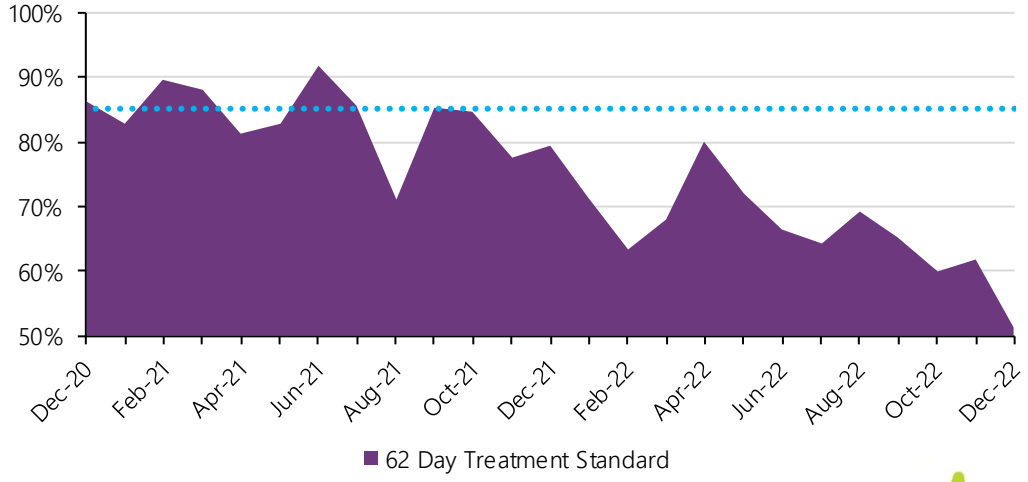
RAG status: Failed

2WW – Failed: Poor performance in Skin at 1%.
28 FDS – Failed: Poor performance in Gynae, Lower GI & Urology. Improvement groups in place to address this.
62 Days – Failed: Breaches mainly in Lung, Colorectal, Skin and Urology, due to delays in the pathway and complex patients.

2 Week Cancer Targets



62 Day Treatment Standard



Outpatients Transformation

2022/23 YTD

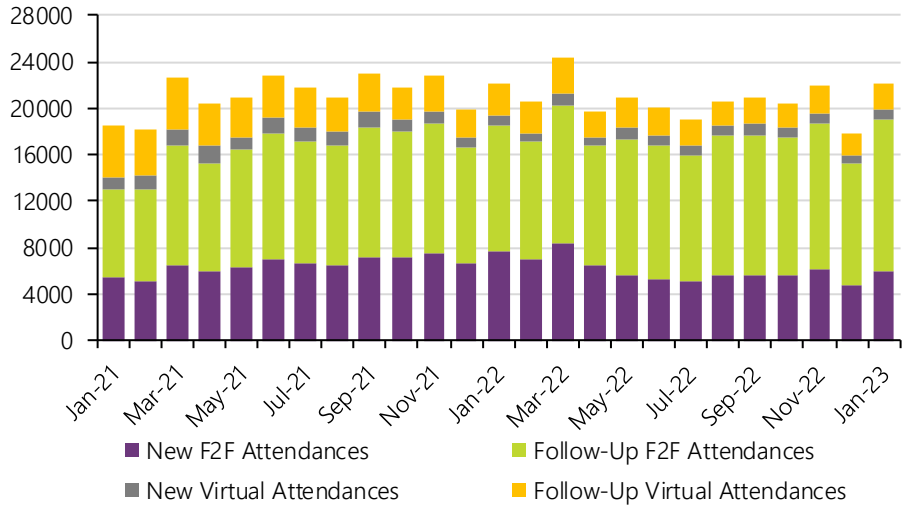
Total Outpatients Activity	Outpatient Procedures Proportion	Virtual Clinic Activity Proportion
203,265	**15.64%**	**14.2%**
ASI Rate	Average Wait to First OP (Weeks)	DNA Rate
103.30%	**10.67**	**6.30%**
All Appointment Cancellations	Patient Cancellations	Trust Cancellations
27.15%	**9.20%**	**17.95%**
Patients Offered PIFU Rate		
12.36%		

Comments

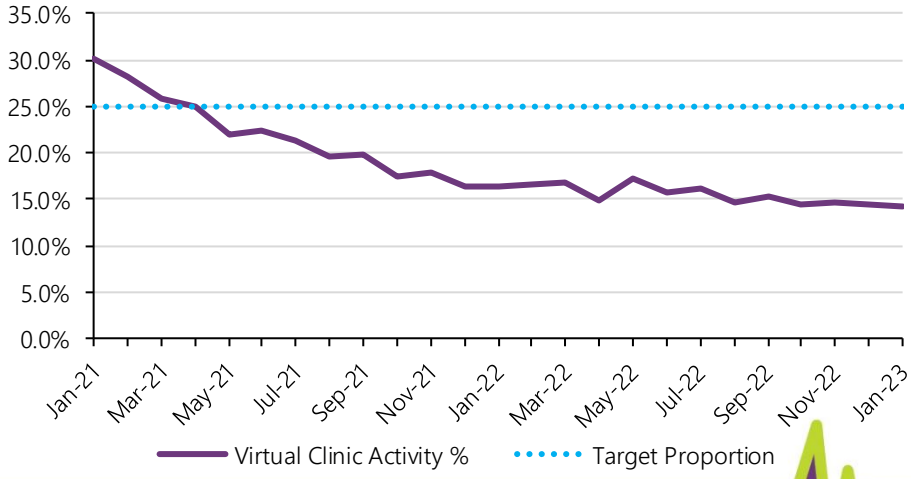
Please note that 'Virtual' Clinic activity includes Telephone follow-up clinics.

- The % Virtual activity has been in decline as the focus has shifted to restoration and recovery activity with more patients needing to be seen face to face.

Number of Outpatient Attendances



Proportion of Virtual Clinic Activity



ED Transformation

January 23

Median Time to Triage (hh:mm)	Median Time in Department (hh:mm)	
00:10	**03:13**	

A&E 4 Hour Performance	Total A&E Attendances	Year on Year A&E Growth (2019)
68.16%	**5012**	**3.83%**

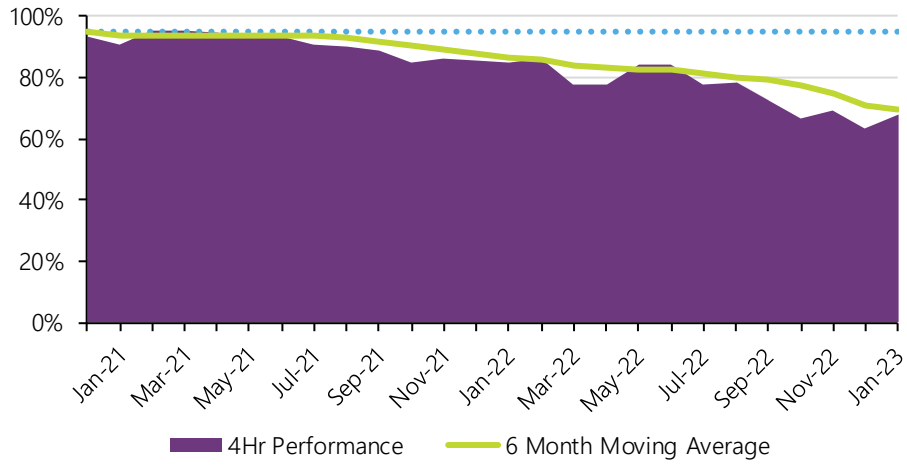
Attendances resulting in an Inpatient stay	12 Hour Trolley Waits	Handovers time lost >15 minutes
25.80%	**0**	**157:54:21**

Total Ambulance Handovers	Ambulance Handovers 30+ mins	Ambulance Handovers Performance
1192	**285**	**76.09%**

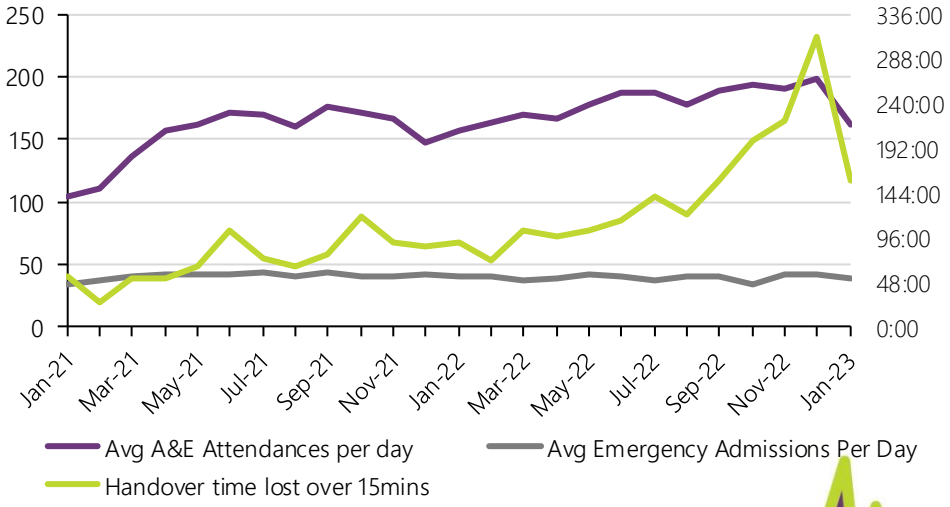
Comments

The continuing bed pressures within the Trust are impacting on the average waiting times in ED and Ambulance handover times which are at the highest level they have been in the last two years.

A&E 4 Hour Performance - All Attendances



Avg A&E Attendances per day



Patient Complaints and PALS

Caring

January 23

Complaints	PALs	PALS Concerns	PALS Enquiries
3	**175**	**47**	**128**

January 20

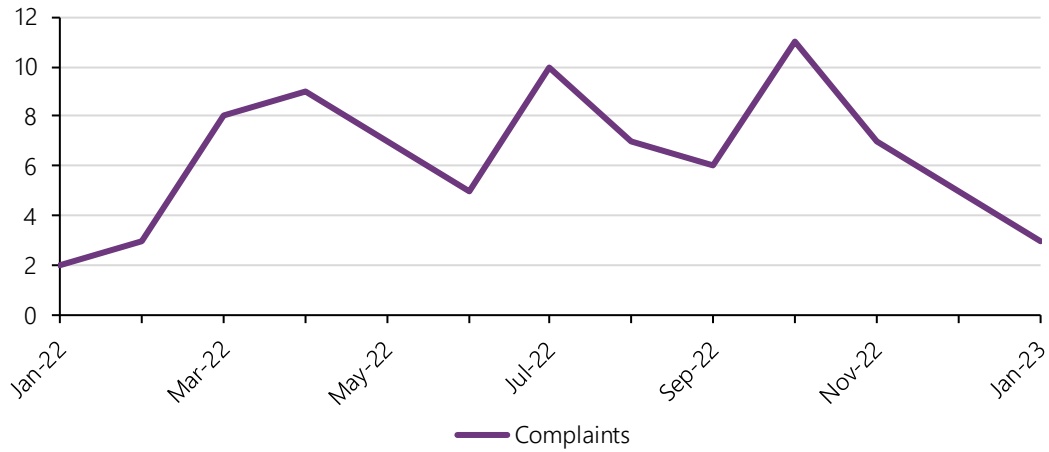
Complaints	PALs	PALS Concerns	PALS Enquiries
8	**128**	**65**	**63**

Additional notes			
• Complaints YTD: • Complaints YTD 19/20:	**70** 47	**+23**	**+48.94%**
• PALs YTD: • PALs YTD 19/20:	**1570** 1062	**+508**	**+47.83%**

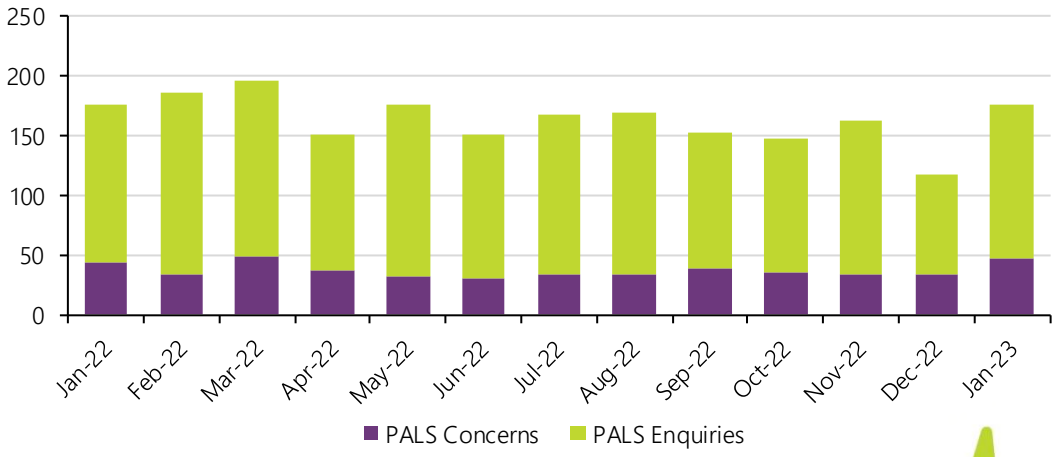
RAG status: Achieved

Themes and trends are discussed at the Patient Experience and Engagement Committee. Communication with relatives and information given to patients and relatives continues to be an issue due to restrictions on visiting. There were also high levels of PALs enquiries around cancelled operations and appointments.

Number of Complaints



PALS Breakdown



YDH Group | Workforce Report Well Led - Staffing

January 23

Workforce Assurance

January 23

Workforce Assurance - **YDH Only**

Workforce	Monthly Position		Contracted FTE						
	Jan-20	Jan-23	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
	1802.4	2209.1	54.8	410.8	463.4	149.0	10.7	298.2	801.0

Workforce	Monthly Position		Labour Turnover							Rolling 12 Month Trend
Target	Jan-20	Jan-23	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	
12% - 17%	16.52%	17.27%	23.17%	22.65%	22.26%	12.96%	16.67%	22.13%	10.29%	

Workforce	Monthly Position		Sickness Absence - In Month							Rolling 12 Month Trend
Target	Dec-19	Dec-22	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	
3%	3.01%	4.71%	3.34%	6.61%	3.80%	4.42%	1.33%	1.43%	5.70%	

Workforce	Monthly Position		Mandatory Training							Rolling 12 Month Trend
Target	Jan-20	Jan-23	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	
85%	90.69%	84.59%	84.87%	84.92%	86.85%	87.27%	87.68%	76.60%	85.93%	

Workforce	Monthly Position		Appraisals							Rolling 12 Month Trend
Target	Jan-20	Jan-23	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	
90%	88.50%	81.43%	91.43%	81.43%	77.84%	87.58%	53.85%	88.51%	79.20%	

In agreement with the People Committee in November 2022 the targets will be reviewed in line with our people strategy focus on creating an environment where colleagues can thrive. This will see a shift away from the traditional measures to a focus on understand the experience of colleagues moving forward.

Contracted FTE

January 23

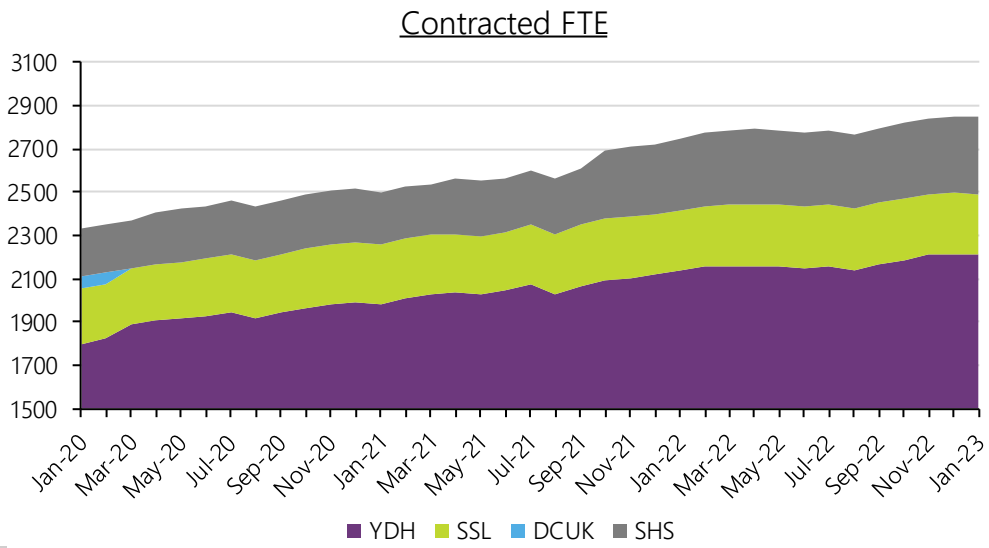
YDH Group	YDH	SHS	SSL
2850.8	**2209.1**	**358.6**	**283.1**

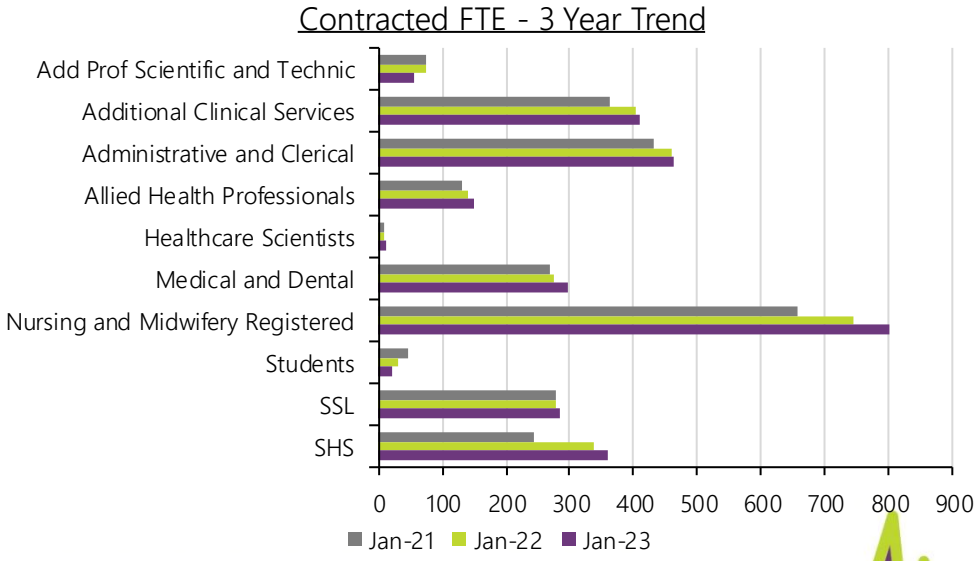
January 20

YDH Group	YDH	SHS	SSL
2337.1	**1802.4**	**223.0**	**257.0**

Additional notes	Count	Diff	% Diff
• Group FTE:	**2850.8**	**+514**	**+21.98%**
• Group FTE 19/20:	2337.1		
• Group FTE (Excl SHS):	**2492.2**	**+378**	**+17.89%**
• Group FTE (Excl SHS) 19/20:	2114.1		

Comments





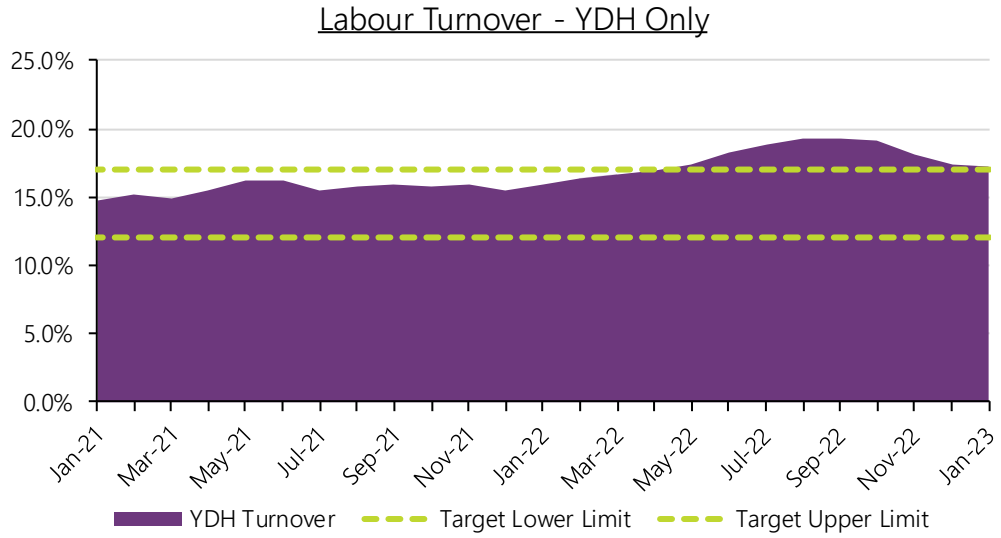
Turnover

January 23

YDH Group	YDH	SHS	SSL
17.53%	**17.27%**	**17.85%**	**19.00%**

January 20

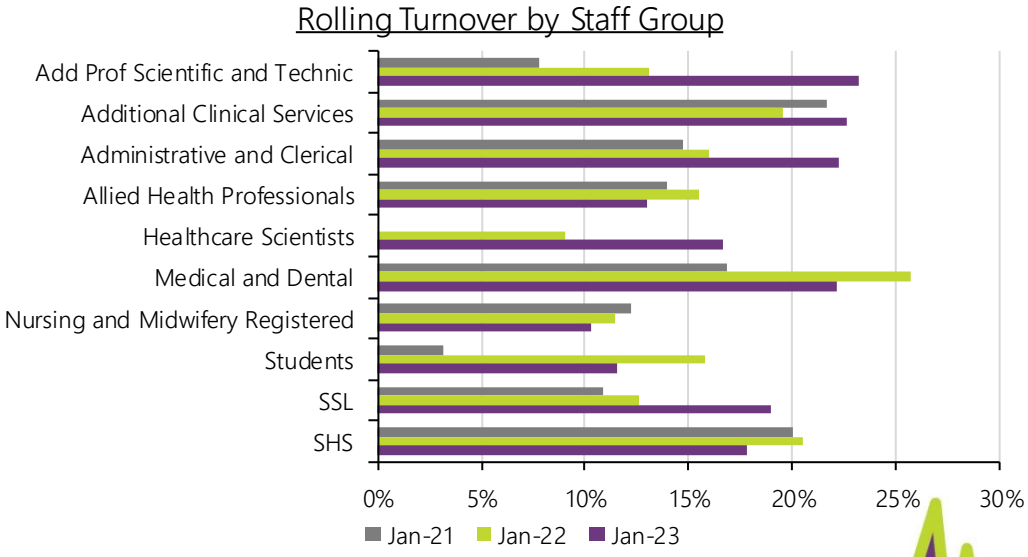
YDH Group	YDH	SHS	SSL
17.90%	**16.52%**	**26.93%**	**13.95%**



Additional notes	Achievement	Diff
• Group Turnover:	**17.53%**	**-0.37%**
• Group Turnover 19/20:	17.90%	
• YDH Turnover:	**17.27%**	**0.75%**
• YDH Turnover 19/20:	16.52%	

Comments

Focus remains on reviewing and understanding turnover, ensuing interventions are in place to reduce the level of turnover by responding to the causes of colleagues leaving. A number of interventions are being developed as part of the focus on the BHS People Promise and retention programme.



Leaving Reasons - YDH

January 23

Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
394	**320**

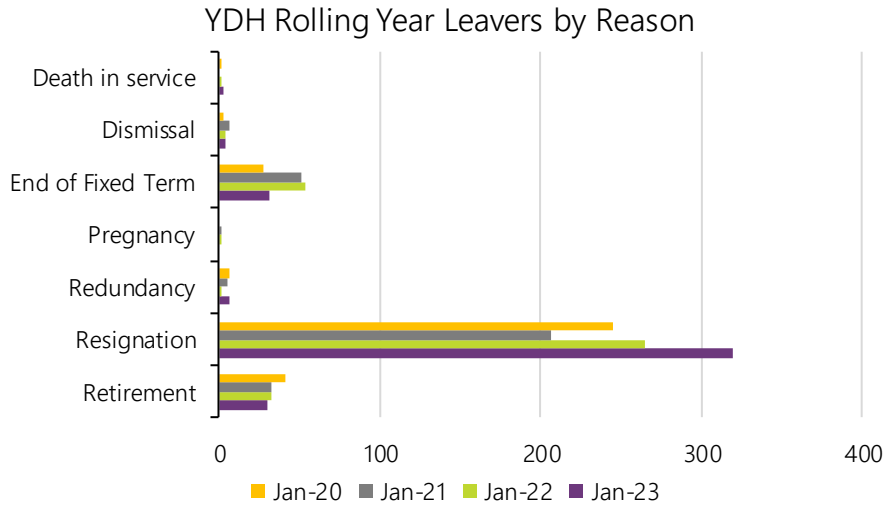
January 20

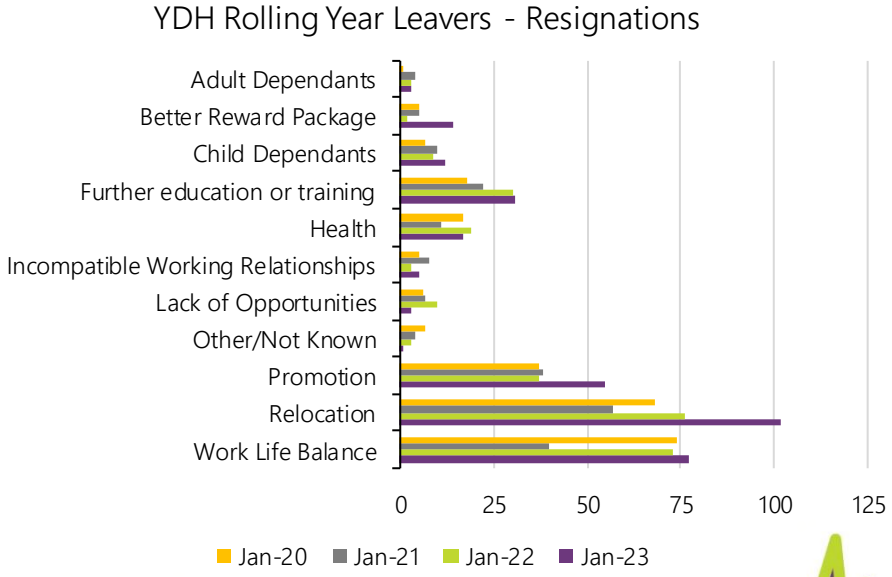
Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
302	**206**

Additional notes	Count	Diff	% Diff
• Rolling Year Leavers:	**394**	**+92**	**+30.46%**
• Rolling Year Leavers 19/20:	302		

Comments

The focus on better understanding the turnover within the admin and clerical and additional clinical services colleague groups continues. A recent review of exit interviews from YDH has reinforced the reasons for leaving as shown in this slide, the majority of leavers are leaving for career progression, relocation and retirement. The plans developed as apart of the People Promise focus will all support improvements in these areas.





Leaving Reasons - SSL

January 23

Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
57	**49**

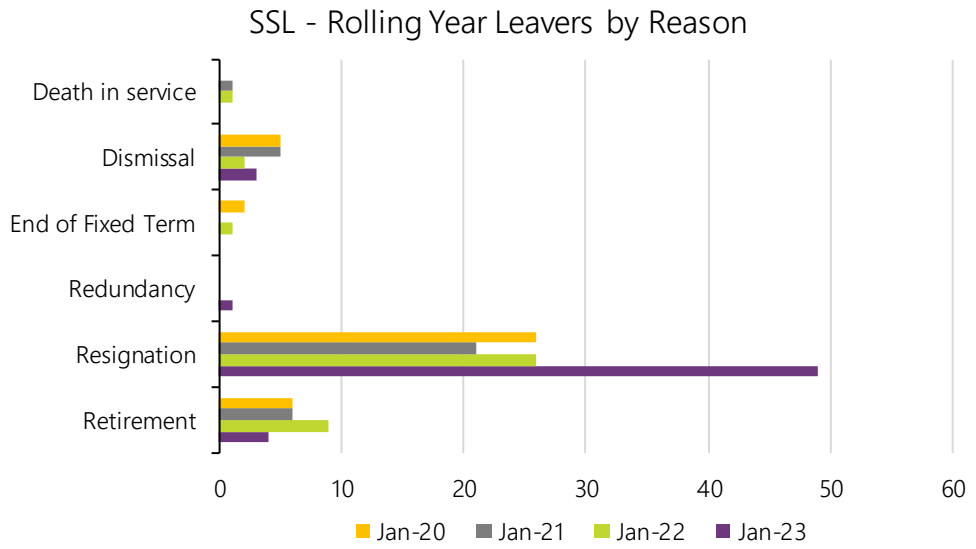
January 20

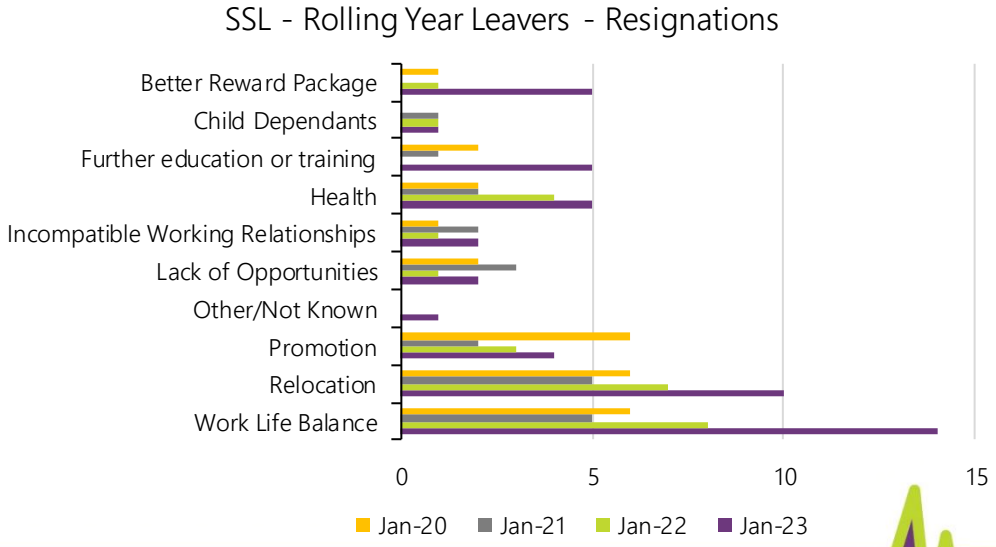
Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
39	**21**

Additional notes	Count	Diff	% Diff
• Rolling Year Leavers:	**57**	**+18**	**+46.2%**
• Rolling Year Leavers 19/20:	39		

Comments

Terms and Conditions – SSL's Terms and Conditions are seen as the major contributor towards the increased turnover rates being experienced, where employees can earn more and have better terms and conditions elsewhere within the local economy.





Leaving Reasons - SHS

January 23

Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
111	**93**

January 20

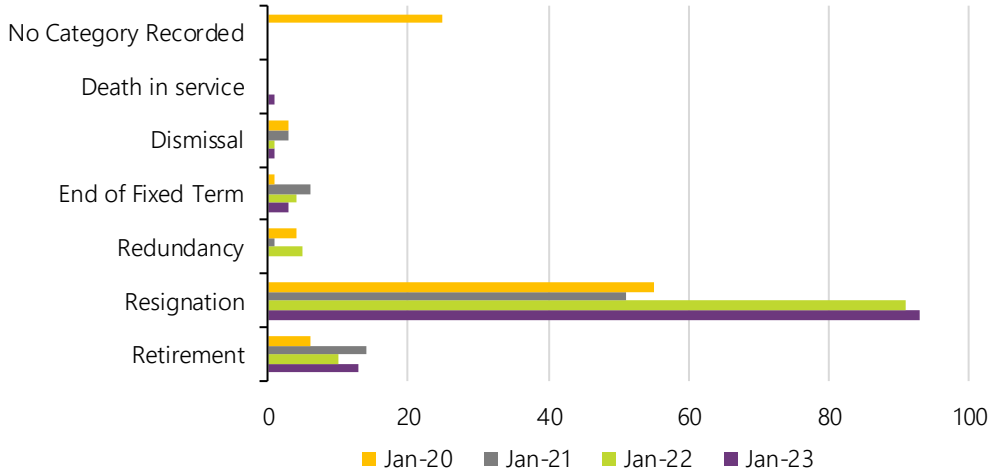
Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
94	**55**

Additional notes	Count	Diff	% Diff
• Rolling Year Leavers:	**111**	**+17**	**+18.1%**
• Rolling Year Leavers 19/20:	94		

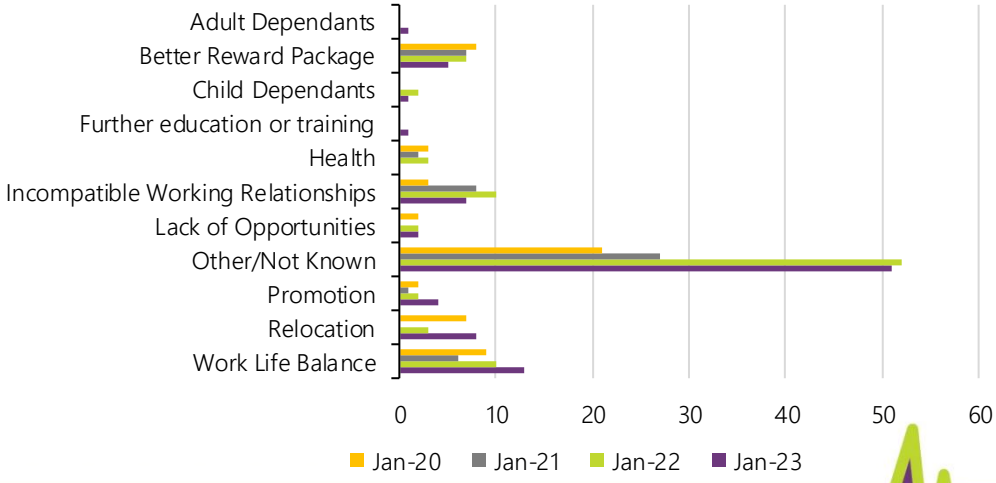
Comments

Reasons for resignations continue to be monitored by SHS.

SHS - Rolling Year Leavers by Reason



SHS - Rolling Year Leavers - Resignations



Leavers in Month

January 23

YDH Group	YDH	SSL	SHS
30	**22**	**4**	**4**

January 20

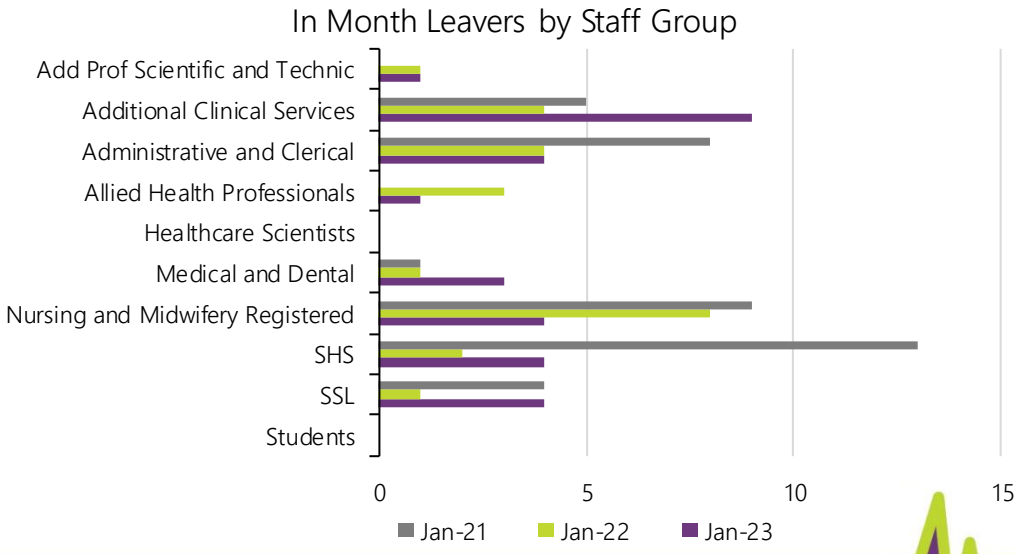
YDH Group	YDH	SSL	SHS
26	**20**	**1**	**2**

	Length of Service			
Staff Group	Less than 1 Yr	1 to 3 Yrs	Over 3 Yrs	**Total**
Add Prof Scientific and Technic	0	0	1	**1**
Additional Clinical Services	5	2	2	**9**
Administrative and Clerical	0	1	3	**4**
Allied Health Professionals	0	0	1	**1**
Healthcare Scientists	0	0	0	**0**
Medical and Dental	0	1	2	**3**
Nursing and Midwifery Registered	0	0	4	**4**
SSL	0	0	0	**0**
SHS	--	--	--	**4**
Total	**5**	**4**	**13**	**26**

Additional notes	Count	Diff	% Diff
• In Month Leavers:	**30**	**+4**	**+15.38%**
• In Month Leavers 19/20:	26		

Comments

Analysis shows that individuals are leaving within the first 3 years and in some instances within the first 12 months. The reasons for this are currently being explored and actions to address will be reported and monitored through the Trust People Committee.



Vacancies Being Recruited to - YDH Group

Vacancies being recruited to (FTE)	Nov-22	Dec-22	Jan-23
Additional Clinical Services	9.4	1.0	6.0
Additional Prof Scientific & Technical	7.3	17.0	4.6
Admin & Clerical	14.1	10.2	13.7
Allied Health Professionals	20.7	10.0	19.0
Ancillary	0.0	0.0	0.0
Estates	0.0	0.0	0.0
HCA's	20.0	27.0	23.0
Medical	17.0	17.0	30.4
Medical Training	6.0	6.0	7.0
Senior Managers	0.0	0.0	0.0
SSL	12.6	5.8	10.7
Specialist Nursing / Band 6	3.4	10.4	3.8
Nursing and Midwifery Qualified - Childrens	0.0	0.0	0.0
Nursing and Midwifery Qualified - Ward Areas	15.0	10.0	10.0
Nursing and Midwifery Qualified - EAU / ED	0.0	0.0	5.0
Nursing and Midwifery Qualified - ICU	0.0	0.0	0.0
Nursing and Midwifery Qualified - Outpatients	1.0	1.0	3.2
Nursing and Midwifery Qualified - Midwifery	0.0	0.0	0.0
Nursing and Midwifery Qualified - Theatres	6.0	0.0	0.0
Nursing and Midwifery Qualified - Total	**22.0**	**11.0**	**18.2**
Total	**132.5**	**115.4**	**136.4**

Additional notes

Sickness Absence

December 22

YDH Group	YDH	SHS	SSL
4.97%	**4.71%**	**5.02%**	**6.88%**

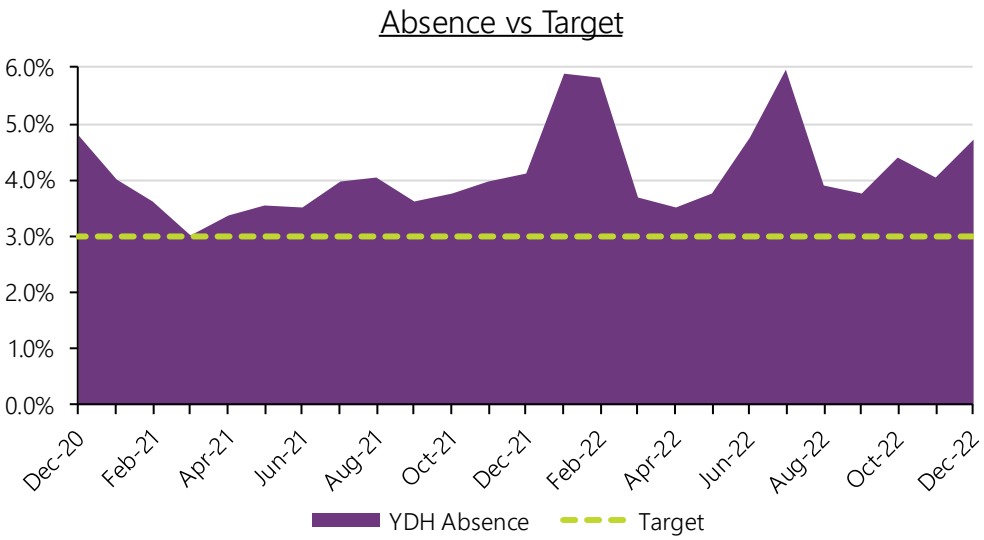
December 19

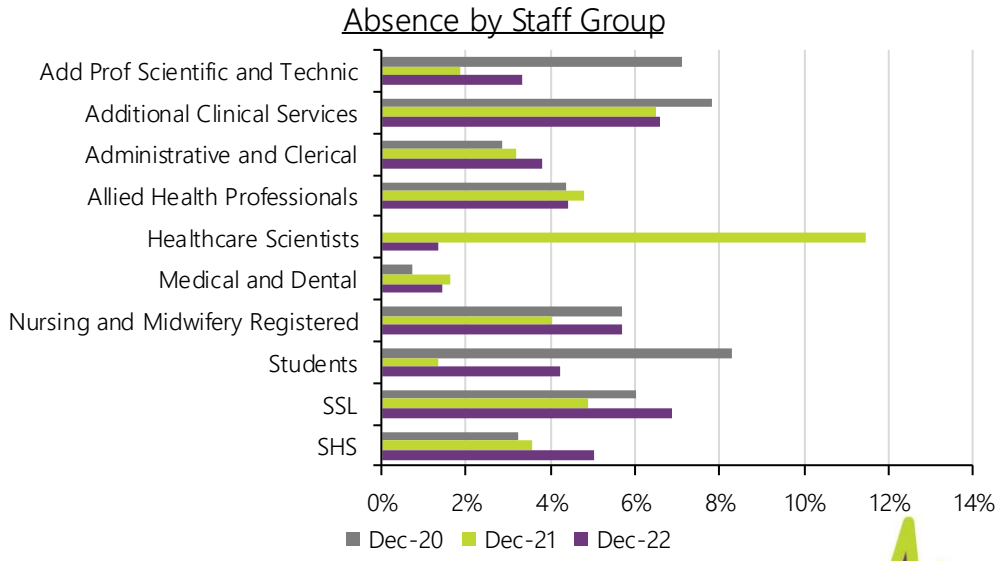
YDH Group	YDH	SHS	SSL
3.36%	**3.01%**	**4.12%**	**3.75%**

Additional notes	Count	Diff
• YDH Covid Absence (All absence):	**0.57%**	
• SSL Covid Absence (All absence):	1.13%	
• Group 12 month sickness absence:	**4.78%**	**1.93%**
• Group 12 month sickness absence 19/20:	2.85%	

Comments

Sickness Absence has increased - driven mainly by seasonal infections over the last 12 months. This is primarily affecting SSL services but also across all staff groups.
Please note that the Absence figures only relate to sickness absence, and is reported one month in arrears.





Statutory Training

January 23

YDH Group	YDH	SHS	SSL
85.56%	**84.59%**	**84.58%**	**95.02%**

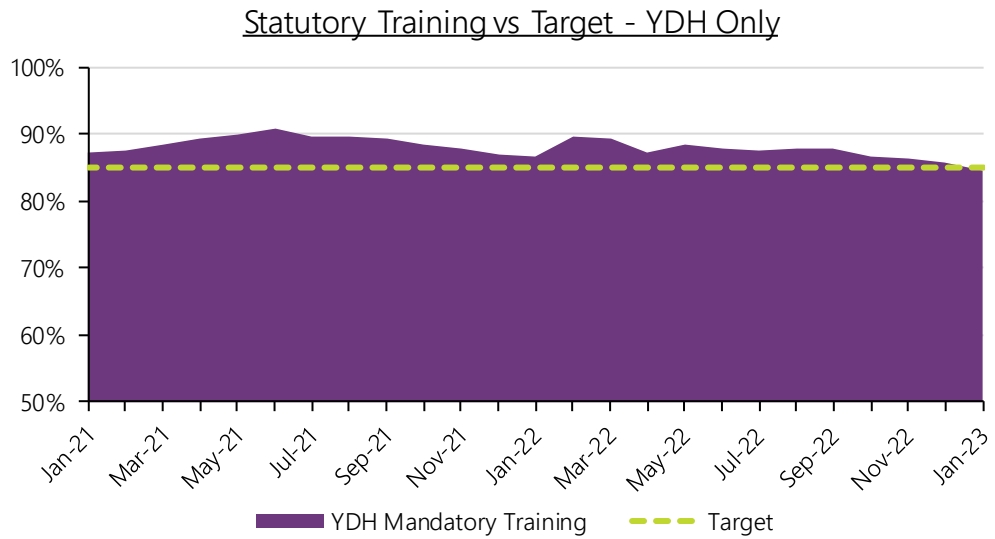
January 20

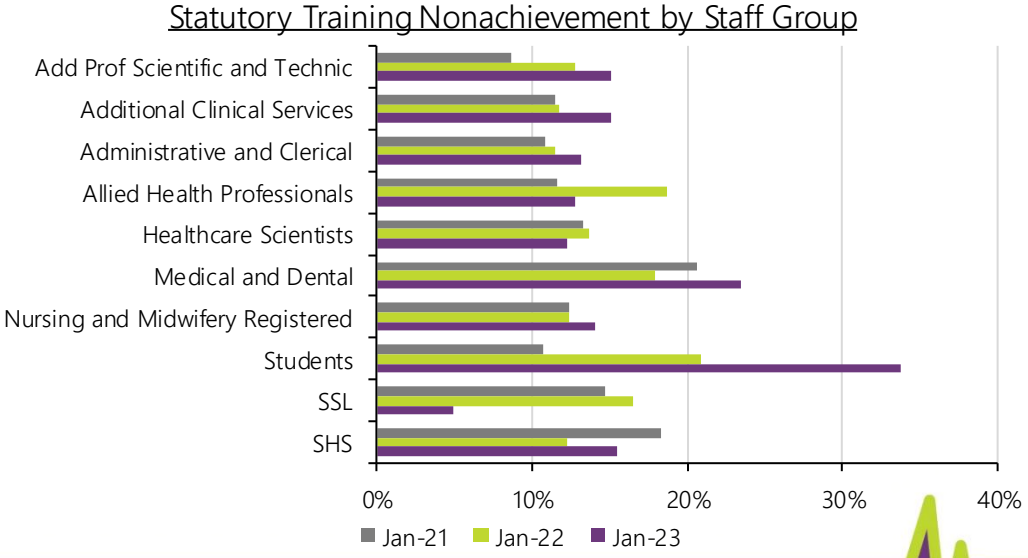
YDH Group	YDH	SHS	SSL
89.71%	**90.69%**	**80.20%**	**92.51%**

Additional notes	Count	Diff
• Group Statutory Training:	**85.56%**	**-4.15%**
• Group Statutory Training 19/20:	89.71%	
• YDH Statutory Training:	**84.59%**	**-6.10%**
• YDH Statutory Training 19/20:	90.69%	

Comments

Remains over target, however Infection Control, Information Governance, and Resus remain a focus. Additional training sessions are being provided on the Wards to support staff who are unable to be released. The Statutory training calculations include the Health, Safety and Welfare element from Aug '21 onwards.





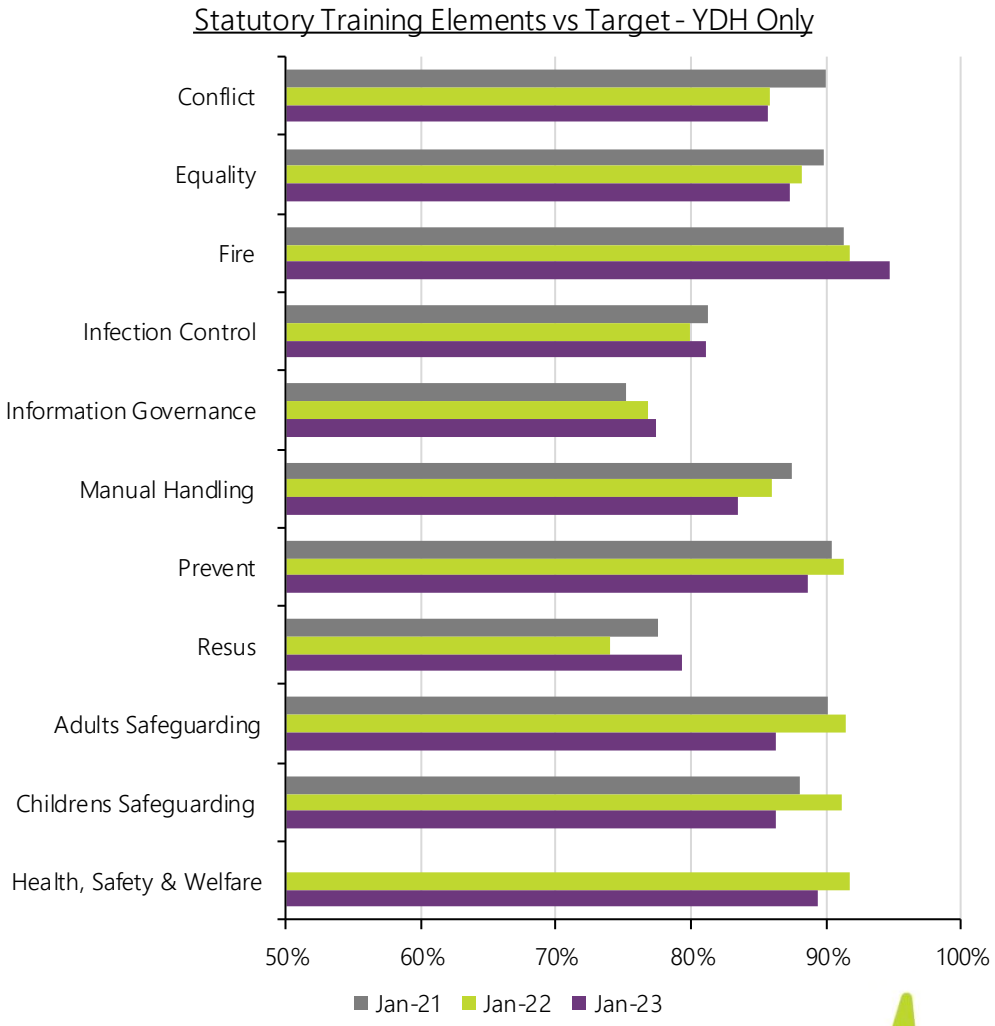
Statutory Training Elements

January 23

Overall Achievement	Conflict	Equality
85.56%	85.63%	87.32%
Fire	**Infection Control**	**Information Governance**
94.66%	81.16%	77.41%
Manual Handling	**Prevent**	**Resus**
83.38%	88.66%	79.32%
Childrens Safeguarding	**Adults Safeguarding**	**Health, Safety & Welfare**
86.29%	86.19%	89.35%

Comments

Please note that the trust's target for statutory training is 85%, with the safeguarding elements benchmarked against a 90% target. Both YDH and SFT Trusts have started to work together to align Mandatory Training programmes and agree targets and reporting approaches in preparation for the upcoming Merger.



Safeguarding Training

January 23

Childrens Safeguarding	Adults Safeguarding
86.29%	86.19%

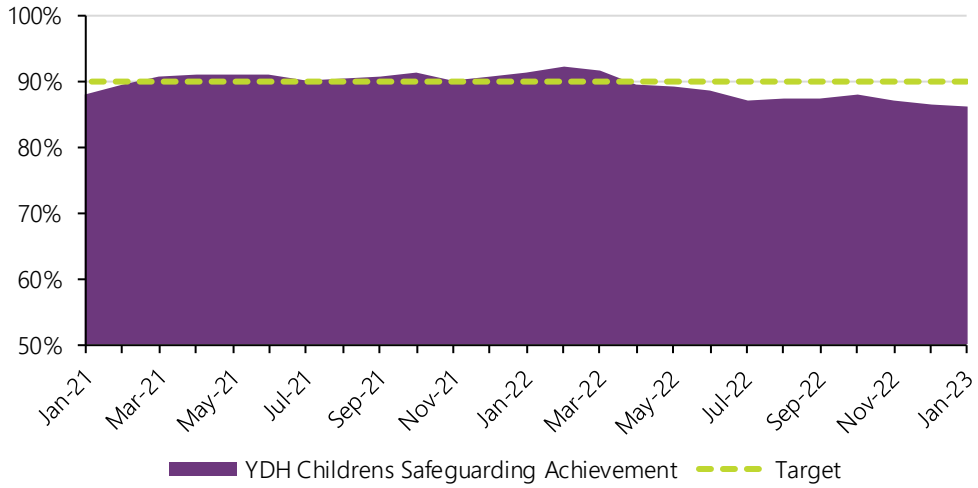
Childrens Safeguarding - Level 1	Childrens Safeguarding - Level 2	Childrens Safeguarding - Level 3
88.59%	85.26%	89.02%

Additional notes	Achievement
• Childrens Safeguarding Level 1 - YDH	85.20%
• Childrens Safeguarding Level 2 - YDH	85.47%
• Childrens Safeguarding Level 3 - YDH	89.02%
• Adults Safeguarding - YDH	85.61%

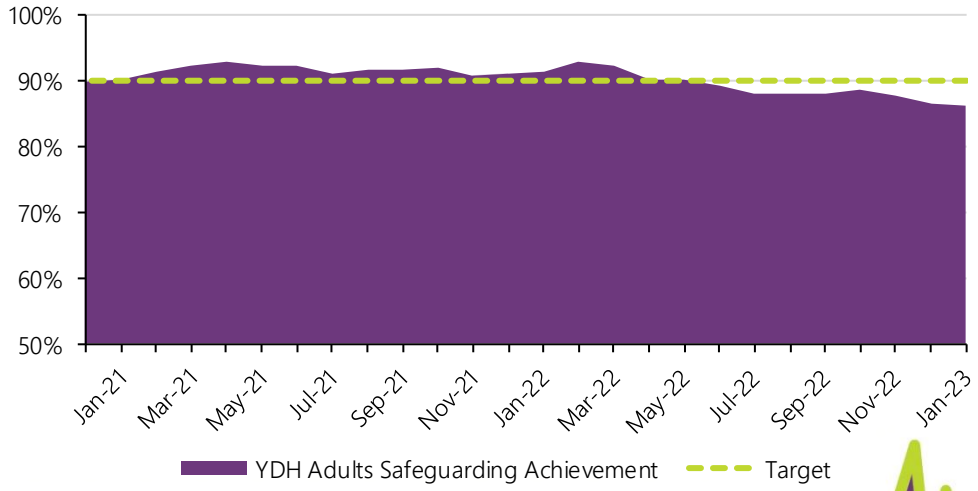
Comments

Please note that the trusts contractual target for safeguarding training compliance is 90%.

Childrens Safeguarding Achievement vs Target - YDH Only



Adults Safeguarding Achievement vs Target - YDH Only



Appraisals

January 23

YDH Group	YDH	SHS	SSL
84.33%	**81.43%**	**92.45%**	**93.42%**

January 20

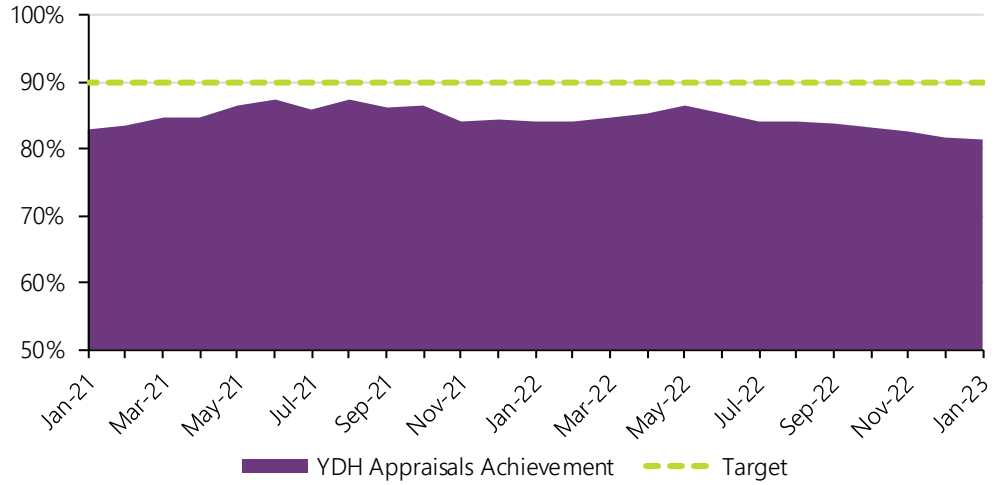
YDH Group	YDH	SHS	SSL
89.22%	**88.50%**	**93.27%**	**90.14%**

Additional notes	Count	Diff
• Group Appraisals:	**84.33%**	**-4.89%**
• Group Appraisals 19/20:	89.22%	
• YDH Appraisals:	**81.43%**	**-7.07%**
• YDH Appraisals 19/20:	88.50%	

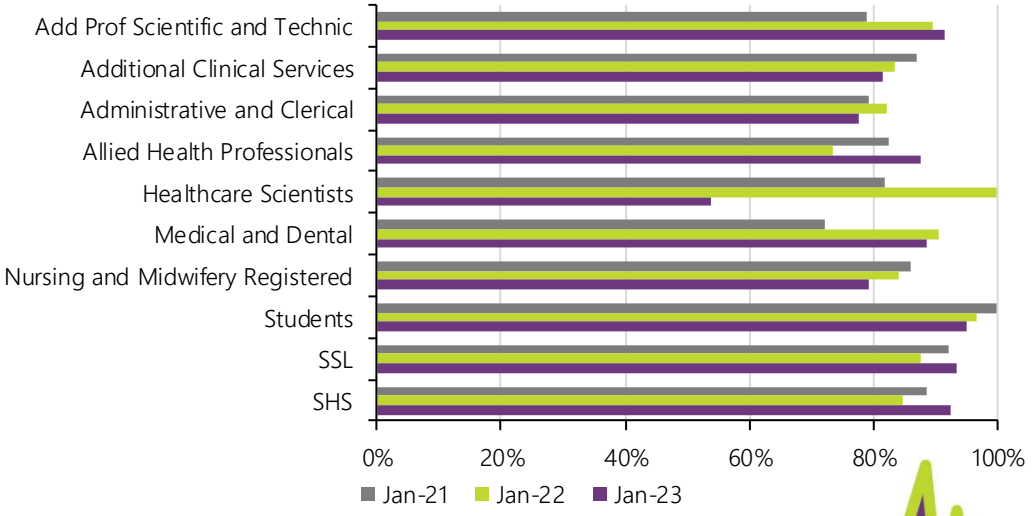
Comments

The YDH Group 12 month appraisals achievement in January was 78.4%. Appraisal performance is below target as expected because of Covid, however there is now a real focus on improving this over the following few months.

Appraisals vs Target - YDH Only



Appraisals by Staff Group



Appendix A - Slide Index

Slide Index - Performance

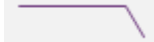
Appendix A - Slide Index

Slide Index - Workforce

Appendix B - YDH Quality Measures

January 23

Admissions	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend
Number of medical outliers in acute wards (beddays)	1063	1252	1333	1152	971	1033	1134	978	1183	1126	1354	1196	
MSA breaches: Acute wards	0	5	0	0	0	0	0	0	0	0	0	0	
Number of patients transferred between acute wards after 10pm	84	143	102	81	61	51	53	70	66	73	95	98	

Mortality (acute services)	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend
Hospital Standardised Mortality Ratio (HSMR)	0.93	0.95	0.97	0.97	0.97	0.95	0.93	0.92	0.90	--	--	--	
Summary Hospital-level Mortality Indicator (SHMI)	95.90	97.60	95.80	96.27	95.00	94.29	94.11	--	--	--	--	--	

Incident reporting	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend
No of Serious Incidents Requiring Investigation (SIRIs)/Never Events - acute services	0	1	0	0	2	1	0	2	0	1	1	1	

Infection Control	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend
Clostridium Difficile cases	0	1	1	0	0	1	4	0	0	1	0	0	
MRSA bacteraemias (post)	0	0	0	0	0	0	0	0	0	0	0	0	
E. coli bacteraemia	0	1	4	2	1	2	4	5	3	2	3	2	
Methicillin-sensitive staphylococcus aureus	1	0	0	0	1	1	3	2	4	3	3	2	

Appendix B - YDH Quality Measures (2)

January 23

Maternity	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend
No. of still births	0	0	0	0	0	1	0	0	0	0	1	1	
No. of babies born in unexpectedly poor condition	0	2	0	2	1	0	1	4	0	2	0	0	

Falls	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend
Number of patient falls - all services	78	108	101	78	55	70	87	72	72	80	94	79	
Rate of falls per 1,000 occupied bed days - all services	7.96	9.42	9.20	6.95	5.17	6.10	7.42	6.54	6.09	6.96	7.74	6.69	
Number of falls resulting in harm - all services	3	4	3	2	1	6	7	6	3	0	4	2	
Rate of falls resulting in harm per 1,000 occupied bed days - all services	0.31	0.35	0.27	0.18	0.09	0.52	0.60	0.55	0.25	0.00	0.33	0.17	

Pressure ulcer damage	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend
Acute wards - number of incidents	885	1118	987	1001	1144	1114	984	915	1025	921	930	938	
Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	1.43	1.05	0.91	1.07	0.75	1.05	0.87	0.92	0.42	0.70	1.01	1.07	

Cardiac Arrests	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend
No. ward-based cardiac arrests - acute wards	12.00	3.00	11.00	9.00	3.00	4.00	14.00	4.00	5.00	6.00	5.00	5.00	

Appendix C - YDH Corporate Scorecard

January 23

Accident & Emergency	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend	Threshold
4-hour performance: Accident and Emergency department (ED)	86.3%	77.7%	78.0%	84.5%	84.4%	78.0%	78.2%	72.2%	66.4%	69.1%	63.4%	68.2%		>=95% = Green >=85% - <95% = Amber <85% = Red
4-hour performance: Trust-wide	86.3%	77.7%	78.0%	84.5%	84.4%	78.0%	78.2%	72.2%	66.4%	69.1%	63.4%	68.2%		

Cancer	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend	Threshold
Maximum 2-week wait from GP referral (suspected cancer)	82.3%	78.6%	78.3%	77.7%	57.8%	51.5%	46.2%	40.3%	47.2%	59.4%	49.7%	--		>=93% = Green <93% = Red
Cancer - 28 days Faster Diagnosis All Cancers	76.5%	73.4%	74.3%	69.7%	74.4%	72.3%	75.9%	67.4%	75.0%	66.4%	69.7%	--		>=75% = Green <75% = Red
Cancer - maximum 31 day wait from diagnosis to first treatment	99.0%	90.4%	91.6%	93.4%	91.6%	92.2%	96.8%	87.9%	90.8%	91.5%	87.8%	--		>=96% = Green <96% = Red
Cancer - maximum 62 day wait from urgent GP referral	63.4%	67.8%	80.0%	71.9%	66.4%	64.2%	69.2%	65.2%	59.9%	61.9%	51.4%	--		>=85% = Green <85% = Red
Cancer: 62-day wait from referral to treatment for urgent GP referrals – number of patients treated on or after day 104	4	6	5	1	6	6	7	6	5	11	12	--		0 = Green >0 = Red

Appendix C - YDH Corporate Scorecard (2)

January 23

Referral to treatment (RTT)	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend	Threshold
Diagnostic 6-week wait - acute services	78.5%	82.8%	78.8%	76.3%	74.4%	66.1%	66.5%	74.6%	74.0%	73.8%	69.4%	61.6%		>=99% = Green >=98% - <99% = Amber <98% = Red
Incomplete pathway: percentage of people waiting under 18 weeks	65.6%	64.5%	63.9%	66.2%	65.9%	67.1%	68.4%	68.6%	70.5%	70.8%	69.7%	67.9%		>=92% = Green <92% = Red
52 week RTT breaches	692	756	837	811	805	827	799	743	646	564	558	497		0 = Green <= Plan = Amber > Plan = Red
78 week RTT breaches	179	183	219	174	103	90	92	96	72	62	58	51		N/A
104 week RTT breaches	24	37	30	12	2	0	0	0	4	1	2	0		0 = Green <= Plan = Amber > Plan = Red
Referral to Treatment (RTT) incomplete pathway waiting list size	11273	11623	11722	12157	12230	12285	12388	12781	13062	13705	13874	14194		<= Plan = Green > Plan = Red

Intermediate Care	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend	Threshold
Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1	84.6%	85.0%	83.5%	83.5%	86.2%	82.6%	82.9%	84.0%	84.1%	79.9%	80.6%	79.5%		>=95% = Green >=85% - <95% = Amber >85% = Red

Appendix C - YDH Corporate Scorecard (3)

January 23

Workforce	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Trend	Threshold
Mandatory training: percentage completed	89.5%	88.7%	87.3%	88.0%	87.2%	86.3%	87.0%	86.8%	87.0%	86.8%	85.9%	85.6%		All courses >=90% = Green Overall rate <80% = Red Any other position = Amber
Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)	3.3%	2.7%	3.0%	4.1%	5.2%	4.3%	4.8%	4.1%	4.4%	5.3%	4.6%	5.5%		<=5% = Green >5% to <=7.5% = Amber >7.5% = Red
Sickness absence levels - rolling 12 month average (Trust-wide)	4.1%	4.2%	4.2%	4.5%	4.6%	4.8%	4.7%	4.7%	4.7%	4.8%	4.8%	4.6%		<=4.6% = Green >4.6% to <=5.1% = Amber >5.1% = Red
Sickness absence levels - monthly average (Trust-wide)	5.7%	4.1%	3.7%	4.0%	4.7%	5.8%	4.2%	3.8%	4.6%	4.2%	5.0%	4.3%		<=4.6% = Green >4.6% to <=5.1% = Amber >5.1% = Red
Reduce the number of working days lost due to stress and anxiety (Trust-wide)	427.8	511.5	458.6	497.5	512.2	524.4	552.4	502.4	576.9	640.9	613.5	453.3		Monitored using Special Cause Variation Rules. Report by exception.
Retention / turnover rates (Trust-wide)	16.5%	17.0%	17.5%	17.8%	18.7%	19.3%	19.6%	19.6%	19.3%	18.6%	17.5%	17.5%		=<12% = Green 12% to <15% = Amber >15% = Red
Career conversations (12 months) - formerly 'Performance review (12-month)'	80.4%	80.5%	78.6%	79.1%	77.9%	77.7%	79.0%	79.2%	79.0%	77.0%	77.1%	78.4%		Trajectory to be agreed

Somerset NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Quality and Performance Exception Report
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Associate Director – Planning and Performance Senior Performance Manager Chief of People and Organisational Development Deputy Chief Nurse Director of Elective Care
PRESENTED BY:	Chief Finance Officer
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. Covid-19 continues to have a significant impact on a range of access standards, whilst restoration work is being undertaken to reduce the number of patients waiting and to shorten waiting times. As referrals recover to pre-Covid-19 levels this will also have an impact on services and numbers waiting. Urgent and emergency patients continue to be prioritised, to receive the treatments they need. Areas in which performance has been sustained or has notably improved include:

	• Compliance in respect of waiting times inside of six weeks for Adult, Learning Disabilities, Older Persons and Children and Young People's mental health services. • Reducing the numbers of patients waiting 52 weeks, 78 weeks and 104 weeks from referral to treatment with our acute services. • The percentage of people beginning treatment with a NICE-recommended care package within two weeks of referral for Early Intervention of Psychosis; • The percentage of Talking Therapies patients moving to recovery; • Patients followed up within 72 hours of discharge from an adult mental ward. Areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • the percentage of patients seen within four hours and spending longer than 12 hours, in our accident and emergency department and minor injury units; • CAMHS Eating Disorders - Urgent referrals to be seen within one week and Routine referrals to be seen within four weeks; • the percentage of people waiting under six weeks for a diagnostic test; • the numbers of people waiting 18 weeks or more to be seen by our community physical health services, including our community dental service.
Recommendation	The Board is asked to discuss and note the report.

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

☒ Obj 6	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ Obj 7	Live within our means and use our resources wisely
☒ Obj 8	Develop a high performing organisation delivering the vision of the Trust

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

Details:

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

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

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

Equality

The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

☒ This report has not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics

☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planning to mitigate any identified inequalities

Public/Staff Involvement History

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

No recommendations are being made, other than to ask the Board to discuss and note the report.

Previous Consideration

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

The report is presented to every Board meeting.

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

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

SOMERSET NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE EXCEPTION REPORT: JANUARY 2023

1. PURPOSE

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

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

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

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

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

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

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

1.7 Supporting information relating to referral levels, activity levels, lengths of stay, tumour-site-specific activity and performance, and other key measures for our services is included in Appendix 5. The activity information in Appendix 5 shows the levels and trends for the current year and last year, and also for 2019/20, the most recent year unaffected by the impact of the pandemic.

Overview

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

Successes	**Priorities**
• we remain ahead of planned levels for making reductions in the numbers of patients waiting over 104 weeks and over 78 weeks from referral to treatment. • the six-week diagnostic wait 75% regional ambition for March 2023 was again met in the month. • urgent and emergency patients continue to receive the treatments they need. • compliance remains high in respect of mental health inpatients receiving a follow-up within 72 hours of discharge. • our Talking Therapies (IAPT) service continues to maintain recovery rates which are above the national standard. • the compliance level in respect of mandatory training has been maintained despite the operational challenges faced by services.	• continue to maintain a safe service and making sure urgent patients are treated as quickly as possible within the context of the challenges the current coronavirus outbreak brings. • continue to support the health and wellbeing, both physically and psychologically, of colleagues across the Trust, as they continue to deliver high quality care to patients whilst managing significant and ongoing pressures associated with COVID-19 and rising levels of demand. • continue to restore and expand capacity above pre-COVID-19 levels, to address backlogs in routine elective work which has built up. • work with the Somerset system to encourage continued referrals and presentations at hospital where needed and appropriate, especially in respect of urgent or emergency care.
Opportunities	**Risks and Threats**
• continue to progress the health and wellbeing plans for our colleagues at pace; this includes the psychological support offered alongside practical aspects of support such as accommodation provision and nutrition. • continue with new ways of working, particularly through the use of technology. • continue to adapt our recruitment practice, developing more innovative arrangements and reducing time to hire significantly. • develop reporting solutions to improve robustness of recording and reporting.	• COVID-19 will continue to have a significant impact on clinical capacity and the Trust's ability to recover elective activity, which will continue to have a negative impact on waiting times for some time to come. • delays in discharging medically fit patients needing domiciliary care will result in further cancellations of surgery which will reduce our capacity to treat long waiting patients. • significantly increasing levels of demand, particularly for urgent care and mental health services, leading potentially to increased pressures on teams and longer waiting times. • nursing vacancy levels remain challenging. Sickness / absence also presents a challenge for colleagues within some critical areas, and we need to ensure that we continue to support colleagues accordingly.

Safe

Infection Prevention and Control (IPC) performance is assessed by means of the numbers of key healthcare associated infections (HCAI) (Trust apportioned) against agreed thresholds. These are: MRSA bloodstream infections (BSI): zero tolerance, Clostridioides difficile (C. diff) infection (CDI): 41 cases, MSSA BSIs: 30 cases E. coli BSIs: 73 cases, Klebsiella BSIs: 23 Pseudomonas aeruginosa BSIs: 12.

Current performance (including factors affecting this)

- **MRSA –** There were no Trust-attributed MRSA bloodstream infections (BSIs) reported during January 2023. The total for the year to date is one case.
- **C. diff** - There were seven Trust-attributed cases in January 2023, bringing the total to 44 against a threshold for the year of 41.
- **MSSA –** Five Trust-attributed MSSA BSIs were reported during January 2023, bringing the total for the year to 40, against an internal threshold of 30.
- **E. coli** - Nine Trust-attributed E. coli BSIs were reported in January 2023, bringing the total to 74 against a threshold of 73.
- **Klebsiella –** Three Trust-attributed Klebsiella BSIs were reported in January 2023. The total to date is 33 against a threshold of 23.
- **Pseudomonas –** No Trust-attributed Pseudomonas aeruginosa BSI were reported in January 2023 leaving the total at six against a threshold of 12.

Respiratory Viral Infections

- **COVID-19:** 157 inpatient cases of COVID-19 were identified during January 2023, of which 77 were healthcare-attributed.
- **Influenza:** 37 inpatient cases were identified during January 2023, predominantly 'Flu A. Most cases were adults over 65 years; all were admitted with 'flu.
- **Respiratory Syncytial Virus (RSV):** 57 inpatient cases of RSV were identified during January 2023, fewer than in December 2022. The season is following the usual pattern, due to end around the end of March 2023. Children have been the affected majority. However, as the season approaches its end there are currently more adults than children hospitalised with RSV.

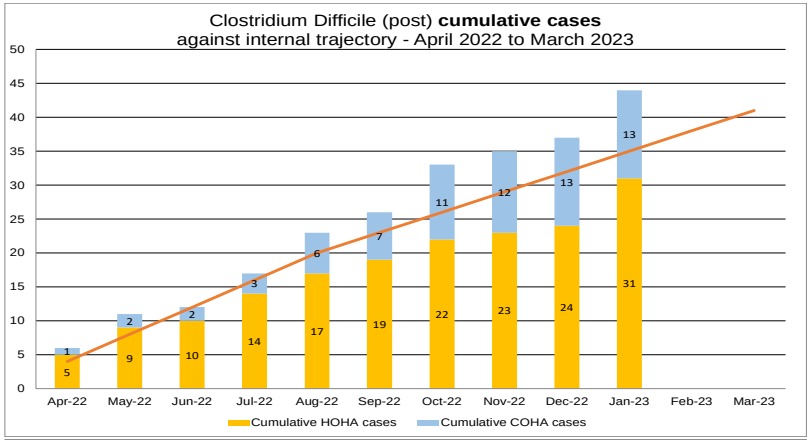
Outbreaks

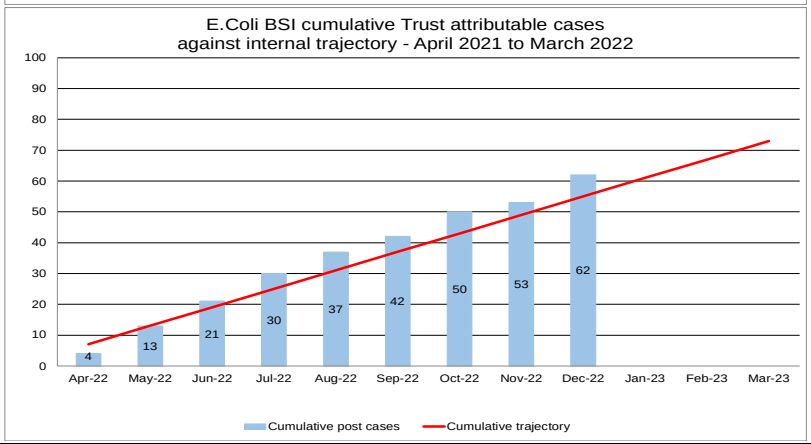
- There were 14 respiratory virus outbreaks affecting inpatient wards during December 2022. These were a mixture of COVID and influenza.

Focus of improvement

- Overall, the case numbers of respiratory viruses and outbreaks remained high through January. 'Flu and RSV levels are following the usual seasonal pattern and are now receding. COVID case numbers have reduced but continue to be a challenge. They have reduced to what appears to be a residual level of up to around 45 inpatient cases indicating the virus has not yet settled to a seasonal pattern.
- A new skin cleansing product has been implemented prior to peripheral cannula insertion which is part of the improvement work linked to MSSA BSIs.

Line/Bar Charts





Recent performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
MRSA	0	1	0	0	O	0
C.Diff	6	3	7	2	2	7
MSSA	0	5	5	2	3	5
E.coli	7	5	8	3	9	11

Safe

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

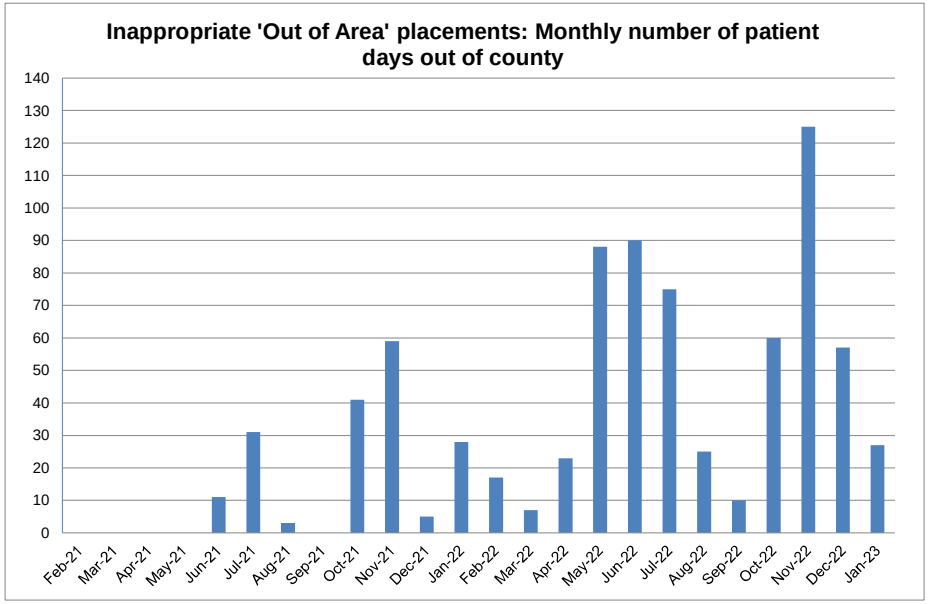
Current performance (including factors affecting this)

- During January 2023, one patient was placed out of area, for a total of 27 days.
- The patient returned to a Somerset inpatient bed on 28 January 2023.
- There are no other patients placed out of area.

Focus of improvement work

- We continue have amongst the lowest levels of inappropriate out of area placements of all providers of mental health services nationally.
- The majority of out of area placements are due to patients requiring admission into our Psychiatric Intensive Care Unit (PICU). With only 10 beds available there are occasions when, due to clinical acuity or gender, it would be unsafe to admit a patient.
- When a patient is so placed, a key worker is immediately assigned to maintain regular contact with the patient until the patient is either transferred back to our wards, discharged, or moved to secure services. The placements sought are always as close to Somerset as possible.
- At times, espisodes relate to patients awaiting transfer to secure services. We work closely with other NHS providers, to facilitate such transfers and closely montitor processes to minimise risk.
- The service is reviewing processes to ensure barriers to repatriation and/or discharge of patients are minimised and escalated with system partners where appropriate.

Bar Chart



How do we compare

Data published by NHS Digital shows that we continue have amongst the lowest levels of inappropriate out of area placements of all providers of mental health services nationally.

Recent Performance

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

Area	Aug	Sep	Oct	Nov	Dec	Jan
Number of Days	25	10	60	125	57	27
Number of patients	2	2	5	6	4	1

esponsive

The Accident & Emergency (A&E) 4-hour standard is a measure of the length of wait from arrival in an Emergency Department (ED) to the time the patient is discharged, admitted or transferred to another provider. The target is that at least 95% of patients will wait less than four hours in the Emergency Department.

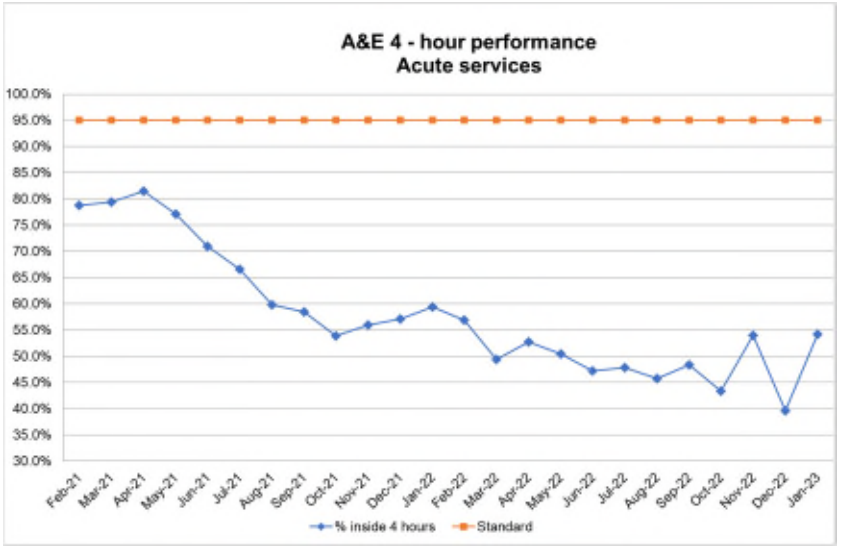
Current performance (including factors affecting this)

- A&E 4-hour performance was 54.2% for the Musgrove site in January 2023, up from 39.6% in December 2022. Compliance within Minor Injury Units (MIUs) was 96.3%. Overall compliance was 77.8%, hence still below the 95% national standard.
- COVID-19 admissions have remained lower than the peaks seen in previous waves of the pandemic. Most patients being admitted with COVID-19 are admitted because of other conditions they have.
- A&E attendances in January 2023 were 3.4% below 2019 levels and 0.3% below January 2021 levels. Overall, emergency admissions in January 2023 were 7.6% below pre-COVID levels, with a significant reduction for zero lengths of stay admissions. Hospital stays of one or more days were down by 6.1%%. Those patients being admitted to an inpatient bed continue to have longer stays. This is consistent with the low rate of discharge for medically fit patients due to domiciliary capacity challenges and a shortfall in bedded care packages. A reduction in the shorter stays may reflect a higher acuity of patients being admitted.

Focus of improvement work

- The recovery plan developed for the ED focuses on:
  1. Internal ED systems and processes, including triage and department flow.
  2. Workforce, including roles and responsibilities, allocation, and internal professional standards.
  3. The wider hospital system, including clinical pathways, new Surgical Decision Unit (SDU) and paediatrics, and hospital patient flow linked to ED escalation pressures.
  4. The wider system, including the implementation of the new SWAST Hospital Ambulance Liaison Officer (HALO) role, and a focus on ambulance handover.
  5. Onboarding of medical patients from the Acute Medical Unit to wards, where patients have been identified for planned discharge on the same day, has now been embedded on several wards.

Line Chart



How do we compare

National average performance for Trusts with a major Emergency Department was 49.6% in December 2022. Our performance was 39.6%. We were ranked 97 out of 110 trusts. With Minor Injury Unit attendances included, we were ranked 28, with performance of 70.5%.

Recent performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
Actual	45.8%	48.4%	43.4%	54.0%	39.6%	54.2%

Responsive

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

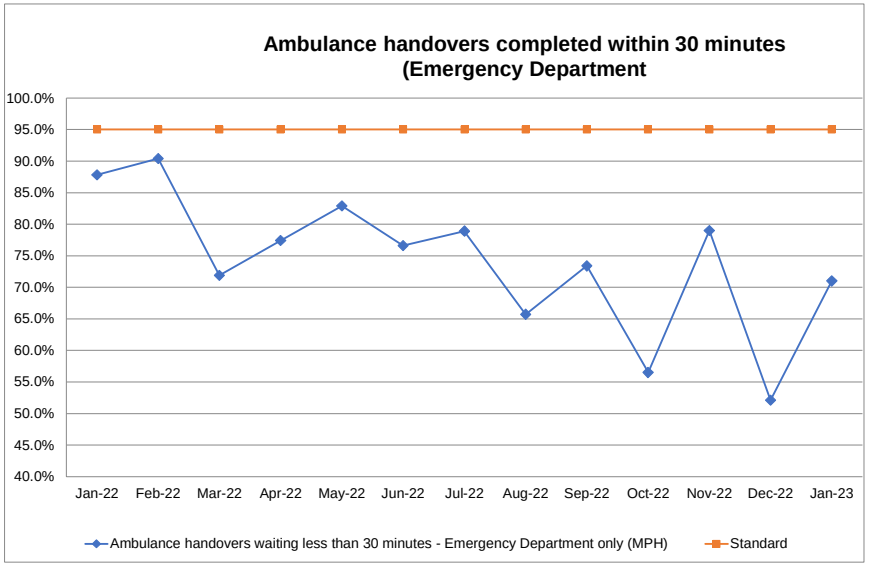
Current performance (including factors affecting this)

- During January 2023, of 2,020 patient arrivals by ambulance received into our Emergency Department (ED), a total of 1,434 (71.0%) were completed within 30 minutes, up from 52.1% in December 2022.
- In January 2023, 42.2% of all ambulance handovers were completed within 15 minutes, compared to 28.6% during December 2022. The average performance across all hospitals served by SWAST in January 2023 was 28.9%.
- Arrivals by ambulance accounted for 33.1% of all patients attending ED during January 2023, up from 29.3% of arrivals during December 2022.

Focus of improvement work

- The new South Western Ambulance Service NHS Foundation Trust (SWAST), Hospital Ambulance Liaison Officer (HALO) role has been implemented across both Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust, to support ambulance flow and handovers.
- HALO liaises with ED team leads and Patient Flow teams, flagging current and pending activity and flow options.
- The new role, along with other planned reviews of current available information, will enable further work to be undertaken to develop improvement plans.
- The ED improvement plan continues to test new ways of working to maximise flow within ED, supporting ambulance handovers.
- Onboarding of medical patients from the Acute Medical Unit to wards, where patients have been identified for planned discharge on the same day, has now been embedded on several wards.
- Bi-monthly meetings are held with the Integrated Care Board (ICB), and system providers, supporting improvement work.

Line Chart



How do we compare

In January 2023, 72% of all ambulance handovers at Musgrove Park Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 54%.

Recent performance

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

Area	Aug	Sept	Oct	Nov	Dec	Jan
Actual	65.7%	73.4%	56.5%	79.0%	52.1%	71.0%

Responsive

Referral to Treatment Time (RTT) is a measure of the length of time a patient waits from the point of referral through to receiving treatment. The target is for at least 92% of patients, who have not yet received treatment, to have been waiting less than 18 weeks at the month-end. Trusts should have no patients waiting over 52 weeks for treatment.

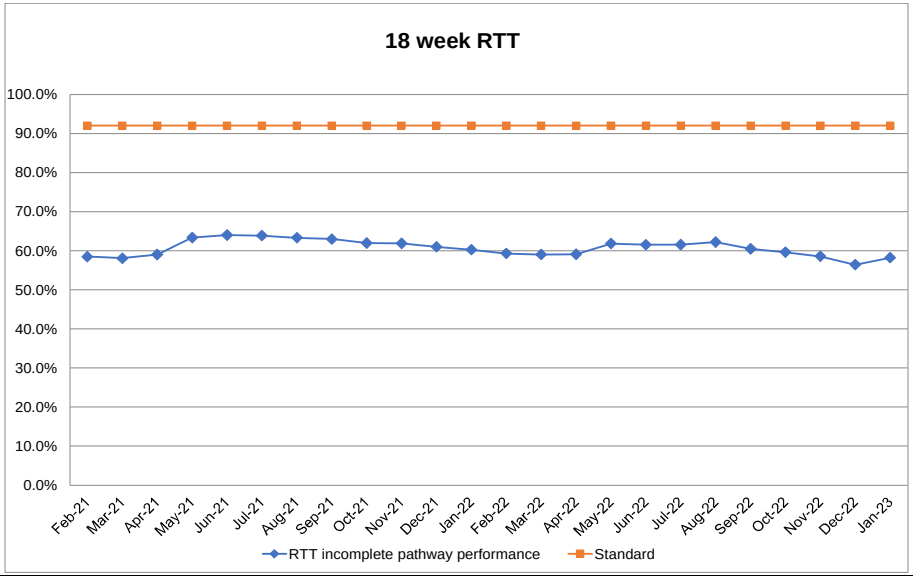
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 58.2% (acute + community) in January 2023.
- The over 18-week backlog decreased by 563 pathways. However, the total waiting list size increased, by 219 pathways, and was 4,022 above (i.e. worse than) trajectory (37,050 actual vs. 33,028). There was an increase in acute, but not community, pathways.
- RTT clock starts (i.e. referrals) in January 2023 were 19.5% above average pre-COVID levels (working days adjusted).
- 52-week waiters decreased by 59 pathways in January 2023 to 1,801 pathways, against a trajectory of 2,373. The number of patients waiting 78 weeks or more decreased by 56 pathways to 201. We reported three patients waiting over 104 weeks (due to clinical complexity).
- Until November 2021 the Trust remained one inpatient theatre's worth of capacity down due to the conversion of a theatre into critical care capacity. This along with other factors has resulted in a backlog of more complex, longer routine cases on the waiting list.
- Significant bed pressures and theatre staff sickness/shortages continue to limit full restoration of inpatient activity, along with other factors such as increasing patient complexity.

Focus of improvement work

- The number of patients needing surgery this year to avoid becoming a 78-week RTT waiter has been quantified for each specialty, and detailed plans continue to be progressed to manage these volumes through improved productivity, increased capacity (including use of the independent sector) and reprioritisation of theatre capacity across the system.
- A significant programme of work to support elective care recovery in the medium and long-term is in place.
- A programme of waiting list validation has been established, which includes contacting patients to check that they still need to be seen.

Line Chart



How do we compare

The national average performance was 58.0% in December 2022, the latest data available. Our performance was 56.4%. National performance deteriorated by 2.0% between November and December 2022, and the number of 52-week waiters across the country decreased by 540 to 406,035 (representing 5.5% of the national waiting list compared with 4.9% for the Trust).

Performance trajectory: 104+ and 78 week wait performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
104 week trajectory	12	10	16	16	16	8
104 week actual	16	13	7	1	3	3
78 week trajectory	417	401	333	432	660	559
78 week actual	330	297	262	219	257	201

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

Responsive

Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) service – Beginning treatment within six weeks of referral. The target is for at least 75% of patients who are discharged during the reporting month to have had their first treatment within six weeks of referral.

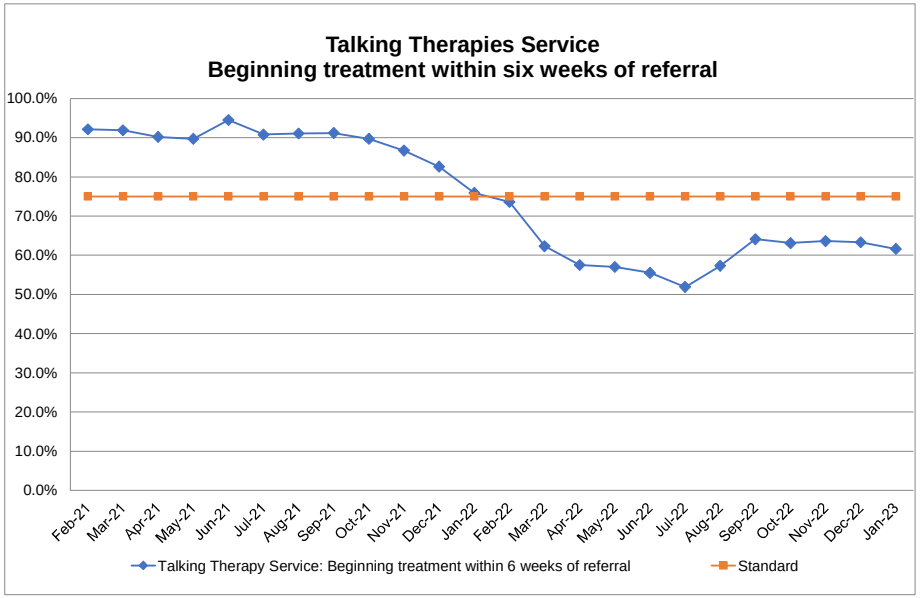
Current performance (including factors affecting this)

- During January 2023, compliance decreased slightly compared to December 2022.
- The fall in compliance that occurred since February 2022 has been primarily due to rising levels of demand and a shortfall in capacity within the service. Between 1 April 2021 and 31 March 2022 referrals into the service increased by 26.7% compared to the same months of 2020/21 and by 17.1% compared to same months of 2019/20.
- Referrals between 1 April 2022 and 31 January 2023 were 5.7% lower than the same months of 2021/22, but 11.1% higher than the same months of 2019/20.
- The position continues to be exacerbated by vacancy levels, long term sickness and maternity leave.

Focus of improvement work

- Recruitment continues to be challenging, which is reflected nationally, although several recent appointments have been made with varying commencement dates. Once new colleagues commence in post, their contribution will be gradual until they are fully up to speed. Further advertisements are currently out and results are awaited as to how many appropriately qualified persons apply.
- A deep dive into the service has commenced to review demand and capacity and to formulate appropriate actions.
- The service is re-asserting the commissioned eight-session treatment model, to offset against too many extensions to treatment.
- The service is also employing locums and is continuing to use external online providers creatively.
- A deep dive of the performance data will be undertaken, to ascertain the impact of vacancy levels and recruitment.

Trend Chart



How do we compare

National average performance against the six-week standard in September 2022 (the latest published data) was 89.3%; our performance was 64.1%.

Recent Performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
Total Discharges	492	398	401	420	379	411
First treatment inside of six weeks	282	255	253	267	240	253
Compliance %	57.3%	64.1%	63.1%	63.6%	63.3%	61.6%

Responsive

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

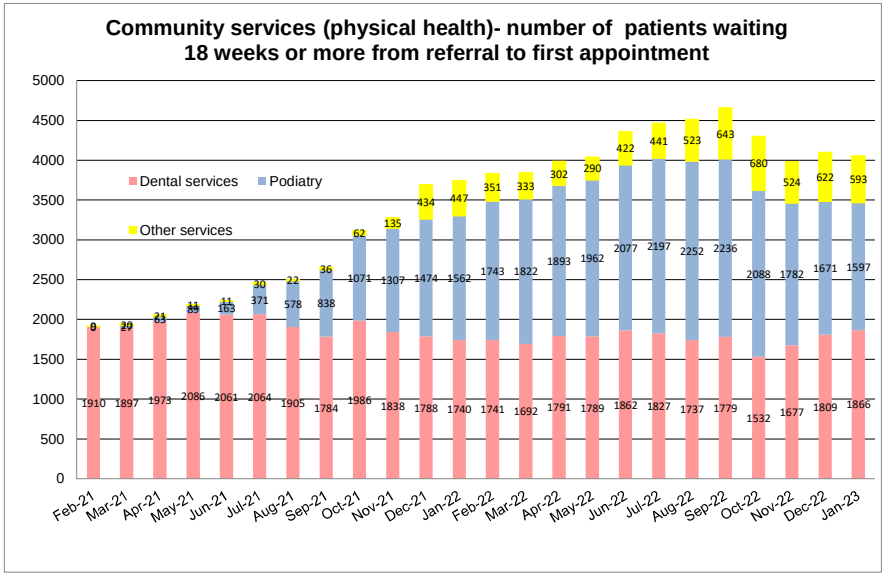
Current performance (including factors affecting this)

- As at 31 January 2023, the number of patients waiting 18 weeks or more totalled 4,056, a decrease of 46 patients compared to the position as at 31 December 2022.
- The number of people waiting 18 weeks or more to be seen by our Podiatry service reduced to 1,597 patients, from 1,671 as at 31 December 2022. The Podiatry service continues to have significant levels of vacancies, which is a national issue.
- Our Somerset and Dorset dental service had 1,866 patients waiting 18 weeks or more to be seen, up from 1,809 as at 31 December 2022 (Somerset: 1,691 patients, up from 1,620 and Dorset: 175 patients, down from 189).
- Of the numbers within 'Others', 50% related to our Musculoskeletal Physiotherapy (MSK) service, which increased from 284 as at 31 December 2022 to 295 as at January 2023.

Focus of improvement work

- In Podiatry, priority has been given to high risk vascular / diabetic foot care and acute nail surgery cases. All routine patients are contacted by letter and telephone to provide advice and guidance. The waiting list initiative to reduce the number of patients waiting and length of wait, which began in September 2022, remains ongoing.
- The Dental service faces challenges due to vacancies, sickness absence and maternity leave, and continues with various recruitment initiatives. The installation of air exchange units has reduced the fallow time between appointments.
- The MSK service has undertaken a review of patients listed as having waited 18 weeks or more. Staffing has improved compared to earlier months, both in respect of vacancies and sickness/absence. The review has enabled actions to be implemented to reduce current lengths of wait.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 January 2023 decreased by 46 when compared to 31 December 2022.

Recent performance

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

Area	Aug	Sep	Oct	Nov	Dec	Jan
Number waiting	4,512	4,658	4,300	3,983	4,102	4,056

Responsive

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

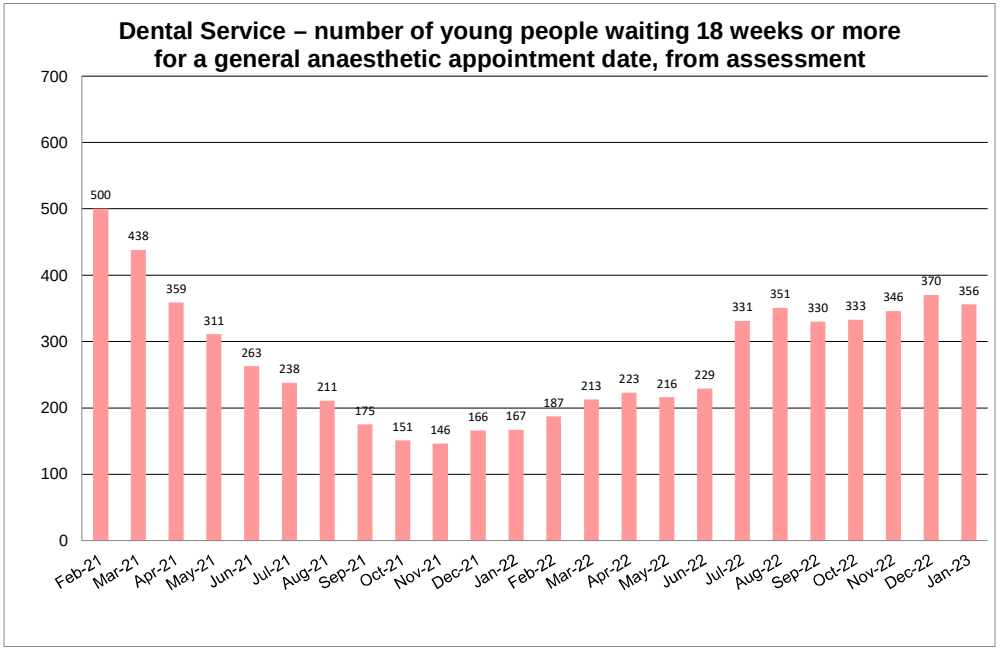
Current performance (including factors affecting this)

- As at 31 January 2023, 356 young people had waited 18 weeks, a decrease of 14 compared to 31 December 2022.
- Of the 356 patients waiting, 317 related to our Dorset service (down from 322 as at 31 December 2022), and 39 related to our Somerset service (down from 48 as at 31 December 2022).
- The service continues to have significant levels of vacancies, which is a national issue, exacerbated by sickness/absence that affects capacity within the service, as well as the loss of some theatre slots.

Focus of improvement work

- The service continues with various initiatives to recruit, and several recent appointments have been made with varying commencement dates. Once new colleagues commence in post, their contribution will be gradual until they are fully up to speed.
- The number of children per list has been increased to five where possible but many of the children with additional needs require more than one slot due to complexities, reducing the number of children who can be seen on a list.
- Work continues to validate the paediatric GA list. A 'welfare check', and using a surgical coding system, will 'RAG' rate children based on clinical need and prioritise accordingly.
- There remain challenges with theatre availability due to current demand pressures of other specialities. The service is working with the theatre management team to establish solutions and resource more theatre time.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 January 2023 decreased by 14 compared to 31 December 2022.

Recent Performance

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

Area	Aug	Sep	Oct	Nov	Dec	Jan
Number waiting	351	330	333	346	370	356
% > 18 weeks	61.1%	56.0%	55.0%	51.3%	51.7%	48.2%

Responsive

Child and Adolescent Mental Health Service Eating Disorders (CEDS) – At least 95% of urgent referrals to be seen within one week and at least 95% of routine referrals to be seen within four weeks, based on performance across a rolling 12 months.

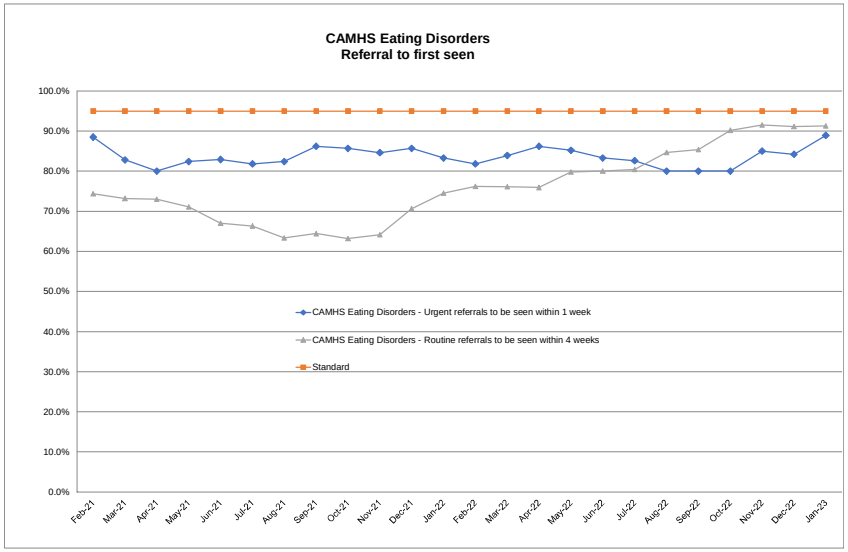
Current performance (including factors affecting this)

- Between 1 February 2022 and 31 January 2023 of 18 urgent referrals, two patients were seen outside of the seven-day reporting standard.
- One urgent referral was seen during January 2023 and was inside of the seven-day standard. With no further breaches, compliance with the 95% 12-month standard is predicted not to be achieved until at least March 2023.
- During the period 1 February 2022 to 31 January 2023, of 104 routine referrals, a total of nine patients were seen outside of the four-week reporting standard.
- During January 2023, of 11 routine referrals, 10 patients were seen within the four-week standard. The one breach occurred due to service delays resulting in patient being seen 34 days after referral. As the monthly numbers referred are low, with no further breaches, compliance of the 95% standard is predicted not be achieved until at least March 2023.
- Over the 12-month reporting period the main reasons for breaches were a shortfall of capacity in the team, and patient / family delays.

Focus of improvement work

- An Assistant Psychologist triages referrals, offering early advice, to help to reduce waiting times.
- The service, alongside Somerset and Wessex Eating Disorder Association (SWEDA), has extended a pilot as part of the pathway to take on early intervention and low-to-moderate presentations, and to reduce referral numbers. The piloted started in July 2022.
- The service is recruiting into a Band 4 role to support the Musgrove Park Hospital paediatric ward with meal support. This will be a 12-month, fixed-term role to gauge effectiveness. The team has recruited a Cognitive Behavioural Therapist Trainee to support with work relating to low mood / anxiety / trauma.
- A new Band 7 role within CEDS has been recruited into and will be positioned within the acute hospital to develop nurse-led clinics. This will free up capacity within the team to increase assessment clinics.

Line Chart



How do we compare

The latest national performance, reported as at 31 December 2022, was 68.6% for urgent referrals and 73.5% for routine referrals. Our performance was 84.2% and 91.1% respectively.

Performance over the last six months

Performance is based on a rolling 12 months.

Area	Aug	Sep	Oct	Nov	Dec	Jan
Urgent – patients seen within one week	80.0%	80.0%	80.0%	85.0%	84.2%	88.9%
Routine – patients seen within four weeks	84.7%	85.4%	90.2%	91.5%	91.1%	91.3%

Responsive

Intermediate Care – Our aim is to ensure that at least 95% of patients aged 65 years or over discharged from acute hospital beds are discharged home on pathway 0 or 1.

Current performance (including factors affecting this)

- During January 2023, 93.2% of patients aged 65 or over who were discharged from acute hospital beds within Somerset were transferred onto Pathway 0 or Pathway 1.

Pathway 0

These are discharges to patients' homes that are arranged at ward level and do not require core intermediate care support on discharge. These discharges are often supported by the voluntary sector and/or other community health services such as district nursing and the community rehabilitation service (CRS).

Pathway 1

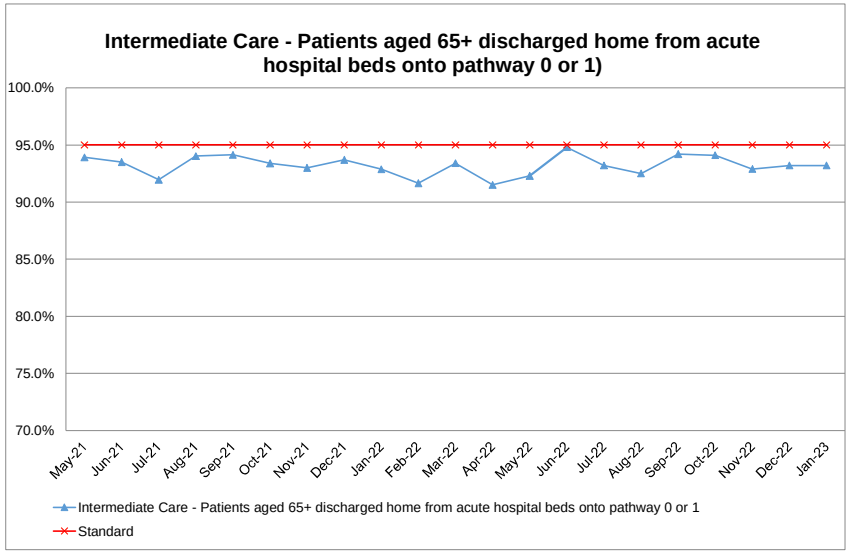
These discharges are supported by the Intermediate Care Discharge to Assess Service (D2A). These people require reablement and ongoing assessment within their own home.

Focus of improvement work

1. Need to increase Somerset PW0 figures – more so at Yeovil District Hospital (YDH) than at Musgrove Park Hospital.
2. Voluntary, Community and Social Enterprise teams are going to enhance the education of the PW0 offer, particularly at YDH.
3. D2A homecare capacity remains low – this limits the number of daily discharges. The D2A commissioning model is to be reviewed and adjusted as part of the current strategic review of Intermediate Care.
4. End of pathway delays – good progress has been made in the sourcing of packages of care. More focus is now needed on:
   a. Reducing the number of outstanding social work assessment delays.
   b. Reducing the number of people awaiting long term placement.

   An improvement plan for a and b is to follow.

Line Chart



How do we compare

The percentage of patients aged 65 or more transferred onto pathway 0 or 1 during January 2023 was the same as during December 2022.

Performance over the last six months

Area	Aug	Sep	Oct	Nov	Dec	Jan
Total Discharges	2,869	2,916	2,665	2,804	2,799	2,571
Pathway 0	2,450	2,529	2,324	2,398	2,443	2,190
Pathway 1	201	217	183	207	166	207
% onto P0 or P1	92.4%	94.2%	94.1%	92.9%	93.2%	93.2%

Responsive

The two-week wait for suspected cancer is a measure of the length of wait to see a specialist following urgent referral for suspected cancer. The target is for at least 93% of patients to be seen within 14 days of referral. This standard is the first step in the 62-day GP cancer pathway standard.

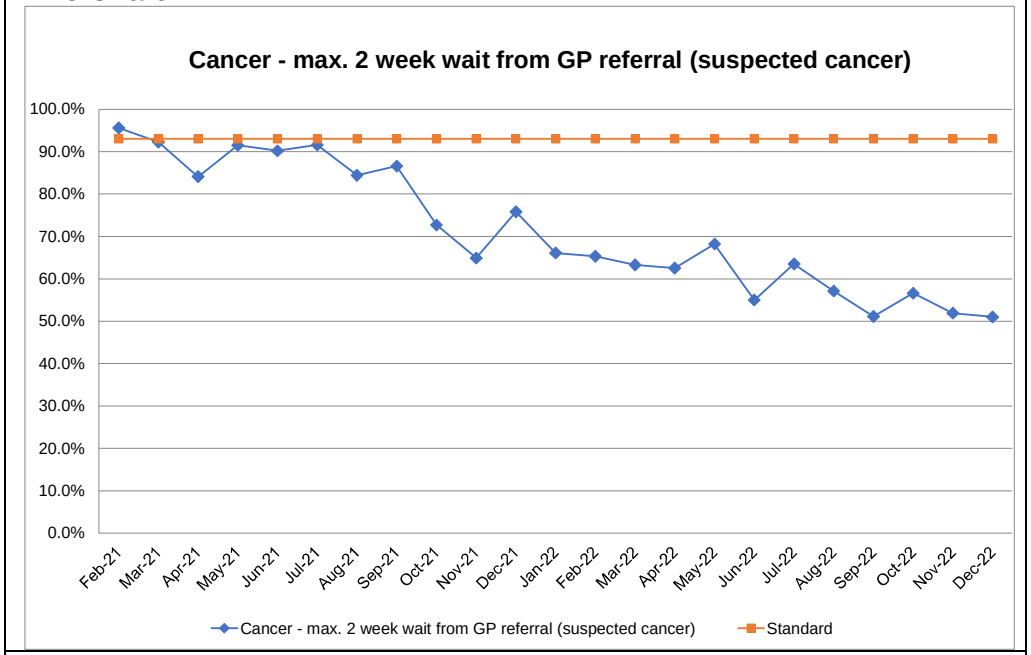
Current performance (including factors affecting this)

- The percentage of patients seen within 14 days of referral by their GP for a suspected cancer was 51.0% in December 2022, below both the 93% national standard and the national average.
- Colorectal made up 37% of two week wait breaches in December 2022. The triage time has now reduced significantly. The primary care-based colorectal referral hub, funded by Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance, is also helping to reduce pathway delays as far as possible. However, waiting times for colonoscopies, which are the two-week wait step for more than a third of lower GI referrals, have lengthened due to the recent very high levels of demand and staff shortages.
- Breast made up a further 28% of the breaches. Changes to service capacity due to a departure from the team has limited the ability of the service to meet demand and keep waits within two weeks, although the 28-day Faster Diagnosis Standard is now being met.
- The breast symptomatic (cancer not suspected) 93% two week wait standard was not achieved in December 2022, with performance of 22.2% and 42 breaches, all due to the capacity problems described above.

Focus of improvement work

- A review has been undertaken of the breast service capacity and demand. Evening clinics have been run, to provide additional capacity. Yeovil District Hospital has also again been supporting with capacity. With the recruited GPs now trained to run clinics independently, there has been a significant improvement in the 28-day Faster Diagnostic Standard performance (see the exception report). However, consistently meeting the two week wait standard will remain a challenge.
- Please refer also to the Diagnostics exception report for actions to address the increase in colonoscopy waiting times.

Line Chart



How do we compare

National average performance in December 2022, the latest data available, was 80.3%. Our performance was 51.0%. We were ranked 137 out of 142 providers.

Recent Performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
% seen in two weeks	63.5%	57.1%	51.1%	56.6%	51.9%	51.0%
Patient choice breaches	60	56	50	54	63	49
Other breaches (including capacity, delayed blood tests)	290	356	510	393	498	427

Responsive

28 Day Faster Diagnosis Cancer Standard is a measure of the length of wait from referral through to diagnosis (benign or cancer). The target is for at least 75% of patients to be diagnosed within 28 days of referral. The first step in a 62-day cancer pathway.

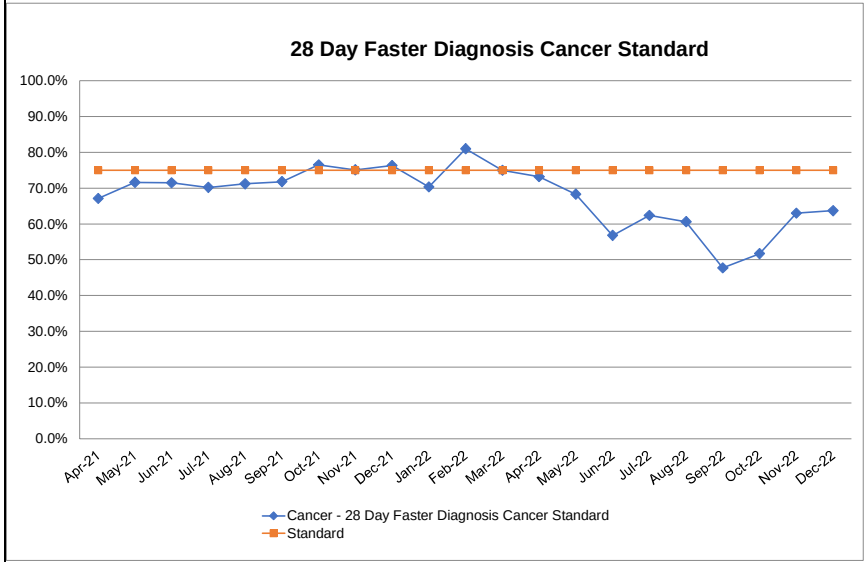
Current performance (including factors affecting this)

- The percentage of patients diagnosed with cancer or given a benign diagnosis within 28 days of referral improved to 63.7% in December 2022 but remained below the national standard and the national average.
- The higher-volume tumour sites not meeting the 75% national standard in December 2022 were: colorectal (34% against the 75% standard), and gynaecology (34%). Overall colorectal made up 42% of all the breaches of the 28-day standard and gynaecology 27%. Colorectal and gynaecology have seen a growth in referrals of 11% and 27% in recent months, respectively, compared to pre-COVID levels.
- The recent improvement in performance has largely been due to breast achieving the standard again in the month. Breast achieved the 28-day standard in November and December 2022 for the first time since last achieving in April 2022, following the additional capacity put in place with GPs recruited and trained to run two-week wait clinics, support provided by Yeovil District Hospital, and evening clinics established by the team.

Focus of improvement work

- A significant programme of work continues to try to reduce delays in the diagnostic part of the colorectal pathway (please see the two-week wait exception report); improvements have already been made but work is focusing on how to sustain these in the face of exceptional growth in demand.
- For details of the actions taken to address the breast issues please also see the two-week wait exception report.
- A new community-based/self-referral gynaecology pathway is being introduced for post-menopausal bleed patients comprising a one-stop clinic appointment and ultrasound scan. Patients for which a benign cause of their bleeding cannot be identified, and those requiring additional investigations, will be referred to secondary care.

Line Chart



How do we compare

National average performance for providers was 70.7% in December 2022, the latest data available. Our performance was 63.0%. We ranked 120 out of 142 providers.

Recent performance

Performance in recent months was as follows:

28-day Faster Diagnosis performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
Compliance	62.4%	60.6%	47.7%	51.7%	63.0%	63.7%

Responsive

31 day waiting times standard is a measure of the length of wait between diagnosis and first treatment. The standard requires at least 96% of patients are treated within 31 days diagnosis. The second step in a 62-day cancer pathway.

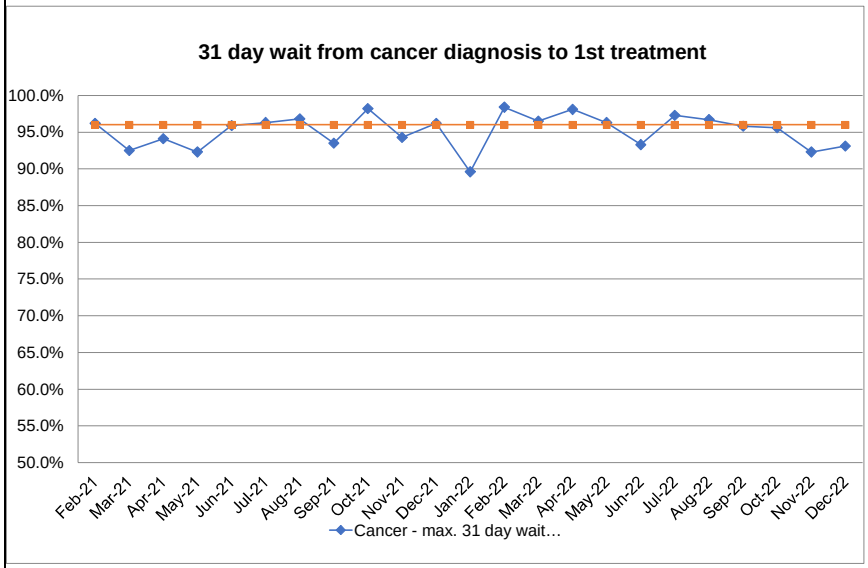
Current performance (including factors affecting this)

- Performance against the 31-day first definitive treatment standard was 93.1% in December 2022, below the 96% national standard but above national average performance.
- There were 13 breaches of the first definitive treatment standard, six for colorectal pathways.
- The reason for the higher levels of breaches in December 2022 was largely related to surgical capacity, with the recent bed pressures but also bulges in demand for colorectal and other tumour sites impacting on the ability to operate on patients within the target. All delays or cancellations of surgery are clinically risk-assessed on a case-by-case basis by the operating surgeon.

Focus of improvement work

- Cancer and other urgent surgical patients continue to be prioritised for access to beds.
- The allocation of theatre lists to specialties/surgeons continues to be monitored and discussed with clinical teams on a week-to-week basis.
- The Trust has a wide-ranging plan to try to improve bed availability where this is within the control of the Trust.
- Work outlined in the other cancer exception reports (two-week wait, 28-day Faster Diagnosis Standard and 62-day GP) will also help to reduce delays in cancer pathways which will also help to smooth bulges in demand for cancer surgery.

Line Chart



How do we compare

National average performance for providers was 92.7% in December 2022, the latest data available. Our performance was 93.1%. We ranked 101 out of 142 providers.

Recent performance

28-day Faster Diagnosis performance

Area	Jul	Aug	Sept	Oct	Nov	Dec
Compliance	97.3%	96.7%	95.8%	95.6%	92.3%	93.1%

Responsive

The 62-day cancer waiting time standard is a measure of the length of wait from urgent referral by a GP for suspected cancer, to the start of first definitive treatment. The target is for at least 85% of patients to be treated within 62 days of referral.

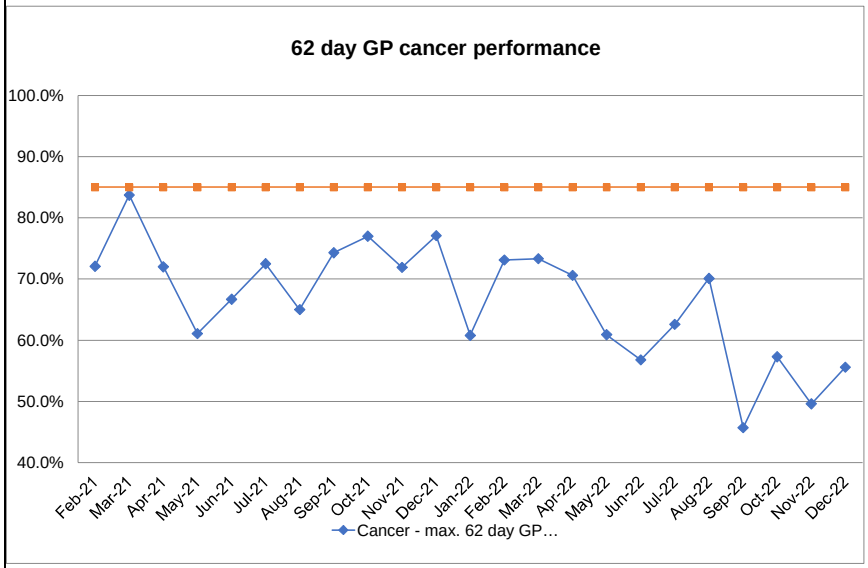
Current performance (including factors affecting this)

- The percentage of cancer patients treated within 62 days of referral by their GP was 55.6% in December 2022, up from 49.6% in November 2022, but below both the national standard and the national average.
- The main breaches of the 62-day GP standards were in urology (47% of breaches) and gynaecology (13%). The main causes of the breaches for urology and gynaecology were very high growth in demand (up 31% and 27% respectively relative to pre-COVID,) and an associated increase in diagnostic waiting times. There are also delays in patients undergoing prostate surgery at another provider due to the high level of demand.
- Ten patients were treated in December 2022 on or after day 104 (the national 'backstop'). For further details please see Appendix 5a.
- The number of patients waiting over 62 days at the end of December 2022 was above (i.e. worse than) the recovery trajectory (141 against a plan of 120). The high level of the backlog relative to pre-COVID levels mainly reflects the growth in colorectal referrals received in recent months (52% above 2019/20 levels), the breast staffing challenges and the recent shortfall in Multidisciplinary team Co-ordinators due to vacancies and sickness.

Focus of improvement work

- Additional prostate biopsy sessions are being run to reduce the waits for this step in the pathway.
- Pathways redesign work is continuing for prostate, across both Yeovil District Hospital and this Trust.
- The colorectal improvement group continues to meet weekly to redesign the diagnostic part of the colorectal cancer pathway.
- Please also see the 28-day Faster Diagnosis exception report for details of the gynaecology post-menopausal bleed pathway, which should help to reduce inappropriate referrals into the service and the high levels of demand experienced over the past few months.

Line Chart



How do we compare

National average performance for providers was 61.8% in December 2022, the latest data available. Our performance was 55.6%. We were ranked 105 out of 139 trusts.

Recent performance

62-day GP cancer performance

Area	Jul	Aug	Sep	Oct	Nov	Dec
Compliance	62.6%	70.1%	45.7%	57.3%	49.6%	55.6%

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

Responsive

The Diagnostic six-week wait is a measure of the length of wait from referral through to diagnostic testing being carried out. This standard is applied to the top 15 national high-volume tests. The target is for at least 99% of patients to have been waiting less than six weeks for a test at month-end.

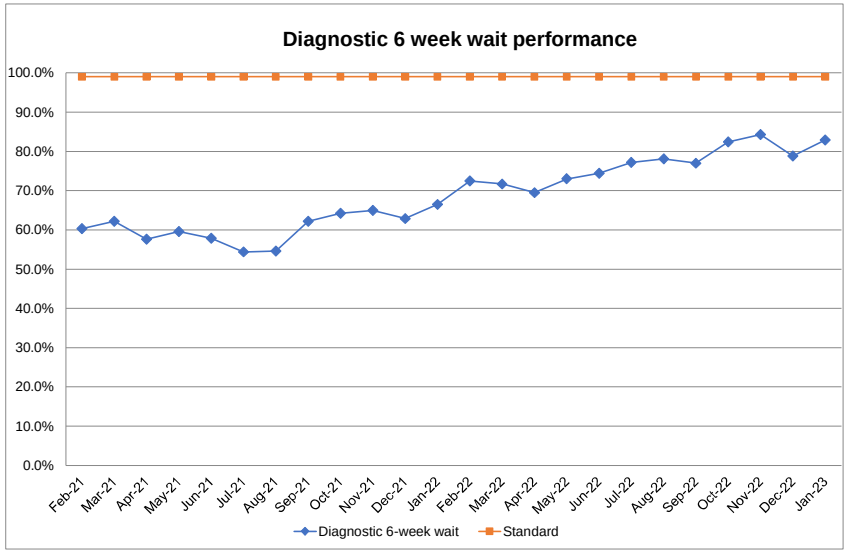
Current performance (including factors affecting this)

- The percentage of patients waiting under six weeks for their diagnostic test increased to 82.9% in January 2023, continuing to meet the regional March 2023 ambition of greater than 75%.
- The number of patients waiting over six weeks decreased from 1,340 in December 2022 to 1,105 in January 2023; the highest numbers of patients were waiting for a Colonoscopy (decreased from 325 to 269), CT (274 to 245), MRI (137 to 162) and Audiology (254 to 149) together making up 75% of the long waiters.
- The total waiting list size decreased by 2% due to more of the longer waiting patents being seen.
- The high level of colonoscopy over six-week waiters is due to both high demand (an 11% increase in lower GI cancer referrals compared with pre-COVID, down from a 52% increase a few months ago) and staffing shortfalls earlier in the year.

Focus of improvement work

- The third endoscopy room at Bridgwater Community Hospital is open, allowing additional colonoscopy sessions to be run.
- Additional insourcing endoscopy sessions are being run in-week, as well as at the weekend.
- A member of the endoscopy team returned in September 2022 following extended leave, which has increased colonoscopy capacity again.
- Additional in-house clinics are being run in audiology, to support backlog clearance, on top of the existing outsourcing contract.
- The current backlog of CT over six-week waiters is now largely specialist scans needed for cardiac patients. Additional sessions continue to be run in February 2023.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 67.9% in December 2022. Our performance was 78.8%. We were ranked 73 out of 158 trusts for the 15 high volume diagnostic tests.

Recent performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
Actual	78.1%	77.0%	82.4%	84.3%	78.8%	82.9%

Responsive

Our aim is to ensure that at least 90% of the complaints we receive are responded to within 40 working days.

Current performance (including factors affecting this)

- During January 2023, 33 responses were issued, an increase on the 30 responses issued in December 2022.
- Of the 33 complaints responded to during January 2023, a total of 13 (39.4%) were responded to within the 40 working day standard, down from 46.7% in December 2022.

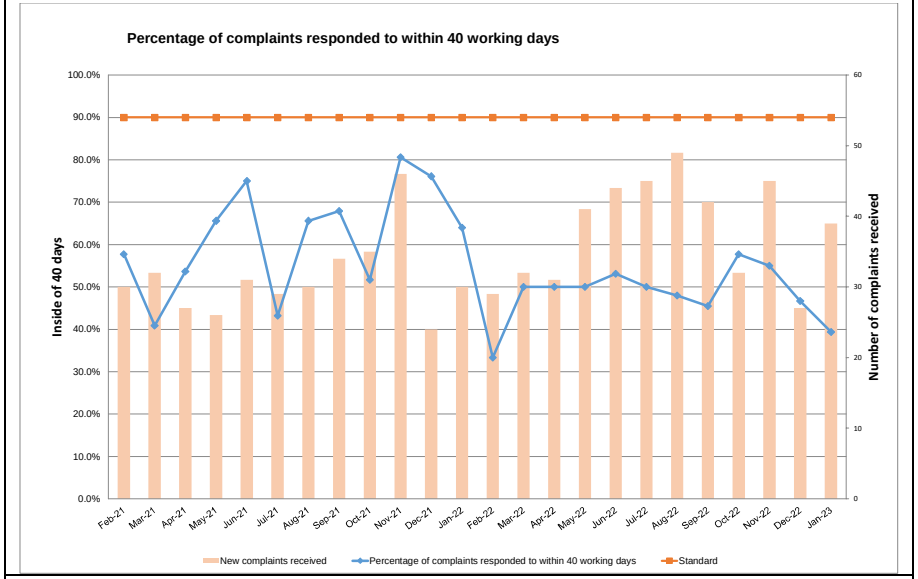
Delays occurred due to a combination of reasons including:

- The Trust received 39 new complaints in January 2023 (compared to 27 in December 2022). The receipt and processing of the high number of new complaints negatively impacted on responding to existing complaints.
- The highest number of complaints remains in the Surgical directorate, which is experiencing difficulties due to continued changing of governance co-ordinator staff, which in turn can add to the delay in responses being reviewed and processed.
- The recent increased pressures across the Trust's services have affected the time available for managers, clinicians, ward sisters and matrons to investigate complaints.
- A number of complaints received over recent months have required responses from different services, which can increase the complexity in compiling responses and the time required to do this effectively.
- Staff absence within the complaints team has also had some impact on workload.

Focus of improvement work.

- The Complaints Lead has met with the Surgical Associate Directors of Patient Care (ADPCs) regarding the backlog of late complaint responses.
- It was agreed that a member of the complaints team will continue to assist the Surgical team for two days a week, specifically to address the oldest cases, working closely with Community Service Managers and matrons to assist in finalising and writing responses.
- The complaints team continues to meet bi-weekly with Directorate Co-ordinators/ADPCs to review the progress and co-ordination of every open complaint.
- Two new posts, Director and Head for Patient Experience, will review resources and processes and engaging with staff to align services.

Line Chart



How do we compare

During January 2023 the percentage of complaints responded to within 40 working days decreased compared to December 2022.

Recent Performance

Our performance in recent months is as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
% within 40 working days	48.0%	45.5%	57.7%	55.0%	46.7%	39.4%

Current open complaints:

Directorate	Within date	Late	Total
Surgery	20	28	48
Integrated	15	5	20
Families	10	2	12
Mental Health	10	4	14
Primary Care	2	0	2
Clinical Support	4	4	8
Centrally Coordinated	0	1	1
Totals:	**61**	**44**	**105**

Well Led

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

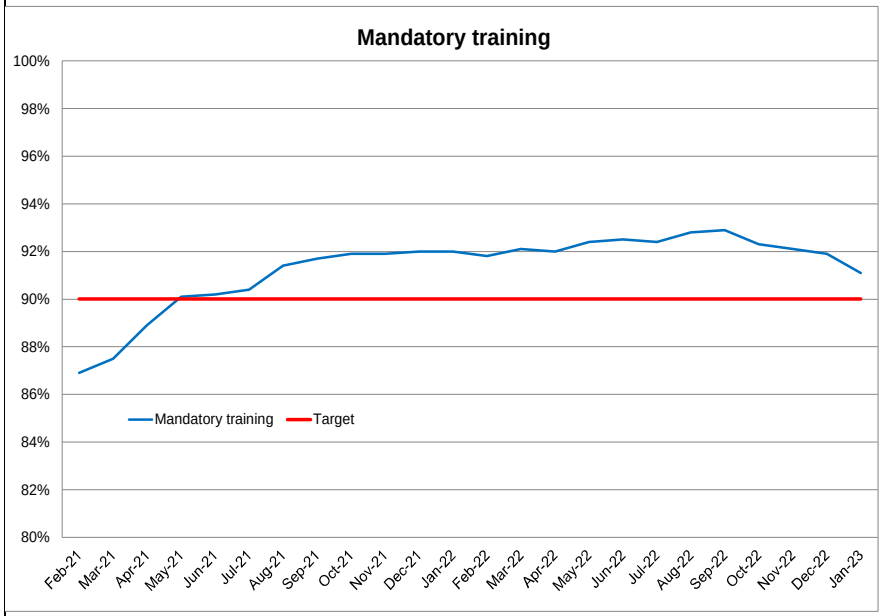
Current performance (including factors affecting this)

- As at 31 January 2023, our overall mandatory training rate was 91.1%, down slightly from 91.9% as at 31 December 2022.
- To be compliant, all eleven core training subjects must have compliance rates above 90%. Of the 31 courses within these eleven core subjects, the 90% target has been met for 15.
- Eleven of the 16 courses below 90% compliance relate to resuscitation.
- Operational pressures, and limited resource capacity for areas with large backlogs such as life support and safeguarding continue to remain a challenge to full recovery.
- 'Failure to attend' rates also remain high, reflecting the operational pressures, for face-to-face and increasingly virtual courses.

Focus of improvement work

- The Resuscitation team continues to create additional curriculum and training opportunities to target those who will become out of date now that the reversion to a 12-month training cycle has been applied.
- Merger charter project work continues to address compliance rates for the merged organisation and the preparation of a single learning management system for the merged Trust from day one.
- Directorates continue to receive tailored reports via their People Business Partners, and have real-time access via the learning management system to data on their teams, to help identify areas which need action.
- Action is underway to support re-mapping in directorates for Level 3 safeguarding, where teams indicate that they may be incorrectly mapped.
- Work is being undertaken with the Safeguarding Team to consider a risk-based solution to cover periods when operational pressures occur.

Run Chart



How do we compare

The compliance rate as at 31 January 2023 was 0.8% lower than the rate as at 31 December 2022.

Recent Performance

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

Area	Aug	Sep	Oct	Nov	Dec	Jan
Compliance %	92.8%	92.9%	92.3%	92.1%	91.9%	91.1%

Well Led

Career Conversations: We are committed ensuring that colleagues have timely and appropriate career reviews, at least annually, to outline all aspects of their role, to highlight and promote excellence and identify core or developmental training needs to enable colleagues to progress in their chosen careers. A trajectory has been set to attain 92% compliance by 30 April 2023.

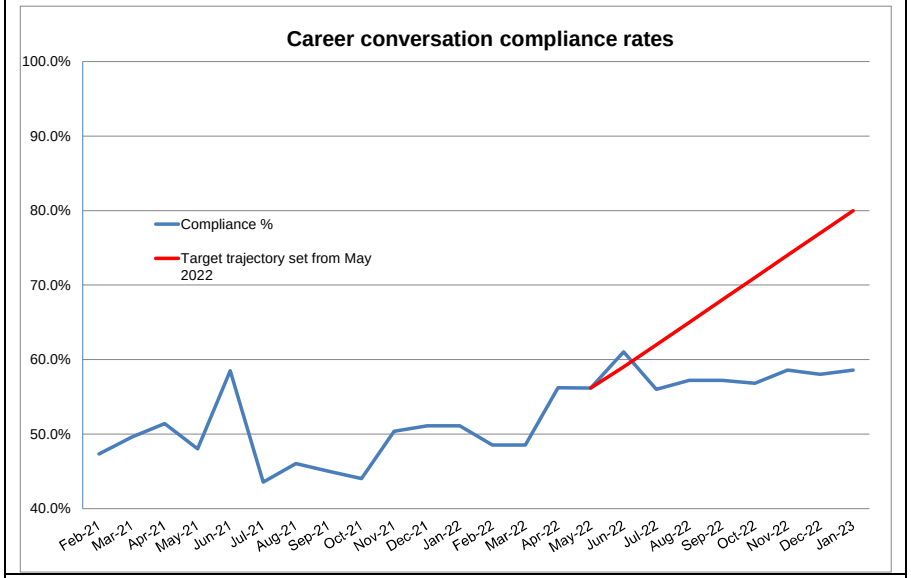
Current performance (including factors affecting this)

- Compliance as at 31 January 2023, in respect of career conversation reviews being undertaken at least annually, increased by 0.6% from the rate as at 31 December 2022.
- The rate recorded as at 31 January 2023 was 58.6%, which was 21.4% below the target trajectory set to restore compliance to 92% by 30 April 2023.
- A combination of operational pressures and high levels of sickness absence continue to affect compliance.

Focus of improvement work

- Continued conversations with People Business Partners and Leadership and directorate leads with a more focused approach with directorates to support teams in understanding and removing barriers to achieving the trajectory.
- Continued focus on career conversations in directorate meetings to ensure this is reviewed at every opportunity and the right level of focus is given.
- People Business Partners now have access to information relating to colleagues who are due an increment award this year and whose review is currently out of date. This informs the monthly conversations held with service managers and assists with highlighting the importance of ensuring that career conversations for all colleagues are in date.
- The accessibility and functionality of the recording system is being reviewed, with feedback from focus groups being collated with a view to possible adjustments of the system and support within the leadership development programme. The review also forms part of a comprehensive review of career conversations and the alignment of the SFT and Yeovil District Hospital processes.

Run Chart



How do we compare

Compliance as at 31 January 2023 increased compared to rate as at 31 December 2022.

Recent performance

The compliance rates in recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
Trajectory	65.0%	68.0%	71.0%	74.0%	77.0%	80.0%
Monthly rate	57.2%	57.2%	56.8%	58.6%	58.0%	58.6%

Well Led

Sickness/Absence: We are committed to improving the health and wellbeing of our workforce in a supportive work environment, in order to reduce sickness absence and thereby ensure continuity of care and quality service provision. Our aim is to reduce staff sickness absence levels to 4.6% or less. The data outlined shows our monthly sickness absence percentage rate.

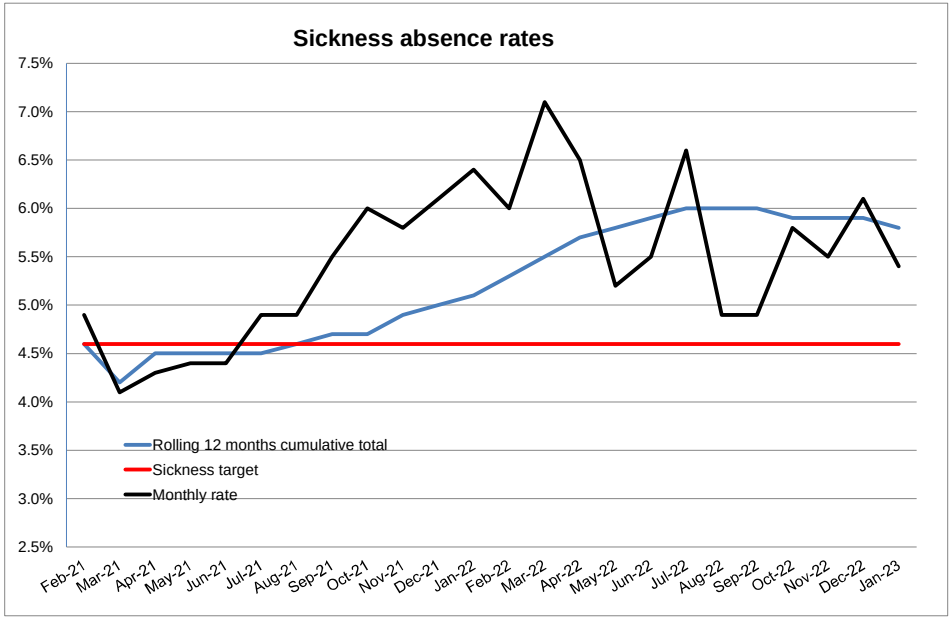
Current performance (including factors affecting this)

- The 12-month rolling sickness absence rate for the period ending 31 January 2023 slightly reduced to 5.8%, the lowest it has been since May 2022. The monthly rate of sickness absence also decreased to 5.4% in January 2023, from 6.1% in December 2022.
- The number of working days lost due to stress and anxiety totalled 332, up from 306 reported during December 2022.
- COVID-19 accounted for 19.5% of all sickness absence in the 12 months to 31 January 2023. The monthly percentage of all absence that was due to COVID-19 in January 2023 significantly decreased to 4.9%, from 9.8% recorded during December 2022.

Focus of improvement work

- The wellbeing team continue to focus on different elements of wellbeing each month to ensure colleagues are able to access support and guidance to help reduce absence levels.
- Continued focus on long-term absence and opportunities to support colleagues back to work is taken by the HR Advisor team.
- Early conversations around the future of occupational health services are being undertaken to consider opportunities to refresh the model and support to colleagues.
- Absence levels continues to be an area of focus for our Quality, Outcomes, Finance and Performance (QOFP) meetings.

Run Chart



How do we compare

As the only acute, community and mental health Trust we are currently unable to benchmark our position directly against similar providers. We have used national data published by NHS Digital to review our target level, and to develop a realistic target.

Recent performance

The sickness absence rates in recent months were as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
12 monthly rate	6.0%	6.0%	5.9%	5.9%	5.9%	5.8%
Monthly rate	4.9%	4.9%	5.8%	5.5%	6.1%	5.4%

Well Led

Vacancy: We are committed to recruiting and maintaining a strong workforce. Our aim is to reduce and maintain vacancy levels to 5% or less. The data outlined shows the difference between contracted full time equivalent (FTE) number of colleagues in post and our budgeted establishment.

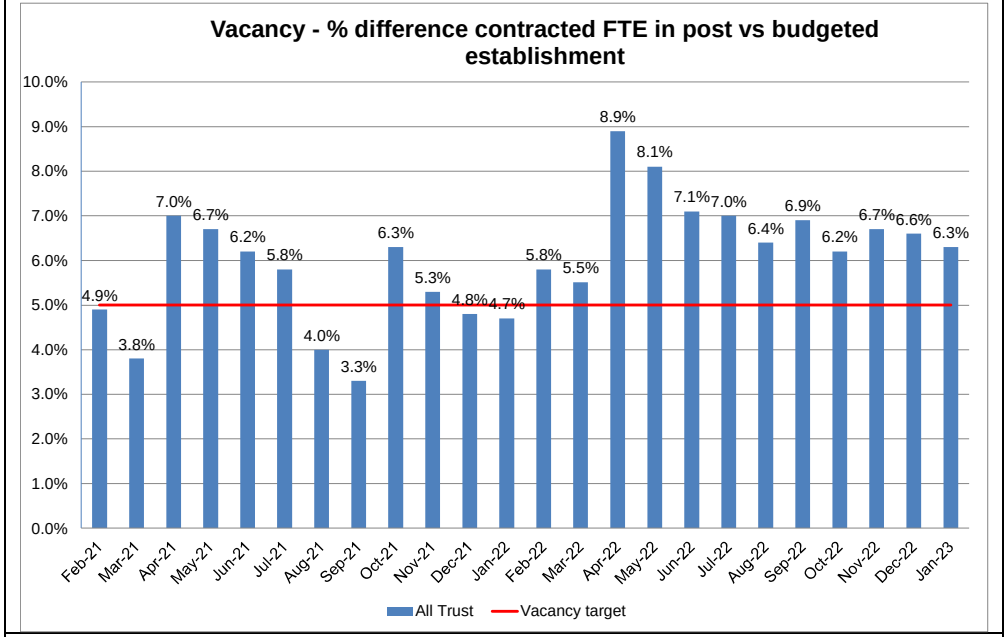
Current performance (including factors affecting this)

- The vacancy rate as at 31 January 2023 was 6.3%, down from 6.6% as at 31 December 2022.
- Many areas where vacancies are of particular concern are recognised nationally as areas of shortage, including psychologists, registered mental health nurses, theatres, and a range of medical staffing including orthogeriatric, orthodontic, endoscopy, cardiology and respiratory consultants.
- Retaining healthcare support workers also continues to be a challenge

Focus of improvement work

- Continuing to deliver and monitor the impact of the People Promise Exemplar work.
- Reviewing our workforce plans and approach with service groups to ensure that the focus on addressing vacancies remains a priority.
- The focus on reducing agency spend to achieve the NHS England agency cap will support improvements in the vacancy position.

Run Chart



How do we compare

A recent benchmarking exercise relating to employment checks showed the best performance was approximately 18 days, for Trusts with similar activity to us, and the worst was 68 days. Our Trust performance was 27 days.

Recent performance

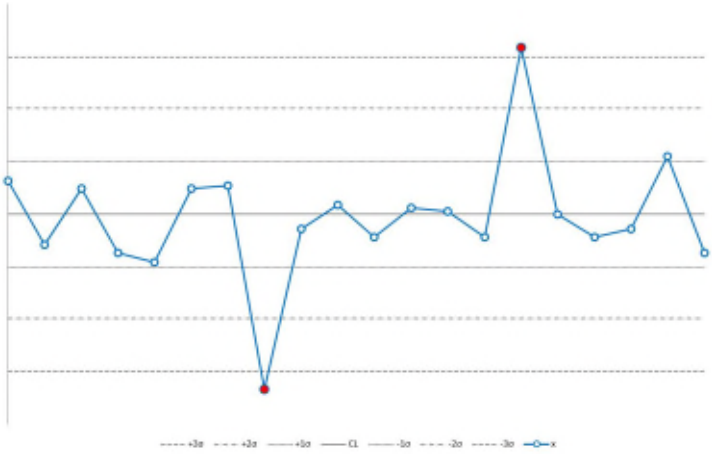
The performance against the vacancy rate standard in recent months was as follows:

Area	Aug	Sep	Oct	Nov	Dec	Jan
Vacancy rate	6.4%	6.9%	6.2%	6.7%	6.6%	6.3%

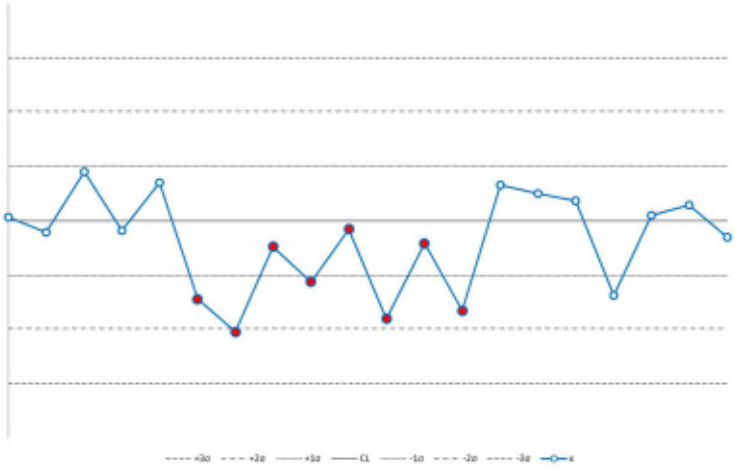
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

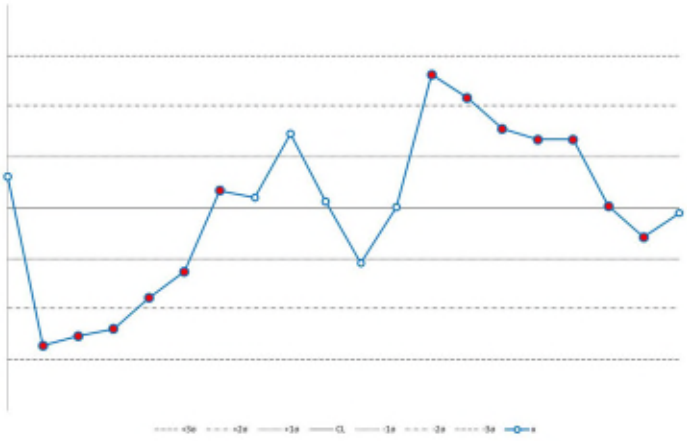
1. A single point outside the control limits



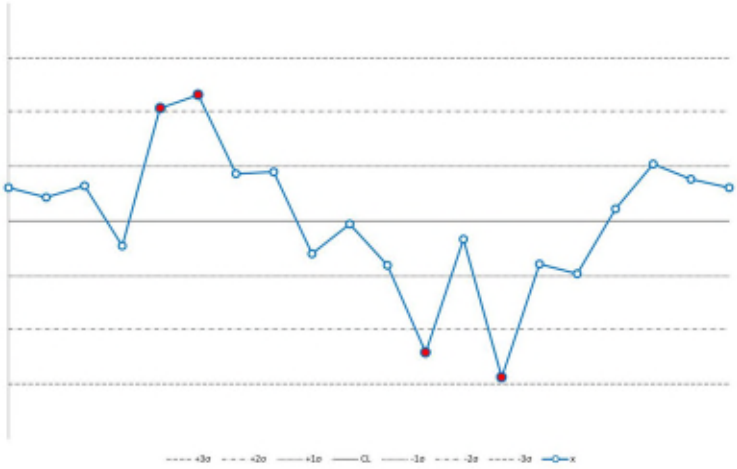
2. A run of eight or more points in a row above (or below) the centreline



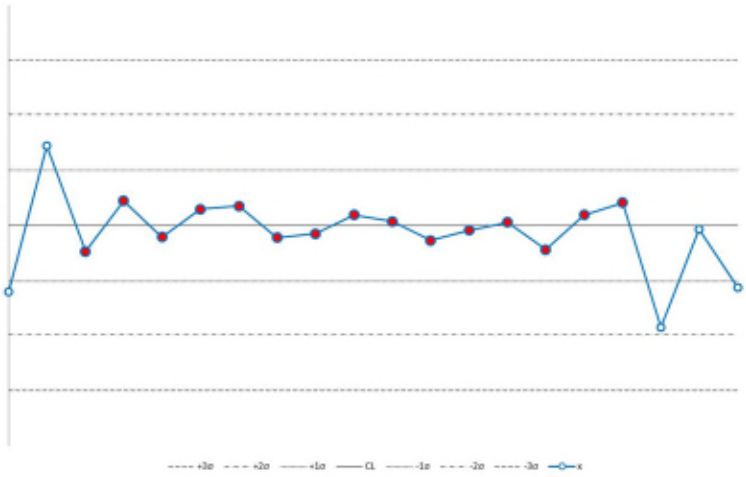
3. Six consecutive points increasing (trend up) or decreasing (trend down)



4. Two out of three consecutive points near (outer one-third) a control limit



5. Fifteen consecutive points close (inner one-third of the chart) to the centreline



APPENDIX 2

OUR CARE QUALITY COMMISSION RATINGS

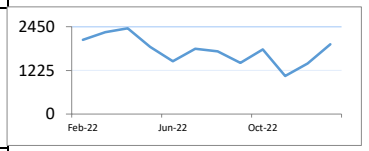
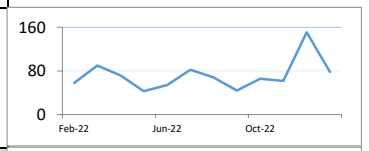
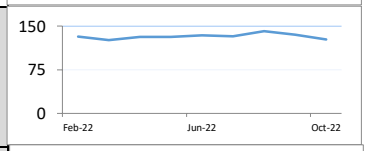
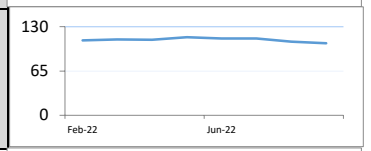
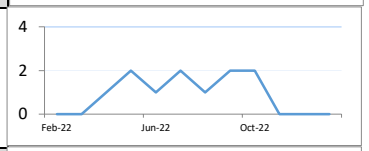
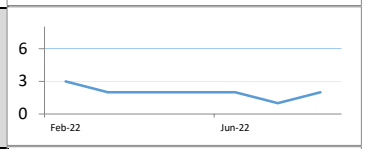
Our current Care Quality Commission ratings are as follows:

	Somerset NHS Foundation Trust
Overall rating for the Trust	**Good**

Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well led?	**Good**

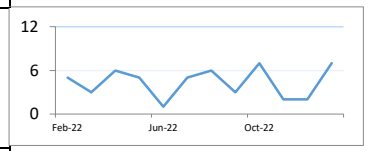
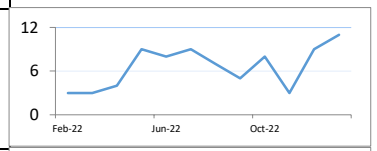
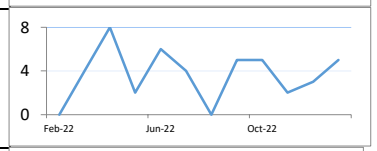
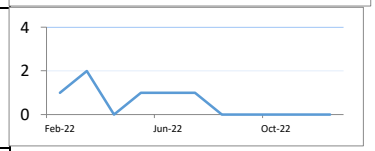
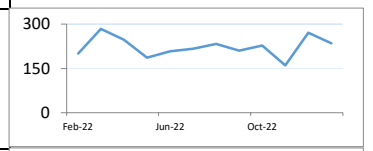
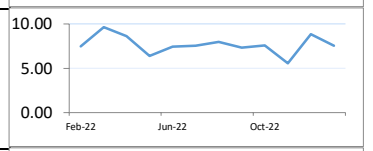
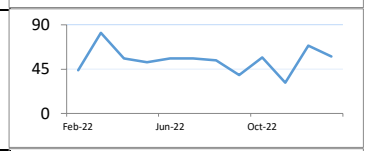
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure		Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
Admissions	1	Number of medical and surgical outliers in acute wards		2089	2309	2410	1893	1489	1835	1770	1442	1824	1067	1424	1964	
	2	Admissions of under 16 year olds to adult mental health wards		0	0	0	0	0	0	0	0	0	0	0	0	
	3	Mixed sex accommodation breaches	Acute wards	0	0	0	0	0	0	0	0	0	0	0	0	
	4		Community and mental health wards	0	0	0	0	0	0	0	0	0	0	0	0	
	5	Number of patients transferred between acute wards after 10pm		58	90	72	43	54	82	68	44	66	62	151	78	
Mortality (acute services)	6	Hospital Standardised Mortality Ratio (HSMR)		132.06	126.28	131.79	131.57	134.23	132.86	141.61	135.31	127.20	112.92	December 2022 to be reported after February 2023		
	7	Summary Hospital-level Mortality Indicator (SHMI)		109.86	111.5	110.83	114.49	112.73	113.05	108.06	105.91	103.35	November 2022 to be reported after February 2023			
Incident reporting	8	No of Serious Incidents Requiring Investigation (SIRIs)/Never Events - acute services		0	0	1	2	1	2	1	2	2	0	0	0	
	9	Number of recorded Serious Incidents Requiring Investigation - community and mental health services		1	3	2	2	2	2	1	2	Review of reporting being undertaken. Will recommence from February 2023				

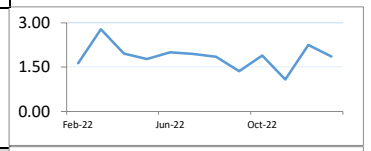
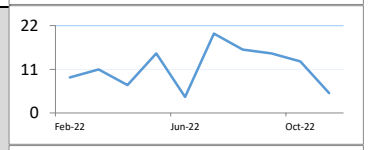
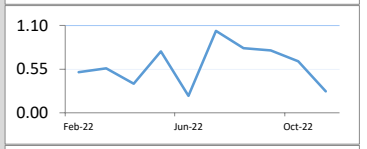
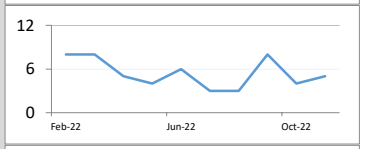
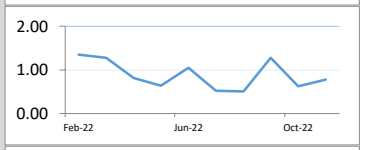
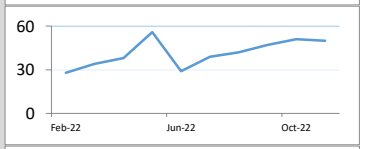
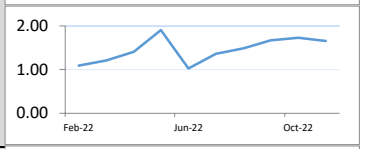
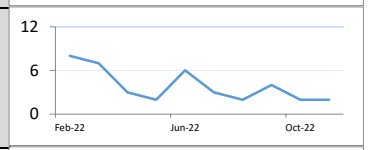
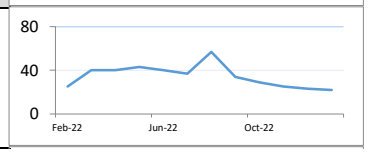
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
Infection Control	10	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)	5	3	6	5	1	5	6	3	7	2	2	7	
Infection Control (acute services)	11	MRSA bacteraemias (post)	0	0	0	0	0	0	0	1	0	0	0	0	
	12	E. coli bacteraemia	3	3	4	9	8	9	7	5	8	3	9	11	
	13	Methicillin-sensitive staphylococcus aureus	0	4	8	2	6	4	0	5	5	2	3	5	
Maternity	14	No. of still births	1	2	0	1	1	1	0	0	0	0	0	0	
	15	No. of babies born in unexpectedly poor condition	0	0	0	0	0	0	0	0	0	0	0	0	
Falls	16	Number of patient falls - all services	201	284	247	187	208	217	233	210	228	160	271	235	
	17	Rate of falls per 1,000 occupied bed days - all services	7.49	9.63	8.65	6.39	7.43	7.54	8.00	7.32	7.58	5.57	8.84	7.55	
	18	Number of falls resulting in harm - all services	44	82	56	52	56	56	54	39	57	31	69	58	

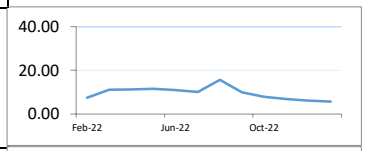
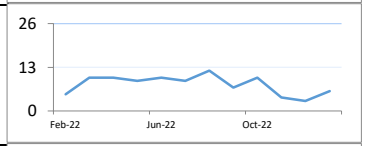
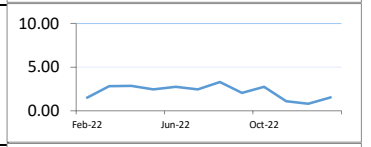
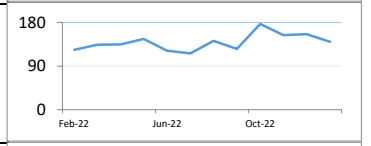
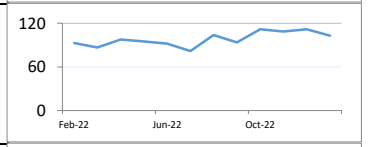
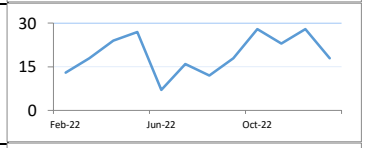
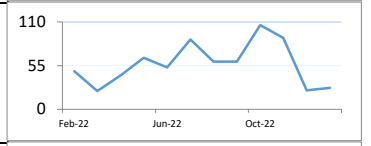
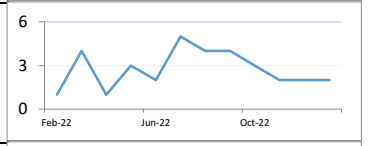
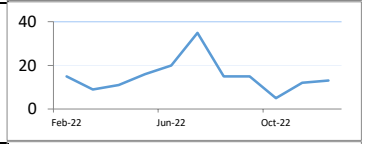
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
Falls	19	Rate of falls resulting in harm per 1,000 occupied bed days - all services	1.64	2.78	1.96	1.78	2.00	1.95	1.85	1.36	1.89	1.08	2.25	1.86	
Pressure ulcer damage	20	Acute wards - number of incidents	9	11	7	15	4	20	16	15	13	5	Data being validated		
	21	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	0.51	0.56	0.37	0.78	0.21	1.03	0.82	0.79	0.65	0.27			
	22	Community hospitals - number of incidents	8	8	5	4	6	3	3	8	4	5			
	23	Rate of pressure ulcer damage per 1,000 community hospital occupied bed days	1.35	1.27	0.82	0.64	1.05	0.52	0.51	1.28	0.62	0.78			
	24	District nursing - number of incidents	28	34	38	56	29	39	42	47	51	50			
	25	Rate of pressure ulcer damage per 1,000 district nursing contacts	1.09	1.21	1.41	1.91	1.03	1.36	1.49	1.67	1.73	1.66			
Cardiac Arrests	26	No. ward-based cardiac arrests - acute wards	8	7	3	2	6	3	2	4	2	2	2	Data awaited	
Restraints (mental health wards)	27	Total number of incidents	25	40	40	43	40	37	57	34	29	25	23	22	

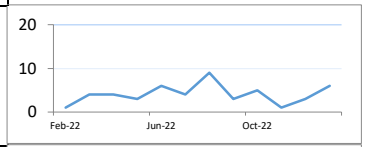
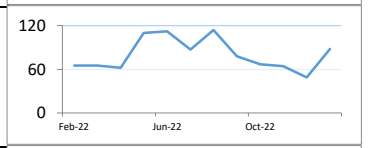
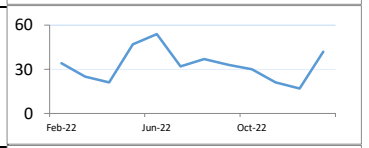
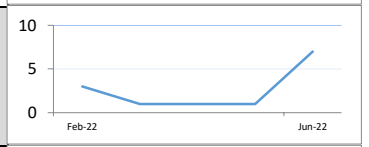
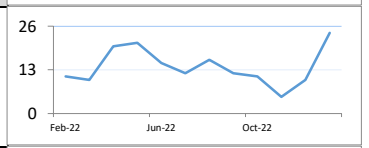
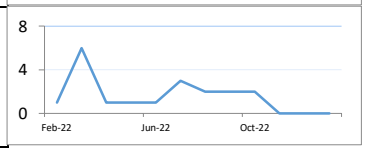
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
Restraints (mental health wards)	28	Restraints per 1,000 occupied bed days	7.55	11.26	11.44	11.74	11.13	10.15	15.69	10.06	8.00	7.02	6.25	5.77	
	29	Number of prone restraints	5	10	10	9	10	9	12	7	10	4	3	6	
	30	Prone restraints per 1,000 occupied bed days	1.51	2.82	2.86	2.46	2.78	2.47	3.30	2.07	2.76	1.12	0.82	1.57	
Medication incidents - community and mental health wards	31	Total number of medication incidents	124	134	135	146	122	116	142	126	177	154	156	140	
	32	Medication incidents - drug errors	93	87	98	95	92	82	104	94	112	109	112	103	
	33	Medication incidents - incorrect storage	13	18	24	27	7	16	12	18	28	23	28	18	
Ligatures and ligature points - mental health wards	34	Ligatures: Total number of incidents	48	23	43	65	53	88	60	60	106	90	24	27	
	35	Number of ligature point incidents	1	4	1	3	2	5	4	4	3	2	2	2	
Aggression - mental health wards	36	Violence and Aggression: Number of incidents patient on patient (inpatients only)	9	15	9	11	16	20	35	15	15	5	12	13	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
Violence and community and wa	37	Violence and Aggression: Incidents resulting in harm - patient on patient (inpatient only)	1	4	4	3	6	4	9	3	5	1	3	6	
Violence and Aggression - community and mental health services	38	Violence and Aggression: Number of incidents patient on staff	65	65	62	110	112	87	114	78	67	64	49	88	
	39	Violence and Aggression: Incidents resulting in harm - patient on staff	34	25	21	47	54	32	37	33	30	21	17	42	
Unexpected deaths	40	Unexpected Deaths: Total number of incidents to be investigated - community and mental health services	3	1	1	1	7	Review of reporting being undertaken. Will recommence from February 2023							
Seclusion - mental health wards	41	Number of Type 1 -Traditional Seclusion	11	10	20	21	15	12	16	12	11	5	10	24	
	42	Number of Type 2 -Short term Segregation	1	6	1	1	1	3	2	2	2	0	0	0	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2022/23

No.	Description		Links to corporate objectives	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Thresholds
1	Accident and Emergency / Minor Injury Unit 4-hour performance	Accident and Emergency department (ED)	4, 6, 9	56.9%	49.4%	52.7%	50.5%	47.3%	47.9%	45.8%	48.4%	43.4%	54.0%	39.6%	54.2%	>=95%= Green >=85% - <95% =Amber <85% =Red
2		Minor Injury Units	4, 6, 9	98.9%	98.1%	98.0%	97.9%	97.4%	97.1%	96.9%	96.8%	97.0%	97.6%	93.9%	96.3%	
3		Trust-wide	4, 6, 9	79.7%	76.8%	78.6%	77.4%	76.4%	75.9%	75.6%	75.8%	73.1%	77.9%	70.5%	77.8%	
4	Accident and Emergency / Minor Injury Units: percentage of patients spending more than 12-hours in the department	Accident and Emergency department (ED)	4, 6, 9	4.5%	7.9%	7.0%	3.7%	4.1%	4.7%	8.8%	4.2%	8.4%	2.9%	10.2%	7.1%	<=2%= Green >2% - <=5% =Amber >5% =Red
5		Minor Injury Units	4, 6, 9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
6	Ambulance handovers waiting less than 30 minutes - Emergency Department only (MPH)		4, 6, 9	90.4%	71.9%	77.4%	82.9%	76.6%	78.9%	65.7%	73.4%	56.5%	79.0%	52.1%	71.0%	>=95%= Green >=85% - <95% =Amber <85% =Red
7	Cancer - maximum 2-week wait from GP referral (suspected cancer)		3, 4, 9	65.3%	63.3%	62.5%	68.2%	55.0%	63.5%	57.1%	51.1%	56.6%	51.9%	51.0%	Data awaited	>=93%= Green <93% =Red
8	Cancer - 28 days Faster Diagnosis All Cancers		3, 4, 9	81.0%	75.0%	73.2%	68.3%	56.8%	62.4%	60.6%	47.7%	51.7%	63.0%	63.7%	Data awaited	>=75%= Green <75% =Red
9	Cancer - maximum 31 day wait from diagnosis to first treatment		3, 4, 9	98.4%	96.5%	98.1%	96.3%	93.3%	97.3%	96.7%	95.8%	95.6%	92.3%	93.1%	Data awaited	>=96%= Green <96% =Red
10	Cancer - maximum 62 day wait from urgent GP referral		3, 4, 9	73.1%	73.3%	70.6%	60.9%	56.8%	62.6%	70.1%	45.7%	57.3%	49.6%	55.6%	Data awaited	>=85%= Green <85% =Red
11	Cancer: 62-day wait from referral to treatment for urgent GP referrals – number of patients treated on or after day 104		3, 4, 9	10	10	3	10	18	12	10	13	11	10	10	Data awaited	0= Green >0 = Red
12	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week (rolling 12 months)		3, 4, 9	81.8%	83.9%	86.2%	85.2%	83.3%	82.6%	80.0%	80.0%	80.0%	85.0%	84.2%	88.9%	>=95%= Green >=85% - <95% =Amber <85% =Red
13	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks (rolling 12 months)		3, 4, 9	75.2%	75.2%	75.0%	74.0%	79.0%	80.4%	84.7%	85.4%	90.2%	91.5%	91.1%	91.3%	>=95%= Green >=85% - <95% =Amber <85% =Red
14	Mental health referrals offered first appointments within 6 weeks	All mental health services	4, 6, 9	92.1%	93.4%	89.5%	93.4%	91.9%	93.2%	93.8%	90.4%	90.8%	91.9%	89.0%	91.3%	>=90%= Green >=80% - <90% =Amber <80% =Red
15		Adult mental health services	4, 6, 9	91.7%	90.3%	86.4%	90.2%	87.9%	94.7%	93.6%	87.4%	89.2%	90.0%	86.3%	90.2%	>=90%= Green >=80% - <90% =Amber <80% =Red
16		Older Persons mental health services	4, 6, 9	90.4%	96.0%	90.1%	95.1%	93.1%	92.0%	93.0%	90.2%	90.0%	90.8%	89.8%	91.1%	>=90%= Green >=80% - <90% =Amber <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2022/23

No.	Description		Links to corporate objectives	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Thresholds
17	Mental health referrals offered first appointments within 6 weeks	Learning disabilities service	4, 6, 9	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	88.9%	92.3%	>=90%= Green >=80% - <90% =Amber <80% =Red
18		Children and young people's mental health services	4, 6, 9	96.9%	96.8%	98.3%	98.6%	98.9%	91.9%	100.0%	100.0%	97.3%	100.0%	95.9%	95.1%	>=90%= Green >=80% - <90% =Amber <80% =Red
19	Diagnostic 6-week wait - acute services		4, 9	72.5%	71.7%	69.5%	73.0%	74.4%	77.2%	78.1%	77.0%	82.4%	84.3%	78.8%	82.9%	>=99%= Green >=98% - <99% =Amber <98% =Red
20	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		4, 6, 9	59.3%	59.0%	59.1%	61.8%	61.5%	61.5%	62.2%	60.5%	59.6%	58.6%	56.4%	58.2%	>=92%= Green <92% =Red
21	52 week RTT breaches		4, 6, 9	1,736	1,741	1,923	1,934	1,984	1,952	1,915	1,952	1,955	1,841	1,860	1,801	At or below trajectory = Green Above trajectory = Red
22	78 week RTT breaches		4, 6, 9	418	359	427	427	400	373	330	297	262	219	257	201	From April 2022 At or below trajectory = Green Above trajectory = Red
23	104 week RTT breaches		4, 6, 9	145	86	80	61	33	17	16	13	7	1	3	3	From April 2022 At or below trajectory = Green Above trajectory = Red
24	Referral to Treatment (RTT) incomplete pathway waiting list size		4, 6, 9	32,729	33,196	33,822	34,349	35,000	34,392	34,826	35,513	36,342	36,707	36,831	37,050	From April 2022 At or below trajectory = Green Above trajectory = Red
25	Average length of stay of patients on Musgrove Park wards (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).		4, 9	7.1	7.0	7.8	7.2	6.5	6.5	7.0	6.6	6.6	6.9	6.6	Data awaited	Monitored using Special Cause Variation Rules. Report by exception.
26	Waiting times: number of people waiting over 18 weeks from referral to first appointment - community services including dental		4, 6, 9	3,835	3,847	3,986	4,041	4,361	4,465	4,512	4,658	4,881	3,983	4,102	4,056	< 82 patients (2017/18 outturn) = Green >=82 - <86 = Amber >86 = Red
27	Community dental services - Child GA waiters waiting 18 weeks or more		4, 6, 9	187	213	223	216	229	331	351	330	333	346	370	356	0 = Green >=0 - =<50 =Amber >50 =Red
28	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		4, 6, 9	78.6%	66.7%	63.2%	75.0%	76.9%	63.6%	69.2%	66.7%	75.0%	58.8%	61.9%	60.9%	>=60%= Green <60% =Red
29	Improving Access to Psychological Therapies (IAPT) RTT : percentage of people waiting under 6 weeks		4, 6, 9	73.6%	62.3%	57.5%	57.0%	55.5%	51.9%	57.3%	64.1%	63.1%	63.6%	63.3%	61.6%	>=75%= Green <75% =Red
30	Improving Access to Psychological Therapies (IAPT) RTT: percentage of people waiting under 18 weeks		4, 6, 9	98.9%	97.9%	97.9%	98.4%	98.3%	98.6%	98.6%	98.0%	97.5%	98.1%	98.7%	98.5%	>=95%= Green <95% =Red
31	Improving Access to Psychological Therapies (IAPT) Recovery Rates		4, 7, 9	58.4%	55.7%	66.6%	63.1%	62.1%	57.6%	60.1%	64.0%	54.4%	59.8%	56.5%	61.4%	>=50%= Green <50% =Red
32	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		4, 9	90.2%	88.9%	97.1%	90.2%	97.2%	91.4%	100.0%	96.6%	100.0%	97.4%	100.0%	93.9%	>=80%= Green <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2022/23

No.	Description	Links to corporate objectives	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Thresholds
33	Inappropriate Out of Area Placements for non-specialist mental health inpatient care (monthly number of patient days)	4, 5, 9	17	7	23	88	90	75	25	10	60	125	57	27	0= Green >0 = Red
34	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1	4, 5, 9	91.7%	93.4%	91.5%	92.2%	94.8%	93.2%	92.4%	94.2%	94.1%	92.9%	93.2%	93.2%	>=95%= Green >=85% - <95% =Amber >85% =Red
35	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	4, 9	90.0%	93.0%	76.0%	96.0%	90.0%	89.0%	85.0%	82.0%	83.0%	93.0%	89.0%	100.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
36	Percentage of emergency patients screened for sepsis - acute services	4, 9	90.0%		75.0%			86.0%			Reported quarterly Results of audit being validated.			Reported quarterly	>=90%= Green >=49% - <90% =Amber <49% =Red
37	Percentage of patients receiving antibiotics within one hour of red flag diagnosis of sepsis - acute services	4, 9	62.5%		47.1%			75.0%							>=90%= Green >=49% - <90% =Amber <49% =Red
38	Percentage of patients with a NEWS of 5 or more acted upon appropriately - acute services	4, 9	61.1%	49.1%	57.4%	Reporting processes being reviewed and updated and will recommence from February 2023									TBC
39	District nursing - cumulative increase / (reduction) in external referrals from 1 April 2021 to 31 March 2022 compared to same months of 2019/20	9	-0.2%	0.3%	-8.5%	-9.1%	-6.4%	-6.0%	-3.4%	-1.9%	-2.3%	0.3%	1.3%		TBC
40	Percentage of complaints responded to within 40 working days - Trust-wide	9	33.3%	50.0%	50.0%	50.0%	53.1%	50.0%	48.0%	45.5%	57.7%	55.0%	46.7%	39.4%	>=90%= Green >=75% - <90% =Amber >75% =Red
41	Mandatory training: percentage completed	1, 8, 9	91.8%	92.1%	92.0%	92.4%	92.5%	92.4%	92.8%	92.9%	92.3%	92.1%	91.9%	91.1%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
42	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)	8, 9	5.8%	5.5%	8.9%	8.1%	7.1%	7.0%	6.4%	6.9%	6.2%	6.7%	6.6%	6.3%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
43	Sickness absence levels - rolling 12 month average (Trust-wide)	8, 9	5.3%	5.5%	5.7%	5.8%	5.9%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.8%	<=4.6%= Green >4.6% to <=5.1% =Amber >5.1% =Red
44	Sickness absence levels - monthly average (Trust-wide)	8, 9	6.0%	7.1%	6.5%	5.2%	5.5%	6.6%	4.9%	4.9%	5.8%	5.5%	6.1%	5.4%	<=4.6%= Green >4.6% to <=5.1% =Amber >5.1% =Red
45	Reduce the number of working days lost due to stress and anxiety (Trust-wide)	8, 9	311	333	341	361	314	330	279	301	351	326	306	332	Monitored using Special Cause Variation Rules. Report by exception.
46	Retention / turnover rates (Trust-wide)	8, 9	12.4%	11.9%	11.9%	11.9%	11.2%	10.9%	11.0%	10.8%	11.0%	11.3%	11.2%	11.1%	=<12%= Green 12% to <15% =Amber >15% =Red
47	Career conversations (12 months) - formerly 'Performance review (12-month)'	8, 9	48.5%	48.5%	56.2%	56.2%	61.0%	56.0%	57.2%	57.2%	56.8%	58.6%	58.0%	58.6%	From May 2022 At or above trajectory = Green Below trajectory = Red

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in January 2023, including the number of patients waiting over 18 weeks, the number of patients waiting over 52 weeks, and the average (mean) number of weeks patients have waited on the Trust's waiting list.

RTT specialty	Over 18 week waiters	Over 52 week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	225	36	393	42.7%
Urology	989	177	2009	50.8%
Trauma & Orthopaedics	1826	428	4989	63.4%
Ear, Nose & Throat (ENT)	1345	89	3204	58.0%
Ophthalmology	2200	206	4301	48.8%
Oral Surgery	1084	117	2450	55.8%
Plastic Surgery	1	0	2	50.0%
Cardiothoracic Surgery	3	0	22	86.4%
General Medicine	0	0	3	100.0%
Gastroenterology	1033	7	2174	52.5%
Cardiology	921	19	2246	59.0%
Dermatology	47	0	255	81.6%
Thoracic Medicine	463	0	1174	60.6%
Neurology	395	7	998	60.4%
Rheumatology	196	8	575	65.9%
Geriatric Medicine	90	1	423	78.7%
Gynaecology	874	115	2498	65.0%
Other – Medical Services	887	134	2126	58.3%
Other - Paediatric Services	320	10	1053	69.6%
Other - Surgical Services	2398	442	5458	56.1%
Other – Other Services	190	5	697	72.7%
Total	**15,487**	**1,801**	**37,057**	**58.2%**

Table 2 – Performance against the 62-day GP cancer standard in December 2022.

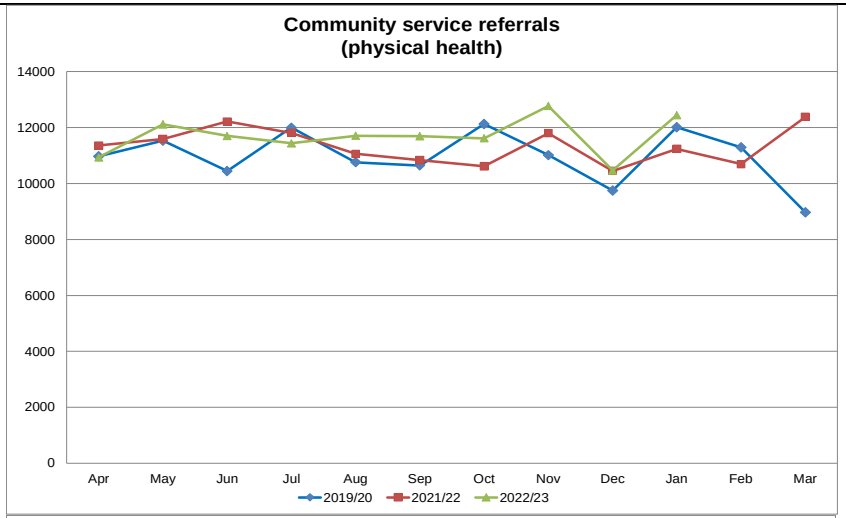
Tumour site	No of breaches	Trust performance
Breast	2.0	75.0%
Colorectal	4.0	20.0%
Gynaecology	5.0	28.6%
Haematology	1.5	40.0%
Head & Neck	1.0	87.5%
Lung	4.0	50.0%
Skin	0.5	83.3%
Upper GI	2.0	50.0%
Urology	17.5	54.5%
Total	**37.5**	**55.6%**

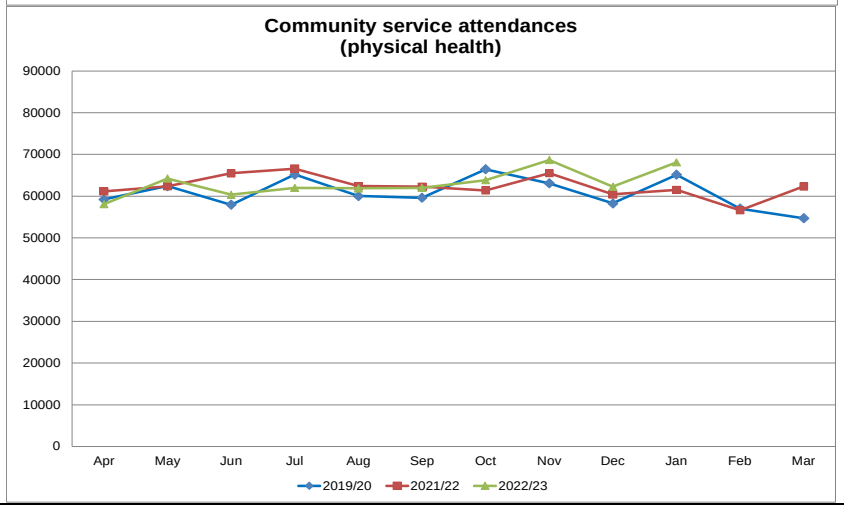
Ten patients were treated in December on or after day 104 (the national 'backstop'). Nine were assessed as having unavoidable delays. A breakdown of the breaches is as follows:

- Five patient pathways had some internal delays, mainly due to capacity, but pathways were further delayed for unavoidable reasons including additional diagnostics being required, complex treatment planning, patient thinking time and Involvement required from another provider and clinical teams.
- Two patients had a complex pathway, including pts requiring additional diagnostics, transferring from a different cancer pathway and treatment plan changing.
- Two patients transferred to us late in their pathway for treatment, because of the referring hospital's capacity shortfall and patient complexity.
- One pathway (deemed to have avoidable delays) was delayed due to endoscopy, pre-operative assessment clinic and surgical capacity.

Operational context

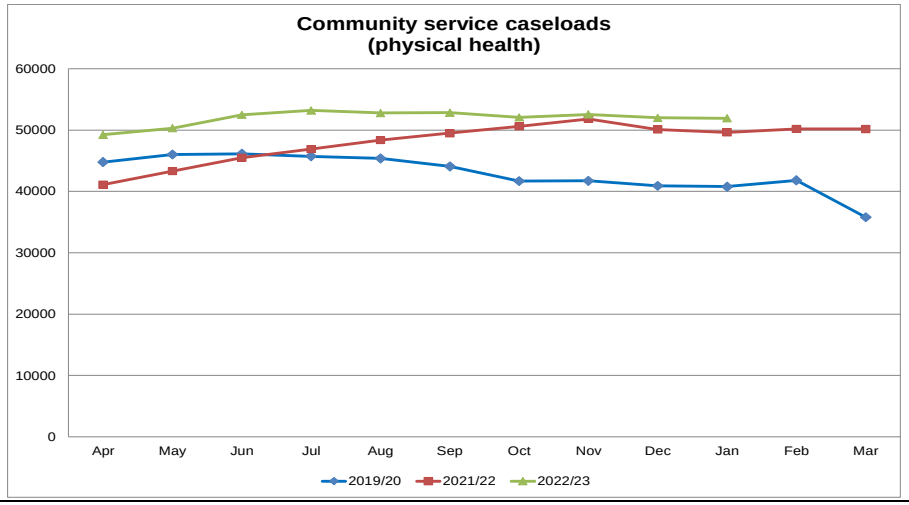
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





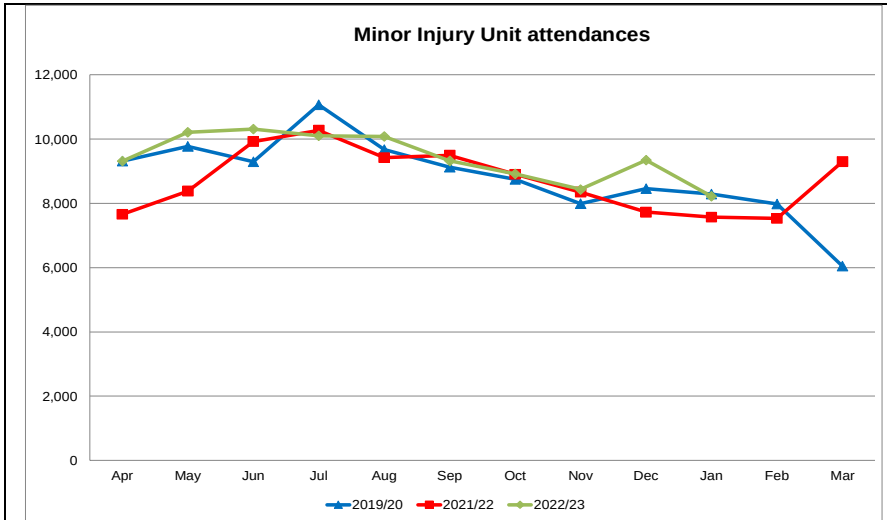
Summary:

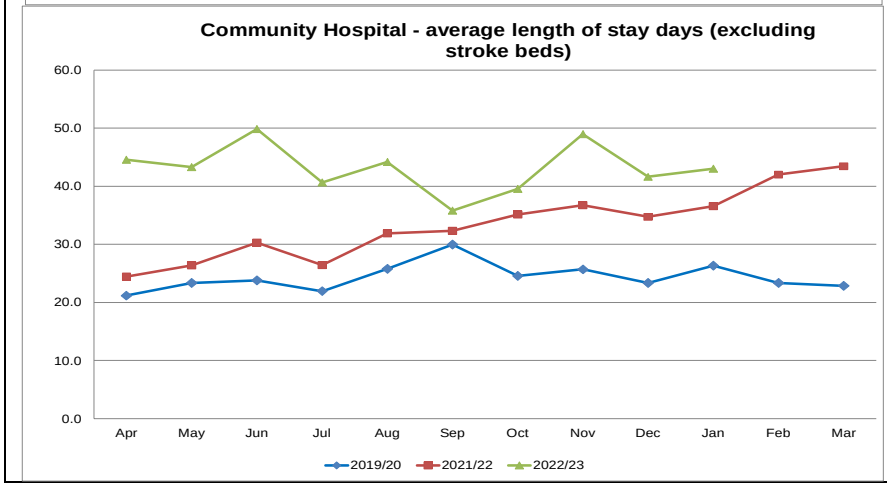
- Direct referrals to our community physical health services between 1 April 2022 and 31 January 2023 were 3.5% higher than in the same months of 2021/22 and 5.1% higher than the same months of 2019/20.
- Attendances for the same period were 0.4% lower than the same months of 2021/22 but 2.3% higher than the levels of 2019/20.
- Community service caseload levels as at 31 January 2023 were 4.6% higher than as at 31 January 2022, and were 27.4% above 31 January 2021 levels.



Operational context

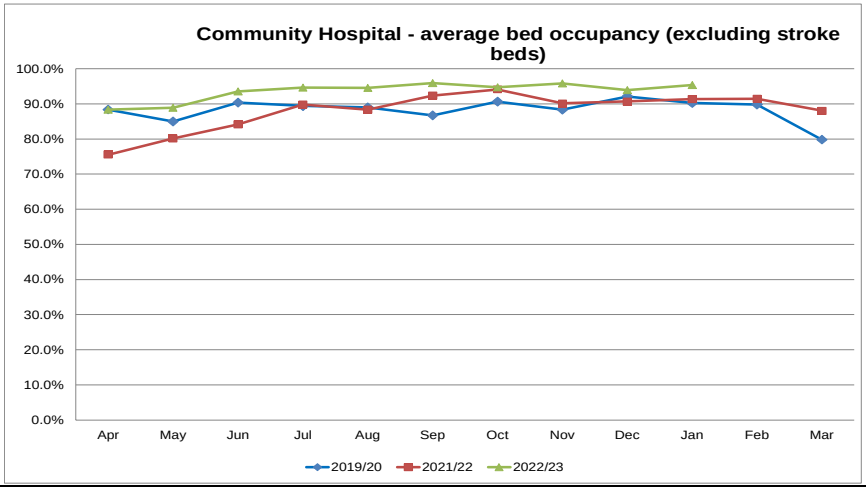
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





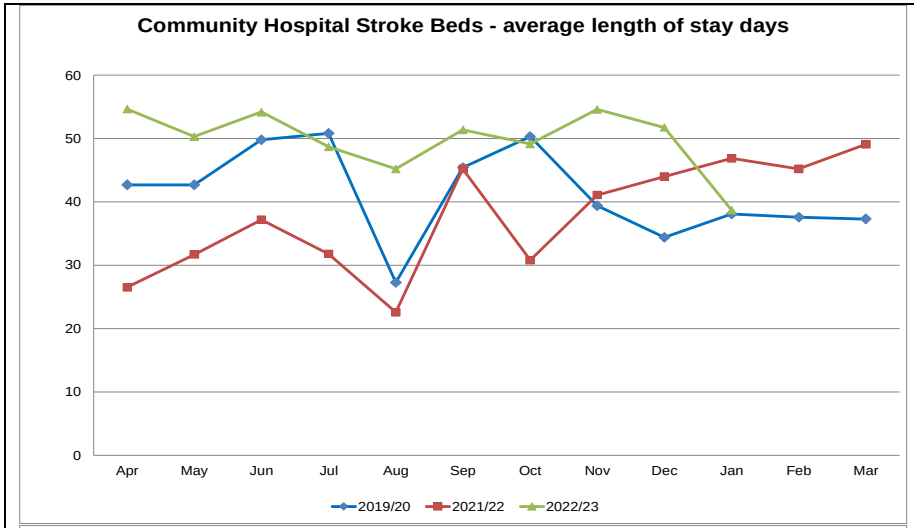
Summary:

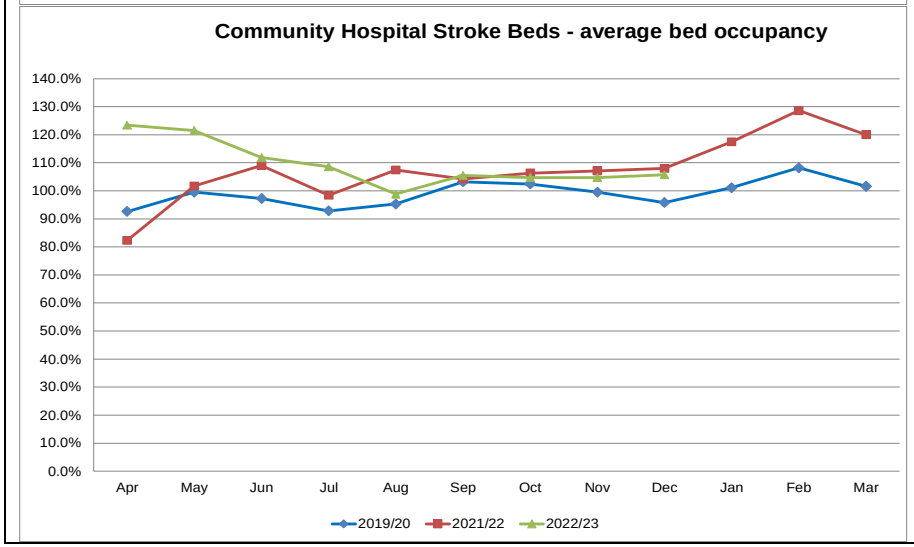
- Between 1 April 2022 and 31 January 2023, the number of Minor Injury Unit attendances was 7.4% higher than the same months of 2021/22 and 2.7% higher the same months of 2019/20. During January 2023, 96.3% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 95%.
- The average length of stay for non-stroke patients in our community hospitals in January 2023 was 43.0 days, an increase compared to December 2022. A total of ten patients with stays longer than 100 days were discharged; the longest was 272 days for a patient at Minehead community hospital.
- The community hospital bed occupancy rate for non-stroke patients in January 2023 remained high, at 95.3%, up from 93.9% in December 2022.



Operational context

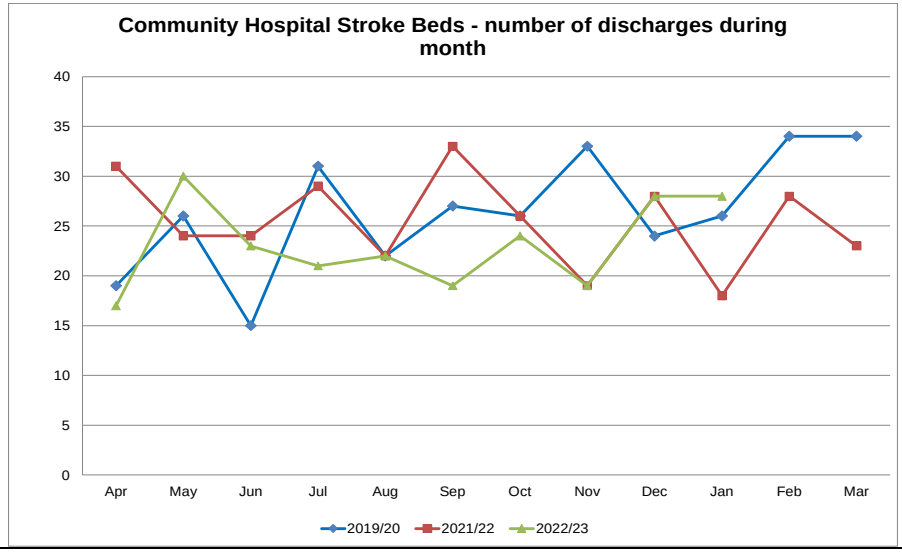
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





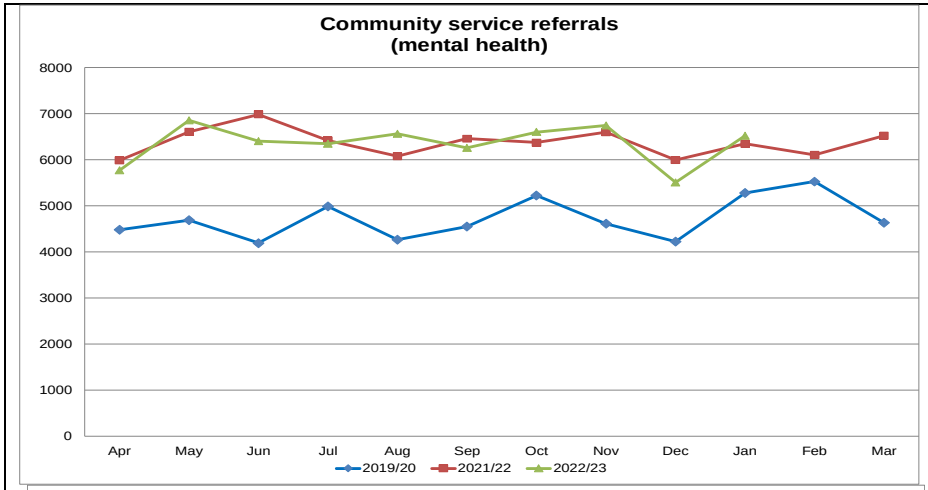
Summary:

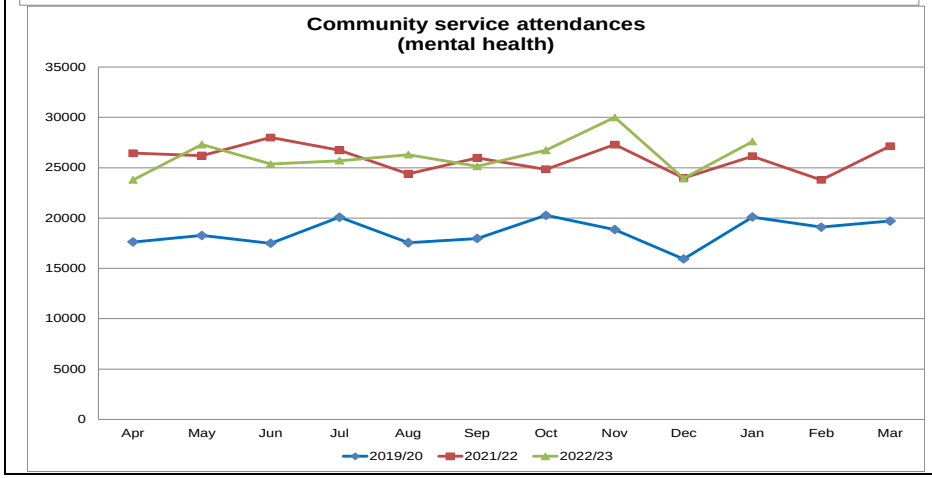
- The average length of stay for stroke patients in our community hospitals in January 2023 decreased to 38.7 days, from 51.8 days in December 2022. One South Petherton community hospital patient discharged during January 2023 had a length of stay longer than 100 days (111 days).
- Stroke bed occupancy in January 2023 increased compared to December 2022.
- During January 2023 there were 28 discharges of stroke patients, the same as in December 2022. The monthly average number of stroke patients discharged from our community hospitals in 2021/22 was 25.



Operational context

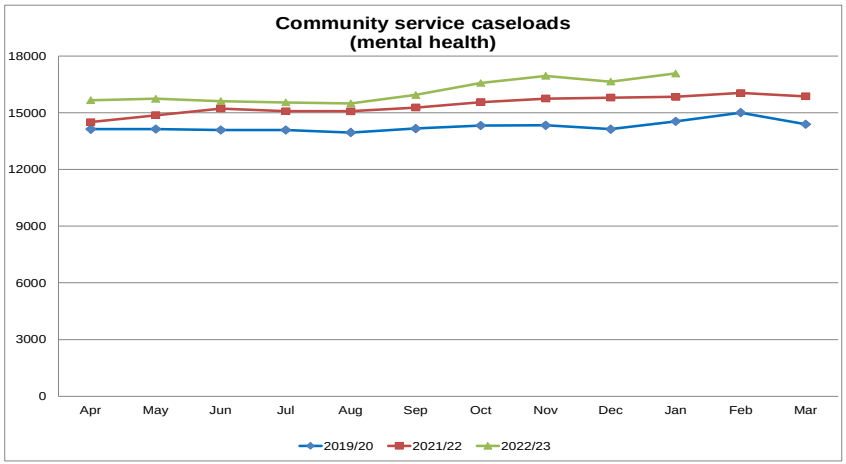
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





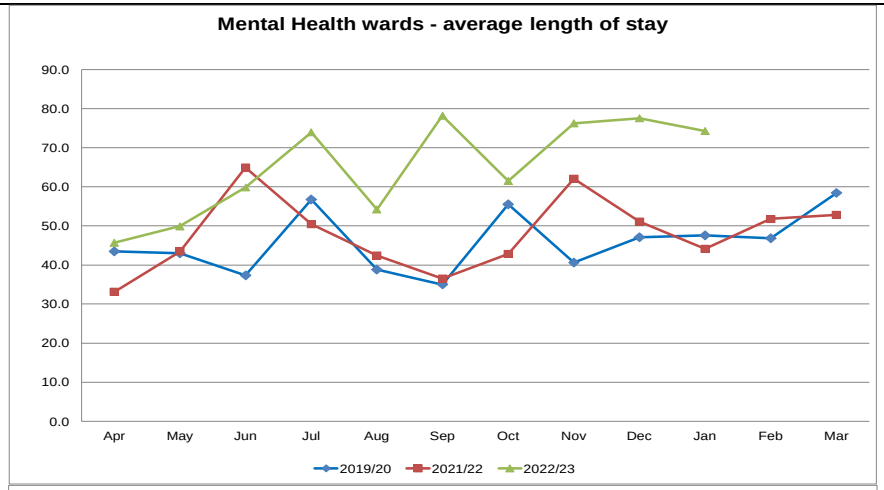
Summary:

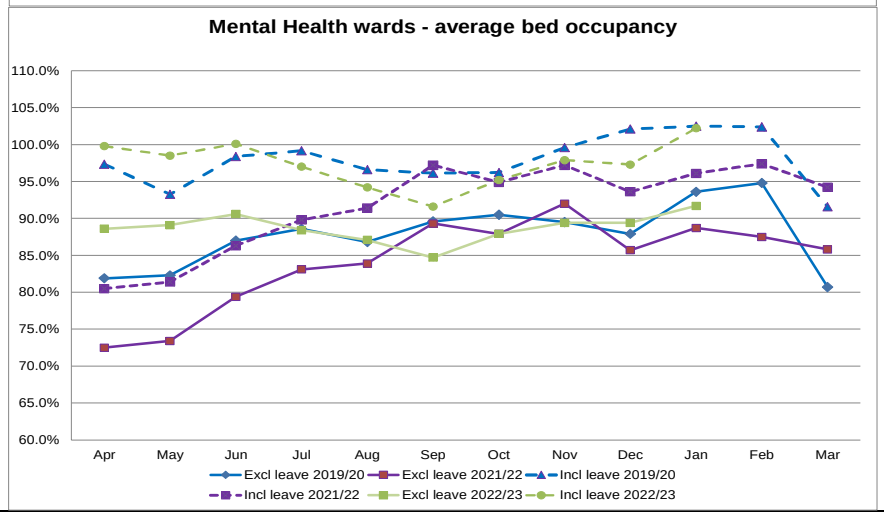
- Referrals to our community mental health services between 1 April 2022 and 31 January 2023 were 0.4% lower than in the same months of 2021/22 but 36.7% higher than the same months of 2019/20.
- Attendances for the same period were 0.7% higher than the corresponding months of 2021/22 but 42.2% higher than in 2019/20.
- Community mental health service caseloads as at 31 January 2023 increased by 7.8% when compared to 31 January 2022 and were 17.4% higher than as at 31 January 2021. It should be noted that investment in mental health services since 2019 has facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

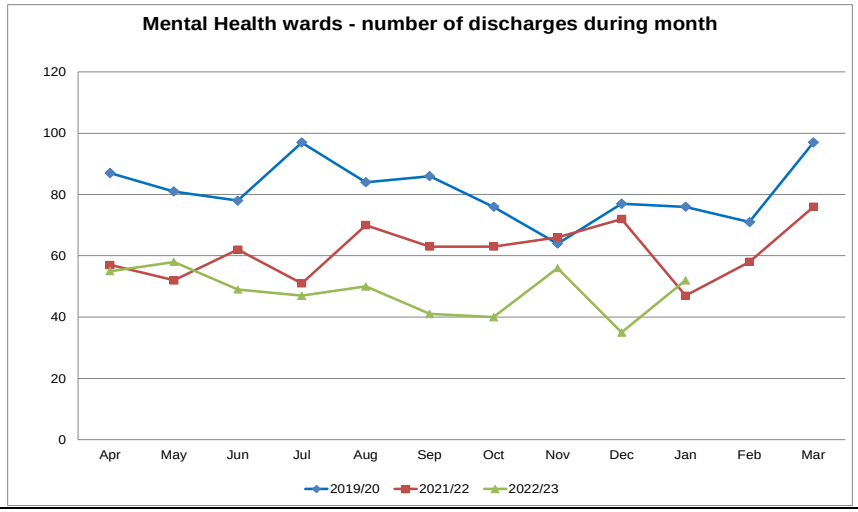
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





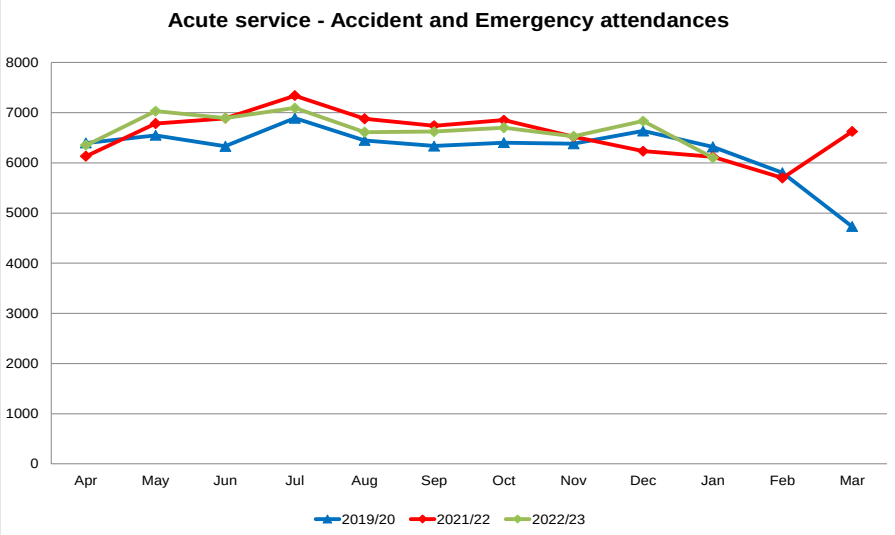
Summary:

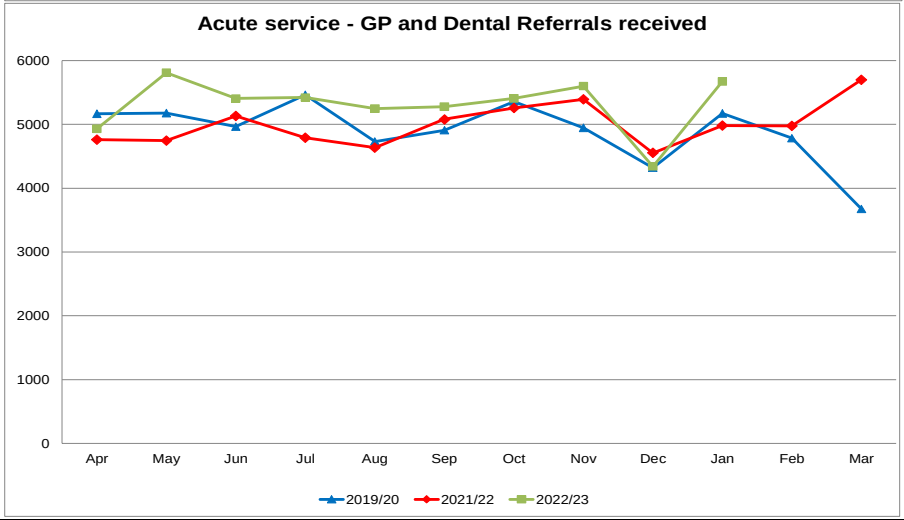
- The average length of stay in our mental health wards in January 2023 was 74.3 days, a decrease compared to December 2022. 14 patients discharged in January 2023 had lengths of stay of 100 days or more. Increases in delayed transfers of care and the responsiveness / availability of step-down options have resulted in longer lengths of stay in our mental health wards.
- The mental health bed occupancy rate in January 2023, based on excluding and including leave increased compared to December 2022.
- A total of 52 patients were discharged in January 2023, up from 35 in December 2022.



Operational context

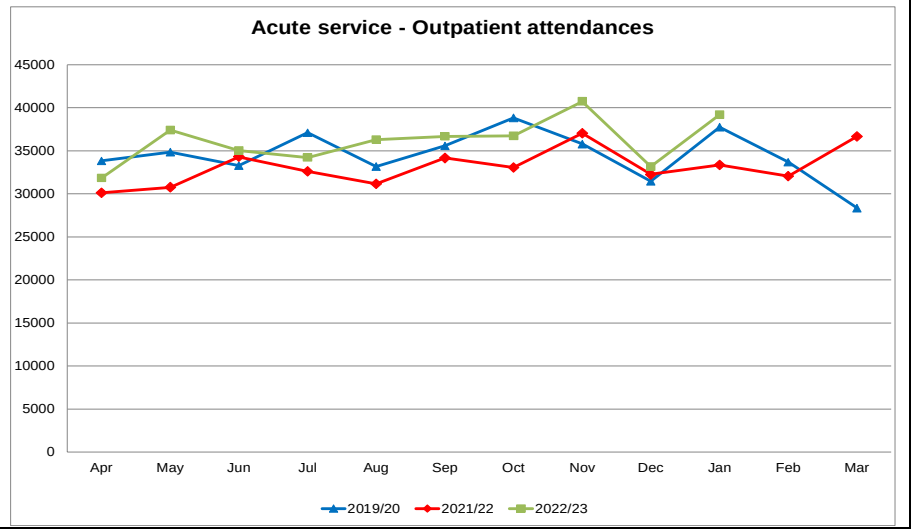
Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





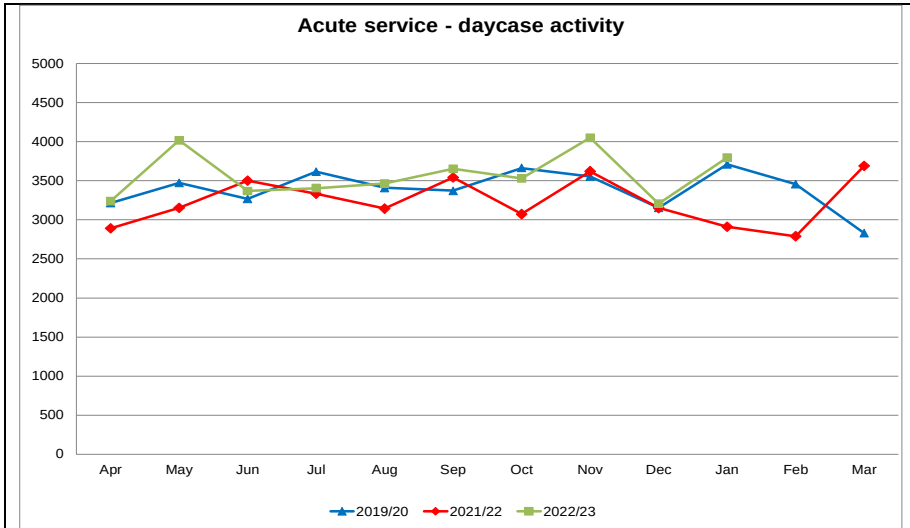
Summary:

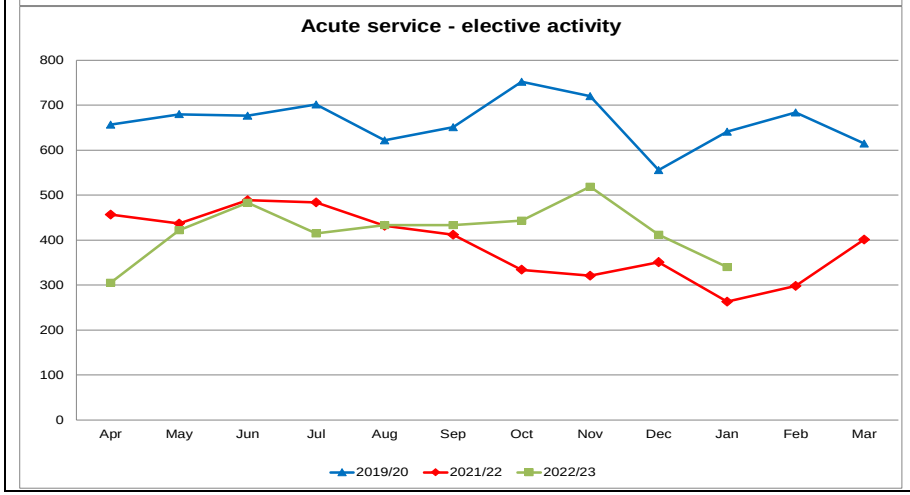
- Between 1 April 2022 and 31 January 2023 attendances to Accident and Emergency were 0.4% higher than the same months of 2021/22, and 3.2% higher than the same months of 2019/20. In January 2023, 54.2% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 95%.
- GP and Dental referrals between 1 April 2022 and 31 January 2023 were 7.7% higher than the same months of 2021/22, and 5.8% higher than the same months of 2019/20.
- Outpatient attendances for the same period were 9.9% higher than the same months of 2021/22, and 2.8% higher than the same months of 2019/20.



Operational context

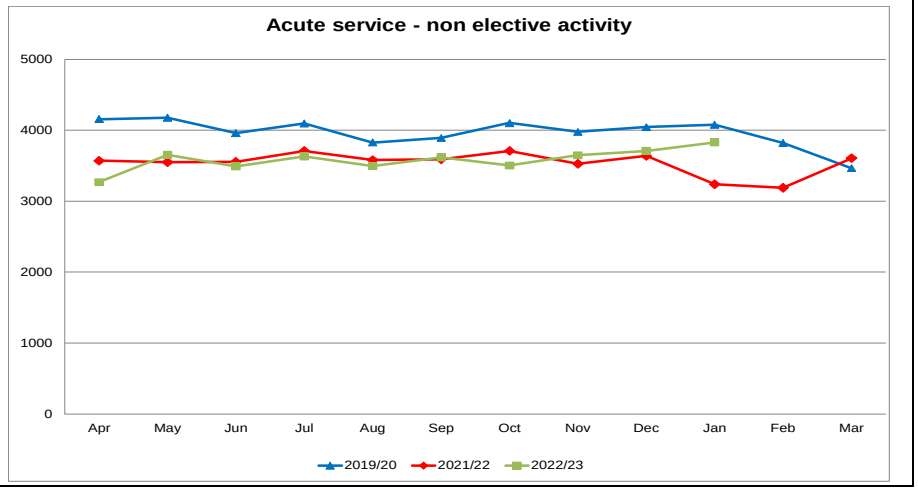
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior year.





Summary:

- The number of day cases undertaken by our acute services between 1 April 2022 and 31 January 2023 increased by 10.5% compared to the same months of 2021/22 and was 3.8% higher than the same months of 2019/20.
- Over the same period elective admissions were 5.7% higher than the same months of 2021/22, but 36.8% lower than the same months of 2019/20, which reflects the significant operational pressures experienced at Musgrove Park Hospital over recent months.
- Non elective admissions between 1 April 2022 and 31 January 2023 were 0.5% lower than the same months of 2021/22 and were 11.1% lower than the same months of 2019/20.



Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Draft Risk Management Strategy
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Samantha Hann, Deputy Director of Integrated Governance
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	This draft strategy outlines the Trust's strategic approach to identifying and managing both opportunities and threats within its healthcare environment, and through adoption will help to create an environment which meets the needs of the Trust's users, colleagues and other key stakeholders for the next three years. The strategy has been developed to comply with legal and statutory requirements; assist in compliance with national standards; promote proactive risk management; and to improve the safety and quality of patient care and colleague experience. The strategy takes account of the discussions at previous Board meetings about the risk appetite and risk tolerance statements and risk appetite and tolerance levels for each of the strategic objectives.
Recommendation	The Board is asked to approve the strategy.

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

- ☐ Obj 1 Improve health and wellbeing of population
- ☐ Obj 2 Provide the best care and support to children and adults
- ☐ Obj 3 Strengthen care and support in local communities
- ☐ Obj 4 Reduce inequalities
- ☐ Obj 5 Respond well to complex needs
- ☒ Obj 6 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture

☐ Obj 7 Live within our means and use our resources wisely
☐ Obj 8 Develop a high performing organisation delivering the vision of the Trust

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

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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The risk appetite and risk tolerance statements have been discussed at previous Board meetings.

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

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

Somerset
NHS Foundation Trust

Risk Management Strategy 2023-2026

CONTENTS

INTRODUCTION & PURPOSE

In a rapidly changing environment Somerset NHS Foundation Trust (the Trust) faces unprecedented challenges in providing and delivering high quality services for now and the future whilst adhering to its statutory obligations, creating a complex matrix of risks that require managing.

This strategy outlines the Trust's strategic approach to identifying and managing both opportunities and threats within its healthcare environment, and through adoption will help to create an environment which meets the needs of the Trust's users, colleagues and other key stakeholders for the next three years. It has been developed to comply with legal and statutory requirements; assist in compliance with national standards; promote proactive risk management; and to improve the safety and quality of patient care and colleague experience.

The Trust Board of Directors acknowledge that developing and improving services will never be 'risk free'. The Trust ensures that risks are assessed and that service improvements/developments that take place are informed not only by risk assessments but by the pre-determined level of risk the Trust is willing to accept in order to develop and improve.

It is important that the Board understands the risks that face the Trust both at a strategic level, but also operational. The 'golden thread' through all risk registers for oversight and appropriate action by the Board will evidence a culture of embedded risk management.

Risk management is the responsibility of all colleagues and risks need to be identified and managed at the appropriate level - ward/department; Specialty; Service Group; operational or strategic.

Good risk management practice includes considered, well-controlled risk-taking in pursuit of opportunities to develop, improve and add value to the services and functions of the Trust as well as acknowledging that risks can also present threats to delivery of our strategic objectives. A mature risk management organisation is risk aware and able to handle risk. It is not risk averse.

The purpose of the Trust's Risk Management Framework is to set out the overarching principles and processes that enable the Trust to manage risk well and uphold high standards of risk management and governance practice. It describes how the Trust's risk management activities dovetail with other governance and assurance arrangements to form a coherent system of internal control.

As part of governance arrangements, this strategy together with the Trust's Risk Management Policy outlines the risk management framework, emphasising the way that the Trust can implement its strategic objectives through an integrated risk management approach. This strategy supports the Trust to deliver its objectives by ensuring that:

- Risks to objectives are identified and managed in a timely and effective manner;
- Opportunities for strategic development and service improvement are embraced and delivered safely;

- The prevailing risk management and assurance culture is open and constructive;
- Risk management and assurance activity, including risk assessment and business continuity, adds value to the life and work of the Trust.

A clear understanding of the key strategic objectives and a commitment to corporate governance will ensure that risk analysis and management are applied throughout the organisation. This Strategy also endeavours to promote a culture whereby patient safety and quality are at the heart of all clinical practice and all colleagues are open to sharing learning from the experiences related to the management of risk and for our organisation to be an employer of choice.

The Assurance Committees on behalf of the Board of Directors will ensure that safe systems and robust risk management arrangements are in place for delivering quality and safe care.

INTEGRATED RISK MANAGEMENT

Risk management is a central part of the Trust's strategic and operational management. Integrated risk management is the process through which the organisation will identify, assess, analyse and manage all risks (clinical and corporate) inherent to and arising from its activities and puts in place robust and effective controls to mitigate those risks for every level of the organisation, aggregating the results at a corporate level to understand the impact on the delivery of the Trust's strategic objectives ensuring risks are not seen in isolation. It ensures there is a risk-aware culture that improves decision making and performance. In practice this means:

- Integrating risk management functions within service development and clinical and corporate governance activity to unify frameworks and improve outcomes for patients;
- Integrating all sources of information, both reactive (e.g. incidents) and proactive (e.g. risk assessments);
- Integrating systems of risk assessment incorporating all risks into the process ensuring there is clarity on the use of the risk registers; the validation process for risks; and the link between the Service Group risk registers and the Corporate risk register;
- Identifying how risks interact with each other and the impact on the organisation's strategic objectives;
- Implementing a consistent approach to training;
- Integrating processes and decisions about risk into future operational and strategic plans.

This strategy describes the systems that the Trust will use to embed risk management throughout the organisation in order to provide assurance that risks are managed and an effective control system is in place. The strategy is a trust-wide document, and is applicable to all employees, as well as sub-contracted staff at all levels of the organisation.

Our Trust aspires to develop a cohesive and integrated risk management system that aligns strategically with the Trust's strategic objectives by adopting best practices in the identification, evaluation and control of both clinical and non-clinical risks in order to deliver met our objectives.

Good risk management is a tool that supports and empowers the workforce to take risks in a measured, considered and appropriate way in line with the organisation's risk appetite and risk tolerance levels by enabling our colleagues to identify, assess and control risks in a way that is visible, consistent and makes best use of resources.

The Trust Board assume responsibility for the governance of risk by setting the direction of how risk should be approached and addressed to encompass the following risk management responsibilities:

- Opportunities and associated risks when developing their strategies including the positive and negative effects on achievement of the objectives
- Evaluate and agree the nature and extent of the risks that the organisation should be willing to take and in particular approve its risk appetite and risk tolerance levels
- Understand that the services it provides, and the way it provides these services, carries unavoidable and inherent risks
- Understand that effective risk management is not an end in itself, but an integral part of the trust's quality, governance and performance management processes

BENEFITS OF EFFECTIVE RISK MANAGEMENT

The organisational and personal benefits of effective risk management are listed below. The Trust's risk management strategy; policy; procedures; and systems will be designed to support these benefits.

Benefit	**Effective risk management…**
Better for patients	… helps to ensure that the Trust delivers the best services it can within the resources available, and that public money resources are used effectively and patient outcomes are improved.
Successful organisation	… will help the Trust to deliver its vision of "Thriving Colleagues, Integrated Care, Healthier People" and enable the Trust to achieve its strategic objectives and deliver its mission "to improve the health and wellbeing of everyone in Somerset and to deliver outstanding integrated care by supporting our colleagues and nurturing an inclusive culture of kindness, respect and teamwork".
Better decision making	… helps the organisation and its workforce to make better decisions by ensuring the threats and opportunities associated with different courses of action are understood so informed choices can be made. Decisions of the Trust will be taken with full consideration and awareness of the risk environment acknowledging healthcare has a high level of inherent risk already built within it.
Better planning and resource allocation	… helps the Trust to plan and prioritise where resources (time; people; and funding) and energy are used. It also helps to reduce volatility; provides more stability; predictability and confidence. This allows the organisation to identify and resolve problems more efficiently
Supports innovation	… allows an organisation to consciously think about and manage new challenges that may

and new ways of working	not fit into existing ways of working or establishes processes and procedures.
Provides protection	… protects an organisation and its workforce and helps to reduce avoidable incidents and fraud. There will be a measurable reduction in detrimental impact upon the quality of health care services provided, thereby improving service user safety and experience.
Empower-ment	… empowers the workforce in their role, helping them to undertake their role more effectively and supports decision making.
Good governance and provides assurance	… supports good governance by decisions being made in an open and transparent way based on sound reasoning. The process is auditable providing the Board of Directors, the Trust's Regulators and Internal and External Auditors with assurance that the organisation has an effective system of internal controls. The Board and Sub-Committees will have full understanding and assurance of the key strategic and high level operational risks that may affect the Trust's optimum functioning.
Provides confidence to key stake-holders	… provides all relevant stakeholders including the public and all professional partners with the evidence that the Trust is aware of its environment; pressures; threats; and opportunities; and is taking all appropriate remedial actions in line with its legal and ethical responsibilities, so as to ensure continuous quality improvement.

TRUST STRATEGY

The Risk Management Strategy aims to support the Trust in achieving its Strategic Objectives:

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

Only by active management of risks will the Trust be able to meet its strategic objectives. Therefore it is intended that every risk is linked to a strategy objective which will help enforce an active stance to managing these risks, ensuring that less time is spent reacting to situations and more time is spent taking advantage of opportunities.

This Strategy aims to support the Trust's vision by providing a framework of risk management that underpins our organisational values, namely; Respect, Kindness and Teamwork.

RISK MANAGEMENT VISION STATEMENT

In September 2022, the Board of Directors developed and approved the Trust's Risk Management Vision statement for 2023-2026:

The Trust will develop and maintain a strong and positive risk management culture which properly manages risks and achieves compliance with statutory requirements through a comprehensive system of internal controls and committees.

This will be supported by a risk management framework which maximises the potential for flexibility, is open and transparent, encourages innovation supporting new ways of working, and continually seeks to improve the quality and safety of the services provided by the Trust in delivery of its strategic objectives.

This will be achieved by devolving Risk Management to the individual Service Groups and corporate teams who know best how to manage their risks.

RISK MANAGEMENT OBJECTIVES

The Trust is committed to continuously improving and developing our risk management arrangements. This strategy specifies the actions that the Trust will take, detailed within Appendix 1, in the form of six specific risk management objectives that will ensure we achieve the vision for risk management and continue to do so over the life of this strategy.

From April 2023 to March 2026, the Trust will aim to achieve the following Risk Management objectives:

1. To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Ward to Board) ensuring that risk management is an essential part of governance and leadership and is fundamental to how the Trust is directed, managed and controlled at all levels

2. To support the Trust Board in being able to receive and provide assurance that the Trust has a clear line of sight of all risks across the organisation and embedded risk management processes

3. To ensure that risk management will be an integral part of the organisation's activities to support decision making ensuring that risks to the delivery of the Trust's objectives are identified and managed within the Trust's risk appetite and appropriately escalated

4. To refine processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust

5. To support all staff to understand risk management, their personal responsibility within their role and to act proactively to maximise the organisation's ability to deliver its strategic objectives and minimise things going wrong for patients, staff and other stakeholders

6. To ensure that risk management will be continually improved through learning and experience

These objectives are underpinned by the principles of the Trust's approach to risk management that is proportionate, aligned, comprehensive, embedded and dynamic.

How will the Trust know it has achieved the risk management objectives?

It is imperative that the agreed approach to risk management is continuously monitored and provides assurance that the Trust is delivering against its aims. Measurements of achievement against our risk management objectives include:

- Risks are systematically and pro-actively identified;
- All risks are clearly articulated;
- There is one risk management system in place;
- Risk registers are dynamic, with appropriate action plans in place;
- All risks are assigned risk owners, Executive Leads and assigned to Committees/Groups within the Governance Structure;
- Colleagues understand and can describe their role in relation to the identification and management of risk;
- There is clear linkage, visibility and oversight from Ward to Board of risks;
- Risk drives business planning and decision-making;
- All decisions are taken relative to the Trust's risk appetite and level of tolerable risk and escalated where this is exceeded;
- There is evidence that the Board, the Board Assurance Committees, Services Groups and Specialities embed risk in their meetings, with risks being reviewed and the validation processes followed;
- Assurance is received by the Audit Committee, the Board of Directors, and the Quality Assurance Group
- There is an annual review of the Risk Management Strategy and risk appetite & tolerance statement;
- There is an annual review of the effectiveness of the Committees within the Governance structure reviewing adherence against the Terms of Reference;
- There is evidence that the Board & the Board Assurance Committees have regular oversight of Trustwide risks, including receiving the Board Assurance Framework and the Corporate Risk Register at least four times a year

Building Blocks to Achievement

Each of the objectives will be linked to and delivered through the use of six key building blocks as shown in Appendix 1. The seventh overarching building block, risk culture, encompasses each of the other six building blocks.

The plan to support the delivery and implementation of the Trust's risk management objectives is detailed at Appendix 2.

Risk Culture

Set by the Board. The values and behaviours expected by the workforce when managing risk. Risk Culture encompasses each of the other building blocks

The Board of Directors with the support of its committees have a key role in ensuring a robust risk management system is effectively maintained and to develop and lead a culture whereby risk management is embedded across the Trust through its policy, strategy and plans, setting out its strategic ambitions and priorities in respect of risk management when delivering a safe high quality service.

A culture whereby risk management is “business as usual” at all levels across the organisation will be developed. Senior leaders in addition to the Board of Directors will lead change by being an example for behaviour and culture; ensuring risks are identified, assessed and managed.

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust and intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation.

Risks at the Trust will be managed in an open, honest and transparent way within a culture that supports and encourages this approach.

The Board recognises that to deliver its objectives there is a need for robust systems and processes to support continuous improvement, enabling staff to integrate risk management into their daily activities wherever possible and supporting better decision making through a good understanding of risks and their likely impact.

This can only be achieved through an ‘open and just’ culture where risk management is everyone’s business and where risks are identified promptly and acted upon in a positive and constructive way. Colleagues are, therefore, encouraged and supported to share best practice in a way that creates a culture of learning.

A key component of an effective and mature risk management framework is a culture of knowledge and understanding of risk management and leadership. This means that roles and responsibilities need to be clearly defined so that risk management is ‘owned’ by appropriate members of staff, and that all staff are encouraged to be more risk-aware through promotion of openness and support for local management of risk where possible. It also means visible and supportive leadership from the Board in ensuring effective systems and processes for the management and escalation of risks.

The Trust has board level leadership for risk management and a clear committee structure that supports the aggregation and escalation of risk at Service Group level.

Service Group Risk Registers will be used by the Executive team to inform discussions to ensure that risk is considered collectively and holistically, taking into account quality of care, finances and operational performance. The Governance structure in place will be the mechanism by which Service Groups and Corporate Teams are held to account for the

management of all aspects of their services, including the management of risks.

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

The BAF sets out the main strategic risks to the organisation's objectives and the associated controls and mitigation actions. It presents an assessment of the strength of internal controls in place to reduce the likelihood and impact of key risks materialising, and it identifies the main sources of internal and external assurance regarding the effectiveness of those internal controls. Risks recorded on the Corporate Risk Register may also appear on the BAF if they have the potential to compromise delivery of strategic objectives. Not every high scoring risk on the Corporate Risk Register will appear on the BAF, and not all BAF entries will appear on the Corporate Risk Register, which is a tool for the management of operational risk.

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

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

As well as structure, a mature risk management culture requires risk management to be at the heart of board level discussion. To enhance the maturity of existing conversations at board level, two of the aims of this strategy are to ensure there is a clear link between assurance and risk management which is embedded and integral in all of the organisation activities. Using the agreed risk appetite matrix, the Board can set out a framework within which all risks should be considered, linking objectives, business planning and risk appetite. This will also help to develop an approach that engenders risk forecasting.

Partnership Working

It is often at the interface between organisations that the highest risks exist and clarity about responsibilities and accountabilities for those risks are most difficult to ascertain. Only by working closely and collaboratively with a wide range of partner organisations can these risks be identified and properly managed.

The Trust will therefore endeavour to involve partner organisations in all aspects of risk management as appropriate including in the consultation of the risk management framework documentation and supporting the risk management arrangements development work that is underway for the Somerset Integrated Care System.

The Trust is committed to the continuing development of partnership working with other health and social care organisations. When partnership agreements are being developed risk management will be specifically addressed, outlining clear lines of accountability and responsibility for risk management structures and systems across organisations. Key partners include but are not limited to providers of shared services; Somerset & Dorset Integrated Care Boards; Local Authorities; the Police; statutory and voluntary bodies; and patient representative groups.

Risk Management Policy

Clearly articulates the processes and responsibilities for the management of risks

Risk Management Objective 1

To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Ward to Board) ensuring that risk management is an essential part of governance and leadership and is fundamental to how the Trust is directed, managed and controlled at all levels

This strategy aims to promote an integrated and consistent approach across all parts of the organisation to managing risk and provide the context of why risk management is important. It is supported by a detailed Risk Management Policy that sets out the Trust's requirements regarding risk management practice including the processes and procedures. The Policy includes;

- Key Definitions – including what is meant by the terms risk, risk management, risk assessment, and Integrated Risk Management;
- Contextual information – strategic objectives, risk appetite and risk tolerance, culture and leadership
- Roles & Responsibilities – for key Committees/Groups within the Governance structure, for key individuals, and for all staff
- Training and awareness – for all colleagues as well as key individuals within the Trust
- The Risk Management Process – identification, assessment (analysis and evaluation) & risk response, risk scoring, risk mitigation, and the risk management system
- Escalation, reporting and oversight of risks;
- Monitoring of the Risk Management Process.

Risk management is about continually asking the following questions which the Risk Management Framework documents endeavour to support our colleagues and stakeholders to answer.

Context - What are the objectives we wish to achieve?
Identify - What are the risks associated with our objectives?

Analyse - What will be the impact if the risks occurred and what will be the likelihood of the risks occurring at that impact?
Evaluate - What is our capacity, appetite and tolerance for the identified risks?
Treat - How should we respond to the risks?
Escalate - What is our escalation process (ward to board)?
Monitor - How do we assure ourselves we are managing our risks effectively?
Communicate - Are we communicating our risks via the right channels?

The structure of our Risk Management Policy, together with the questions above, have been based on the UK Risk Management standard ISO 31000. This model is internationally recognised and has been adopted by the Trust as a risk management model which is effective at managing risk at any level.

One of the key aims of this strategy is to ensure greater local ownership of risks. To achieve this, we will continue to strengthen risk registers at Ward/Department; Specialty; Service Group; and Corporate levels, supported by clear criteria and timeframes for escalation of risks.

The policy applies to all directly employed staff, agency staff, contractors and volunteers engaged in work or other activities on behalf of the Trust working in all areas of the Trust. The policy also identifies certain designated roles with specific responsibilities relating to risk management in the Trust including; Trust Chairman and Non-Executive Directors; Chief Executive Officer, as the Trust's Chief Accounting Officer; Executive Directors; Integrated Governance Team; Risk Owners; and Specialist Roles.

All Trust colleagues have a clear responsibility for identifying risks relevant to their service, team and/or working environment. These risks may be apparent as a result of colleagues' observations, or they may require the triangulation of information from a range of sources. A range of tools and resources will be maintained to support colleagues in the identification and escalation of risks, including:

- a portfolio of fully documented risk management, protocols, procedures and guidance documents that will be readily available via the Trust intranet;

- an electronically maintained set of risk registers, that together, identify the extent of significant operational risks faced by the Trust and that are defined by specialty and Service Group and
- standardised risk assessment forms

The Trust uses a 5x5 risk matrix which is common across the NHS and based on AS/NZS 4360:1999, a globally recognised standard for risk measurement and management. Using the 5x5 matrix supports our colleagues as the tool is simple to use; provides consistent results when used across a variety of colleague groups; and is capable of assessing a broad range of risks including but not limited to clinical, financial, quality, people, and reputational.

In April 2022, the Trust Board of Directors agreed on the following matrix to be used across the Trust: *Figure 1*

Risk Scoring Matrix

Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Certain 5
Insignificant - 1	1	2	3	4	5
Minor - 2	2	4	6	8	10
Moderate - 3	3	6	9	12	15
Major - 4	4	8	12	16	20
Catastrophic - 5	5	10	15	20	25

KEY: Low Risk | Medium Risk | High Risk

1-6	=	Low Risk	Needs to be resolved or accepted at Departmental level*
8-12	=	Medium Risk	Needs to be resolved or accepted at Service Group level*
15-25	=	High Risk	To be resolved or accepted at Trust level

**If the risk is not acceptable and cannot be resolved at the appropriate level, it needs to be escalated to the next level*

Oversight & Scrutiny

Ensuring the correct Committee Structures, reporting arrangements and frequency are in place

Risk Management Objective 2

To support the Trust Board in being able to receive and provide assurance that the Trust has a clear line of sight of all risks across the organisation and embedded risk management processes

Whilst this Strategy is focused on risk management at a strategic level, it is important to recognise that failure to manage operational risks will ultimately have an impact on strategic risks.

Strategic Risks relate to the delivery of the organisation's strategic objectives and should not change significantly over time. They have the highest potential for external impact – for example, does the organisation meet the publics' expectations of access to treatment times.

Operational risks relate to the organisation's on-going day to day business delivery – for example, patient safety; staff safety; security; information; and finances. Whilst they may have some external impact, operational risks mostly affect internal functioning and services. Significant operational risks, which are not effectively managed, can also have an impact on the delivery of the organisation's strategic objectives and therefore it is important that the Trust has in place a process for escalation of risks based not solely on risk score (figure 1) but also the agreed approach to risk tolerance using the gap scoring matrix (figure 2).

Figure 2

Gap Score Matrix (difference between Current Risk Score & Target Risk Score)		Review Period
Gap Score 0	Risk target achieved	Consider archiving the risk on the risk register
Gap Score 1 – 5	Tolerable	Minimum review every 6 months
Gap Score 6 - 9	Close Monitoring	Minimum review every quarter
Gap Score 10 or above	Increased monitoring and escalate for focused treatment of the risk	Minimum monthly review

By defining the level of risk that is to be managed at each tier of the organisation, risks can be managed by the correct level of seniority and each tier has oversight of the risks managed in the tier below. Appendix 3 identifies the tiers throughout the organisation and summarises the roles of Committees and Groups at each level of governance within the Trust responsible for receiving, reviewing and managing risk registers.

Risk will be managed through risk assessments and risk registers at all levels of the Trust, from "Ward to Board" with a clear escalation system and line of sight by the Board for those risks that cannot be managed at a Service Group or operational level (Appendix 3).

Risk Appetite & Risk Tolerance

Set by the Board. Encompasses the amount & type of risk the Trust is willing to take to achieve its objectives

Risk Management Objective 3

To ensure that risk management will be an integral part of the organisation's activities to support decision making ensuring that risks to the delivery of the Trust's objectives are identified and managed within the Trust's risk appetite and appropriately escalated

	Definition
Risk Appetite	'The amount and type of risk that an organisation is willing to take on in order to meet its strategic objectives'. The level at which the Trust Board determines whether an individual risk, or a specific category of risks are considered acceptable or unacceptable based upon the circumstances / situation facing the Trust, and the desired balance between the potential benefits of innovation and the threats.
Risk Tolerance	Reflects the boundaries within which the Executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the Board's strategy and risk appetite. It is the application of risk appetite to specific objectives. It is the level of risk within which the Board expects sub-committees to operate and management to manage,

In basic terms, it is how much risk you want to take (risk appetite) vs how much risk you can live with (risk tolerance).

The UK Corporate Governance Code states that “the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions”. As well as meeting the requirements imposed by corporate governance standards which makes risk appetite a core consideration in any corporate risk management approach, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

To this end, the Trust Board has developed a Risk Appetite and Risk Tolerance Statement (Appendix 4) which describes the agreed approach within the organisation which has been based on the Good Governance Institute Board Guidance on Risk Appetite, and summarised in figures 3 and 4 below.

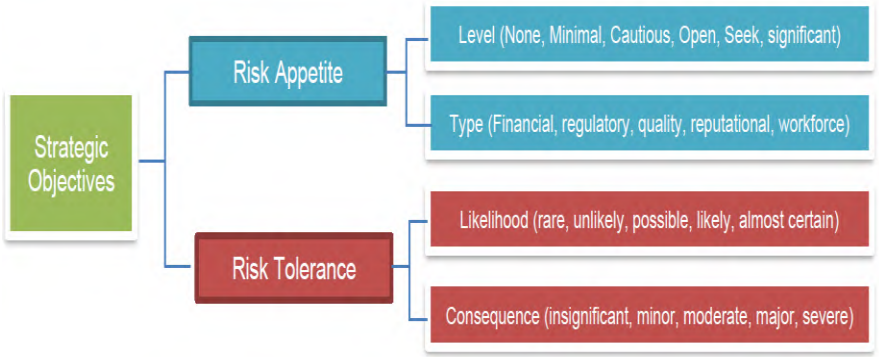


Figure 3 Good Governance Institute

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

Figure 4

System

Risk Management System in place which will ensure it is easy for the workforce to use with clear escalation and reporting

Risk Management Objective 4

To refine processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust

The Trust maintains an organisation-wide risk management system to support a standard approach to risk management practice. At present due to the integration of Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust which took place on 1 April 2023, there are currently two systems in use across the Trust – RADAR and Ulysses. During 2023/24, a decision will be made as to which system the organisation will be taking forward and be in sole use by April 2024. This is reflected in the delivery of the objectives in Appendix 2.

RADAR and Ulysses are used by the Trust to create risk registers which support day-to-day risk management and facilitate the monitoring and reporting of risk information, including changes to risks, controls and the delivery of mitigating actions. RADAR and Ulysses host the Corporate Risk Register as well as risk registers produced for other tiers of activity such as Service Groups and specialties.

The Trust's Risk Management Policy requires all identified risks to be recorded and managed via the risk management systems. No identified risks should be recorded or managed in local systems or spreadsheets external to RADAR or Ulysses. This applies to all categories of risk, with the exception at this stage for programme and project risks (please refer to Appendix 2 in relation to programme and project risks). This requirement supports consistent practice in recording and managing risks relating to all activities and at all levels of the Trust. It also gives the organisation a fully informed view of its current and projected risk exposures and of the controls and actions in place to mitigate these.

Training & Support

Building capability by enabling the workforce to use the system and manage risk

Risk Management Objective 5

To support all staff to understand risk management, their personal responsibility within their role and to act proactively to maximise the organisation's ability to deliver its strategic objectives and minimise things going wrong for patients, staff and other stakeholders

In order to develop a culture for risk management and to ensure successful implementation of this strategy, there needs to be a targeted training programme for colleagues to supplement existing training provision.

We recognise we will need to develop a more structured risk management training programme to increase colleague knowledge and understanding of risk management. That training will help to embed a consistent language of risk management, including concepts such as risk appetite, tolerance, controls, mitigations, assurances and target risk. This will enhance the quality of conversation and consistency of approach. We will therefore review the existing training programme and training materials during year 1 of this strategy to ensure appropriate knowledge and skills in risk management at different levels of the organisation.

The Trust will ensure that its risk management training is appropriate to fulfil the personal development needs of all colleagues. This is equally applicable whether the training is being provided to frontline colleagues within operational

teams who need to understand how to identify, report and escalate operational risks within their services, or whether the training is more specialist and therefore targeted at meeting the needs of those Trust colleagues with specific role-based responsibility for risk management, such as Information Governance and Medicines Management.

Specialist risk management training will be delivered across the organisation in a range of settings and using a variety of formats. In order to augment the Trust's risk management training programmes and to provide additional and supplemental advice and support to colleagues related to risk, detailed guidance materials and resources will be developed and then maintained on the Trust intranet which will enable colleagues to access the information and support that they need, where and when is most convenient and appropriate to them.

It is intended that there will be three levels of risk management training available to staff from Year 2 of this strategy. The levels are summarised below with additional information available in Appendix 5.

Level 1 Training – Identification, Assessment, and Escalation

Level 1 training is provided to all staff in order that they are able to understand their individual responsibilities in relation to risk management. The training raises the awareness of risk and ensures the role of risk management within the Trust is understood.

In addition, other risk management related training forms part of staff Mandatory Training which will be provided by Trust competent persons, at intervals designated in the Trust training needs analysis for mandatory training, including:

- Health, Safety & Welfare training
- Safer Moving and Handling training;
- Fire training;
- Infection Prevention and Control training;
- Safeguarding training;
- Data Security & Information Governance training

This training may be provided face to face or via e-learning and is not an exhaustive list.

The Trust will provide the range of training programmes necessary to ensure all Trust colleagues have a clear understanding of risk identification, assessment and management and of the processes and procedures to be followed to manage and mitigate risks. Such training will clearly demonstrate to all colleagues across the Trust, how their routine and consistent application of risk management processes will serve as a key enabler to ensuring continuous improvement in the quality of the Trust's delivered care and colleague experience.

Level 2 Training - Risk Management and Escalation

Prior to any colleague being named as a risk owner responsible for risks on the risk register, they must undertake the Level 2 risk management training. This training will focus on the key requirements of the Strategy and Policy including their responsibilities as risk owners; risk appetite; risk

tolerance; and the use of the risk register as a risk assessment tool. The Integrated Governance Team will monitor the risk register to ensure new risk owners added to the system have received training. If they have not received Level 2 training, this will be arranged as a matter of priority.

Management of risk at operational levels within the Service Groups are supported by Governance Leads. We aim to further standardise, develop and support these roles to ensure the delivery of this strategy and at this stage intend that all Governance Leads will also be provided with Level 2 training.

The longer term intention is that additional bespoke support and training will be provided by the Integrated Governance Team. This will include 'Train the Trainer' sessions for Service Group Governance Leads which will empower key risk management champions to support with risk discussions within the Service Groups and provide expertise within services on the Trust risk management framework.

Level 3 Training - Strategic Risk Management

All Board members will receive an annual Board development and risk awareness training in accordance with the training requirements outlined in Appendix 5. This training will be tailored to the needs of the Trust Board but as a minimum will cover an overview of the development of risk management arrangements within the Trust and annual review of the Trust's risk appetite and risk tolerance statement.

Monitoring & Effectiveness

Through defined performance indicators, internal audit and continuous feedback via the Governance Structure

Risk Management Objective 6
To ensure that risk management will be continually improved through learning and experience

The Trust recognises that there is scope to further develop its risk management arrangements towards best practice and to ensure that, as with all aspects of governance, its systems and processes are subject to a continuous cycle of improvement.

The Trust has therefore identified performance indicators (PIs) to further strengthen its risk management arrangements and identify areas for improvement. These are detailed within Appendix 6. Updates on progress against the PIs will be provided in the Corporate Risk Register summary reports where appropriate and reported to the Quality Assurance Group on an annual basis.

Organisational Learning

The Trust will ensure that learning from risks is communicated and integrated so as to inform future service delivery arrangements.

The Trust is committed to learning from its risk experiences, including learning from how risks occurred; how they were identified, mitigated or otherwise managed; and how they

were resolved or accepted within the Trust's agreed risk appetite.

By sharing such critical learning across teams and Service Groups, the Trust will seek to encourage closer working relationships within and across services, and will also strengthen its operational service delivery.

Through its routine communications and engagement processes, the Trust will seek to ensure that all changes to practice that result from learning from risks are effectively communicated to the Trust's key stakeholders including professional partners in order to evidence the organisation's integrity and commitment to continuous quality improvement.

CONSULTATION, DISSEMINATION & REVIEW

Prior to approval of the Risk Management Strategy, this document has been consulted upon by key stakeholders, internal and external, to the organisation as listed in Appendix 7. Upon successful consultation, the policy has been recommended to the Audit Committee for approval which is the specialist Committee with the authority to approve The Trust's policies relating to the Trust's system of internal control. The Board of Directors ratified the strategy before it was disseminated to key internal stakeholders for use within the organisation.

There is a need to measure the impact of the strategy, to measure its effectiveness in developing the maturity of the Trust's risk management framework. A report to the Audit Committee will be made no less than annually on progress and achievement of objectives as set out in the implementation plan.

This Strategy will be reviewed three years after ratification or following any significant change in the management arrangements or governance structure within the Trust. It will also be reviewed following any recommendations from external assessment bodies. The Trust has a system for consistently reviewing policies and procedures and this Strategy will be treated as a policy for this purpose.

The Trust will seek assurance that risk management and related systems are sound, by commissioning an annual internal audit on the effectiveness of the system of internal control which includes a review of risk management arrangements.

The Terms of Reference (ToRs) of the Board and sub-committees will be reviewed on an annual basis to ensure that responsibilities, in relation to risk management, are discharged appropriately.

In addition, the annual governance statement which provides assurance of the level at which the Trust's system of internal control is managing organisational risks will be produced and included within the Trust's Annual Report.

APPENDIX 1 – RISK MANAGEMENT AMBITIONS AND RISK MANAGEMENT BUILDING BLOCKS

Risk Management Objective 1
To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Ward to Board) ensuring that risk management is an essential part of governance and leadership and is fundamental to how the Trust is directed, managed and controlled at all levels

Risk Management Objective 2
To support the Trust Board in being able to receive and provide assurance that the Trust has a clear line of sight of all risks across the organisation and embedded risk management processes

Risk Management Objective 3
To ensure that risk management will be an integral part of the organisation's activities to support decision making ensuring that risks to the delivery of the Trust's objectives are identified and managed within the Trust's risk appetite and appropriately escalated

Risk Management Objective 4
To refine processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust

Risk Management Objective 5
To support all staff to understand risk management, their personal responsibility within their role and to act proactively to maximise the organisation's ability to deliver its strategic objectives and minimise things going wrong for patients, staff and other stakeholders

Risk Management Objective 6
To ensure that risk management will be continually improved through learning and experience

APPENDIX 2 – RISK MANAGEMENT STRATEGY 2023-2026 IMPLEMENTATION PLAN

From April 2023 to March 2026 the following tasks will be undertaken to support the delivery of this strategy. This is not an exhaustive list and additional tasks may be added during the period covered by this Strategy as this strategy and the Risk Management policy are implemented and embedded throughout the organisation.

Risk Management Objective	Year 1 - 2023/24	Year 2 - 2024/25	Year 3 - 2025/26
Objective 1 To support greater devolution of decision making and accountability for management of risk throughout the organisation from Trust Board to point of delivery (Ward to Board) ensuring that risk management is an essential part of governance and leadership and is fundamental to how the Trust is directed, managed and controlled at all levels	• Develop a CRR report which identifies the corporate risks and the linked service groups risks • Board to approve Risk Management Strategy • Board to approve Risk Management Policy • Once approved, Risk Management Strategy and Policy to be disseminated to key stakeholders • Ensure all risks have an Executive Owner	• Review effectiveness of the management of risk throughout the organisation (Ward to Board)	• Review and refresh Trust Risk Management Framework documents – Strategy and Policy – in conjunction with key stakeholders
Objective 2 To support the Trust Board in being able to receive and provide assurance that the Trust has a clear line of sight of all risks across the organisation and embedded risk management processes	• Map each risk on the risk register to the monitoring committee/group and depending on which system is used, build in this functionality if this is not already available • Governance structure to be approved • ToRs for each tier of the organisation to be reviewed and approved ensuring risk management responsibilities are clearly articulated • Develop an agreed approach for the management of programme and project	• ToRs for the Board and its sub-committees to be reviewed and approved • Undertake annual review of the effectiveness of risk management processes providing assurance to the Quality Assurance Group and the Audit Committee • Introduce adequacy and assurance of controls within the risk management system	• ToRs for the Board and its sub-committees to be reviewed and approved • Undertake annual review of the effectiveness of risk management processes providing assurance to the Quality Assurance Group and the Audit Committee • Complete annual governance statement

APPENDIX 2 – RISK MANAGEMENT STRATEGY 2023-2026 IMPLEMENTATION PLAN

	risks and a formal route of escalation onto the Trust risk register • Ensure risk management responsibilities are included within the standard ToRs developed for each tier of governance structure • Undertake annual review of the effectiveness of risk management processes providing assurance to the Quality Assurance Group and the Audit Committee • Complete annual governance statement • BDO to undertake risk management internal audit	• Complete annual governance statement	
Objective 3 To ensure that risk management will be an integral part of the organisation's activities to support decision making ensuring that risks to the delivery of the Trust's objectives are identified and managed within the Trust's risk appetite and appropriately escalated	• Risks to be aligned on the risk register to the strategic objectives and depending on which system is used, build in this functionality if this is not already available • Undertake annual review of the risks on the risk register which are not aligned to any of the Trust's strategic objectives and escalate these to the Board of Directors to consider when reviewing the Trust's strategic objectives • Board to review Risk Appetite & Risk Tolerance approach and any required changes to be made • Deep dive on all risks which have been on the risk registers for more than 3 years	• Once each risk is assigned to a strategic objective, build within the risk registers the agreed risk appetite and risk tolerance levels • Board to review Risk Appetite & Risk Tolerance approach and any required changes to be made • Embedding of risk appetite and risk tolerance • Undertake annual review of the risks on the risk register which are not aligned to any of the Trust's strategic objectives and escalate these to the Board of Directors to consider when reviewing the Trust's strategic objectives • Undertake a review of the business planning cycle	• Board to review Risk Appetite & Risk Tolerance approach and any required changes to be made • Undertake annual review of the risks on the risk register which are not aligned to any of the Trust's strategic objectives and escalate these to the Board of Directors to consider when reviewing the Trust's strategic objectives

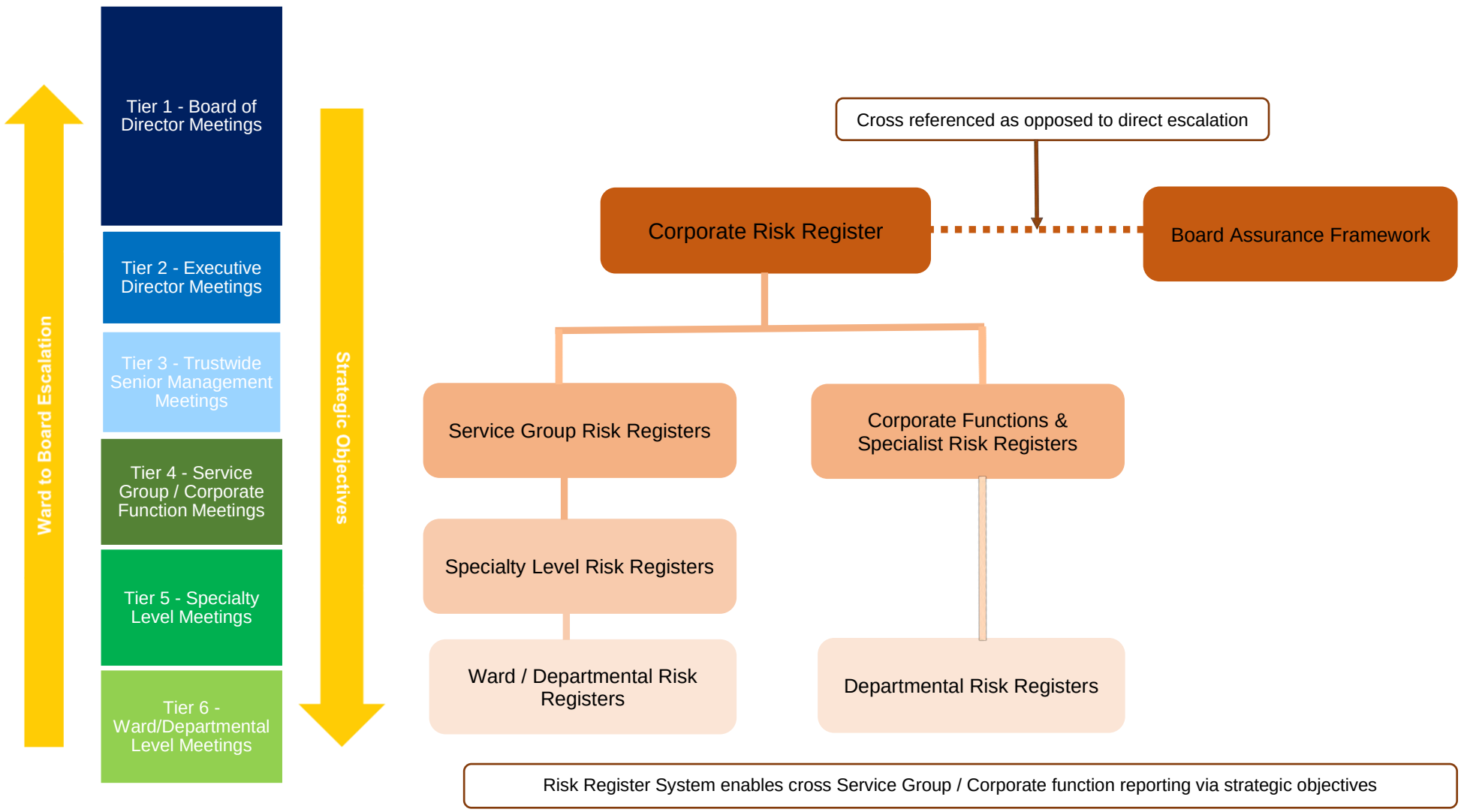
		ensuring that risk management is integral to this process and informs decisions made	
Objective 4 To refine processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust	• Through the use of user workshops agree on the criteria to use for the risk management system and undertake the tender process • Bring together the two risk management systems into one for the Trust by the end of the financial year • Launch and roll out of a new Trust wide risk assessment form • Introduce standard method for describing risk • Develop an agreed approach for the management of pathway risks within the risk management system • Introduce standardised reporting templates for each tier of the governance structure • Develop a suite of risk management guidance documents (not risk management system specific) which will be disseminated to key stakeholders and made available on the Trusts risk management intranet page and on the Trust's risk management system • Data cleanse exercise to ensure all risks on the current risk registers held on RADAR and Ulysses are current • Duplication of all risks held on the current risk registers on RADAR and Ulysses	• Train all risk owners who do not have the system we go with on this new system for them e.g. previous YDH staff on RADAR • Develop information sharing processes to ensure identification of emerging risks and triangulation of information • Design and implement risk dashboards for use by Service Groups and Corporate teams • Develop within the risk management system risk appetite and risk tolerance reporting fields • Develop a suite of risk management guidance documents (risk management system specific) which will be disseminated to key stakeholders and made available on the Trusts risk management intranet page and on the Trust's risk management system • Develop alerts within the risk management system for: risks outside of risk appetite and risk tolerance; for risks which have	• Undertake actions as a result of the findings from the internal audit into risk management

APPENDIX 2 – RISK MANAGEMENT STRATEGY 2023-2026 IMPLEMENTATION PLAN

		been on the risk register for over 3 years; tracked movement of risks highlighting risks which have not moved within 12 months; new risks added; new risk owners added to the system • Undertake actions as a result of the findings from the internal audit into risk management	
Objective 5 To support all staff to understand risk management, their personal responsibility within their role and to act proactively to maximise the organisation's ability to deliver its strategic objectives and minimise things going wrong for patients, staff and other stakeholders	• Provide ad hoc training for colleagues whilst formal training programme and risk management/governance system decisions are yet to be made • Develop a register of risk management training provided during the year • Work with learning and development team to identify how ad hoc risk training can be recorded on a colleagues training record • Develop formal and ad hoc training programmes ready to be implemented by Year 2 • Update of the current intranet pages on risk management • Explore the introduction of risk management as part of the Trust-wide induction package for all new colleagues • Level 3 Strategic risk management training to be undertaken with the Board of Directors	• Delivery of formal and ad hoc training programmes to commence in line with risk management training levels • System for recording of risk management training in place • Introduce risk champions throughout the Trust to champion risk management and inform and guide colleagues • Level 3 Strategic risk management training to be undertaken with the Board of Directors	• Continue with the delivery of formal and ad hoc training programmes in line with risk management training levels • Review effectiveness of the system for recording risk management training • Level 3 Strategic risk management training to be undertaken with the Board of Directors
Objective 6 To ensure that risk management will be	• Work with the ICB to develop the ICS risk management arrangements	• Review risk management performance through the use of the agreed KPIs and	• Review risk management performance through the use of the agreed KPIs and

continually improved through learning and experience	• Review risk management performance through the use of the agreed KPIs and develop action plans accordingly for areas that require improvement • Ensure CPD is undertaken by key colleagues with specific risk management responsibilities ensuring that their expertise and knowledge is kept up to date and relevant	develop action plans accordingly for areas that require improvement • Explore and if appropriate develop BAF in the risk management system • Review effectiveness of CRR report and make changes accordingly • Ensure horizon scanning is built into the risk management processes and lessons from best practice both within and outside of the NHS are reviewed and where applicable taken forward • Develop KPI in relation to longstanding risks • Ensure CPD is undertaken by key colleagues with specific risk management responsibilities ensuring that their expertise and knowledge is kept up to date and relevant	develop action plans accordingly for areas that require improvement • Ensure CPD is undertaken by key colleagues with specific risk management responsibilities ensuring that their expertise and knowledge is kept up to date and relevant

APPENDIX 3 – ESCALATION OF RISK 'WARD TO BOARD'



APPENDIX 3 – ESCALATION OF RISK 'WARD TO BOARD'

In receipt of…	Accountability for…
Board Assurance Framework Corporate Risk Register (not noting)	Seeking assurance through Committees that risk is being managed effectively within the Trust
Board Assurance Framework Corporate Risk Register	Seeking assurance on behalf of the Board that risks are appropriately managed and specifically for the Audit Committee, that the risk management processes and arrangements within the Trust are fit for purpose
Board Assurance Framework Corporate Risk Register	Scrunity and challenge of operational risks considering the impacts to strategic risks Holding Senior Management Teams within Service Groups and Corporate Functions to account for timely and appropriate management of risk
8+ Risk Registers	Scrutiny and challenge of risks Trustwide ensuring the impacts across multiple Service Groups and Corporate Functions are identified and appropriately assessed; holding Service Groups and Corporate Functions to account for timely and appropriate management of risk
8+ Risk Registers	Ensuring risks are appropriately identified, assessed, recorded and managed in line with the Trust's Risk Management Framework and escalated where required; scrutiny and challenge of risks ensuring impacts within the Service Groups and Corporate Functions are identified and appropriately assessed; holding specialities and Corporate Functions to account for timely and appropriate management of risk
6+ Risk Registers	Ensuring risks are appropriately identified, assessed, recorded and managed in line with the Trust's Risk Management Framework and escalated where required; scrutiny and challenge of risks ensuring impacts within the Specialties are identified and appropriately assessed; holding wards, departments and Corporate Funcions to account for timely and appropriate management of risk
6+ Risk Registers	Ensuring risks are appropriately identified, assessed, recorded and managed in line with the Trust's Risk Management Framework and escalated where required

INTRODUCTION

The UK Corporate Governance Code states that "the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions". As well as meeting the requirements imposed by corporate governance standards which makes risk appetite a core consideration in any corporate risk management approach, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

No organisation, whether in the private, public or third sector can achieve its objectives without taking risks. The question for the decision-makers is how much risk do they need to or are prepared to take.

Risk management within our Trust aims to achieve the optimum balance between quality of care, treatment of patients, and the provision of services which are safe by optimising use of resources and identifying prioritised risk control action plans. Therefore, an approach to risk appetite which puts the quality of care and the safety of patients and colleagues at the centre but recognises the requirement for speed, especially in today's climate, has been considered to support clear decision making and accountability for our Trust.

We recognise it is neither possible nor desirable to eliminate all risks which are inherent in achieving our objectives and fulfilling our statutory obligations, and that we may need to consider and/or accept a certain degree of risk where it is in our and ultimately our patients' and colleagues' best interests i.e., where taking managed risk (in keeping with our statements of risk appetite) may result in positive benefits for our patients, service users, colleagues and visitors.

We carry out analysis, make judgements, take decisions, provide services and run projects every day. We do not operate in a vacuum; equally risks are not static, nor are they mutually exclusive. We therefore view risks holistically, assessing interdependencies to provide a more rounded assessment of risk, finding a better balance between the potential benefits of managed risk taking and avoidance of risk.

Our Trust recognises that good risk management is not about being risk averse, it is about recognising the potential that outcomes may result in opportunities for improvement, as well as possible threats to success. Our Trust is a 'risk aware' organisation that embraces innovation in order to achieve its strategic objectives and looks to exploit opportunities.

Risk appetite at the Trust is:

- set by the Board;
- aligned with our strategy and corporate objectives and embedded into key business processes;
- linked to the underlying risks we face and integrated with our control culture, balancing our propensity to take risk with the propensity to exercise control;
- not a single, fixed concept. Our appetite and tolerances may vary over time; in particular the Board will have freedom to vary the amount of risk which it is

prepared to take as circumstances change, such as, periods of increased uncertainty or adverse changes in the operating environment; and

- reviewed once a year, or sooner if circumstances dictate. This helps demonstrate to our regulators, services users and other stakeholders that there are clear and effective processes for managing risks, issues and performance across the Trust.

The Trust endeavours to establish a positive risk culture within the organisation where every colleague feels committed and empowered to identify and escalate concerns and system weaknesses. To deliver safe, effective services, the Trust encourages colleagues to work in collaboration with each other and service users to promote patient and colleague's safety and well-being. Additionally, the Trust seeks to minimise the harm to service users and/or colleagues arising from their own actions and harm to others arising from the actions of service users and/or staff. The Trust may take considered risks, where the long-term benefits outweigh any short-term losses. Well managed risk taking will ensure that the skills, ability, and knowledge are there to support innovation and maximise opportunities to further improve services.

In conclusion, risk appetite within our Trust aims to prevent failure caused as a consequence of excessive risk-taking and ensure that Executive Management and the Board are taking the right risks for success (e.g., to maintain or enhance patient and colleague safety and experience, to maintain performance within an appropriate use of resources, and to deliver improved outcomes for patients and deliver Value for Money). It should facilitate a forward-looking view of risk and be adaptable to local circumstances across our Trust to help drive management action and facilitate informed decisions.

DEFINITIONS

Risk Appetite

'The amount and type of risk that an organisation is willing to take on in order to meet its strategic objectives'

The level at which the Trust Board determines whether an individual risk, or a specific category of risks are considered acceptable or unacceptable based upon the circumstances / situation facing the Trust, and the desired balance between the potential benefits of innovation and the threats.

Risk Tolerance

Reflects the boundaries within which the Executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the Board's strategy and risk appetite. It is the application of risk appetite to specific objectives.

It is the level of risk within which the Board expects sub-committees to operate and management to manage.

In basic terms, it is how much risk you want to take (risk appetite) vs how much risk you can live with (risk tolerance).

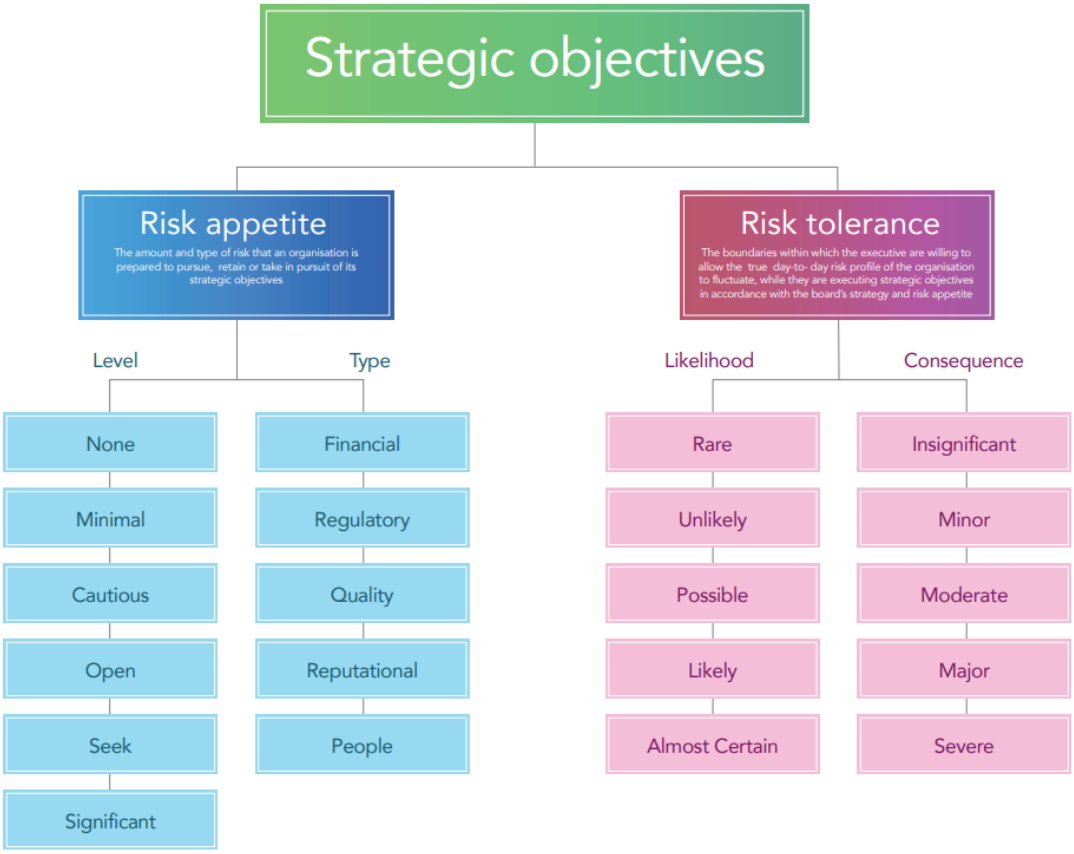


Figure 1 - Good Governance Institute (GGI) – Board Guidance on Risk Appetite – May 2020

WHY DO WE NEED RISK APPETITE

Increasing pressures, both internally and externally driven across the health and social care system, may mean that our colleagues may need to take decisions they may not have taken previously, or needed to have taken as quickly. The focus on maintaining the statutory duty of patient and colleague safety and quality of care remains at the fore and our Board, Executive Team and Management teams may have to make difficult decisions to balance quality, finance and operational performance.

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

Risk appetite also provides clear expectations for colleagues and managers regarding the management of risk. It allows for controlled risk taking; evidencing preparedness to take risk appropriately and if correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run.

The Board has developed an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging innovation.

The risk appetite helps to set the tone at the top which the organisation is then required to adopt and follow. Communication and application of the Board of Directors' attitude to risk is essential if decision making is to be successful.

The Trust expectation is that risks across the organisation will be managed within the Trust's risk appetite and tolerance. However, the Risk Appetite & Risk Tolerance Statement does not negate the opportunity to potentially make decisions that result in risk taking that is outside of the risk appetite however these instances would usually be required to be referred to the Board. Where risks are identified that fall outside the risk appetite these will be escalated through the Trust's governance structure.

The Trust needs to be aware of its risk appetite because if the organisation's collective appetite is not clear and the reasons for this unknown, this may lead to erratic or inopportune risk-taking, thereby exposing the organisation to a risk it cannot tolerate. Conversely, an overly cautious approach could be taken which may stifle growth and development.

PURPOSE OF RISK APPETITE

A well-articulated risk appetite statement is a critical part of the Trust's overall risk governance process. The purpose of stating risk appetite within the Trust is therefore to:

- Create transparency and consistency for the type and level of risks that the Trust undertakes to achieve strategic and operational goals. It provides awareness and an overall view of our risk profile, giving context to our risk position and exposure;

- Drive risk behaviour and set the tone for the organisation's risk culture;

- Help steer decision making across the organisation by providing a position against which potential decisions can be tested and challenged. Risk appetite provides freedom for prudent decision-making within agreed risk boundaries by:
  - ❖ Provides early warning where risks are outside of our limits
  - ❖ Creates a "freedom" that promotes flexibility and accountability to management and operations
  - ❖ Makes sure a breach, triggers internal actions designed to escalate and respond before it threatens the reputation and viability of the Trust
  - ❖ Eliminates excessive risk aversion by articulating preference for risk taking
  - ❖ Defines thresholds for risk taking that optimise risk and reward
  - ❖ Helps integrate risk taking and performance management
  - ❖ Assists with the definition of risk metrics that support day-to-day business operations
  - ❖ Defines escalation and reporting procedures related to pre-set levels

RISK APPETITE STATEMENT

In September 2022, The Trust Board of Directors approved the use of the risk appetite levels, taken from the Good Governance Institute Risk Appetite for NHS Organisations Matrix, for use within the organisation (figure 2).

Figure 2

Risk Appetite	Definition
None (0)	Avoidance of risk and uncertainty is a key organisational objective
Minimal (1)	Minimal (as little as reasonably possible). Preference for very safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious (2)	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open (3)	Willing to consider all potential delivery options while also providing an acceptable level of reward (and value for money)
Seek (4)	Eager to be innovative and choose options offering potentially higher business rewards (despite greater inherent risk)
Significant (5)	Confident in setting high levels of risk appetite because of controls, forward scanning and responsiveness systems are robust

The Board commissioned the Board Sub Committees to develop the Trust risk appetite for strategic objectives 2-7 relevant to their areas. The Board of Directors set the risk appetite for strategic objectives 1 and 8. The agreed levels are shown in figure 3.

Figure 3

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

RISK TOLERANCE STATEMENT

A component of risk appetite is tolerance. Risk tolerance is subtly different to risk appetite in that it reflects the boundaries within which the Executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the Board's strategy and

risk appetite. It is the level of risk within which the Board expects sub-committees to operate and management to manage.

Risk tolerance is different to risk appetite in that it represents the *application of risk appetite* to specific objectives and refers to the acceptable level of variation relative to achievement of a specific objective.

Risk tolerance is important because it informs the governance structure and escalation procedures if breaches occur as breaches requires escalation to the Board for consideration of the impact on other objectives, competing resources, and timescales. In line with its Risk Appetite, the Board has delegated oversight of risks, including decisions about whether a risk should be tolerated, to different tiers within the organisation. The Board of Directors have set a risk matrix (figure 4) that will ensure risks are escalated appropriately to allow for "informed decision-making" at the right level of the organization.

Figure 4

Risk Scoring Matrix

Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Certain 5
Insignificant - 1	1	2	3	4	5
Minor - 2	2	4	6	8	10
Moderate - 3	3	6	9	12	15
Major - 4	4	8	12	16	20
Catastrophic - 5	5	10	15	20	25

KEY: Low Risk | Medium Risk | High Risk

1-6	=	Low Risk	Needs to be resolved or accepted at Departmental level*
8-12	=	Medium Risk	Needs to be resolved or accepted at Service Group level*
15-25	=	High Risk	To be resolved or accepted at Trust level

**If the risk is not acceptable and cannot be resolved at the appropriate level, it needs to be escalated to the next level*

Some risks are unavoidable and outside of the Trust's ability to mitigate to an acceptable level. Once identified, a risk requires a response in line with the Trust's defined risk appetite approach and risk tolerance levels. These include; tolerate; transfer; treat; terminate; and take the opportunity as described in figure 5.

Strategic risks are more likely to be influenced by external factors such as regulatory requirements and economic factors. This may make them more difficult to manage. Strategic risks which are not deemed as treatable will be specifically highlighted during the Board Assurance Framework (BAF) review process. The majority of operational risks should have the ability to reduce in consequence and/or likelihood and the relevant risk treatment must be performed to mitigate risks to an acceptable level. High risks that are not deemed as treatable should be highlighted as such as part of routine risk reporting.

Figure 5

The Trust Board has created a gap score matrix (figure 6) which would further enhance the escalation of risks which are not within the tolerance levels. This has the advantage of being able to identify the level of risk the organisation is carrying above which the Board have set within its appetite. The monitoring of the organisations risks will also be set by the gap score and built into the risk register review periods as shown within figure 6. This will use target risk as the measure of risk that is acceptable to management or the desired optimal level of risk. When colleagues are assessing the target risk score, they are asked to assess where they are comfortable with the risk they are assessing sitting at. This supports the Trust's risk management vision statement in relation to empowering our colleagues to manage their risks within their own areas and take local ownership and accountability.

Figure 6

Gap Score Matrix (difference between Current Risk Score & Target Risk Score)		Review Period
Gap Score 0	Risk target achieved	Consider archiving the risk on the risk register
Gap Score 1 – 5	Tolerable	Minimum review every 6 months
Gap Score 6 - 9	Close Monitoring	Minimum review every quarter
Gap Score 10 or above	Increased monitoring and escalate for focused treatment of the risk	Minimum monthly review

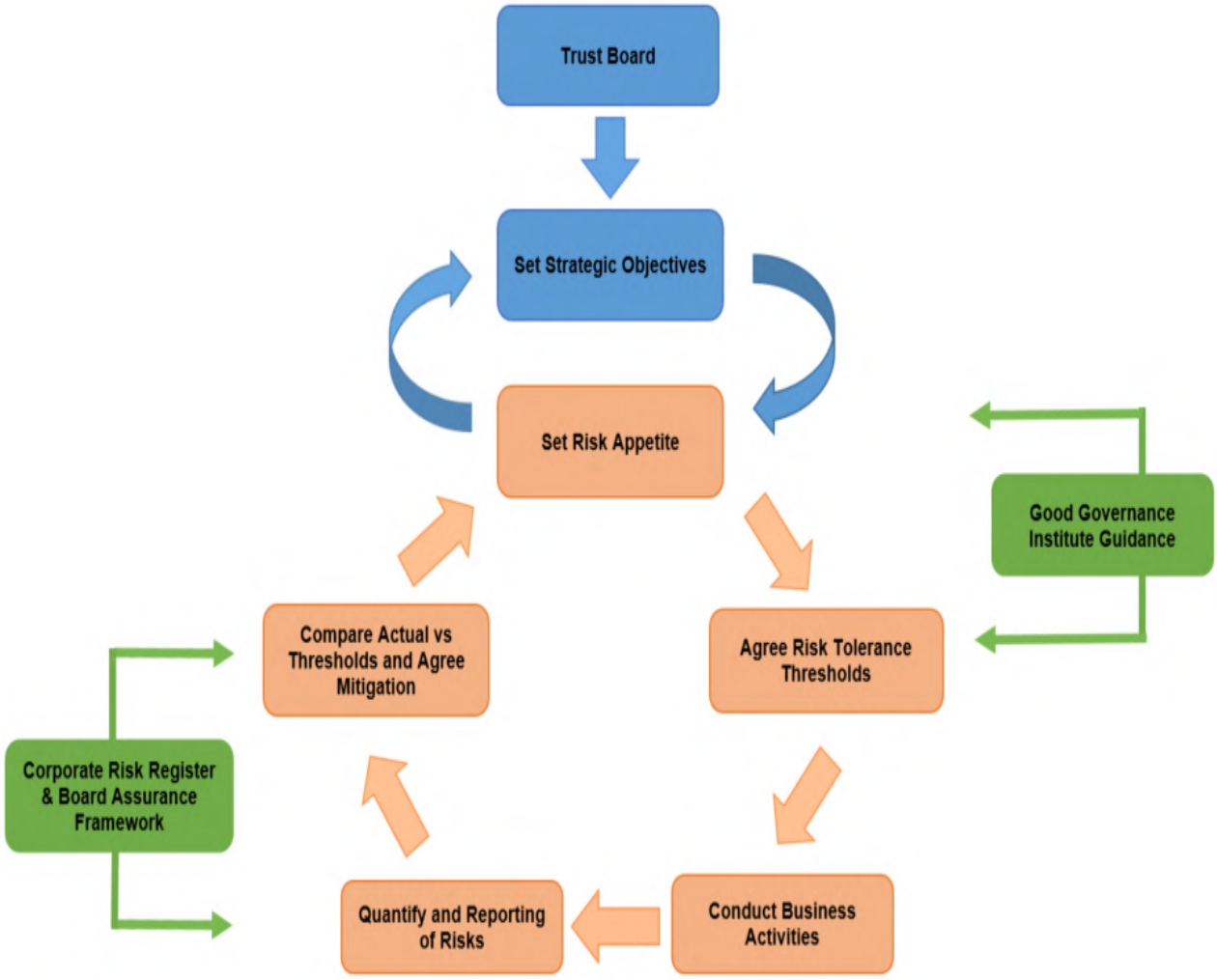
REVIEW

The review of appetite and tolerance should occur on an annual basis and also be reviewed during periods of increased uncertainty or adverse changes in the business environment. These in-year triggers may mean there is a need to re-examine the level of risk the Trust is willing to tolerate, for example:

- A catastrophic event which may prompt other national or local action in response i.e. Pandemic;

- CQC or other significant regulatory action against the Trust;
- Significant changes in legislation or the regulatory framework.

The Board will follow the process as aligned in figure 7 below:



APPENDIX 4 – RISK APPETITE AND RISK TOLERANCE STATEMENT

Good Governance Institute

Applying risk appetite matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

APPENDIX 5 – RISK MANAGEMENT TRAINING

Training Level	Colleague Group	Training Activity	Training Aim	Training to Include	Frequency	Format
1 – Identification; Assessment; and Escalation	All Colleagues	Risk awareness training and understanding of the role of risk management within the Trust	To raise awareness of the Trust's approach to risk including the Risk Management Strategy and Policy documents and how to access the risk register	• To understand what a risk is; • To identify and escalate risk; • To understand the risk assessment (risk matrix, risk controls and actions); • To identify any immediate risks to patient or colleague safety and correct them	Once	Face to face or online training provision (MS Teams or e-learning module)
2 – Risk Management and Escalation	Risk Owners and Service Group Gover-nance Leads	Risk Management Training focusing on the key requirements of the Strategy and Policy including their responsibilities as risk owners / governance leads; risk appetite; risk tolerance; and the risk register	To provide information on the link between operational and strategic risks; on the use and functionality of the risk register; and risk awareness	• To undertake formal risk assessments, clearly describing the risk and assessing the ratings, identifying controls and actions; • To undertake formal risk assessments and utilise the risk management software (Ulysses / RADAR) • To assess adequacy of controls; • To be able to action and document mitigations against risks and evidence future actions required • To be able to escalate risks when unable to control risks within own resources (including identifying for escalation to Corporate Risk Register); • To understand the process of risk escalation and de-escalation; • Awareness of the escalation process and the committee scrutiny and ownership of risks – risk control and escalation and risk registers; • To understand risk tolerance against risk appetite for the organisation	Before entering a risk on RADAR / Ulysses	Face to face or online training provision via MS Teams

APPENDIX 5 – RISK MANAGEMENT TRAINING

3 – Strategic Risk Management	Board of Directors – Executive & Non-Executive Directors	This training will be tailored to the needs of the Trust Board but as a minimum will cover an overview of the development of risk management arrangements within the Trust and annual review of the Trust's risk appetite and risk tolerance statement	Improve strategic management and understanding of the risks to the Trust	• To be able to lead on the management of all corporate and strategic risks; • To understand and provide scrutiny of the Board Assurance Framework and its use within the Board environment ensuring that appropriate mitigation is in place; • Overview of risk principles, framework and process within the organisation detailed within this strategy; • Setting of the Board's risk appetite and identification of strategic risks	Annual - In the event that a member of the Board of Directors is unable to attend the annual risk workshop, the Deputy Director of Integrated Governance will provide a one to one session using the same materials	Workshop session as part of the Board Develop-ment Programme

APPENDIX 6 – PERFORMANCE INDICATORS

Performance Indicators	Evidence	Method	Frequency	Responsible Lead	Oversight Committee
100% of risks to have an agreed risk owner and Executive Lead	Risk Register report	Audit of risk register entries	Annual	Deputy Director of Integrated Governance	Audit Committee
No less than 90% of risks on the risk register will meet the minimum required dataset for the articulation of risks	Quality of Risk Register entries	Audit of risk register entries	Annual	Deputy Director of Integrated Governance	Audit Committee
100% of risks to have a documented action plan which contain clear and appropriately assigned actions	Risk Register report	Audit of risk register entries	Annual	Deputy Director of Integrated Governance	Audit Committee
No less than 85% of mitigating actions to have been completed in line with the action dates	Risk Register report	Audit of risk register entries	Annual	Deputy Director of Integrated Governance	Audit Committee
100% of risks to have the risk appetite documented and risk tolerance reflected in the target risk score	Risk Register report	Audit of risk register entries	Annual	Deputy Director of Integrated Governance	Audit Committee
For no more than 25% of risks to sit at a risk level above their risk appetite	Risk Register report	Audit of risk register entries	Annual	Deputy Director of Integrated Governance	Audit Committee
No less than 90% of risks to have been reviewed in line with the timeframes set out in the Risk Management Policy	Risk Register report	Audit of risk register entries	Annual	Deputy Director of Integrated Governance	Audit Committee
100% of Service Groups will have a risk register with active risks recorded on it	Risk Register report	Audit of risk register entries	Annual	Deputy Director of Integrated Governance	Operational Leadership Group
100% of closed/archived risks will include the reason for closure/archive	Quality of Risk Register entries	Audit of risk register entries	Annual	Deputy Director of Integrated Governance	Audit Committee
No less than 95% compliance that all Service Group Governance meetings, have reviewed the level of risks defined within the Risk Management Policy at each meeting	Minutes of Meetings	Review of minutes	Annual	Deputy Director of Integrated Governance	Operational Leadership Group

APPENDIX 6 – PERFORMANCE INDICATORS

100% compliance that the Board of Directors and Board Assurance Committees review the Board Assurance Framework and Corporate Risk Register at least four times per year (minimum of once each quarter)	Agenda and Minutes of Meetings	Review of minutes and meeting papers	Quarterly	Deputy Director of Integrated Governance	Audit Committee
100% compliance that an annual review of the Trust's Risk Appetite and Risk Tolerance statement has been undertaken by the Board of Directors	Board Development Session Presentation or Report and Agenda and Minutes of Meetings for formal Board meeting where revised statement has been approved	Board Development Session and Review of minutes and meeting papers	Annual	Deputy Director of Integrated Governance	Audit Committee
100% compliance that the annual completion of the Trust's Annual Governance Statement has been reviewed and scrutinised by the External Auditors	Minutes of Audit Committee Meeting, Annual Report	Review of minutes and meeting papers	Annual	Deputy Director of Integrated Governance	Audit Committee
90% compliance for all staff to receive Level 1 Risk Management Training	Training Records	Audit of training records	Annual	Deputy Director of Integrated Governance	Audit Committee
No less than 95% compliance for Risk Owners to have attended Level 2 risk management training within a month of being allocated a risk on the risk register	Training Records	Audit of training records	Annual	Deputy Director of Integrated Governance	Audit Committee
100% compliance for Level 3 risk management training	Board Development Session Presentation or Report and/or Agenda and Minutes of Board Meeting(s)	Board Development Session and Review of minutes and meeting papers	Annual	Deputy Director of Integrated Governance	Board of Directors

APPENDIX 7 – KEY STAKEHOLDERS

Key stakeholders included within the development of this Strategy included:

- Somerset NHS Foundation Trust Board of Directors – including Non-Executive & Executive Directors
- Integrated Governance Team
- Corporate Risk Team
- Staff side
- Service Group Directors
- Medical Directors
- Associate Medical Directors
- Associate Directors of Patient Care
- Clinical Directors
- Site Directors
- Directors (non-Board Members)
- Deputy Directors
- Associate Directors
- All risk owners recorded on RADAR and Ulysses
- Somerset Integrated Care Board
- Members of the NHS Healthcare Risk Management Network

The development of this strategy took place before the formal integration of Somerset NHS Foundation Trust and Somerset NHS Foundation Trust on 1 April 2023 and therefore job title may have changed by the point at which this strategy was presented for approval to the Audit Committee and Board of Directors and disseminated to colleagues throughout the organisation.

Somerset
NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST (SFT)
RISK APPETITE & RISK TOLERANCE STATEMENT 2023/24

INTRODUCTION

The UK Corporate Governance Code states that "the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions". As well as meeting the requirements imposed by corporate governance standards which makes risk appetite a core consideration in any corporate risk management approach, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

No organisation, whether in the private, public or third sector can achieve its objectives without taking risks. The question for the decision-makers is how much risk do they need to or are prepared to take.

Risk management within our Trust aims to achieve the optimum balance between quality of care, treatment of patients, and the provision of services which are safe by optimising use of resources and identifying prioritised risk control action plans. Therefore, an approach to risk appetite which puts the quality of care and the safety of patients and colleagues at the centre but recognises the requirement for speed, especially in today's climate, has been considered to support clear decision making and accountability for our Trust.

We recognise it is neither possible nor desirable to eliminate all risks which are inherent in achieving our objectives and fulfilling our statutory obligations, and that we may need to consider and/or accept a certain degree of risk where it is in our and ultimately our patients' and colleagues' best interests i.e., where taking managed risk (in keeping with our statements of risk appetite) may result in positive benefits for our patients, service users, colleagues and visitors.

We carry out analysis, make judgements, take decisions, provide services and run projects every day. We do not operate in a vacuum; equally risks are not static, nor are they mutually exclusive. We therefore view risks holistically, assessing interdependencies to provide a more rounded assessment of risk, finding a better balance between the potential benefits of managed risk taking and avoidance of risk.

Our Trust recognises that good risk management is not about being risk averse, it is about recognising the potential that outcomes may result in opportunities for improvement, as well as possible threats to success. Our Trust is a 'risk aware' organisation that embraces innovation in order to achieve its strategic objectives and looks to exploit opportunities.

Risk appetite at the Trust is:

- set by the Board;
- aligned with our strategy and corporate objectives and embedded into key business processes;
- linked to the underlying risks we face and integrated with our control culture, balancing our propensity to take risk with the propensity to exercise control;

- not a single, fixed concept. Our appetite and tolerances may vary over time; in particular the Board will have freedom to vary the amount of risk which it is prepared to take as circumstances change, such as, periods of increased uncertainty or adverse changes in the operating environment; and
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The Trust endeavours to establish a positive risk culture within the organisation where every colleague feels committed and empowered to identify and escalate concerns and system weaknesses. To deliver safe, effective services, the Trust encourages colleagues to work in collaboration with each other and service users to promote patient and colleague's safety and well-being. Additionally, the Trust seeks to minimise the harm to service users and/or colleagues arising from their own actions and harm to others arising from the actions of service users and/or staff. The Trust may take considered risks, where the long-term benefits outweigh any short-term losses. Well managed risk taking will ensure that the skills, ability, and knowledge are there to support innovation and maximise opportunities to further improve services.

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The level at which the Trust Board determines whether an individual risk, or a specific category of risks are considered acceptable or unacceptable based upon the circumstances / situation facing the Trust, and the desired balance between the potential benefits of innovation and the threats.

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Reflects the boundaries within which the Executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the Board's strategy and risk appetite. It is the application of risk appetite to specific objectives.

It is the level of risk within which the Board expects sub-committees to operate and management to manage.

In basic terms, it is how much risk you want to take (risk appetite) vs how much risk you can live with (risk tolerance).

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  - ❖ Makes sure a breach, triggers internal actions designed to escalate and respond before it threatens the reputation and viability of the Trust
  - ❖ Eliminates excessive risk aversion by articulating preference for risk taking
  - ❖ Defines thresholds for risk taking that optimise risk and reward
  - ❖ Helps integrate risk taking and performance management

- ❖ Assists with the definition of risk metrics that support day-to-day business operations
- ❖ Defines escalation and reporting procedures related to pre-set levels

RISK APPETITE STATEMENT

In September 2022, The Trust Board of Directors approved the use of the risk appetite levels, taken from the Good Governance Institute Risk Appetite for NHS Organisations Matrix, for use within the organisation (figure 2).

Figure 2

Risk Appetite	Definition
None (0)	Avoidance of risk and uncertainty is a key organisational objective
Minimal (1)	Minimal (as little as reasonably possible). Preference for very safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious (2)	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open (3)	Willing to consider all potential delivery options while also providing an acceptable level of reward (and value for money)
Seek (4)	Eager to be innovative and choose options offering potentially higher business rewards (despite greater inherent risk)
Significant (5)	Confident in setting high levels of risk appetite because of controls, forward scanning and responsiveness systems are robust

The Board commissioned the Board Sub Committees to develop the Trust risk appetite for strategic objectives 2-7 relevant to their areas. The Board of Directors set the risk appetite for strategic objectives 1 and 8. The agreed levels are shown in figure 3.

Figure 3

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

RISK TOLERANCE STATEMENT

A component of risk appetite is tolerance. Risk tolerance is subtly different to risk appetite in that it reflects the boundaries within which the Executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the Board's strategy and risk appetite. It is the level of risk within which the Board expects sub-committees to operate and management to manage.

Risk tolerance is different to risk appetite in that it represents the *application of risk appetite* to specific objectives and refers to the acceptable level of variation relative to achievement of a specific objective.

Risk tolerance is important because it informs the governance structure and escalation procedures if breaches occur as breaches requires escalation to the Board for consideration of the impact on other objectives, competing resources, and timescales. In line with its Risk Appetite, the Board has delegated oversight of risks, including decisions about whether a risk should be tolerated, to different tiers within the organisation. The Board of Directors have set a risk matrix (figure 4) that will ensure risks are escalated appropriately to allow for "informed decision-making" at the right level of the organization.

Figure 4

Risk Scoring Matrix

Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Certain 5
Insignificant - 1	1	2	3	4	5
Minor - 2	2	4	6	8	10
Moderate - 3	3	6	9	12	15
Major - 4	4	8	12	16	20
Catastrophic - 5	5	10	15	20	25

KEY:	Low Risk	Medium Risk	High Risk

1-6	=	Low Risk	Needs to be resolved or accepted at Departmental level*
8-12	=	Medium Risk	Needs to be resolved or accepted at Service Group level*
15-25	=	High Risk	To be resolved or accepted at Trust level

**If the risk is not acceptable and cannot be resolved at the appropriate level, it needs to be escalated to the next level*

Some risks are unavoidable and outside of the Trust's ability to mitigate to an acceptable level. Once identified, a risk requires a response in line with the Trust's defined risk appetite approach and risk tolerance levels. These include; tolerate; transfer; treat; terminate; and take the opportunity as described in figure 5.

Strategic risks are more likely to be influenced by external factors such as regulatory requirements and economic factors. This may make them more difficult to manage. Strategic risks which are not deemed as treatable will be specifically highlighted

during the Board Assurance Framework (BAF) review process. The majority of operational risks should have the ability to reduce in consequence and/or likelihood and the relevant risk treatment must be performed to mitigate risks to an acceptable level. High risks that are not deemed as treatable should be highlighted as such as part of routine risk reporting.

Figure 5

The Trust Board has created a gap score matrix (figure 6) which would further enhance the escalation of risks which are not within the tolerance levels. This has the advantage of being able to identify the level of risk the organisation is carrying above which the Board have set within its appetite. The monitoring of the organisations risks will also be set by the gap score and built into the risk register review periods as shown within figure 6. This will use target risk as the measure of risk that is acceptable to management or the desired optimal level of risk. When colleagues are assessing the target risk score, they are asked to assess where they are comfortable with the risk they are assessing sitting at. This supports the Trust's risk management vision statement in relation to empowering our colleagues to manage their risks within their own areas and take local ownership and accountability.

Figure 6

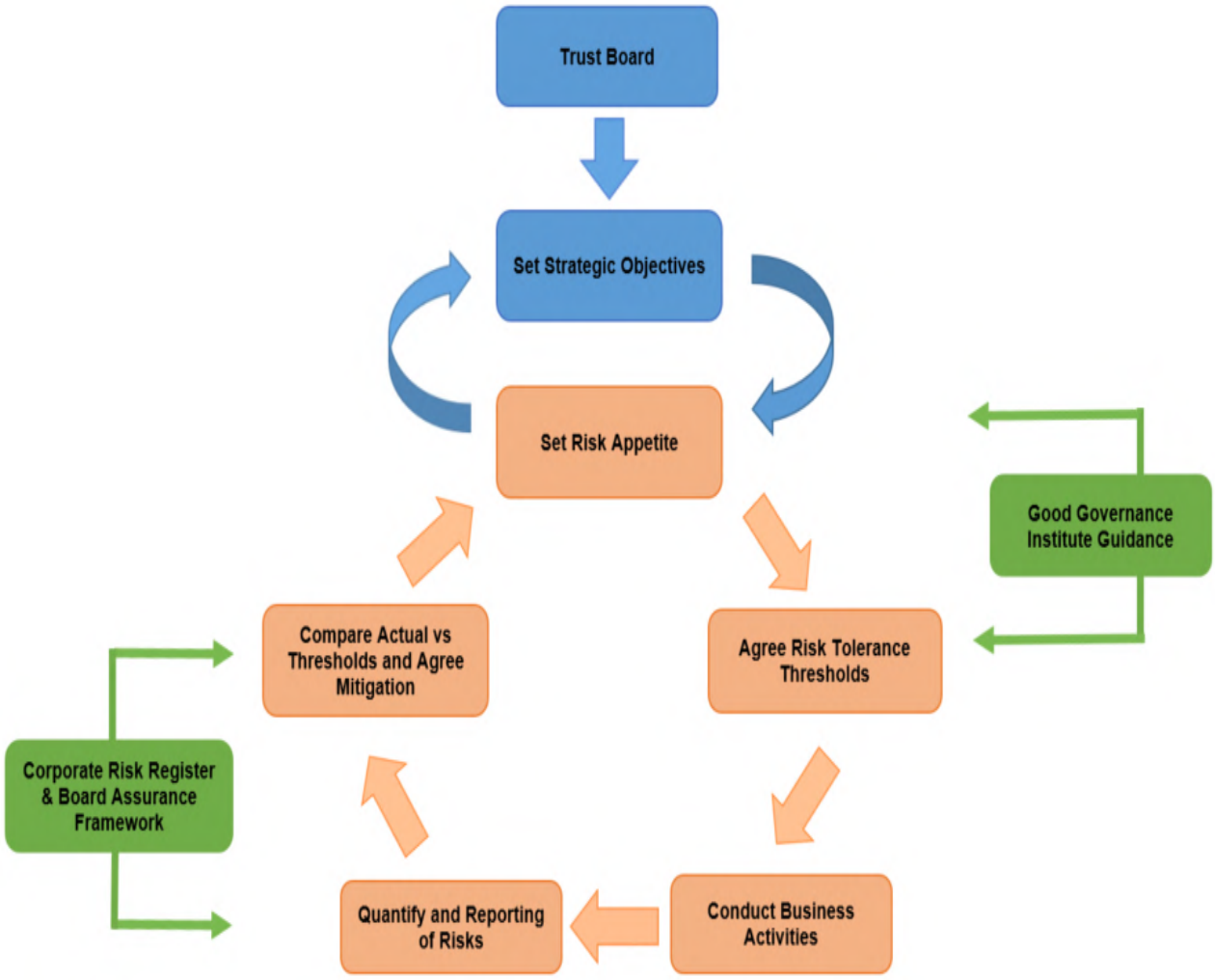
Gap Score Matrix (difference between Current Risk Score & Target Risk Score)		Review Period
Gap Score 0	Risk target achieved	Consider archiving the risk on the risk register
Gap Score 1 – 5	Tolerable	Minimum review every 6 months
Gap Score 6 - 9	Close Monitoring	Minimum review every quarter
Gap Score 10 or above	Increased monitoring and escalate for focused treatment of the risk	Minimum monthly review

REVIEW

The review of appetite and tolerance should occur on an annual basis and also be reviewed during periods of increased uncertainty or adverse changes in the business environment. These in-year triggers may mean there is a need to re-examine the level of risk the Trust is willing to tolerate, for example:

- A catastrophic event which may prompt other national or local action in response i.e. Pandemic;
- CQC or other significant regulatory action against the Trust;
- Significant changes in legislation or the regulatory framework.

The Board will follow the process as aligned in figure 7 below:



APPENDIX 1 – Good Governance Institute Risk Appetite for NHS Organisations Matrix

Applying risk appetite matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL **How will we use our resources?**	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY **How will we be perceived by our regulator?**	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY **How will we deliver safe services?**	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE **How will we be perceived by the public and our partners?**	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan.

APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	
Risk Score	0-3	3-6	8-10	12	15-16	20-25

[Good Governance Institute (GGI) – Board Guidance on Risk Appetite – May 2020]

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Freedom To Speak Up Guardian (FTSU) report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Caroline Sealey, Freedom to Speak Up Guardians
PRESENTED BY:	Caroline Sealey, Freedom to Speal Up Guardians
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the report Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. This paper provides an update regarding FTSU activity in Somerset Foundation Trust (SFT) and Yeovil District Hospital (YDH). It informs the Trust Board about the number of concerns received and the professional background of the colleagues contacting the service. It also outlines the themes of the concerns, the service progress and planned actions. It covers the period April 2022 – September 2022. A total of 71 cases were raised in this period by SFT colleagues and 19 by YDH colleagues. This is a reduction of 22.8% for SFT and a reduction of 24.0% for YDH compared to the previous two quarters. This may be a reflection of an improving culture where colleagues feel safe to raise concerns via other routes. Data collected demonstrates that Nursing and Midwifery colleagues and Admin / Clerical colleagues raised most concerns in Q1 and Q2. A significant number of concerns (SFT = 59%, YDH = 74%) contained an element of bullying / harassment or inappropriate attitudes / behaviours.
Recommendation	The Board is asked to note and discuss the report.

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

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

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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The SFT Freedom to Speak Up six monthly progress report was presented to the September 2022 Board meeting.

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

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

SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT HOSPITAL

FREEDOM TO SPEAK UP GUARDIAN REPORT

1. INTRODUCTION

1.1 There is now a joint speaking up service across Somerset Foundation Trust (SFT) and Yeovil District hospital (YDH) that is in the early stages, so work is continuing to align the services in preparation for the merger. This is the second joint paper that has been presented to Board.

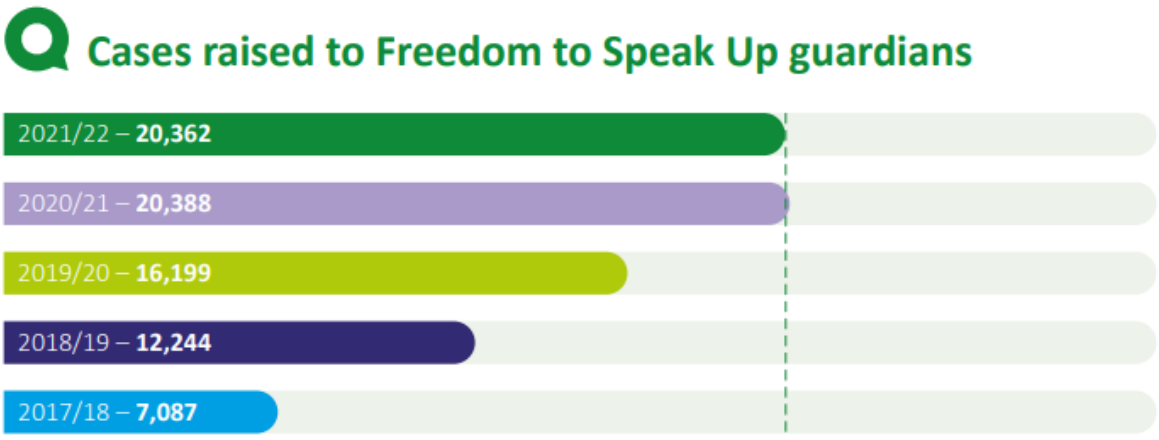
1.2 This paper is presented in a structured format to ensure compliance with guidance published, June 2022, Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services. B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf (england.nhs.uk)

1.3 The Freedom to Speak Up (FTSU) model consists of a full-time lead guardian, Caroline Sealey, and a newly appointed guardian, SJ Hayward, who has been in post since 5 December 2022 following a competitive recruitment process. This is succeeding the Boards approval to increase ringfenced FTSU time to allow an equitable service across the soon to be merged organisation. In addition, Debbie Matthewson and Yvonne Thorne have supported cases in YDH alongside their substantive roles but will be stepping back from the FTSU role.

1.4 Our vision is to provide an open and transparent culture across our Trust to ensure all colleagues feel safe, supported and confident to speak up and raise their concerns and that learning and continuous improvement happens as a result of speaking up.

2. ASSESSMENT OF FTSU CASES

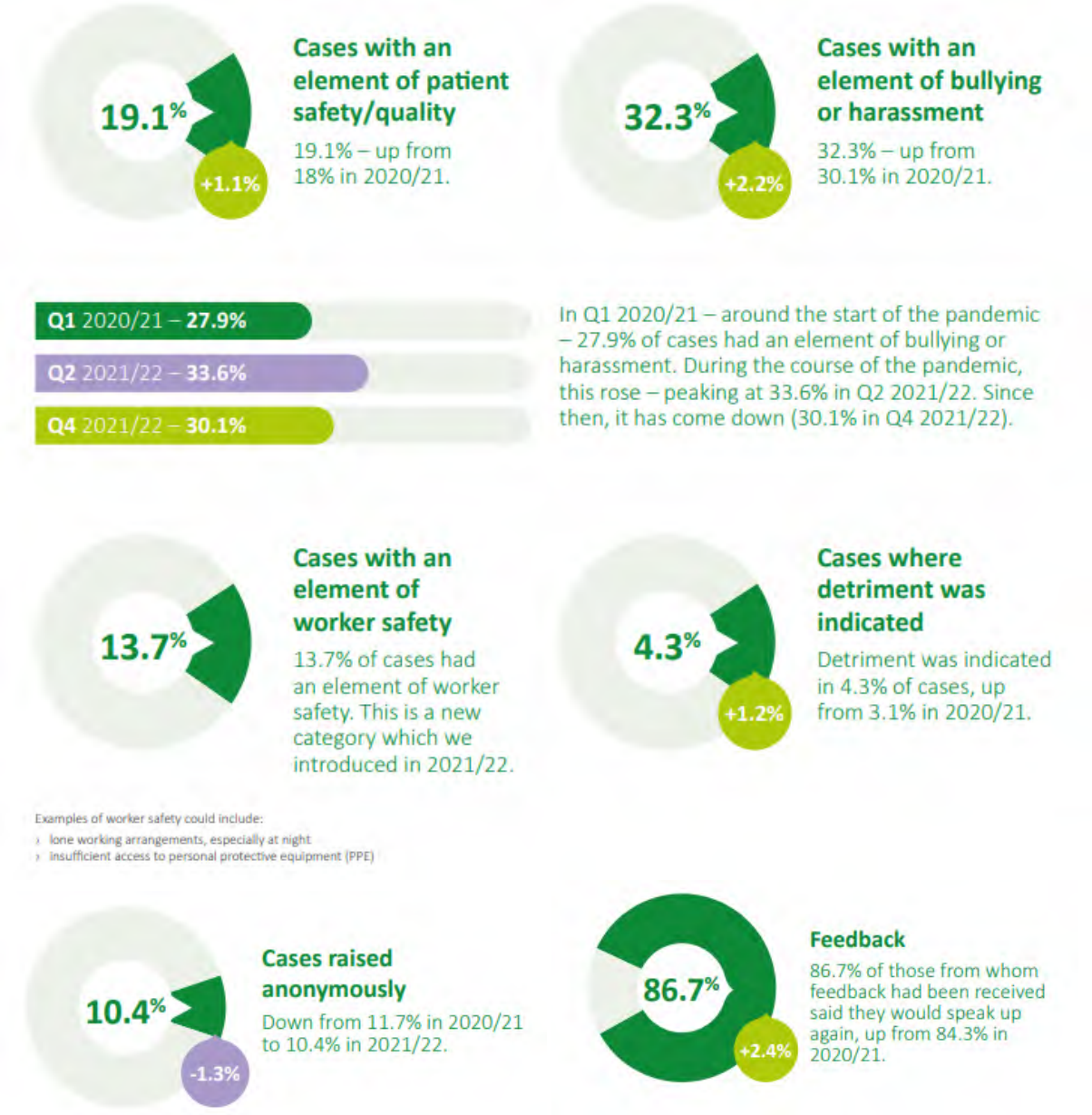
2.1 Nationally FTSU Guardians reported 20,362 cases between 1 April 2021 and 31 March 2022. This is almost identical to the number raised in 2020-21 (20,388) and a rise on previous years:



NGO_AR_2022_Digital.pdf (nationalguardian.org.uk)

In total, FTSU Guardians have handled over 75,000 cases since the National Guardian's Office first started collecting data in 2017.

2.2 The national picture shows the following trends:



NGO_AR_2022_Digital.pdf (nationalguardian.org.uk)

- Data for Q1 and Q2 2022-23 demonstrates an increase of cases nationally. Q1 saw 5312 cases raised, an 8.9% increase compared to the same quarter last year. Q2 saw 5796 cases raised. A 27.2% increase compared to the same quarter last year.

- Approximately a third of cases in both quarters included an element of inappropriate behaviours and attitudes, a new category added for 2022/23.

- Over a quarter of the cases in Q1 (25.6%) and Q2 (28.3%) included an element of worker safety or wellbeing. This is an 11% rise from Q4 2021-22 to Q1 2022-23 and a further 3% rise from Q1 to Q2 this year.

3. LOCAL DATA FOR SFT AND YDH

3.1 Concerns raised through the FTSU route are detailed in Table 1:

Table 1

Quarter	Number of concerns raised		Number of cases raised anonymously		Disadvantageous and / or demeaning treatment	
	SFT	YDH	SFT	YDH	SFT	YDH
Q1: 2022-23	39	9	7	5	2*	0
Q2: 2022-23	32	10	3	4	0	0

* The colleague feedback was unspecific and no follow up was requested.

3.2 As of 22 February 2023 the FTSU Guardians are supporting 15 cases of speaking up.

Themes (for period 1 April 22 – 30 September 2022)

SFT	YDH
• Poor leadership and lack of support • Bullying / harassment • Incivility / microaggressions • Discrimination • Toxic culture • Increased work demands impacting on patient safety • Lack of staffing / poor skill mix • Lack of adherence to policy / procedure and a delay in implementation • Colleague wellbeing	• Bullying and Harassment • Poor staff behaviour and attitude • Lack of effective leadership • Concerns regarding demand on services, staffing levels or poor skill mix • Lack of adherence to policy • Poor management/lack of manager's empathy

3.3 The tables below show the breakdown by quarter of the themes as well as the breakdown of staff groups reporting. This is data that has been mandated and submitted to the (NGO) in line with the reporting guidance Recording Cases and Reporting Data (nationalguardian.org.uk).

Table 2

	Number with an element of patient safety/ Quality*		Number of concerns with an element of worker safety or wellbeing*		Number with an element of bullying or Harassment*		Number with an element of inappropriate attitudes / behaviours* (introduced from April 22)		Number of other concerns*	
Quarter	**SFT**	**YDH**	**SFT**	**YDH**	**SFT**	**YDH**	**SFT**	**YDH**	**SFT**	**YDH**
Q1 2022-23	**7**	**3**	**15**	**0**	**4**	**4**	**19**	**4**	**10**	**0**
Q2 2022-23	**4**	**1**	**6**	**1**	**12**	**0**	**7**	**6**	**9**	**2**

* Some concerns have elements that span multiple categories

Table 3 Professional / Worker Group of colleagues speaking up:

Professional / Worker Group	**Q1: 2022-23**		**Q2: 2022-23**		**Totals**	
	SFT	**YDH**	**SFT**	**YDH**	**SFT**	**YDH**
Additional clinical services	6	0	5	1	11	1
Additional professional scientific & technical	3	0	0	0	3	0
Admin and clerical	5	1	7	1	12	2
AHP's	6	0	3	1	9	1
Estates and ancillary	2	1	1	0	3	1
Healthcare scientists	0	0	0	0	0	0
Medical and dental	0	0	1	2	1	2
Nursing and midwifery - registered	8	1	9	4	17	5
Students	1	0	3	0	4	0
Other	2	0	1	0	3	0
Not Known	6	6	2	1	8	7

3.4 Some examples of speaking up in this period include:

- A colleague spoke up about bullying behaviours from their line manager, a toxic team culture and risk to patient safety. These concerns were echoed by a number of other colleagues in the team. Support and resolution was provided though a collective approach including input from FTSU Guardian, service managers, wellbeing, HR Business Partners and organisational development.

- A colleague spoke up about a recruitment process they believed hadn't been followed. Through conversation with the HRBP's and recruitment team the facts were established and feedback given to the colleague providing assurance the processes was open and transparent. Learning taken was that communication to the team should have been timelier and clearer in its explanation.

3.5 Nationally, approximately a third of cases in Q1 and Q2 included an element of inappropriate behaviours and attitudes and over a quarter of cases included an element of worker safety or wellbeing. The table below outlines the SFT and YDH data for these metrics:

Quarter	**Number of concerns raised**		**No of concerns with an element of inappropriate behaviours and attitudes**		**No of concerns with an element of worker safety or wellbeing**	
	SFT	**YDH**	**SFT**	**YDH**	**SFT**	**YDH**
Q1: 2022-23	39	9	19 (48.7%)	4 (44.4%)	15 (38.5%)	0 (0%)
Q2: 2022-23	32	10	7 (21.9%)	6 (60.0%)	6 (18.7%)	1 (10.0%)

3.6 The combined SFT data for Q1 and Q2 is aligned to the National data. Currently, YDH data for inappropriate behaviours and attitudes is higher than the National average at 52.2% for Q1 and Q2 combined. Data for worker safety and wellbeing however sits below the National average at 5% for Q1 and Q2 combined.

3.7 In line with service monitoring and standards, an audit of response times from point of first contact for SFT has been undertaken. The target is to respond to all concerns within three working days.

Quarter	Working Days taken to respond				
	0	1	2	3	3+
1 (39 concerns)	39 (100%)	0	0	0	0
2 (32 concerns)	32 (100%)	0	0	0	0

3.8 YDH data has not been collected but, due to the number of concerns and the fact they are mostly actioned by one person, all have been responded to within 3 working days. Due to sickness in Q1 2022/23, 3 concerns not actioned until 5 days. YDH data collection will commence from April 2023.

3.9 Local data for Q1-Q2 2022/23 has shown:

- 22.8% decrease in reported cases from Q3 – Q4 2021/22 for SFT and 24.0% decrease for YDH.
- 15.5% of the cases raised in this period for SFT and 21.1% for YDH contained an element of patient safety/quality compared to 19.5% for SFT and 16.0% for YDH in Q3 – Q4 2021/22.
- 22.5% of the cases raised in this period for SFT and 21.1% for YDH contained and element of bullying and harassment compared to 41.3% for SFT and 12.0% for YDH in Q3– Q4 2021/22.
- 14.1% of cases were raised anonymously for SFT and 47.4% for YDH compared to 8.7% for SFT and 56.0% for YDH in Q3 – Q4 2021/22. Although this is higher than the national average, very few organisations have invested in an anonymous reporting system.
- Disadvantageous and / or demeaning treatment as a result of speaking up is 2.8% of cases, a decrease from 3.3% in Q3 – Q4 2021/22 for SFT. YDH are 0% for both periods.
- In SFT, 23.9% of concerns raised came from Nursing and Midwifery colleagues, 16.9% from Admin and Clerical colleagues, 15.5% from colleagues in additional clinical services roles and 12.7% from allied health professionals. In YDH, 36.8% of concerns raised came from colleagues of unknown professional background, 26.3% from Nursing and midwifery colleagues, 10.5% from Admin and Clerical colleagues and 10.5% from medical and dental colleagues.
- Over 97% of those who gave feedback across both organisations said they would speak up again. This is an increase of 8% from Q1 and Q2 2021-22.

4. ACTIONS and RECOMMENDATIONS

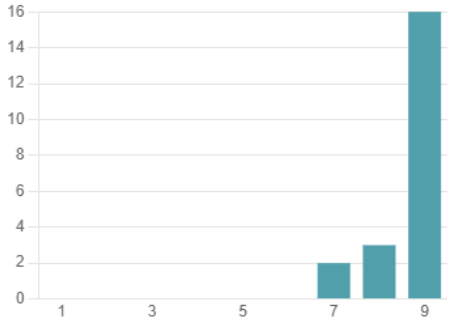
4.1 Our progress continues to raise awareness of FTSU and create a positive speaking up culture. We have over 90% compliance with the 'Speaking Up' module of mandatory training in SFT following the launch in August 2021. In YDH it is lower at 45.7% but the roll out was later, not starting until December 2021. There will be a relaunch in April 23 in line with the merger.

4.2 Colleagues who have used the FTSU service in SFT since start of Q3 2021-22* have given an average rating of 8.67 out of 9 with how satisfied they are with the service:

5. How satisfied are you with the Freedom To Speak Up Process? (1 = totally disagree to 9 = totally agree)

More Details Insights

8.67
Average Rating



*the rating is only available from Q3 2021-22 due to a change in feedback provider

4.3 Data collection for YDH colleagues has just commenced. The first full quarter of data will be available in Q1 2022/23.

4.4 The service also collates feedback from service users and some of the feedback received is detailed below:

- Really helpful and listened to my concerns.
- Fantastic.
- The freedom to speak up guardian was very approachable and supportive.
- I feel heard.
- We were given clear advice around the various possible ways of dealing with the situation.
- Quick response from the Freedom to Speak up Guardian and felt heard.
- Very helpful, addressed my issue and produced an acceptable resolution.
- Very quick to get in contact with, extremely helpful and very friendly/approachable. Has helped me further my concerns to the correct people and supportive.
- Very approachable, sympathetic and shared good advice.

4.5 During national Speak Up month in October 2022 the theme was 'Speak Up for Everyone'. During the month we celebrated with colleagues and raised the awareness of FTSU with a specific focus on Safety, Civility and Inclusion.

4.6 The team are continuing to build on the progress achieved to date and work to fully align the services in SFT and YDH, to support the creation of a culture where every colleague, irrespective of role, feels safe to speak up. Some of the work includes:

- Creating a single point of access for all colleagues across the soon to be merged organisations.
- Increasing visibility in both acute hospitals and throughout the community sites.
- Reviewing and updating the Freedom to Speak Up policy in line with the National policy by January 2024.
  NHS-Freedom-to-speak-up-national-policy-eBook.pdf (england.nhs.uk)
- Continue collaborative working with Wellbeing, Leadership & OD, Colleague Support Service, Patient Safety and Inclusion team able to:
  - ✓ offer timely, bespoke, integrated support for individuals, teams and the organisation that can be tailored according to need and intensity
  - ✓ identify areas in need and coordinate the appropriate support, reducing duplication and improving communication between us
  - ✓ learn from areas of success and to run QI projects where we can test the impact of a range of interventions
  - ✓ This results in improved colleague experience and satisfaction, reduced sickness absence and a reduced complexity of cases
- Alongside the wellbeing lead, supporting the wellbeing champion model across the merged organisation by provide training and support sessions to extend the reach and diversity of the FTSU service.
- Reviewing and updating the training videos: 'Speak Up' for all colleagues and 'Listen Up' for managers and promotional posters.
- Launching the 3rd training module 'Follow Up' for all colleagues band 8a and above in April 2023 and relaunching the 'Speak Up' and 'Listen Up' Modules.
- Supporting teams with departmental / ward training either post incident or proactively.

- Continuation of the speaking up network meetings that now brings stakeholders from both organisations together on a 6 weekly basis to share themes and triangulate information. This enables the Trust to address concerns in a robust way.

- Working in union with Network chairs to raise the profile of FTSU and also ensure effective resolution to concerns raised through the networks.

- Attending the Safety Action Group to allow triangulation of safety specific data and themes.

- Implementing changes to address areas identified through the service gap analysis.

- Supporting the delivery of the respectful resolution work.

- Working more closely with bank colleagues, volunteers and estates / ancillary colleagues as these are areas that demonstrate more barriers to speaking up.

- Further work with the Trust Board and Exec lead to ensure the FTSU arrangements comply with the latest guidance and provide assurance that we are on track to implement an improvement plan

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Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Six monthly staffing establishment report
SPONSORING EXEC:	Hayley Peters, Chief Nurse
REPORT BY:	Alison Wootton, Deputy Chief Nurse SFT (Development of report supported by Associate Directors of Patient Care in directorates and Mark Robinson YDH)
PRESENTED BY:	Hayley Peters, Chief Nurse
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report provides a six monthly update of safer staffing assurance for all SFT and YDH inpatient wards, critical care, and emergency departments. The paper provides information on associated safer staffing risks and the controls and mitigations in place for these risks. The review methodology requires the senior care directors to support and provide oversight and affirmation of the clinical directorate services in their review of their data, risks, and their assurance systems and processes. This report offers high level assurance that safe staffing is regularly reviewed on a dynamic day-to-day and shift-by-shift basis and that appropriate action is in place to support safest and best possible quality of care. Over the winter we have experienced increased pressures from: • Delays to discharge with higher numbers of medically fit for discharge, many who still have complex nursing needs. • High pressures on emergency care.

	• Ongoing higher levels colleague absence. • Elevated levels of infectious respiratory conditions with a peak wave of Covid and Flu coinciding. • Industrial action. The restoration phase the NHS continues to challenge with high demand for services across many service areas, which is compounded by system and social care pressures leading to the ongoing requirement for high numbers of escalation beds to be opened. The Board are asked to note the following: • Safe staffing levels have been reviewed as detailed in this report and have broadly been found to meet the standards and guidance. • There remains disruption and challenges to service delivery requiring a focus on a dynamic approach to monitor and oversee staffing. • Some services have vulnerabilities that require on going and close monitoring as well as action to mitigate and deliver safe care. There is directorate level ownership and oversight of these risks and issues and there is a clear and accessible escalation process to raise concern if the risk is considered inadequately managed or mitigated.
Recommendation	The Board is asked to accept reassurance that the trusts are taking all actions to try and ensure safe staffing levels in all ward areas and where this is not possible, escalation and actions are followed to try and mitigate the risks of working with a compromised level of staff.

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

☒ Obj 7 Live within our means and use our resources wisely. ☒ Obj 8 Develop a high performing organisation delivering the vision of the Trust.

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
Senior nursing and directorate level leadership teams have been involved in the preparation of 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 – e.g., in Part B]
The six monthly review was last presented to board in September 2022

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 AND YEOVIL DISTRICT HOSPITAL

SIX MONTHLY STAFFING ESTABLISHMENT REPORT

1. BACKGROUND AND PURPOSE

1.1 This report is part of the safe staffing requirement in response to the Francis Report (2013) and subsequent guidance and policy including the National Quality Board (2016) guidance to deliver the right staff, with the right skills, in the right place at the right time. NHSI (2018) safeguards to support providers to deliver high quality care through safe and effective staffing built on previous guidance to support organisations and boards to demonstrate that safe staffing levels have been reviewed for all clinical groups and that a robust governance framework is in place to support these reviews and any proposed changes in staffing level or skill mix.

1.2 The intention of this report is to provide assurance data, thematic issues, risks, and mitigations to give the required Board assurance that Somerset Foundation Trust (SFT) and Yeovil District Hospital (YDH) have planned core safe nurse staffing levels across all in-patient ward areas and that we respond to changes in care requirements in our ward areas. This report covers the reporting period for July 2022 to December 2022.

2. BUSINESS CASES

2.1 It is not intended to present any business cases in this report. Directorates may seek local resource investment through standard Trust processes but at this point there are no cases linked with general inpatient care.

3. DATA METRICS

3.1 Standard data is used through the report to assure registered and unregistered nursing shift fill rate, Care Hours Per Patient Day metrics, absence, turnover, and vacancy rates.

4. RISKS

4.1 Summary of risks above 15 that relate to / apply to inpatient care:

YDH

- Risk 0021 Unsafe numbers of attendances in the Emergency Department (25)
- Risk 0049 Increased demand – opening of escalation areas (20)
- Risk 0925 Pressure on colleagues (16)

SFT

- RSK-0690 Organisation Ongoing unsustainable pressure to colleagues in the Trust (16)
- RSK- 0372 Overcrowding in ED (20)
- RSK-01625 Paediatric HDU training and staffing (16)
- RSK- 001510 Mental Health & Learning Disabilities – high use of agency (16)
- RSK-000862 Escalation Beds - risks to patient safety and patient experience (16)
- RSK-000205 I&UC Acute Medical Wards HCA vacancies -55 WTE (16)
- RSK-001400 Paediatric Inpatients - Significant nursing and support staff vacancies on the Paediatric ward (16)
- RSK-000082 Organisation level - Nurse and AHP (Allied Health Professions) Staffing Shortage and increased activity across all services (15)

4.2 Directorates and individual areas will have risks that relate to safe staffing that score below 15, these are not detailed in this report, these risks are discussed as part of directorate governance and are escalated through Quality Assurance, Finance and Performance (QAFP) meetings.

5. SIX MONTHLY REVIEW OF SAFE STAFFING – SOMERSET FOUNDATION TRUST AND YEOVIL DIRSTRICT HOSPITAL

Overview (Directorate and inpatient level data is presented in Appendix 1.)

YDH inpatient areas

Table 1. YDH overall inpatient position July 2022 – December 2022

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Registered Nursing Fill Rate	95%	98%	98%	98%	99%	97%
Unregistered Nursing Fill Rate	93%	92%	86%	88%	96%	91%
All Staff Fill Rate - Day	93%	94%	92%	92%	96%	93%
All Staff Fill Rate - Night	97%	99%	94%	96%	100%	97%
All Staff Fill Rate - Overall	94%	96%	93%	94%	98%	95%
Care Hours per Patient Day	6.9	6.9	7.1	7.0	7.1	6.9
Registered Hours per Patient Day	4.1	4.1	4.3	4.2	4.1	4.0

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Sickness	5.8%	4.2%	3.8%	4.6%	4.2%	5.0%
Total Absence						
Labour Turnover Rate	16%	16%	16%	18%	18%	17%
Registered Nurse Vacancy Rate	2.0%	2.0%	1.8%	2.5%	3.2%	2.7%
Unregistered Nurse Vacancy Rate	7.6%	7.9%	6.8%	6.9%	5.7%	5.7%
All Clinical Staff Vacancy Rate	4.8%	5.4%	4.7%	5.0%	6.0%	5.2%

5.1 The overall YDH picture demonstrates that over the six months there was a good fill rate against the planned establishment for registered nurse shifts, however due to vacancy the basic core level of unregistered nurses could not be achieved even with the mitigation of temporary staffing solutions. This was managed so that this risk fell more in the daytime as there is more support to call on, rather than at night when there are less people around to offer support.

5.2 The registered nurse vacancy level has been consistently low. The turnover position was raised during this reporting period and that has particularly been in the unregistered staff lines, work has been undertaken to provide extra support to starters at this level and it is anticipated that the turnover level will be improved to reflect this.

SFT inpatient areas

Table 2. SFT overall inpatient position July 2022 – December 2022

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Registered Nursing Fill Rate	97%	95%	96%	97%	96%	97%	
Unregistered Nursing Fill Rate	100%	98%	104%	102%	102%	102%	
All Staff Fill Rate - Day	95%	94%	97%	98%	97%	97%	
All Staff Fill Rate - Night	101%	101%	105%	104%	104%	105%	
All Staff Fill Rate - Overall	98%	97%	101%	100%	100%	100%	
Care Hours per Patient Day	12.6	7.2	8.5	12.0	13.1	8.3	
Registered Hours per Patient Day	6.4	3.6	4.2	6.0	6.6	4.2	
Completing Safer Staffing Measures	81%	77%	79%	81%	76%	73%	
Sickness	7.7%	5.8%	6.3%	7.8%	6.8%	7.5%	
Medical Suspension	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	
Total Absence	7.8%	5.8%	6.3%	7.8%	6.8%	5.8%	
Labour Turnover Rate	10.3%	9.9%	9.8%	9.9%	10.1%	9.9%	
Registered Nurse Vacancy Rate	9.5%	9.8%	8.5%	6.6%	5.8%	7.2%	
All Clinical Staff Vacancy Rate	7.0%	8.0%	6.7%	5.9%	5.8%	7.4%	

5.3 The overall SFT average all colleague shift fill rate was maintained within a range 94 – 105%. While the overall SFT position is shown to be strong for fill rates across the wards, the individual directorate performance details a more mixed picture. It is noted that overall, there is a stable picture for sickness, turnover, and vacancy.

Narrative for YDH and SFT (acute, community and mental health inpatient areas)

5.4 Following the work of previous years each inpatient area has a core level of staffing agreed that we aim for to meet the usual care needs in each area and speciality. Each area is established with a wholetime equivalent head count, that if all posts are recruited can support these numbers being rostered and an allowance for a planned level for annual leave, study leave and sickness cover.

5.5 At this time, in most ward areas, we continue to see a generally positive and improving position of registered nurse vacancy, but we do still have some pockets of higher levels of vacancy where areas are more difficult to fill vacancy due to lack of speciality specific staff, an example of this would be in paediatrics and intensive care. The other areas where it can be more difficult to fill positions is in our community hospitals. Many vacant posts have been filled by internationally recruited colleagues and these individuals struggle to accept posts in the community or community hospital due to the rurality of these posts and need for transport or local accommodation.

5.6 Our position for unregistered healthcare assistants has not been the same over the 6-month period with a worsening position for vacancy and an ongoing issue with a higher level of turnover of colleagues. Work is continuing to fill positions and to work on schemes to improve retention. The higher vacancy position for unregistered healthcare assistants has caused an elevated level of requests for bank or agency colleagues to fill the shifts and fill rates are not always adequate despite these requests and attempts to cover shifts.

5.7 The last six months have seen an elevated level of pressure that has affected all our emergency admission areas and inpatient wards; acute, community and mental health. This pressure has been caused by a combination of issues:

- Delays to discharge with higher numbers of medically fit for discharge.
- High pressures on emergency care.
- Ongoing higher levels colleague absence du to ill health.
- Elevated levels of infectious respiratory conditions with a peak wave of Covid and Flu coinciding.
- Industrial action.
- Reported increased complexity of admissions with a resulting higher level of acuity and dependency.
- High numbers of escalation beds consistently in use.

- Higher numbers of colleagues who are new to the organisation and have less or no specialist experience in the areas they are working.

5.8 The pressures and changes in activity that we have been experiencing, does mean that this core agreed level will need enhancing on occasions. One reason for enhancement is extra capacity, we have seen a considerable number of escalation beds in use over the report period. Each area has an assessment in place that lays out the normal staffing requirements for these extra beds. Across both organisations in both acute and community hospitals the number of extra beds is equivalent to 6.5 extra hospital wards. Many of these extra beds are spread with most wards taking 2-3 extra patients. The intention will be to provide the extra required staff to care for patients in areas but with the level of pressure this leads to demand outstripping supply, so teams are required to work within a lower or altered ratio of staff compared to the planned or aspired to level.

5.9 Due to a mix of reducing vacancy (registered nurses) and higher turnover (registered and unregistered nurses) we have a very new / newer workforce in most inpatient areas, with a lower level of experienced colleagues, most teams are requiring higher levels of support and supervision. In many areas our establishments are set for the band 7 ward sisters to be supernumerary (depending on team size) so they can provide leadership, supervision, and management of the ward teams, it often not possible to maintain this status and they often go into the numbers to support the teams to provide safe care. However, a consequence of this is an impact on KPIs such as appraisals, they are also unable to spend the time required clinically teaching and mentoring the new members of the team which prolongs the concerns with regards to skill mix.

5.10 Night shifts remain concerning as numbers can be reduced and this is often compounded by last minute sickness, our data demonstrates that it is often night staffing levels that are more compromised. Teams are often more junior and due to less numbers of staff at night and a less experienced skill mix, this is mitigated where possible, but this may require people moving from one area to another which is difficult, not always possible and does not fully mitigate the issues.

5.11 In some areas we are running below core numbers for both RN and HCA on many shifts. The matrons mitigate risk by reviewing the numbers daily, they enact the safer staffing SOP and move colleagues around to best manage risk and safety. They also review each request that comes in for enhanced care to ensure that those patients that require a higher level of support are prioritised, however as we are seeing an increase in our patients with acute confusion, delirium, and dementia we are often not able to source support, leaving wards further challenged.

5.12 During the last six months sickness has continued to be consistently high with both Covid and a particularly high Flu season adding to the increase. Stress related reasons are also high on the list of most common reasons for absence.

5.13 The data shows a deterioration from the previous six months which is indicative of the challenges described, it remains a high-level cumulative picture which does not accurately represent the day-to-day challenges on each of the wards.

5.14 In summary, the challenges faced by nursing teams over the last six months have been significant with all teams reporting a change in the acuity and dependency of the patients they are caring for and elevated levels of colleague sickness. The need to consistently manage and staff escalation areas across the Trust and the increasing frequency of pre-emptive boarding have required colleagues to be increasingly adaptive to maintain safer staffing levels.

Maternity (update from 22 Feb 2023 onwards)

5.15 Maternity services have not been formally reviewed as part of this report as they report regularly through Quality and Governance Assurance (Q&GA) Sub Board Committee and data can be viewed in Appendix 2. However, at this time maternity services are experiencing a higher level of vacancy and sickness that is affecting the ability to run all aspects of service safely. A decision has been made to temporarily suspend home births (including those through the Mary Stanley Unit). A risk assessment is in place for staffing levels in maternity services and this has been reviewed to ensure that all plans and mitigations are robust. A quality impact assessment is being completed and appropriate communications have been undertaken with stakeholders. This will remain under regular review with updates provided through Q&GA.

6. OVERALL RECOMMENDATION:

6.1 The Board is asked to discuss and approve the report.

6.2 The Board is further asked to consider if this provide the required reassurance on actions being taken to maintain and monitor safe staffing levels across SFT and YDH inpatient areas.

Appendix 1 – YDH acute ward data and SFT Directorate level inpatient area data.

YDH Acute wards only - Nursing

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Registered Nursing Fill Rate	100%	101%	103%	103%	101%	100%
Unregistered Nursing Fill Rate	95%	95%	88%	89%	97%	92%
All Staff Fill Rate - Day	96%	96%	96%	95%	98%	95%
All Staff Fill Rate - Night	100%	101%	98%	99%	100%	98%
All Staff Fill Rate - Overall	98%	98%	96%	96%	99%	96%
Care Hours per Patient Day	6.5	6.6	6.7	6.6	6.8	6.9
Registered Hours per Patient Day	3.8	3.8	4.0	3.8	3.7	4.0
Sickness	4.7%	4.7%	4.7%	4.7%	4.7%	4.8%
Total Absence						
Labour Turnover Rate	16%	16%	16%	18%	18%	17%
Registered Nurse Vacancy Rate	2.2%	2.2%	2.0%	2.7%	3.5%	2.9%
Unregistered Nurse Vacancy Rate	7.6%	7.9%	6.8%	6.9%	5.7%	5.7%
All Clinical Staff Vacancy Rate	4.9%	5.6%	4.8%	5.2%	6.2%	5.4%

Integrated and Urgent Care Directorate (I&UC)

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Registered Nursing Fill Rate	100%	93%	96%	97%	97%	98%	
Unregistered Nursing Fill Rate	96%	91%	99%	94%	97%	92%	
All Staff Fill Rate - Day	97%	91%	96%	96%	96%	95%	
All Staff Fill Rate - Night	100%	100%	106%	102%	103%	101%	
All Staff Fill Rate - Overall	98%	95%	100%	98%	100%	98%	
Care Hours per Patient Day	8.6	3.5	8.1	8.1	8.5	7.4	
Registered Hours per Patient Day	4.4	1.8	4.0	4.1	4.3	3.8	
Completing Safer Staffing Measures	79%	73%	74%	72%	76%	76%	
Sickness	7.8%	5.5%	6.6%	7.9%	6.9%	7.1%	
Medical Suspension	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Total Absence	7.8%	5.5%	6.6%	7.9%	6.9%	7.1%	
Labour Turnover Rate	9.6%	8.9%	8.9%	9.5%	9.5%	9.8%	
Registered Nurse Vacancy Rate	6.7%	5.1%	2.8%	2.5%	3.6%	7.6%	
All Clinical Staff Vacancy Rate	3.5%	3.0%	1.9%	2.8%	5.3%	8.2%	

Primary Care and Neighbourhoods Directorate

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Registered Nursing Fill Rate	95%	100%	102%	103%	107%	104%	
Unregistered Nursing Fill Rate	91%	97%	106%	110%	111%	111%	
All Staff Fill Rate - Day	90%	97%	104%	106%	109%	106%	
All Staff Fill Rate - Night	97%	102%	109%	111%	114%	115%	
All Staff Fill Rate - Overall	93%	99%	106%	108%	111%	110%	
Care Hours per Patient Day	6.3	6.4	6.2	6.3	6.3	6.4	
Registered Hours per Patient Day	2.8	2.8	2.6	2.7	2.8	2.7	
Completing Safer Staffing Measures	95%	96%	95%	97%	99%	87%	
Sickness	8.9%	9.1%	10.2%	8.6%	8.1%	8.2%	
Medical Suspension	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Total Absence	8.9%	9.1%	10.2%	8.6%	8.1%	8.2%	
Labour Turnover Rate	15.4%	14.3%	12.5%	13.8%	15.5%	15.8%	
Registered Nurse Vacancy Rate	21.0%	21.9%	20.1%	16.8%	19.1%	18.9%	
All Clinical Staff Vacancy Rate	16.8%	16.8%	15.0%	11.0%	11.7%	12.2%	

Mental Health Directorate

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Registered Nursing Fill Rate	104%	102%	100%	104%	100%	101%	
Unregistered Nursing Fill Rate	110%	107%	119%	115%	109%	114%	
All Staff Fill Rate - Day	96%	97%	101%	102%	98%	99%	
All Staff Fill Rate - Night	106%	106%	112%	109%	105%	109%	
All Staff Fill Rate - Overall	100%	100%	105%	104%	101%	102%	
Care Hours per Patient Day	11.6	11.7	12.9	12.4	12.5	12.4	
Registered Hours per Patient Day	4.1	4.2	4.3	4.3	4.4	4.4	
Completing Safer Staffing Measures	82%	84%	89%	87%	84%	80%	
Sickness	8.3%	6.1%	5.4%	7.5%	6.9%	8.1%	
Medical Suspension	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	
Total Absence	8.3%	6.1%	5.4%	7.5%	6.9%	8.3%	
Labour Turnover Rate	12.3%	11.3%	11.3%	10.5%	10.5%	10.4%	
Registered Nurse Vacancy Rate	23.3%	24.7%	24.8%	18.2%	17.1%	19.3%	
All Clinical Staff Vacancy Rate	15.1%	16.2%	15.5%	14.7%	12.1%	12.3%	

Surgical and Critical Care Directorate

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Registered Nursing Fill Rate	93%	92%	93%	92%	93%	95%	
Unregistered Nursing Fill Rate	107%	104%	100%	105%	101%	109%	
All Staff Fill Rate - Day	96%	96%	93%	96%	92%	96%	
All Staff Fill Rate - Night	102%	102%	102%	103%	104%	109%	
All Staff Fill Rate - Overall	99%	99%	97%	99%	97%	102%	
Care Hours per Patient Day	8.8	8.4	7.8	8.2	9.3	8.6	
Registered Hours per Patient Day	4.8	4.6	4.4	4.5	5.1	4.7	
Completing Safer Staffing Measures	71%	71%	73%	74%	64%	67%	
Sickness	7.5%	5.9%	5.9%	8.1%	6.0%	6.7%	
Medical Suspension	0.1%	0.0%	0.2%	0.2%	0.2%	0.1%	
Total Absence	7.6%	5.9%	6.1%	8.3%	6.2%	6.8%	
Labour Turnover Rate	9.3%	9.4%	9.3%	9.6%	9.6%	10.0%	
Registered Nurse Vacancy Rate	4.5%	4.4%	3.2%	2.9%	-1.6%	-1.4%	
All Clinical Staff Vacancy Rate	0.3%	3.3%	2.0%	1.7%	0.1%	2.5%	

Clinical Support Directorate

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Registered Nursing Fill Rate	98%	94%	90%	94%	97%	96%	
Unregistered Nursing Fill Rate	98%	96%	94%	89%	96%	92%	
All Staff Fill Rate - Day	98%	94%	90%	90%	97%	93%	
All Staff Fill Rate - Night	99%	99%	98%	99%	100%	100%	
All Staff Fill Rate - Overall	98%	96%	93%	93%	98%	96%	
Care Hours per Patient Day	7.5	7.0	6.8	7.2	7.6	7.5	
Registered Hours per Patient Day	4.7	4.5	4.3	4.6	4.9	4.9	
Completing Safer Staffing Measures	83%	78%	80%	78%	85%	77%	
Sickness	5.7%	1.7%	7.2%	13.0%	8.5%	5.6%	
Medical Suspension	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Total Absence	5.7%	1.7%	7.2%	13.0%	8.5%	5.6%	
Labour Turnover Rate	3.4%	1.3%	0.0%	0.0%	0.0%	0.9%	
Registered Nurse Vacancy Rate	-2.6%	4.6%	-1.2%	-4.7%	-4.7%	-4.2%	
All Clinical Staff Vacancy Rate	-2.2%	2.7%	-3.1%	-3.1%	-2.9%	-1.5%	

Families Directorate (paediatrics only)

(Maternity information is included in appendix 2 but is separately reported through the Quality and Governance Assurance meeting)

Measure	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Trend
Registered Nursing Fill Rate	95%	93%	95%	95%	93%	93%	
Unregistered Nursing Fill Rate	90%	93%	101%	88%	87%	87%	
All Staff Fill Rate - Day	93%	94%	97%	94%	95%	94%	
All Staff Fill Rate - Night	95%	96%	100%	96%	94%	95%	
All Staff Fill Rate - Overall	94%	95%	98%	95%	94%	95%	
Care Hours per Patient Day	10.6	10.9	14.0	10.7	12.4	10.8	
Registered Hours per Patient Day	8.1	8.1	10.3	8.1	9.3	8.1	
Completing Safer Staffing Measures	74%	61%	64%	76%	73%	56%	
Sickness	6.3%	4.4%	4.6%	5.2%	6.4%	8.0%	
Medical Suspension	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Total Absence	6.3%	4.4%	4.6%	5.2%	6.4%	8.0%	
Labour Turnover Rate	8.6%	9.8%	10.5%	9.8%	9.1%	8.8%	
Registered Nurse Vacancy Rate	7.1%	9.0%	8.4%	5.9%	6.3%	6.8%	
All Clinical Staff Vacancy Rate	9.7%	10.8%	9.3%	6.2%	5.3%	5.3%	

Appendix 2 Maternity SFT and YDH (both report to quality and governance so here for info only)

1. MATERNITY SFT

1.1 The integration of the maternity services in Somerset is now actively being developed as part of the SFT and YDH merger. There are three LMNS funded project roles at this time working across the system to drive implementation of the National Maternity Service Review deliverables (Better Births 2015). This includes the maternity specific public health agenda and development of bereavement services aligned to the National Bereavement Care Pathway (NCBP).

1.2 SFT has undertaken the staffing assessment Birthrate plus using retrospective data from August to October 2020. The final report was sent in November 2021. The methodology used in this review draws upon a set of national assumptions and benchmarked data from other recent reviews. The data assessed that establishment met the requirement at the time of the data capture. Additional assessments were undertaken to calculate the number of midwives required to deliver continuity of care. Although a reduction in birth rate, the report acknowledged a 23% rise in complexity of women accessing maternity care, both socially and medically. Maternal mental health and safeguarding concerns and referrals have seen a significant rise during the pandemic.

1.3 In the last six months midwifery numbers have fluctuated but overall, the establishment has remained within national recommendations for a 1:28 midwife to birth ratio.

Midwife to Birth ratio July to December 2022

2022	Jul	Aug	Sep		Oct	Nov	Dec
Midwife/birth ratio (including maternity & sick leave)	1:26	1:28	1:27		1:25	1:20	1:24

1.4 The care acuity levels have remained low between 52 – 77%. Midwifery Red Flag events (NICE – safe staffing in Midwifery Settings 2015), have been impacted with a frequent delay in treatment and staffing shortages. There have been no reported safety incidents because of delays, although user feedback has reflected dissatisfaction with some induction of labour delays. Supernumerary labour ward co-ordinator and 1:1 care in labour ward remains 100%. The acuity assessment does not reflect workforce requirements outside of the obstetric led labour ward.

Red Flag Acuity Data July – December 2022

	Acuity	Supernumerary labour ward coordinator	1:1 care in labour (core delivery suite only)
July	52%	100%	100%
Aug	57%	100%	100%
Sept	60%	100%	100%
Oct	66%	100%	100%
Nov	77%	100%	100%
Dec	60%	100%	100%

1.5 Workforce review is ongoing to ensure each area has staffing and appropriate skill mix to support the changing national drivers. Following publication in September 2022 by NHS England the Chief Nursing and Chief Midwifery Officers stated that due to the continued workforce challenges facing maternity services there would no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and that local services will instead be supported to develop local plans that work for them. Provision of MCoC at SFT remains a challenge and will be dependent upon the workforce review being completed.

1.6 Active recruitment is in place for 12wte midwives to work across both inpatient and community settings the challenges are still around a national shortage of senior midwives. The impact on this will be recruiting more junior midwives who will need more support by our practice development teams. We currently have three international recruits with plans for another four to join us this year. We are also taking blended learning students from September. A risk assessment has been written to identify our staffing recruitment shortages.

1.7 SFT Maternity has a small separate pool of bank staff and vacant shifts are covered by substantive staff working additional hours.

1.8 The number of specialist maternity midwives is 9.32wte. This includes 1.28wte nursing associate. This is the lower end of the Birthrate plus recommendation wte which suggests 8-10% of the funded establishment.

1.9 The new-born hearing screening service is system wide. Despite the current issues with retention of staff, the service continues to provide an exceptional service meeting KPI’s and the top performing in the Southwest Region.

2. MATERNITY YDH

2.1 The integration of the maternity services in Somerset is now actively being developed as part of the SFT and YDH merger. Ongoing service changes due to the COVID-19 pandemic are already aligning across the Somerset Local MatNeo Maternity System (LMNS) to continue supporting an equitable service for all users. There are 3 LMNS funded project roles at this time working across the system to drive implementation of the National

Maternity Service Review deliverables (Better Births 2015). This includes the maternity specific public health agenda and development of bereavement services aligned to the National Bereavement Care Pathway (NCBP).

2.2 YDH has undertaken the staffing assessment Birthrate plus using retrospective data IN 2021. The final report was sent in December 2021 and has been reviewed by the Trust's executive team.

2.3 The 2021 BirthRate+ report shows a current deficit in midwifery staffing of 1wte at Yeovil District Hospital. This is a reduction from the last staffing report in June which showed a 1.59wte deficit. Active local and international recruitment for midwives is ongoing. `The first 2 internationally recruited midwives who joined us July 2022, have now passed their OSCE exams and move into band 5 preceptorship roles from January 2023. This brings us in line to show current midwifery staffing is equal to the funded establishment.

2.4 The table below shows the acuity data which demonstrates YDH have achieved 100% 1:1 care in labour, this data is collected through the Birthrate Plus red flag reporting.

	Jul 22	**Aug 22**	**Sept 22**	**Oct 22**	**Nov 22**	**Dec 22**
One to One care in labour NOT achieved	0	0	0	0	0	0
LW Coordinator NOT supernumerary	10	20	20	12	5	3
Unable to fill vacant shifts	40%	36%	30%	31%	23%	17%

2.5 The supernumerary status of the labour ward coordinator (defined as when the coordinator is required to be the lead care provider for a woman on the labour ward e.g., requiring 1:1 care and is unable to redeploy staff to either coordinate the labour ward or take over the care of the woman) has not been consistently achieved in this 6-month time period according to the Birthrate+ reporting. The numbers in table 2 represent a 4-hour period, i.e., there can be up to 6 episodes recorded for just one 24-hour period. When supernumerary status has not been achieved, it has been when acuity is high, alongside vacant unfilled midwife shifts (staff sickness). Annual leave is always at maximum capacity during the summer months and colleagues are less likely to take up extra duties, which will go unfulfilled from bank and agency requests. Extra incentives are offered to our own midwives to support covering the shortfall in the rota and the maternity management team will continue to review the workforce and an action plan has been devised to address this.

2.6 In the six months this report covers, the birthrate plus data has been inputted with a 76.27% confidence factor. 11% of this time red flags have been recorded. Of these red flags 71% are when the supernumerary status of the labour ward coordinator has not been achieved. Alongside unplanned staff absence this is also due to the workflow/admissions currently reviewed on labour ward at YDH. The Safe Staffing Action Plan

details work underway to improve workflow which will help the coordinator achieve supernumerary status in times of high acuity.

2.7 Ongoing work to achieve 100% supernumerary status of the labour ward coordinator will be a priority for focus through 2023. Details inputted through birthrate by the coordinators will also be addressed to ensure correct and consistent compliance to complete the birthrate tool.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Assurance Report from the People Committee meetings held in common on 30 January 2023
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Stephen Harrison and Graham Hughes, Chairmen of the People Committees
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the People and Workforce Committee meetings held in common on 30 January 2023 and the assurance received by the Committees. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • The colleague story – the focus on continued professional development and local workforce planning. • The management of the strategic workforce risks on the Board Assurance Framework. • The nursing deep dive – and the focus on workforce planning, retention and education. The Committees did not identify any areas for follow up. No issues have been identified to be followed up by other Committees or to be reported to the Board. The Committees are able to provide the Boards with assurance that the items discussed at the meeting provide significant assurance in relation to addressing gaps in

	controls and assurances for objective six of the Board Assurance Framework.
Recommendation	The Board is asked to discuss the report and note the areas of assurance and follow up.

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST (SFT)

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST (YDH)

ASSURANCE REPORT FROM THE PEOPLE COMMITTEES

1. PURPOSE

1.1. The report sets out the items discussed at the meetings held in common on 30 January 2023, the assurance received by the Committees and any areas of concern identified.

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

2. ASSURANCE RECEIVED

2.1. **Colleague Story – Continued Professional Development**
The Committees received a story from a colleague on Continued Professional Development (CPD) funding within the integrated and urgent care (IUC) directorate.

2.2. The Committees noted the funding received; the allocation of this funding.to specific development programmes or topics – clinical skills facilitators; restorative clinical supervision facilitator; leadership; workforce planning; continuous development; and upskilling/clinical development - and the success and impact of the CPD.

2.3. The Committees noted that a further funding bid had been submitted and that the outcome of the bid was awaited.

2.4. The Committees agreed that the update provided assurance that local workforce plans were becoming business as usual.

Review of the Board Assurance Framework

2.5. The Committees noted that the action dates for the people objective will be reviewed.

2.6. The Committees discussed the rating of the “workforce supply” and “engagement of colleague” risks and noted that these risk ratings will be reviewed.

2.7. The Committees further discussed the “green” rating for “workforce planning across the system” and noted that the management of the majority of the workforce related challenges was within the responsibility of the trusts. The trusts were in control of these risks and robust workforce planning was taking place. The Committees subsequently agreed that robust workforce planning was taking place.

Nursing Deep Dive

2.8. The Committee received an update on the key challenges within the nursing profession.

2.9. The Committees received a five year nursing vacancy forecast and noted that although the vacancy factor was less than 7%, there were specific risks, particularly in frontline services. The update showed that, based on the forecast and the assumptions made, there will be an estimated gap of +8 wte nurses by March 2027. The forecast further showed the additional capacity requirements (with exception of the Ready to Go Units) and the theatre recruitment challenges.

2.10. The Committee further received a five year temporary staffing forecast and noted the increase in demand and drivers; the reduction in bank supply; and the areas with the largest agency spend.

2.11. The Committees noted the key challenges and data areas to be further interrogated.

2.12. The Committee asked for further consideration to be given as to the difference in uptake between weekdays and weekends.

Nursing Retention

2.13. The Committees received an update on nursing retention and noted the retention rates across both trusts; the focus on finding out why colleagues were leaving; the key reasons for leaving – work/life balance and relocation; the difference in the retirement rate across SFT and YDH; the key actions identified to improve colleague experience; the success of international recruitment and the need for a focus on career development of international nurses.

Nurse Education

2.14. The Committees received an update on nurse education and noted: the key challenges; the work taking place to attract people into nursing and midwifery roles; the increase in the number of nurses; the improvements to the preceptorship programme to improve retention; and the next steps.

Reflections and consideration for strategic decisions

2.15. The Committees noted:

- That a large part of the data as presented was based on assumptions.
- That decisions will need to be made in relation to escalation and what can be achieved in the next 12 months to reduce the bed base.
- The focus and ongoing work with local providers to get a sustainable pre-registration programme.

- The impact of the ongoing operational pressures on the clinical strategy.

- The success in relation to the recruitment of international mental health nurses; the difficulties recruiting into community services; and the need for a community hospital strategy.

2.16. The Committees agreed that it will be helpful to share the presentation with Board members. The Committees further agreed that it had received assurance that robust workforce planning was taking place.

3. AREAS OF CONCERNS/FOLLOW UP

3.1. No areas of concern or follow up had been identified at this meeting.

4. ISSUES REQUESTED TO BE FOLLOWED UP BY OTHER COMMITTEES

4.1. No issues had been requested to be followed up by the People Committee.

5. ASSURANCE FRAMEWORK

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

- workforce planning.

- Retention.

- Education.

- Colleague story on continued professional development within the IUC directorate.

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Yeovil District Hospital NHS Foundation Trust Finance Report – Month 10
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	The finance report sets out the overall income and expenditure position for the Trust. It includes commentary on the key issues, risks and variances, which are affecting the financial position.
Recommendation	The Board is requested to discuss the report**.**

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

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

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

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

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

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

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

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

YDH | Consolidated Financial Performance

| Month 10 - January 2023

Month 10 | Contents

Executive summary

In month, the Group reported a £0.283m surplus which was in line with the plan. Year to date the Group has a £0.150m surplus which is also consistent with the plan.

Services continue to be under significant pressure from high levels of demand and difficulties in discharging patients in a timely manner. Funding for escalation (£1.6m) was included in the YDH block contract and although year to date expenditure is already c£1.2m above this level, winter funding from the ICB of £0.67m has been recognised to date to help with this. There is an ongoing process in place with the ICB to fund the unplanned costs of escalation/winter from system contingencies until year end. Overachievement of CIP against the year to date trajectory is also partially offsetting pressures. Agency costs have dropped in month as the trust looks to manage the pressure the hospital is seeing in non elective activity and staffing.

Risks to our overall outturn are considered with the ICB as part of the system financial oversight process. A number of commissioner and provider risks (e.g. further winter escalation) are noted with identified mitigations in place.

The Trust is forecasting to achieve £4.563m in CIP (in line with plan). However, of this only £1.058m (23%) is recurrent. Work will continue to support groups to mitigate any residual risks in their plans and increase the level of recurrent delivery.

The capital programme continues to be behind plan. This is due primarily to slippage on externally funded schemes (Salix, Breast Care Unit & Modular theatre). Although significant expenditure is planned in the second half of the year, it is now forecast that the PDC funded theatre 5 plan will not be achieved in this year. NHSE have agreed to rephase the funding for this scheme in line with our revised plans.

Performance on a financial trajectory basis	1.	In Month	The Group reported an in month surplus of £0.283m against a planned surplus of £0.283m, and is therefore in line with the plan in month.
		YTD	The Group deficit year to date is £0.150m compared with a planned deficit of £0.150m, and is therefore consistent with the plan.
Cash	2.	The total cash balance and working cash balance at the 31st January was £24.364m. The year end forecast position £22.655m.	
Capital	3.	YTD	Gross capital expenditure YTD was £11.134m (no MES additions) versus planned £24.364m (£25.582m including MES). The plan will be revised after agreement by NHSE to reprofile funding for the theatre scheme.
CIP performance	4.	YTD	£4.345m has been delivered compared with £3.565m of planned efficiencies; of which 22% have been achieved recurrently. The Trust is forecasting to achieve it's CIP target at year end.

Group I&E - Summary

January 2023			£'000'	YTD			Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)	
21,143	20,399	744	Operating Income	209,365	200,620	8,745	240,404
(13,377)	(13,209)	(168)	Staff Expenditure	(137,133)	(131,677)	(5,456)	(158,123)
(7,147)	(6,547)	(601)	Operating Expenditure	(69,573)	(65,839)	(3,734)	(78,750)
619	**643**	**(24)**	**Operating I&E**	**2,659**	**3,104**	**(446)**	**3,530**
(336)	(360)	24	Non-Operating Expenditure	(2,509)	(2,954)	446	(3,531)
283	**283**	**0**	**Adj to Financial Improvement Trajectory (FIT) Basis**	**150**	**150**	**(0)**	**(0)**
1,685	961	724	Donated Assets and other adjustments excluded from FIT	6,833	11,367	(4,534)	11,819
1,969	**1,244**	**724**	**I&E surplus/(deficit)**	**6,983**	**11,517**	**(4,534)**	**11,819**

Key headlines:

Operating Income - The year to date position includes £2.543m of pay award funding above plan and an additional £1.201m reimbursement of COVID-19 costs (testing) incurred outside of the system funding envelope. Other reimbursements for extra escalation/winter costs in YDH and higher SHS income (£2.802m fav) have also been seen, including part of £1m further funding newly agreed by the ICB towards SHS pressures. An underperformance on high cost drugs is matched by underspends in high cost drugs expenditure YTD.

Staff Expenditure - SHS costs remain higher than plan due to primary care operational pressures which have been funded by increased ICB support. Agency and bank premium costs relating to escalation capacity/activity continue to drive adverse variances across the group, offset in part by income reimbursement as described above. Total variance due to cost of back-dated pay award YTD is £2.925m offset by income stated above giving net adverse variance £0.382m YTD.

Operating Expenditure - year to date favourable variances continue to be seen in IT and recruitment services. Adverse variances include COVID-19 impact of £0.725m YTD due to testing costs which are offset by income. Additional overspends driven by escalation, inflation, non COVID pathology testing, in tariff funded drugs and impact of non-elective demand on elective expenditure, and one-off system costs.

Group I&E - Detail

January 2023			£'000'	YTD			Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)	
15,831	16,019	(188)	NHS Acute Income	162,949	160,005	2,945	191,970
2,650	2,201	450	NHS Primary Care Income	23,544	18,669	4,875	22,180
312	457	(145)	Non NHS Clinical Income	2,792	4,650	(1,858)	5,536
2,194	1,723	472	Other Income	18,879	16,820	2,059	20,242
155	0	155	Top Up income	1,201	476	725	476
21,143	**20,399**	**744**	**Total Operating Income**	**209,365**	**200,620**	**8,745**	**240,404**
(3,993)	(3,984)	(9)	Medical Staff Expenditure	(41,413)	(39,513)	(1,900)	(47,441)
(3,923)	(3,825)	(99)	Nursing Staff Expenditure (Registered)	(39,960)	(38,058)	(1,901)	(45,728)
(5,460)	(5,400)	(60)	Other Staff Expenditure	(55,760)	(54,105)	(1,655)	(64,955)
(13,377)	**(13,209)**	**(168)**	**Total Staff Expenditure**	**(137,133)**	**(131,677)**	**(5,456)**	**(158,123)**
(2,026)	(1,764)	(262)	Drugs	(18,624)	(17,932)	(692)	(21,299)
(1,672)	(1,391)	(281)	Clinical Supplies & Services	(15,474)	(14,080)	(1,395)	(16,847)
(3,450)	(3,392)	(58)	Other Operating Expenditure	(35,475)	(33,827)	(1,648)	(40,604)
(7,147)	**(6,547)**	**(601)**	**Total Operating Expenditure**	**(69,573)**	**(65,839)**	**(3,734)**	**(78,750)**
619	**643**	**(24)**	**Total Operating I&E**	**2,659**	**3,104**	**(446)**	**3,530**
(336)	(360)	24	Non-Operating Expenditure	(2,509)	(2,954)	446	(3,531)
283	**283**	**0**	**Adj to Financial Improvement Trajectory (FIT) Basis**	**150**	**150**	**(0)**	**(0)**
1,685	961	724	Donated Assets	6,833	11,367	(4,534)	11,819
0	0	0	Other adjustments excluded from FIT	0	0	0	0
1,969	**1,244**	**724**	**I&E surplus/(deficit)**	**6,983**	**11,517**	**(4,534)**	**11,819**

COVID-19 Financial Summary (excl SHS)

Included with Plan

COVID19 Related Expenditure £'000	2022/23 YTD													
	Annual Plan	Plan YTD	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Actual M10	Actual YTD	Variance YTD (adverse)/ favourable
Medical Staff Expenditure	982	818	58	96	73	83	129	93	98	96	98	81	905	(86)
Nursing Staff Expenditure	1,780	1,487	164	119	178	176	143	131	140	131	149	146	1,475	12
Other Staff Expenditure	477	331	81	35	23	25	26	24	24	23	25	27	314	17
Total Staff Expenditure	**3,239**	**2,636**	**302**	**250**	**274**	**283**	**298**	**248**	**263**	**250**	**272**	**255**	**2,694**	**(58)**
Drugs	2	1	0	0	0	0	0	0	0	0	0	0	1	1
Clinical Supplies & Services	14	11	0	0	1	0	0	0	9	0	0	0	10	1
Other Operating Expenditure	231	193	4	(1)	4	24	2	2	1	1	2	0	38	155
Total Non-Staff Operating Expenditure	**247**	**206**	**4**	**(1)**	**5**	**25**	**2**	**2**	**9**	**1**	**2**	**0**	**48**	**157**
Total	**3,486**	**2,841**	**306**	**249**	**279**	**308**	**299**	**250**	**272**	**250**	**274**	**255**	**2,742**	**100**

Outside of Envelope

COVID19 Expenditure to be Reimbursed £'000	2022/23										
	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Actual M10	Actual YTD
Nursing Staff Expenditure	0	0	0	0	0	0	0	0	0	0	0
Other Staff Expenditure	0	0	0	0	0	0	0	0	0	0	0
Clinical Supplies & Services	246	301	79	178	68	(17)	52	66	72	155	1,201
Total	**246**	**301**	**79**	**178**	**68**	**(17)**	**52**	**66**	**72**	**155**	**1,201**

Key headlines:

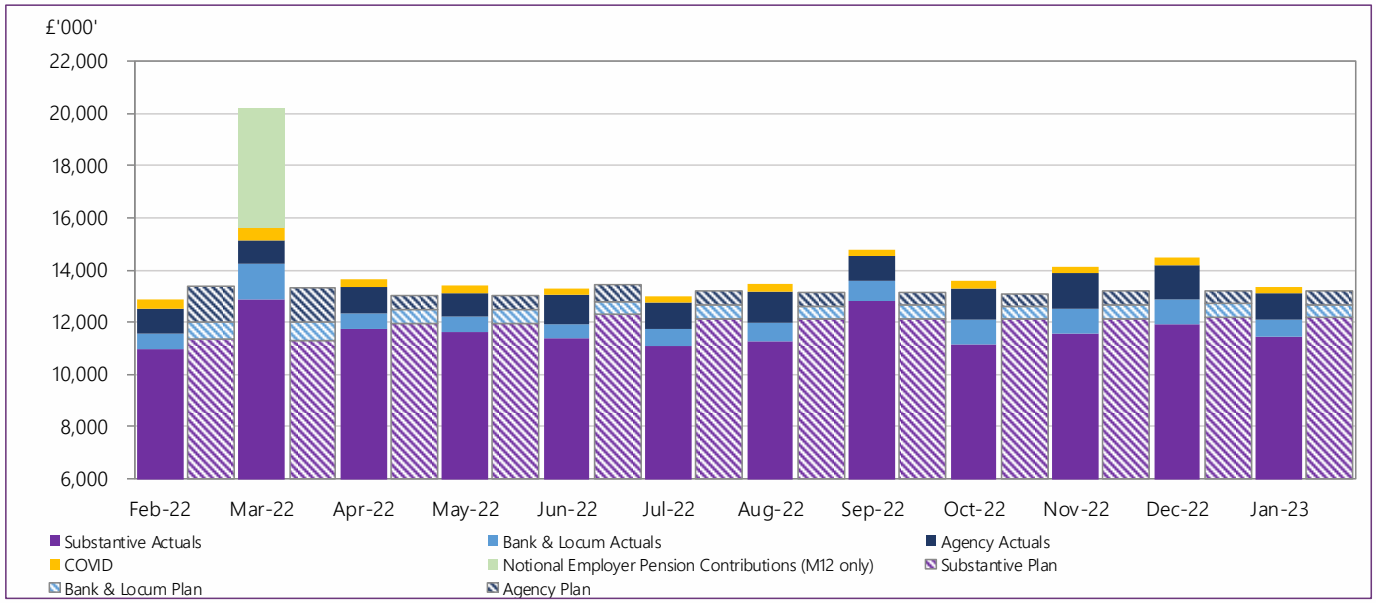
Costs in relation to COVID-19 continue to be reviewed across the trust and system to confirm what additional planned expenditure can be removed aligned to the relaxation in infection prevention and control measures. The level of specific Covid funding the system will receive in 2023/24 has significantly reduced from 2022/23 levels.

Outside of envelope is completely reimbursable from NHSE and relates to COVID testing.

Group staff expenditure

January 2023

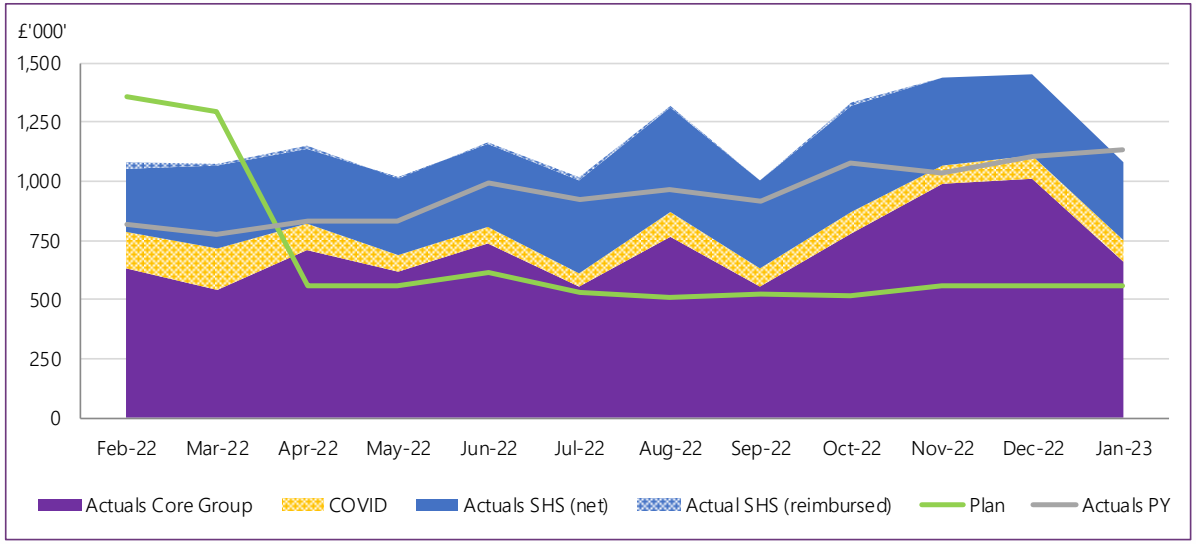
vs Plan in month	£0.168m adverse
vs Plan YTD	£5.456m adverse



January 2023			£'000'	YTD			Comments	Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)		
3,923	3,825	(99)	Registered Nursing, Midwifery and Health Visiting Staff	39,960	38,058	(1,901)	See nursing analysis on following slides.	45,728
1,148	1,064	(84)	Registered Scientific, therapeutic and technical staff	11,730	10,754	(976)	Adverse in SHS pharmacists and YDH ODPs. Favourable in Therapists.	12,892
79	50	(29)	Registered ambulance service staff	801	496	(305)	Part of Emergency Department pressure from high activity.	595
2,320	2,117	(203)	Support to Clinical Staff	22,989	21,071	(1,918)	Majority of the adverse pressure is in support to nursing (see nursing analysis on following slides). Further adv in Radiology.	25,320
1,913	2,170	257	NHS Infrastructure support	20,239	21,784	1,544	Underspends in SHS, IT and O/seas Recruitment (offset in income).	26,148
3,993	3,984	(9)	Medical and Dental	41,413	39,513	(1,900)	See medical analysis on following slides.	47,441
13,377	**13,209**	**(168)**	**Total**	**137,133**	**131,677**	**(5,456)**		**158,123**

Group agency expenditure

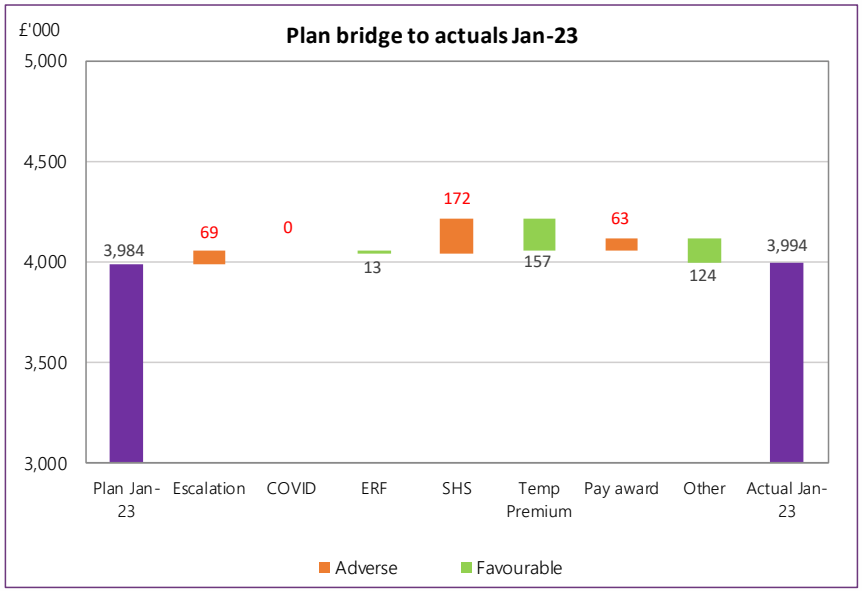
January 2023	
Group plan YTD	£5.479m
Actuals vs Plan YTD	£6.404m adv
Actuals vs prior year YTD	£7.414m over

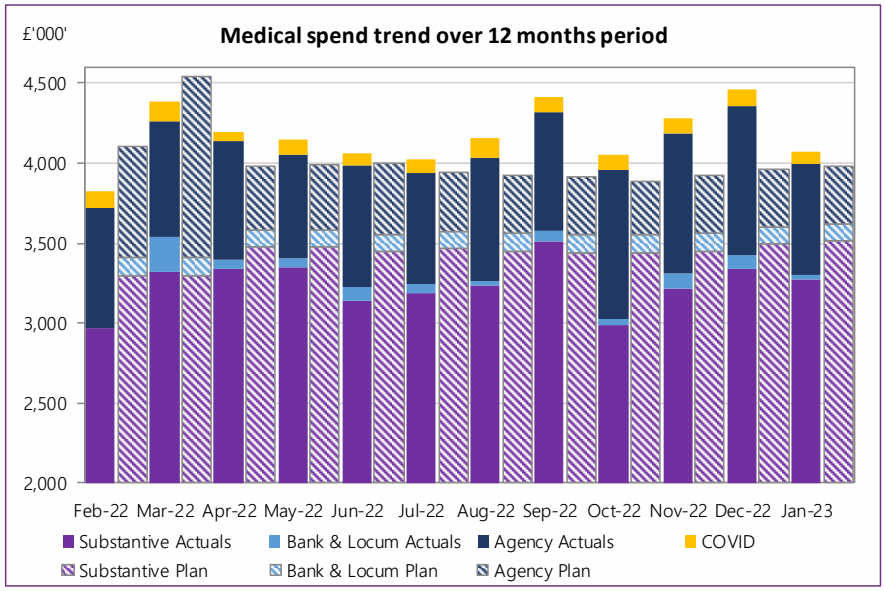


	Variance to Plan fav/(adv)	
£'m	In month	YTD
Nursing	(0.081)	(0.791)
Medical	(0.315)	(4.235)
Other Pay	(0.124)	(1.378)
Total	**(0.520)**	**(6.404)**

January 2023			£'000'	YTD		
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)
395	250	(145)	Medical	4,830	2,493	(2,337)
212	171	(41)	Nursing	1,818	1,541	(277)
117	12	(105)	Other Pay	956	128	(828)
723	***432***	***(291)***	***YDH total***	***7,604***	***4,162***	***(3,442)***
17	0	(17)	Other Pay	527	0	(527)
17	***0***	***(17)***	***SSL total***	***527***	***0***	***(527)***
296	125	(170)	Medical	3,216	1,317	(1,898)
40	0	(40)	Nursing	514	0	(514)
2	0	(2)	Other Pay	24	0	(24)
338	***125***	***(212)***	***SHS total***	***3,753***	***1,317***	***(2,436)***
1,078	**557**	**(520)**	**Group Total**	**11,884**	**5,479**	**(6,404)**

Group medical spend





Plan bridge to Actuals YTD	£'000'
Plan	**39,513**
Escalation	442
COVID	86
ERF	(21)
SHS	1,811
Temp Premium	(677)
Other	(369)
Actual Jan-23	**41,413**
Variance to Plan	**(1,900)**

Key headlines:

Note that month 12 21/22 includes year end provisions for annual leave due to employees and outstanding professional/study leave.

Risk budgets in the Clinical SBUs are underspent in month 10 due to a reduction in premium temporary staffing costs.

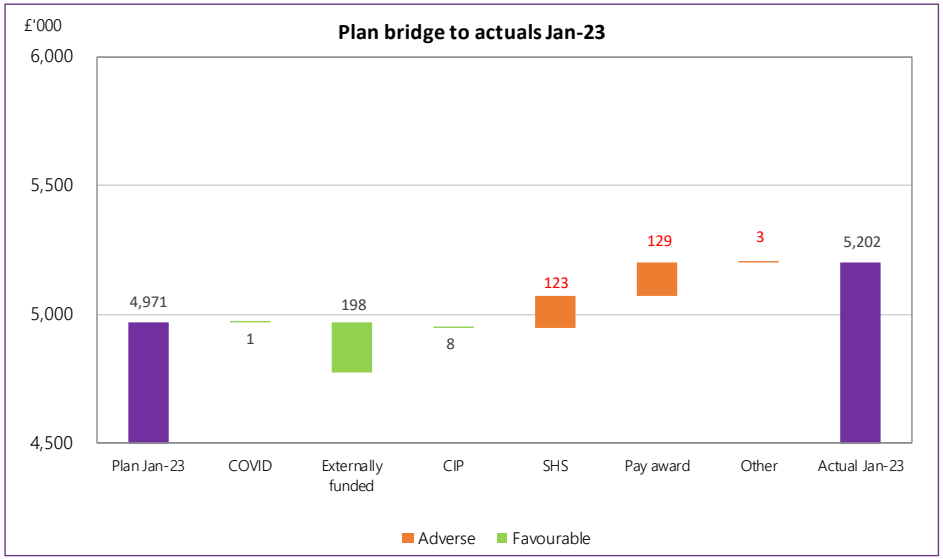
COVID related spend in month was £0.081m (£0.905m YTD), and is adverse to plan due to backfilling staff on sickness leave.

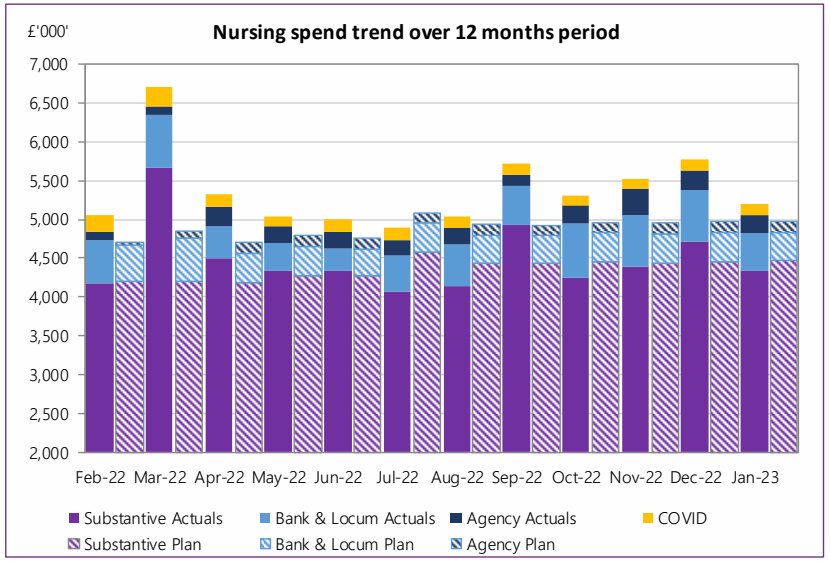
ERF relates to the continuation of 21/22 ERF schemes not in the plan.

£0.442m of additional medical staff shifts were incurred YTD to manage the escalation and acuity of patients being seen on the wards.

SHS includes GP vacancy locum cover and costs incurred due to increased demand.

Group nursing spend





Plan bridge to Actuals YTD	£'000'
Plan	**49,348**
COVID	(12)
Externally funded	195
Escalation	735
CIP	(275)
SHS	1,017
Pay award	1,279
Other	530
Actual Jan-23	52,817
Variance to Plan	**(3,469)**

Key headlines:

Note that month 12 21/22 includes increases in year end provisions for outstanding annual leave and a wellbeing day due to employees as well as outstanding professional/study leave cover and enhancements due.

COVID - expenditure for the additional shifts in ED has been allocated to COVID up to the plan level.

Externally funded - This includes income for midwifery posts, secondments, recharges for CAMHS and variances offset by income e.g. overseas recruitment. In month underspend on development funding, offset by income for expected contract adjustment from ICB.

Escalation - costs incurred above budget for staffing Jasmine, CDUP, FAU Escalation and AEC. Additional winter schemes for AAUP, Clinical Site Managers, KW and Ward 10.

CIP - overachievement in nursing YTD, predominatly non recurrent vacancy factor and COVID reduction for swabbing clinic.

SHS - includes nurse practitioner vacancy locum cover and costs incurred due to increased demand.

Pay award - budget allocated for the pay award, over and above the 2% set at planning. Mostly offset by additional income.

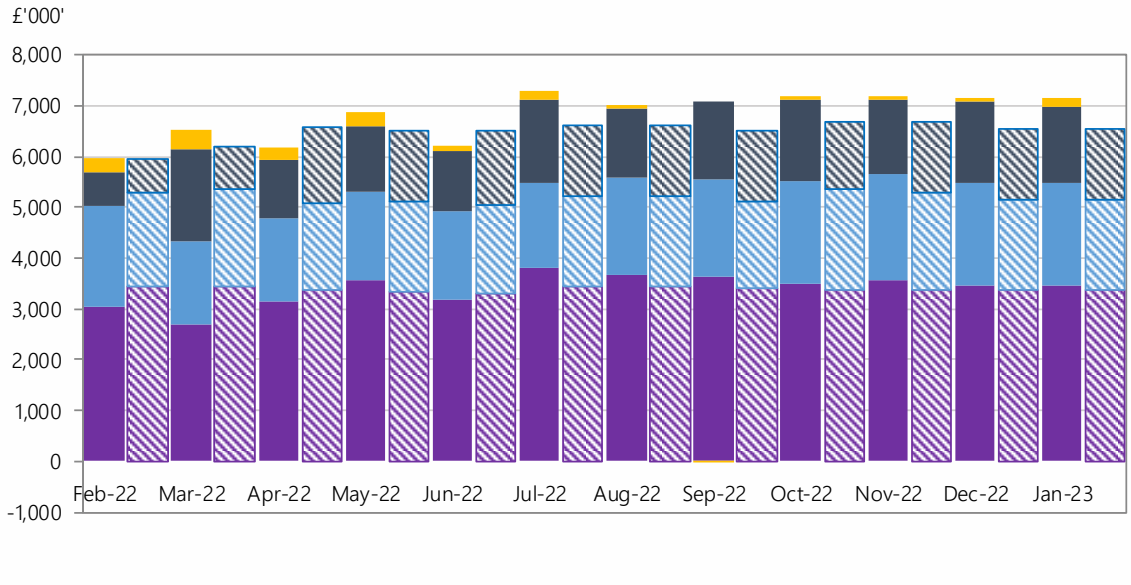
Other - expenditure remains high in ED, General Wards, ICU, Ward 10 and Midwifery. Agency usage increased in month with bank usage consistent with Dec. Shifts booked for increased acuity/dependency, specialing, sickness and vacancies remain high.

Group operating expenditure

January 2023

vs Plan in month	£0.601m adverse
vs Plan YTD	£3.734m adverse

	Variance to Plan fav/(adv)	
£'m	In month	YTD
Clinical Supplies & Services	(0.281)	(1.395)
Drugs	(0.262)	(0.692)
Other Operating Expenditure	(0.058)	(1.648)
Total	**(0.601)**	**(3.734)**



*From Apr-22 category changed to allign to NHSE/I reporting, 2021/22 months data relates to consumables only

Key headlines:

Clinical Supplies & Services - Overspends in pathology testing (excl COVID costs) continuing from high non-elective demand, £0.373m adverse YTD and radiology reporting. Variance also includes private patient medical LLP costs (offset by income) and £0.725m adverse YTD from virus testing expenditure funded by additional income outside the funding envelope.

Drugs - YTD underspend on high cost/pass-through drugs matched by lower income. Remaining adverse variance is reflecting increased activity and escalation areas causing higher than planned spend on in-tariff funded drugs.

Other Operating Expenditure - adverse variances include provisions (catering) driven by escalation and prices, high non-elective activity impact on elective recovery expenditure and one-off system costs in year to date. Underspends continue within recruitment (overseas recruitment, offset by lower income), IT software, recruitment.

All Commissioners Activity & Income

Table based on full PBR for actual activity and income for all commissioners.
Will not reconcile to the financial position of the Trust which reflects the block income arrangements in place.

ACTIVITY					January 2023	INCOME £'000'				
2022/23 Annual Plan	2022/2023 YTD Plan	YTD Actual	YTD Variance fav/(adv)	% variance against plan		2022/23 Annual Plan	2022/2023 YTD Plan	YTD Actual	YTD Variance fav/(adv)	% variance against plan
					Split by Commissioner					
1,133,099	940,559	1,124,300	183,741	19.5%	Somerset (Including NCA activity)	*162,457*	135,592	138,458	2,866	2.1%
54,603	45,405	46,506	1,101	2.4%	Dorset	*19,891*	16,570	17,163	593	3.6%
18,338	15,240	18,468	3,228	21.2%	NHS England (Including Military) Activity	*4,266*	3,552	4,426	873	24.6%
					NHS England (Including Military) Drugs	*8,074*	6,767	7,040	273	4.0%
1,206,040	**1,001,205**	**1,189,275**	**188,070**	**18.8%**	**Total All Activity**	**194,689**	**162,481**	**167,086**	**4,605**	**2.8%**

** Note: the table is reflective of a PbR position and does not consider Commissioner activity challenges, however these changes would not be financially material. This activity is costed at 2022/23 final tariff and includes all additional inflation changes.*

Key headlines:

Indicative Activity Plans (IAPs) have been submitted to all ICBs broadly aligned to trajectories submitted for the Trust wide activity plans. Further metrics were used for waiting lists and Emergency Care that are not reflected fully in these IAPs. Work will be carried out with ICBs to develop these plans throughout 2022/23.

Block contracts have been agreed system wide, however further associated activity from in-year businesses planning, safety, COVID and ESRF is monitored through the associated Elective & Urgent Care Delivery Boards to help inform work on 2023/24 plans.

YTD activity is 188,070, 18.8% over plan, with income £4.605m, 2.8% over indicative plan. This activity variance is mainly due to pathology overachievement of 169,260 to date. Income key variances are emergency excess beddays of £2.365m and critical care discharges of £1.234m over plan to date. Income has also been updated to the latest consultation tariff to include adjustment for pay inflation and NI reduction.

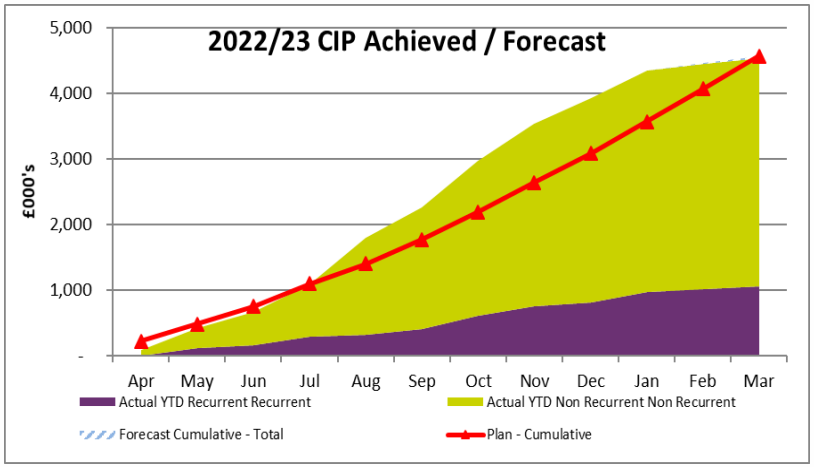
Group activity summary

January 2023			YTD			
Actual	Plan	Variance fav/(adv)	POD (groups)	Actual	Plan	Variance fav/(adv)
1,251	1,427	(176)	Daycase	13,248	14,200	(952)
143	233	(90)	Electives	1,527	2,319	(792)
2,013	2,219	(206)	Non-Elective	20,796	21,900	(1,104)
5,046	4,373	673	Outpatient Firsts	47,763	43,517	4,246
12,772	10,709	2,063	Outpatient F-Up	112,693	106,579	6,114
100,815	81,698	19,117	Other	993,248	812,690	180,558
122,040	**100,658**	**21,382**	**Total**	**1,189,275**	**1,001,204**	**188,071**

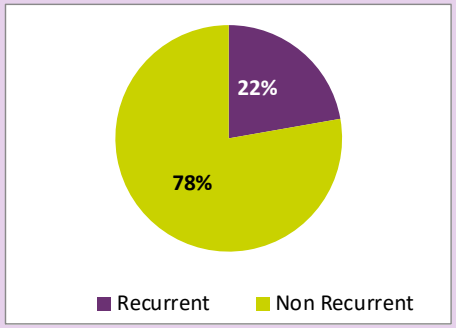
Key notes:

1. Excess beddays activity NOT included.
2. Maternity deliveries have been included.
3. Outpatient procedures included as FA/Fup attendance
4. Non-face to face attendances included as FA/Fup

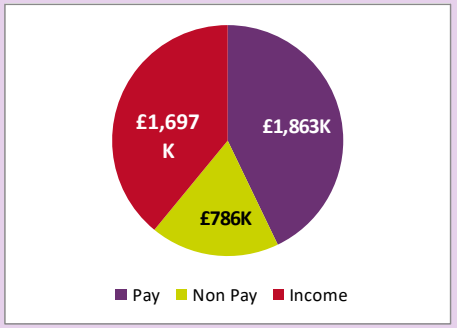
Trust CIP summary



Recurrent v Non Recurrent Savings (YTD)



Savings type (YTD)



Category	In Month					Year To Date						Forecast Outturn			
	Actual Recurrent	Actual Non Recurrent	Total Achieved	Plan	Variance	Actual Recurrent	Actual Non Recurrent	Total Achieved	Plan	Variance	Full Year Plan	FOT recurrent	FOT non recurrent	Forecast outturn total	Variance - Forecast outturn v Plan
Corporate	41	32	73	86	(13)	561	770	1,331	701	630	878	642	834	1,476	599
Elective Care	84	44	128	138	(10)	241	569	810	856	(46)	1,138	251	601	852	(286)
Urgent Care	10	146	156	166	(10)	49	1,319	1,368	1,059	309	1,400	53	1,319	1,372	(28)
SHS	0	0	0	35	(35)	0	367	367	476	(109)	546	0	367	367	(179)
SSL	14	50	65	62	3	116	354	470	473	(3)	600	141	354	495	(105)
Total	**149**	**272**	**421**	**487**	**(66)**	**966**	**3,379**	**4,345**	**3,565**	**780**	**4,562**	**1,088**	**3,475**	**4,562**	**0**

Forecast outturn is £1.088m recurrent CIP (24%) vs a £4.562m plan, however it was assumed within the plan that £3.562m would be delivered recurrently (therefore 31% FOT is against that plan)

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Somerset NHS Foundation Trust Finance Report – Month 10
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Assistant Directors - Financial Management/Financial Services Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	The Finance report sets out the overall income and expenditure position for the Trust. It includes commentary on the key issues, risks, and variances, which are affecting the financial position.
Recommendation	The Board is requested to discuss the report**.**

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

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

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
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 – e.g., 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 TO 31 JANUARY 2023

1. SUMMARY

1.1 In January 2023, the Trust recorded a surplus of £0.888m, which is £0.863m favourable to the plan for the month. Cumulatively, the Trust has a deficit of £2.067m, which is breakeven to plan. The trust received additional income of £1.35m in month in recognition of cost pressures that the trust has experienced through agency and inflation which was the predominate driver for the adverse position.

1.2 Escalation costs in month were £1.328m and have been funded by the ICB from system contingency monies. Costs in January are slightly higher than in December, reflecting the unprecedented level of pressure on services throughout the month. There is an ongoing process in place with the ICB to agree and fund the impact of escalation for the remainder of the financial year.

1.3 Escalation and vacancies continue to drive very high levels of agency, locum, and bank expenditure. January expenditure was £3.2m, an increase of £0.09m on December levels. Cumulatively the Trust has spent £26.1m on agency and locums which is £8.0m above the equivalent 2021/22 period. Sickness and vacancies continue to drive the largest element of agency demand.

1.4 Capital expenditure is £26.0m cumulatively compared with the plan of £40.6m. Further schemes have been identified to ensure the capital resources are fully utilised by year end.

1.5 The CIP shortfall year is forecast to be £1.2m and this has been factored into the year end financial discussions across the system.

1.6 Appendix 1 provides an executive summary of key financial information.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 January 2023:

Table 1: Income and Expenditure Summary

Statement of Comprehensive Income	Annual Plan £000	Current Month 10			Year to date		
		Plan £000	Actual £000	Fav./ (Adv.) Variance £000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
NHS clinical income	594,754	49,560	54,616	5,056	495,608	526,990	31,383
Non-NHS clinical income	3,166	264	170	(94)	2,638	2,681	43
Non-clinical income	37,628	3,134	7,176	4,042	31,360	46,378	15,018
Total operating income (excl STF)	**635,548**	**52,958**	**61,962**	**9,004**	**529,606**	**576,050**	**46,443**
Employee expenses	(436,147)	(36,167)	(39,547)	(3,380)	(365,003)	(384,111)	(19,108)
Drugs	(37,828)	(3,214)	(4,334)	(1,120)	(31,710)	(39,821)	(8,111)
Clinical Supplies	(34,557)	(2,936)	(3,354)	(418)	(28,968)	(31,497)	(2,528)
Non-clinical supplies	(86,070)	(7,201)	(10,008)	(2,807)	(71,856)	(89,914)	(18,059)
PFI expenses	(3,753)	(313)	(318)	(5)	(3,127)	(3,134)	(7)
Depreciation charges	(27,646)	(2,304)	(2,131)	173	(23,038)	(22,187)	851
Total operating expenses	**(626,000)**	**(52,135)**	**(59,692)**	**(7,557)**	**(523,702)**	**(570,664)**	**(46,962)**
EBITDA	**9,548**	**822**	**2,270**	**1,447**	**5,904**	**5,385**	**(519)**
Other income	189	16	(680)	(696)	157	862	705
PDC dividend expense	(7,461)	(622)	(654)	(32)	(6,217)	(6,387)	(169)
Other financing costs	(1,893)	(174)	280	454	(1,546)	(1,937)	(391)
Overall Surplus/(Deficit) after PSF	**382**	**43**	**1,216**	**1,173**	**(1,702)**	**(2,075)**	**(373)**
Adjustments to control total	**(382)**	**(18)**	**(328)**	**(310)**	**(365)**	**9**	**374**
Adjusted Financial Performance	**0**	**25**	**888**	**863**	**(2,067)**	**(2,067)**	**0**

2.2 The total cost of escalation in month was £1.328m, this was higher than December and cumulatively totals £8.2m. Escalation costs are primarily the staffing costs of supporting the additional capacity required to manage the ongoing demand and patient flow issues and associated activity driven costs such as pathology, radiology and soft facilities management (laundry, cleaning, catering etc).

2.3 Non pay variances relate predominantly to pass-through and cancer drugs, imaging, pathology, radiology, and diagnostic hub activity – much of which is either offset by additional funding or will be included within the revised block contract.

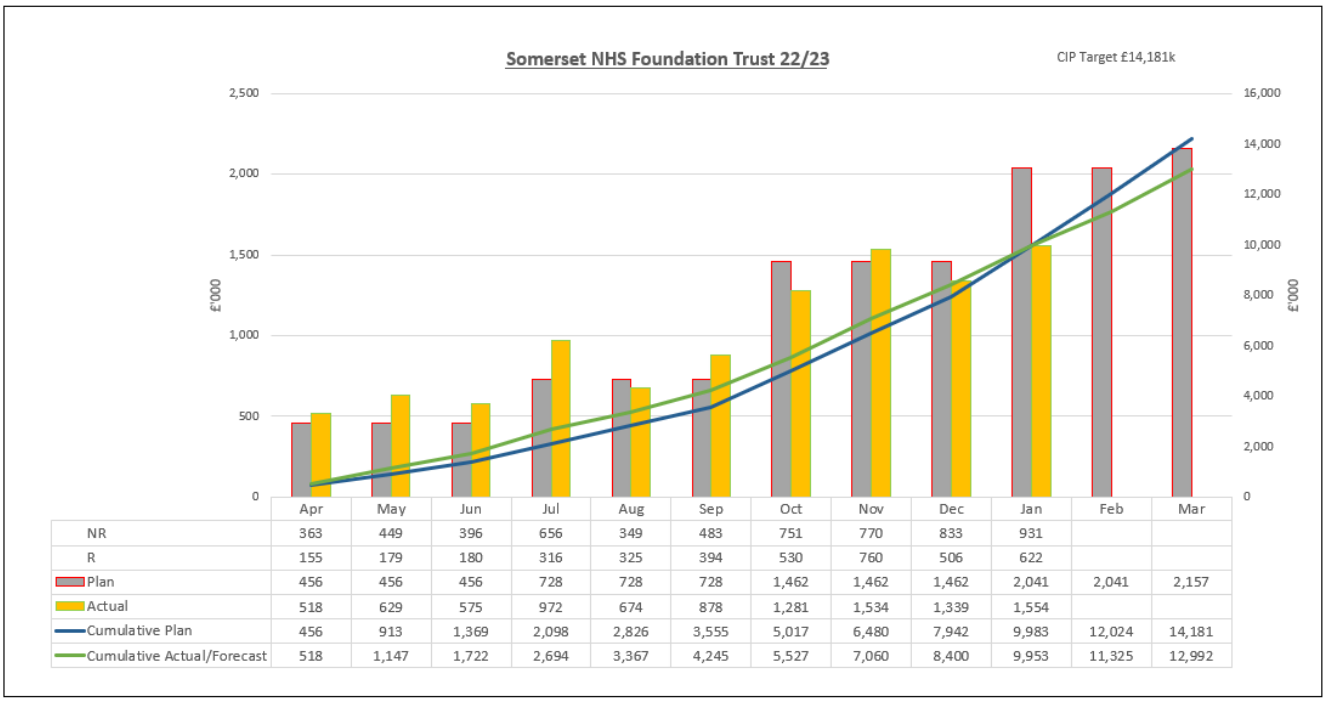
3. COST IMPROVEMENT PROGRAMME

3.1 The Trust has a CIP plan of £14.181m for the year, identifying schemes of this level has been challenging for services as they continue to recover from Covid but also face the day-to-day operational pressures which have been present all year.

3.2 The plan under-achieved in month with savings of £1.554m delivered compared with the plan of £2.041m. Cumulatively, the trust has delivered £9.953m of savings, with £3.967m of recurrent schemes. Through continual reviews the overall forecast outturn has increased by £0.164m to project an annual outturn of £12.992m, with recurrent schemes decreasing slightly by £0.102m.

3.3 The January and cumulative CIP performance is shown in Chart 1 below:

Chart 1: CIP Summary



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NR	363	449	396	656	349	483	751	770	833	931		
R	155	179	180	316	325	394	530	760	506	622		
Plan	456	456	456	728	728	728	1,462	1,462	1,462	2,041	2,041	2,157
Actual	518	629	575	972	674	878	1,281	1,534	1,339	1,554		
Cumulative Plan	456	913	1,369	2,098	2,826	3,555	5,017	6,480	7,942	9,983	12,024	14,181
Cumulative Actual/Forecast	518	1,147	1,722	2,694	3,367	4,245	5,527	7,060	8,400	9,953	11,325	12,992

3.4 The performance to date and forecast delivery by area is set out in Table 2 below: -

Table 2: CIP Detail & Forecast

Somerset NHS Foundation Trust

Cost Improvement Programme 22/23 Trustwide

Directorate	Current Year Plan	Plan to Date	Actual to Date			Variance to Date		Projected Out-turn			Forecast Variance	
			R	NR	TOTAL	R Shortfall	Total	R	NR	TOTAL	R Shortfall	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Integrated & Urgent Care Directorate	2,088	1,441	185	914	1,099	(1,256)	(342)	222	1,060	1,282	(1,866)	(806)
Surgical Directorate	3,090	2,132	572	931	1,503	(1,560)	(629)	815	1,176	1,991	(2,275)	(1,099)
Clinical Support & Specialist Services Directo	2,022	1,510	427	968	1,394	(1,083)	(115)	562	1,461	2,022	(1,460)	0
MH&LD Directorate	1,157	798	566	308	873	(233)	75	679	568	1,247	(478)	90
Families Directorate	1,307	902	513	902	1,415	(388)	513	653	906	1,559	(653)	252
Operational Management	411	284	98	365	463	(186)	180	118	386	504	(294)	94
Estates	787	543	438	125	563	(105)	20	662	125	787	(125)	0
Primary Care & Neighbourhoods Directorate	1,540	1,063	440	763	1,203	(623)	140	528	1,013	1,541	(1,012)	1
Director of Corporate Governance	160	110	66	57	124	(44)	13	79	80	160	(80)	0
Director of Finance	183	126	93	52	145	(33)	19	150	52	202	(33)	19
Director of Nursing	101	70	30	43	73	(40)	3	40	61	101	(61)	0
Director of People	242	167	59	28	88	(108)	(79)	181	61	242	(61)	0
Director of Strategic Development	513	354	369	36	405	15	51	432	109	541	(81)	28
Central	582	485	112	494	606	(373)	121	134	679	813	(448)	231
	14,181	**9,983**	**3,967**	**5,986**	**9,953**	**(6,016)**	**(30)**	**5,254**	**7,738**	**12,992**	**(8,928)**	**(1,189)**

3.5 Clinical areas and corporate functions continue to review their plans to reduce the gap and work will continue Trust wide to identify further opportunities but the financial forecast for the system now assumes a gap of £1.2m.

4. CASH FLOW AND BALANCE SHEET

4.1 The Trust ended the month with cash balances of £31.8m at 31 January and is forecasting a year-end balance of £31.4m as set out in table 3 below:

Table 3: Monthly cash flow

Monthly cash flow and forecast	Jan YTD £000	Feb £000	Mar £000
	Actual	Plan	
Opening Cash Balance	50,416	31,843	39,103
Surplus/(Deficit) from operations	2,291	1,587	1,587
Non-cash flows in operating surplus/(deficit)	1,730	2,878	2,708
Operating cash flows before movements in working capital	4,021	4,465	4,295
Increase/(decrease) in working capital	(18,730)	(541)	1,196
Net cash inflow/(outflow) from operating activities	(14,709)	3,924	5,491
Capital expenditure	(3,450)	(3,511)	(8,782)
Net cash inflow/(outflow) before financing	(18,160)	413	(3,291)
Net cash inflow/(outflow) from financing activities	(414)	6,847	(4,435)
Net increase/(decrease) in cash and cash equivalents	(18,574)	7,260	(7,726)
Closing cash balance	**31,843**	**39,103**	**31,377**

4.2 The Statement of Financial Position is shown in Table 4 below:

Table 4: Statement of financial position as at 31 January 2023

Statement of Financial Position	Opening Balance 1st April 2022 incl IFRS16	Current Month Actual	Movement in Year	Balance at end of Previous Period	Current Month Actual	Movement	Forecast Outturn	2022/23 Plan	Variance from Plan - Increase / (Reduction)
	£000	£000	£000	£000	£000	£'000	£'000	£'000	£'000
Non Current Assets									
Intangible Assets	20,338	19,889	(450)	19,868	19,889	21	19,713	16,694	3,018
Property, Plant and Equipment, Other	302,139	307,435	5,296	305,676	307,435	1,759	321,191	329,793	(8,602)
On SoFP PFI Assets	21,747	23,179	1,432	23,304	23,179	(125)	24,405	22,107	2,298
Right of Use Assets	28,997	26,145	(2,852)	26,393	26,145	(248)	25,303	25,849	(546)
Investments in Joint Ventures	797	203	(595)	1,026	203	(824)	239	797	(558)
Other investments/financial assets	161	14	(146)	14	14	0	14	161	(147)
Trade & other Receivables >1Yr	2,669	2,558	(111)	2,534	2,558	24	2,558	2,669	(111)
Non Current Assets	**376,849**	**379,422**	**2,573**	**378,815**	**379,422**	**607**	**393,422**	**398,070**	**(4,648)**
Current Assets									
Inventories	5,723	7,447	1,724	7,366	7,447	82	7,447	5,723	1,724
Trade and other receivables: NHS receivables	11,399	20,500	9,102	13,683	20,500	6,817	20,398	18,420	1,978
Trade and other receivables: non-NHS receivables	9,316	12,610	3,294	11,231	12,610	1,379	12,610	9,295	3,315
Non Current Assets Held for Sale	15	15	0	15	15	0	0	0	0
Cash	58,729	31,843	(26,887)	50,416	31,843	(18,574)	31,377	40,025	(8,648)
Total Current Assets	**85,182**	**72,416**	**(12,766)**	**82,712**	**72,416**	**(10,296)**	**71,833**	**73,463**	**(1,631)**
Current Liabilities									
Trade and other payables: non-capital	(61,641)	(58,301)	3,340	(58,785)	(58,301)	484	(58,301)	(61,529)	3,228
Trade and other payables: capital	(21,749)	(6,966)	14,784	(7,151)	(6,966)	185	(11,966)	(13,948)	1,982
Deferred Income	(6,893)	(11,456)	(4,563)	(21,018)	(11,456)	9,562	(11,456)	(6,893)	(4,563)
Other Liabilities - Other	(259)	(259)	0	(259)	(259)	0	(259)	(259)	0
Borrowings	(7,072)	(5,352)	1,720	(5,316)	(5,352)	(36)	(4,685)	(6,932)	2,247
Provisions <1yr	(850)	(546)	303	(896)	(546)	350	(884)	(852)	(32)
Current Liabilities	**(98,464)**	**(82,880)**	**15,584**	**(93,425)**	**(82,880)**	**10,545**	**(87,550)**	**(90,413)**	**2,863**
Net Current Assets	**(13,282)**	**(10,464)**	**2,818**	**(10,713)**	**(10,464)**	**249**	**(15,718)**	**(16,950)**	**1,232**
Long Term Liabilities									
Loans >1yr	(47,996)	(44,488)	3,507	(44,755)	(44,488)	267	(44,043)	(41,754)	(2,289)
Provisions >1yr	(3,282)	(3,248)	34	(3,248)	(3,248)	0	(2,837)	(3,182)	345
Deferred Income >1yr	(2,200)	(1,984)	216	(2,006)	(1,984)	22	(1,941)	(1,941)	(0)
Total Long Term Liabilities	**(53,478)**	**(49,721)**	**3,757**	**(50,009)**	**(49,721)**	**289**	**(48,822)**	**(46,877)**	**(1,945)**
Net Assets Employed	**310,089**	**319,237**	**9,148**	**318,093**	**319,237**	**1,144**	**328,883**	**334,244**	**(5,361)**
Tax Payers Equity									
Public Dividend Capital	212,588	224,028	11,440	224,028	224,028	0	231,649	236,356	(4,707)
Revaluation Reserve	77,595	77,595	0	77,595	77,595	0	77,595	77,595	0
Other Reserves	(2,325)	(2,471)	(146)	(2,471)	(2,471)	0	(2,471)	(2,325)	(146)
I&E Reserve	22,231	20,086	(2,146)	18,941	20,086	1,144	22,110	22,618	(508)
Total Tax Payers Equity	**310,089**	**319,237**	**9,148**	**318,093**	**319,237**	**1,144**	**328,883**	**334,244**	**(5,361)**

5. CAPITAL

5.1 Year to date, capital expenditure is £26.0m compared with the plan of £40.6m, resulting in slippage of £14.5m.

5.2 Robust discussions are being held with capital budget managers to refresh forecast assumptions and determine where slippage can be redeployed to faciliate additional/alternative purchases in year to ensure we maximise the overall envelope. This will happen across YDH and SFT jointly. On this basis, the Trust is still expecting to fully deliver schemes which will utilise all of the available capital envelope.

5.3 The capital programme summary is set out in table 5 below:-

Table 5: Capital Programme as at 31 January 2023

Acute Programme	Plan £000	Revised Budget £000	YTD Plan £000	YTD Actual £000	Variance v plan £000	FOT £000
Site Risks / Plant & Equipment	254	254	226	126	(101)	319
Site and Service Development	1,200	1,206	1,140	1,500	360	1,731
Total Acute	**1,454**	**1,460**	**1,367**	**1,625**	**259**	**2,050**
Community/Mental Health Programme						
Site Risks / Plant & Equipment	300	265	264	56	(208)	370
Site and Service Development	5,663	6,202	4,931	2,986	(1,945)	5,350
Total Community/Mental Health	**5,963**	**6,467**	**5,195**	**3,042**	**(2,153)**	**5,720**
Trustwide	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Programme Management & Feasibility Work	400	400	333	313	(20)	400
HEAD (PEAG/ Environment)	100	100	83	17	(66)	114
Backlog Maintenance (Including Queens HV)	3,773	3,677	2,914	1,291	(1,623)	4,062
Major Medical & Surgical Equipment	2,968	2,864	2,465	1,277	(1,188)	2,053
Information Technology	1,401	1,401	1,168	1,367	200	2,862
Site Risks / Plant & Equipment	8,642	8,442	6,963	4,265	(2,699)	9,491
CDC Projects	1,500	1,500	1,500	824	(676)	1,446
EPR/Digital Requirements (Incl Hosp @ Home)	4,647	4,647	3,872	2,398	(1,474)	3,961
Risk contingency	227	152	190	0	(190)	0
Site and Service Development	6,374	6,299	5,562	3,222	(2,340)	5,407
Trustwide	**15,016**	**14,741**	**12,526**	**7,487**	**(5,039)**	**14,898**
Total Internal Capital Envelope	**22,433**	**22,668**	**19,087**	**12,154**	**(6,933)**	**22,668**
Additional Capital Schemes	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
STP 3 - Surgical Centre	20,841	13,350	17,368	11,226	(6,142)	13,350
NHP	1,060	1,060	883	657	(227)	1,060
Cyber Security	94	94	94	94	(0)	94
MRI Upgrade	0	86	0	86	86	86
Mri Simulator	0	25	0	0	0	25
MRI AAT Upgrade	0	102	0	0	0	102
Digital Maturity	711	0	593	0	(593)	0
Wessex House	0	153	0	134	134	153
Pathology Network	0	964	0	0	0	964
Diagnostic Network	0	360	0	0	0	360
Somerset CAMHS Crisis Accom	0	624	0	400	400	624
Audiology Booths	0	89	0	0	0	89
Endoscopy	0	1,856	0	0	0	1,856
Project Wayfinder	0	321	0	0	0	321
Breast Unit Ultrasound	0	79	0	0	0	79
PFI MES Funded IFRIC 12	1,903	1,903	1,427	432	(995)	1,903
Salix	1,062	1,195	885	621	(264)	1,195
Donated	710	712	211	211	0	712
Total Additional Schemes	**26,381**	**22,973**	**21,460**	**13,859**	**(7,601)**	**22,973**
Lease Renewals	21	110	14	14	0	110
TOTAL TRUST PROGRAMME	**48,835**	**45,751**	**40,561**	**26,028**	**(14,534)**	**45,751**

6. RISKS AND OUTTURN

6.1 Operational pressures continue to cause the Trust to run high levels of additional escalation capacity to manage urgent care, flow and winter pressures. This has again generated significant additional costs in month which have been funded non-recurrently by the ICB through use of system contingency funds.

6.2 Staffing challenges continue to create financial pressure. Although there is some offset with vacancy savings of substantive posts, the premium cost of agency staff being used in many services more than exceeds this. The monthly directorate review process continues to review the measures and actions being taken to reduce agency usage

6.3 The ICB remain supportive of the Trust should we not be able to mitigate the financial risks by year end so that all organisations within the system deliver a breakeven outturn.

7. RECOMMENDATION

7.1 The Board is requested to note the financial performance for the month ending 31 January 2023.

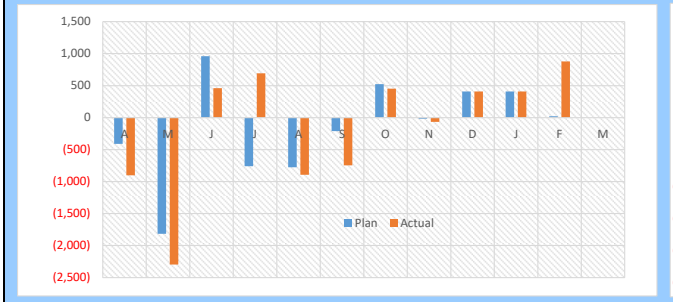
CHIEF FINANCE OFFICER

Appendix 1

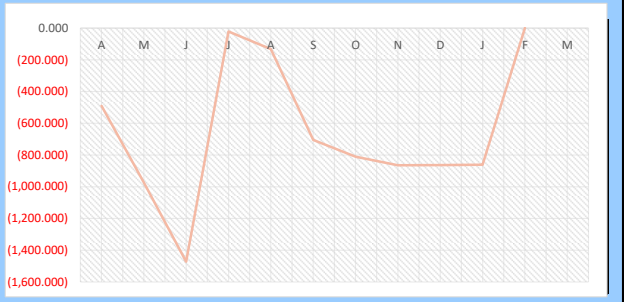
EXECUTIVE SUMMARY AT 31 JANUARY 2022

Financial Performance	Annual Plan	Current Month 10			Year to date		
		Budget £m	Actual £m	Variance £m	Plan	Actual	Fav/(Adv) Variance
Income	635.5	52.96	61.96	9.00	529.61	576.05	46.44
Expenditure	-626.0	-52.14	-59.69	-7.56	-523.70	-570.66	-46.96
Operating Surplus/(Deficit)	**9.54**	**0.82**	**2.27**	**1.45**	**5.90**	**5.39**	**-0.52**
Financing costs	-9.16	-0.78	-1.05	-0.27	-7.61	-7.46	0.15
Overall Surplus/(Deficit) for the period	**0.38**	**0.043**	**1.22**	**1.17**	**-1.70**	**-2.08**	**-0.37**
Adjustments to financial performance	-0.38	-0.02	-0.33	-0.31	-0.37	0.01	0.37
Adjusted financial performance Surplus/(Deficit)	**0.00**	**0.02**	**0.89**	**0.87**	**-2.07**	**-2.07**	**0.00**

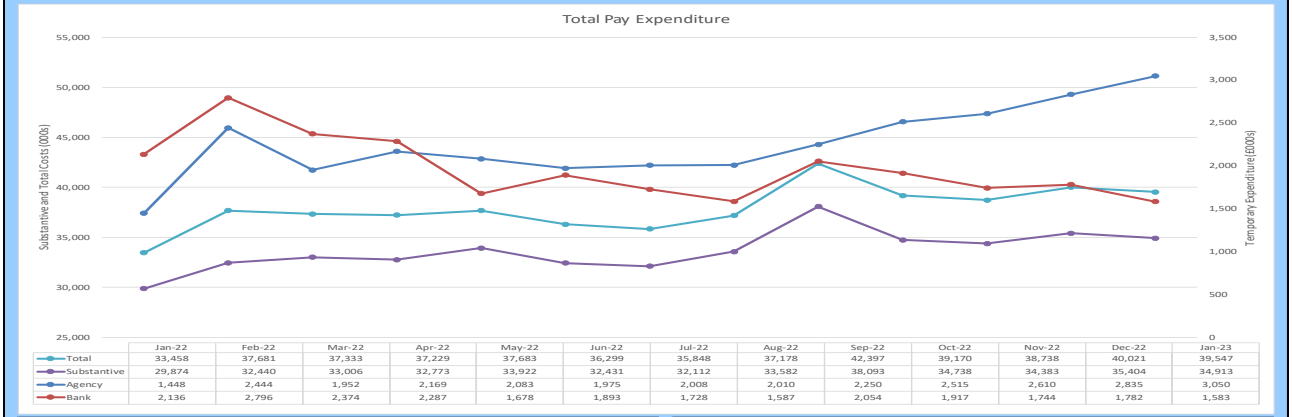
MONTHLY FINANCIAL PERFORMANCE



YEAR TO DATE VARIANCE FROM PLAN

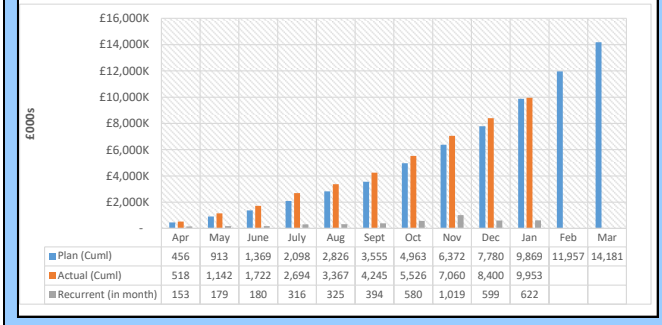


TOTAL PAY EXPENDITURE



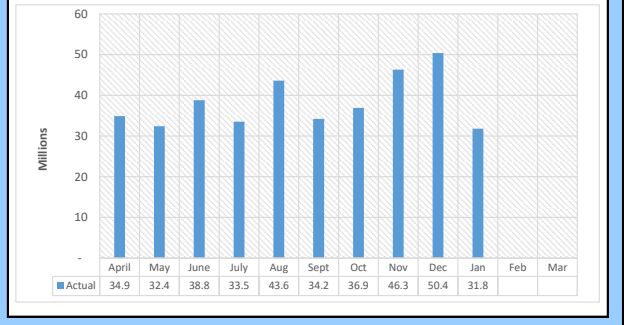
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Total	33,458	37,681	37,333	37,229	37,683	36,299	35,848	37,178	42,397	39,170	38,738	40,021	39,547
Substantive	29,874	32,440	33,006	32,773	33,922	32,431	32,112	33,582	38,093	34,738	34,383	35,404	34,913
Agency	1,448	2,444	1,952	2,169	2,083	1,975	2,008	2,010	2,250	2,515	2,610	2,835	3,050
Bank	2,136	2,796	2,374	2,287	1,678	1,893	1,728	1,587	2,054	1,917	1,744	1,782	1,583

CIP DELIVERY



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Plan (Cuml)	456	913	1,369	2,098	2,826	3,555	4,963	6,372	7,780	9,869	11,957	14,181
Actual (Cuml)	518	1,142	1,722	2,694	3,367	4,245	5,526	7,060	8,400	9,953		
Recurrent (in month)	153	179	180	316	325	394	580	1,019	599	622		

CASH BALANCE



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual	34.9	32.4	38.8	33.5	43.6	34.2	36.9	46.3	50.4	31.8		

COMMENTARY

- A revised financial plan was agreed at the Joint Board meeting on 20 June 2022. The revised plan now means that the system and each organisation will have a balanced position. Escalation pressures continue to have a significant impact on financial performance.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Capital Programme 2023/24
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	Ian Boswall, Director of Redevelopment Neil Murray, Strategic Accountant
PRESENTED BY:	David Shannon, Director of Strategy and Digital Development
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	The report sets out the Capital Plan for 2022/23 for approval.
Recommendation	To review and approve the joint capital programme for the 2023/24 financial year.

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

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

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

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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
Monthly Finance reports to Trust Board. Quarterly progress updates to Finance Committee and Financial Resilience and Commercial Committee

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

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

SOMERSET NHS FOUNDATION TRUST

CAPITAL PROGRAMME 2023/24

1. INTRODUCTION AND SUMMARY

1.1 This report sets out the capital programme for the 2023/24 financial year and identifies some of the risks to programme delivery.

2. 2023/24 CAPITAL PROGRAMME

2.1 A capital programme is attached at appendix A. The capital envelope for Somerset Integrated Care System is set by NHS England (NHSE) and currently stands at £29.726m. The Integrated Care System have been informed that they will be awarded a further £3.063m provided both Trusts and the ICB deliver a combined breakeven position for the 2022/23 financial year. It is fully expected that the breakeven position will be achieved therefore increasing the capital allocation to £32.789m

2.2 Following ICB discussions it is proposed that £0.3m is allocated from the system allocation for primary care property investment in addition to the £1.004m digital funding already allocated and ring-fenced as part of the Somerset capital envelope allocation. Consequently, the combined provider Trust capital envelope allocation is £31.485m.

2.3 At final submission in March, NHSE guidance allows for the capital plan to be 5% above the system capital operational envelope allocation after deductions for primary care. The proposed programme at £33.059m includes £1.574m over-commitment (5%). This over commitment will be managed during the year through the normal slippage of projects.

The table below identifies the key areas of investment.

Scheme	Value
Surgical Centre	£21.967m
Yeovil 5th Theatre and Modular Ward	£13.904m
Yeovil Breast Case Unit	£3.615m
Mental Health and Community Schemes	£1.942m
Digital and IT	£13.945m
Backlog and Equipment	£10.545m
Yeovil and Dorset Community Dental schemes	£3.771m
MPH Infrastructure Improvements	£2.320m
Balance of capital investment	£7.091m
Total	£79.100m

2.4 The plan has been developed following proposed requests and discussion with operational and clinical managers and takes into consideration the capital funding constraints faced by the system. Areas such as back log maintenance and medical and surgical equipment have been risk assessed to inform priority setting of programmes. The programme reflects the commitments carried forward from 2022/23 with a number of new developments which have been identified. Several schemes will require further approval of business cases to proceed but are included within the programme subject to approval.

2.5 Key matters to note in relation to the externally funded 2023/24 programme.

- There is an initial allocation of £1.060m for the New Hospital Programme. This will be subject to revision in year as the future of the Programme becomes clearer.

- There remains some risk around slippage against Elective Recovery schemes and the Surgical Centre as a result of construction challenges. Any slippage will need to be managed within the 2024/25 capital programme as there will be no opportunity to reprofile the drawdown of PDC.

- The Electronic Health Records costs are aligned with NHSE indicative funding and may vary following development of the Full Business Case.

2.6 Appendix A also details the impact of IFRS16 leases over the financial year. These amount to £3.631m and subject to final Treasury agreement of current NHSE guidance do not impact the Somerset system notified capital envelope.

2.7 Risks

- Delivery risk of the programme: there continues to be challenges in the UK construction market in respect to inflation and supply chain shortages. These may impact on the overall programme particularly in respect to larger investments.

- Clinical, regulatory and delivery risk associated with the physical estate, digital estate and associated equipment: The programme has been assessed based on current commitments and high-risk backlog and equipment replacement. There is however limited contingency and risk for any emergency items. Should a significant requirement arise in year this would require a reprioritisation or delay of existing schemes.

- Operational pressures: a number of programmes will require access to clinical areas to undertake essential maintenance and upgrades. Should the current high level of occupancy and clinical pressures continue this will impact on the ability to deliver the overall programme.

3. RECOMMENDATIONS

The Trust Board is asked to approve the capital programme for 2023/24.

Appendix A **Somerset ICS Capital Plan Summary**	**Plan 2023/24 £'000**
Allocated Somerset Capital Envelope Funding	**29,726**
Additional Expected Allocation	**3,063**
Less Ringfenced ICB Capital Allocation	**(1,004)**
Additional Envelope Transfer to ICB	**(300)**
Total Envelope Available to Trust	**31,485**
SCHEMES FUNDED FROM CAPITAL FUNDING ENVELOPE	
COMBINED BUDGETS	
Programme Management & Feasibility Work	400
HEAG (PEAG/ Environment)	100
Backlog Maintenance	6,335
Major Medical & Surgical Equipment	3,605
Information Technology	1,834
Infrastructure Upgrade & Carbon Neutral	750
DWH Redevelopment	250
Digital Programme	3,100
Electronic Prescribing - approved YDH - both Trusts combined replacing trakcare	365
Risk contingency	375
Total Combined Budgets	**17,114**
Acute - Site Risks / Plant & Equipment Replacement	
A4L	25
Fire Precautions / Security	250
Health & Safety incl IPCT	55
on- Site residences refurbishment	70
SSL	70
Ward Refurbishment/Environment upgrade	380
Total Site Risks / Plant & Equipment	**850**
Acute - Site and Service Development	
Minor Schemes	700
Departmental relocations (Includes Corporate Decant)	175
Split air con for drug storage	100
Ventilation Plant Upgrade - SSD	70
IMIP phase 2 onwards	236
Total Site and Service Development	**1,281**

Appendix A **Somerset ICS Capital Plan Summary**	**Plan 2023/24 £'000**
COMMUNITY/ MENTAL HEALTH	
Site Risks / Plant & Equipment Replacement	
Health and Safety Community	250
Patient Environment - PLACE	50
SHS	150
Sundry Equipment - MH & C	0
Total Site Risks / Plant & Equipment	**450**
Site and Service Development	
Sundry Equipment	150
Contingency	125
Total Site and Service Development	**275**
COMMITTED SCHEMES	
Dorset Dental	1,351
Mental Health Ward reconfiguration Rowan	650
Outpatient Unit Slippage	150
Breast Unit Provision	1,115
Pharmacy Robot	323
5th theatre slippage commitment	3,581
SCHEMES NOT YET COMMITTED	
Badger Car Park	200
Yeovil Dental Completion	2,420
B/f mental health new property refurbishment	500
Model Box Room	165
Wells Priory Health Park Pheonix & St Andrews	300
HV Works MPH completion	650
National Grid electrical to site	750
Orthopaedic Mako Robot	0
Macular Injections - Yeovil Town Centre	750
Stroke Services Reconfiguration Planning	60
Swingbridge House CYP	124
Total Commitments	**13,089**
TOTAL TRUST EXPENDITURE FROM CAPITAL ALLOCATION	**33,059**
Balance/(Shortfall) for Site Risks & Site Developments	**(1,574)**

Appendix A Somerset ICS Capital Plan Summary	Plan 2023/24 £'000
EXTERNALLY FUNDED SCHEMES	
STP 3 - Surgical Centre	21,967
NHP - MPH	1,060
Tif - Elective Recovery/Theatre expansion	10,323
Pathology Network	830
Diagnostic Network	898
Digital - EHR	6,668
Somerset CYP Crisis Accomodation safe spaces	368
PFI MES Funded IFRIC 12 - SFT	467
Donated Acute	3,350
Donated Community	110
TOTAL ADDITIONAL CAPITAL SCHEME EXPENDITURE	**46,041**
TOTAL PLANNED CAPITAL EXPENDITURE	**79,100**

Appendix A Somerset ICS Capital Plan Summary	Plan 2023/24 £'000
IFRS 16 Leases	
Burnham GP Practice	3,000
Dental Leased sterilising equipment replacement	220
Harrison House Electric Vehicles	50
Various Vehicle leases	61
Various equipment Leases	300
Total Risks - Not Yet Committed	**3,631**

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Amendments to Constitutional Documents
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	This paper outlines the proposed changes to the Yeovil District Hospital NHS Foundation Trust (YDH) constitutional documents in order to facilitate email voting and an amendment to the quoracy for the Council of Governors bearing in mind the reduced number of Governors following recent resignations or vacancies for the Trust's constituencies. The amendments to the voting process are in light of the upcoming vote on the proposed merger by acquisition between YDH and Somerset NHS Foundation Trust. Consideration has been given to the voting process and it is preferred that the vote is undertaken at the meeting, however a contingency plan will need to be put into place in case of the meeting not being quorate as a result of unforeseen circumstances.
Recommendation	The Board is asked to approve the amendments as set out in the attached report.

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

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

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

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
Discussion with Chairman, Director of Corporate Services and Lead Governor.

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

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

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

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

AMENDMENTS TO THE CONSTITUTIONAL DOCUMENTS

1. INTRODUCTION

1.1. Yeovil District Hospital NHS Foundation Trust (YDH) has two key constitutional documents:

1. Constitution – which sets out the provisions under which the organisation is established. It covers areas such as membership, constituencies, election rules and the composition of the Board and Council of Governors.

2. Standing Orders – which set out the practice and procedure of the Council of Governors and the Board.

1.2. YDH and Somerset NHS Foundation Trust (SFT) are planning on merging (the transaction itself will be a merger by acquisition with SFT acquiring YDH) on 1 April 2023. As part of this process, Governors are responsible for satisfying themselves that the Board of Directors has been thorough and comprehensive in reaching its proposal (that is, it has undertaken proper due diligence), and that it has appropriately obtained and considered the interests of members and the public as part of the decision-making process. Provided appropriate assurance is obtained, Governors should not unreasonably withhold their consent for a proposal to go ahead.

1.3. The Governors of both Trusts are therefore required to approve the application by the Trust which requires a formal vote. This vote is to take place on 20 March 2023.

1.4. Consideration has been given to the voting process and it is preferred that the vote is undertaken at the meeting, however a contingency plan will need to be put into place in case of the meeting not being quorate. Bearing in mind the reduced number of Governors on the YDH Council of Governors, due to several vacancies following the most recent elections and individuals standing down from their roles due to personal circumstances, there is a risk that the Council of Governors will not be quorate for the meeting.

1.5. It is therefore proposed to include a provision within the Standing Orders to allow for electronic voting by email. The provision was drafted by Bevan Brittan, the Trust's solicitors and aligns with provisions already incorporated into the SFT Standing Orders.

1.6. The proposed amendments do **not** change the requirement for more than half of the Council of Governors of each foundation trust to approve the application as set out in the transactions guidance. As per the guidance, there will remain a requirement for a majority of all Governors in post at the relevant time and not just a majority of those voting at the Governors' meeting.

1.7. Any amendment to the Standing Orders requires approval by the Council of Governors and the Board of Directors. Amendments made take effect as soon as more than half of the members of the Board of Directors and the Council of Governors respectively vote to approve the amendments.

2. PROPOSED AMENDMENTS

2.1. The proposed amendments to the Standing Orders are the addition of the following voting protocol (to be included from section 5.9.15 – 5.9.16):

Protocol for Voting by e-mail

5.9.15 The Returning Officer is to e-mail a notice of the e-mail vote stating:

a) The details of the issue(s) to be voted upon;

b) The date and time at which the e-mail votes are required to be sent out to the Governors and/or Directors;

c) The e-mail address for return of e-mail votes including the date and time by which they must be received by the Returning Officer ("Deadline Date"); and

d) The contact details of the Returning Officer.

5.9.16 As soon as is reasonably practicable on or after the e-mail of the notice of the e-mail vote, the Returning Officer is to e-mail to the valid e-mail address of every Governor and/or Director, the following information:

a) a ballot paper attachment in accessible electronic format with clear instructions as to how to cast their vote by e-mail;

b) a Declaration of Eligibility form (if required). This form may be combined with the ballot paper;

c) information about the issue(s) to be voted upon; and

d) a covering e-mail providing:

i. the e-mail address for return of the ballot paper;

ii. clear instructions instructing the voter as to how to return their e-mail vote to the Returning Officer by the Deadline Date ("email voting information").

2.2. The following clauses are also to be added as sections 5.12.5 – 5.12.8

5.3.5 At all times all questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined in the first instance by oral expression or by a show of hands, unless the Chairman used their discretion under SO 5.9.15 to hold an e-mail vote. At all times, no Governor or Director may vote by proxy.

5.3.6 Chairman's discretion to hold an e-mail vote may be exercised at any time, and for any reason in consultation with the Lead Governor.

5.3.7 If the Chairman exercises their discretion to hold an e-mail vote, then the Governors must vote by e-mail by sending their e-mail vote back to the Returning Officer by the Deadline Date (as prescribed under SO 5.9.15 and as agreed with the Lead Governor). For the

avoidance of doubt, if the Chairman exercises their discretion to hold an e-mail vote, this e-mail vote will form the method of voting.

5.3.8 Individual Governors may only cast one vote on the issue(s) to be voted on unless a second further vote is required owing to any previous vote not being passed in accordance with SO 5.9.2. Once an e-mail vote has been cast by a Governor in accordance with SO 5.9.15, the vote cannot be revoked or altered in any way.

Minor Amendments

2.3. Other minor amendments may be required within the Standing Orders and/or Constitution to reflect the above additions/changes in order that these provisions can be utilised.

Quorum

2.4. Bearing in mind the reduced number of Governors, there is a risk that future Council of Governors meetings will not be quorate. On this basis, it is proposed that the quorum for the Council is amended. At present, thirteen members of the Governors are required for a quoracy.

2.5. The requirement for the majority of those Governors to be members of the Public Constituency is to be retained. It is proposed that section 5.12.2 is amended to the following:

5.12.2 At a Council meeting, no business shall be transacted unless at least eleven members of the Governors are present and the majority of those Governors present are members of the Public Constituency of the Trust.

3. RECOMMENDATION

3.1. The Board of Directors is asked to **approve** the proposed changes to the YDH Standing Orders as outlined above in order that the Council of Governors can hold effective meetings and votes as required.

3.2. The proposed changes are to be presented to the Council of Governors on 10 March 2023.

Standing Orders for the Practice and Procedure of the Board of Directors and the Council of Governors

Version Number	~~3~~2.1	Version Date	~~May 2021~~February 2023
Owner	~~Company Secretary~~Director of Corporate Services		
Author	~~Company Secretary~~Deputy Director of Corporate Services		
Staff/Groups Consulted	Deputy Director of Corporate Services ~~Company~~ Trust Secretary Chief Finance Officer Chairman		
Approved by Board of Directors	~~5 May 2021~~TBC		
Next Review Due	~~May 2022~~n/a		

Yeovil District Hospital NHS Foundation Trust
Standing Orders for the Practice and Procedure of
the Board of Directors and
the Council of Governors

1 INTRODUCTION

1.1 Standing Orders provide a formal framework for the conduct of a Trust's business but it is not their function to define the corporate nature of the Trust Board directorship, which requires Directors to participate objectives and to have collective responsibility for its decisions and, since the Trust as an agent of the Secretary of State, to accept the constraints of national policies and priorities and to have concern for the common interests of the NHS.

1.2 Yeovil District Hospital NHS Foundation Trust (the "Trust") was established in accordance with the Health and Social Care (Community Health and Standards) Act 2003 (the "Act"). Authorisation commenced from 1 June 2006 and subject to provisions of Sections 25 and 26 of the Act, this Authorisation is of unlimited duration.

1.3 The Trust applies the principles of the NHS Foundation Trust Code of Governance, most recently revised in July 2014, which is based upon the principles of the UK Corporate Governance Code issues in 2012.

1.4 These Standing Orders together with the Standing Financial Instructions and the Scheme of Reservation and Delegation provide a framework for the administration of the Trust's affairs. All Directors and Officers should be aware of the existence of these documents and, where necessary, be familiar with the detail provisions contained within them.

1.5 The Trust has a number of wholly and partially owned corporate entities. These corporate entities are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As separate, independent corporate entities, they are subject to their own governance arrangements, which are the responsibility of the relevant entity's management structure, and therefore these Standing Orders are not applicable. For avoidance of doubt, any matter reserved to the Trust in relation to such corporate entitles will be treated as an item of the Trust and will be considered in accordance with these Standing Orders.

2 INTERPRETATION

2.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SOs shall bear the same meaning as in the Constitution.

2.2 For the purposes of these SOs, the "Board" means the Board of Directors and the "Council" means the Council of Governors.

3 THE BOARD

3.1 All business shall be conducted in the name of the Trust.

3.2 All funds received in trust shall be in the name of the Trust as corporate trustee. Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees.

3.3 In relation to Funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as the Foundation Trust. Accountability for charitable Funds held on Trust is to the Charity Commission. Accountability for non-charitable Funds held on Trust is only to NHS Improvement (NHSI).

3.4 The Trust has the functions conferred on it by the Regulatory Framework.

3.5 All powers of the Trust shall be exercised by the Board meeting either in public session except as otherwise provided for in SO 5 below.

3.6 The Board has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Scheme of Reservation and Delegation.

3.7 The Board and each Director individually shall at all times seek to comply with the Trust's Code of Governance and the Code of Conduct for the Board.

3.8 The Board shall appoint one of the Non-Executive Directors to be the Senior Independent Director, in consultation with the Council. The Senior Independent Director may also be the Non-Executive Director appointed as Vice-Chairman of the Board. The Senior Independent Director shall be available to Members and Governors if they have concerns which contact through the normal channels of Chairman, Chief Executive or Chief Finance Officer has failed to resolve or for which such contact is inappropriate. The Senior Independent Director shall hold a meeting at least annually with the other Non-Executive Directors in the absence of the Chairman.

4 THE COUNCIL

4.1 The roles and responsibilities of the Council are to be carried out in accordance with the Regulatory Framework include the following:

4.1.1 to hold the Board to account for the performance of the Trust;

4.1.2 to respond as appropriate when consulted by the Board in accordance with the Constitution; and

4.1.3 to prepare and from time to time review the Trust's membership strategy.

4.2 Certain powers and decisions may only be exercised by the Council in formal session.

4.3 The Council and each Governor individually shall at all times seek to comply with the Trust's Code of Governance and the Code of Conduct for the Council.

4.4 The Council is required to nominate one of the members of the Council as the Lead Governor. The Lead Governor shall provide a single point of contact on all Governors' issues and be the primary contact for NHSI when communicating directly to the Governors.

5 MEETINGS OF THE BOARD AND THE COUNCIL

5.1 Admission of the public

5.1.1 Meetings of the Council and the Board are to be open to members of the public, but the members of the public may be excluded from all or any part of the meeting of the Council or the Board on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution of the Council or the Board (as relevant), and arising from the nature of the business or of the proceedings.

5.1.2 The Chairman shall give such directions as he thinks fit (including a decision to expel or exclude any member of the public and/or press if the individual in question is interfering with or preventing the proper conduct of the meeting).

5.1.3 Nothing in these SOs shall require the Board or the Council (as relevant) to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the person chairing the meeting.

5.1.4 Matters to be dealt with by the Board or the Council following the exclusion of the public and representatives of the press under SO 5.1.2 above shall be confidential to the Directors or the Governors (as relevant). Members of the Board or the Council (as relevant) and others in attendance at the request of the person chairing the meeting shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chairman.

5.1.5 The Chairman (or Vice Chairman) will decide what arrangements and terms and conditions he feels are appropriate to offer in extending an invitation to observers, advisors and others to attend and address any meeting of the Board or the Council (as relevant), and may change, alter or vary these terms and conditions as it deems fit.

5.1.6 The Council may invite the Chief Executive or any other member(s) of the Board, or a representative of the Auditor or other advisors of the Trust to attend a meeting of the Council.

5.1.7 The Board may invite Officers of the Trust to attend meetings of the Board either generally or for specific items to be discussed at the meeting of the Board. For the avoidance of doubt, such Officers of the Trust shall not have voting rights and will be recorded as being 'in attendance' for the purposes of the minutes of the meeting of the Board.

5.2 **Calling meetings**

5.2.1 Meetings of the Board and the Council shall be held at such times and places as the Board or the Council (as relevant) may determine.

5.2.2 The Chairman may call a meeting of the Board or the Council at any time.

5.2.3 Members of the Council may, in writing signed by at least eight members of the Council, request a meeting of the Council, and the members of the Board may, in writing signed by at least one-third of the members of the Board may request a meeting of the Board. If the Chairman refuses to call a meeting after a requisition for that purpose signed by at least eight members of the Council, or at least one-third of the members of the Board (as relevant), has been presented to him specifying the business to be carried out, the Secretary shall call a meeting on at least fourteen (14) days but not more than twenty-eight (28) days' written notice to discuss the specified business.

5.2.4 If the Secretary fails to call a meeting as set out in SO 5.2.3 above, the eight members of the Council or the one-third members of the Board (as relevant) shall call such a meeting for the purpose for the purpose of conducting that business. No business shall be conducted at such a meeting other than that specified in the notice of the meeting.

5.3 **Notice of meetings**

5.3.1 Save in an emergency or the need to conduct urgent business, the Secretary shall give at least four (4) days written notice of the date and place of each meeting of the Board or the Council (as relevant). The notice shall specify the business proposed to be transacted at the meeting of the Board or the Council.

5.3.2 The notice shall be emailed to every Director or Governor (as relevant) to the email address provided by each Director or Governor (as relevant) so as to be available to him at least four (4) days before the meeting. A notice shall be presumed to have been served at the time at the same time the email has been delivered unless an error or an undelivered receipt is received.

5.3.3 A public notice of the time and place of the meeting of the Board or the Council, and the agenda, shall be published on the Trust's website.

5.3.4 Lack of service of the notice on any member of the Board or the Council (as relevant) shall not affect the validity of a meeting, but failure to serve such a notice on more than three Directors (at least one executive director and one non-executive director) or Governors (as relevant) will invalidate the meeting of the Board or the Council (as relevant).

5.3.5 In the case of a meeting called in default of the Chairman, in accordance with SO 5.2.3 above, the notice shall be signed by those Directors or Governors (as relevant) who called the meeting and no business shall be transacted at the meeting other than that specified in the notice.

5.3.6 In the event of an emergency giving rise to the need for an immediate meeting, failure to comply with the notice periods referred to in SOs 5.3.1 and 5.3.3 above shall not prevent the calling of or invalidate such meeting provided that every effort is made to make personal contact with every Director or Governor (as relevant) and the agenda for the meeting is restricted to matters arising in that emergency.

5.4 **Agendas and supporting papers**

5.4.1 The Board and the Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted ("Standing Items").

5.4.2 Agendas will be sent to members of the Board or the Council (as relevant) four (4) days before the meeting and supporting papers, shall accompany the agenda, save in an emergency giving rise to the need for an immediate meeting as set out in SO 5.3.6 above, or as otherwise agreed with the Chairman. Failure to serve the agenda and (where relevant) supporting papers on more than three members of the Board or the Council (as relevant) will invalidate the meeting. The agenda and supporting papers shall be presumed to have been served one day after posting, or in the case of a notice being sent electronically, on the date of transmission.

5.4.3 Subject to SO 5.2.3, a Director or a Governor desiring a matter to be included on an agenda other than a Standing Item or a motion under SO 5.5 below, shall make his request in writing to the Chairman at least ten (10) days before the meeting is notified to the Governors or Directors (as relevant). The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten (10) days before a meeting may be included on the agenda at the discretion of the Chairman.

5.4.4 No business may be transacted at any meeting of the Board or the Council which is not specified in the notice of that meeting unless the Chairman, in his absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by the Board or the Council (as relevant) as a matter of urgency. A decision by the Chairman to permit consideration of the item in question and (where relevant) the supporting papers shall be recorded in the minutes of that meeting.

5.5 **Notices of motions**

5.5.1 A Governor or Director desiring to move or amend a motion shall send a written notice, to the Chairman, thereof at least ten (10) days before the meeting of the Council or the Board (as relevant) is notified to Governors or the Directors, who shall insert in the agenda for the meeting of the Council or the Board (as relevant) all notices so received subject to the notice being permissible under the appropriate regulations. This SO shall not prevent any motion being moved during the meeting of the Council or the Director, without notice on any business mentioned on the agenda.

5.5.2 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

5.5.3 Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months shall bear the signature of the Governor or Director who gives it and also the signature of four (4) other Governors or Directors . When any such motion has been disposed of by the Council or the Board, it shall not be competent for any Governor or Director other than the Chairman to propose a motion to the same effect within six (6) months, however the Chairman may do so if he considers it appropriate.

5.5.4 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

5.5.5 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor or Director (as relevant) to move:

(a) an amendment to the motion.

(b) the adjournment of the discussion or the meeting.

(c) that the meeting proceed to the next business (*)

(d) the appointment of an ad hoc committee to deal with a specific item of business.

(e) that the motion be now put to a vote (*)

(f) In the case of SOs denoted by (*) above, to ensure objectivity motions may only be put by a Governor or a Director who has not previously taken part in the debate.

5.5.6 No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

5.6 **Chairman of meetings**

5.6.1 Details in respect of the chair of the meeting of the Board and the Council are set out in the Constitution.

5.6.2 If the Chairman and the Deputy Chairman are absent from a meeting of the Board, or are absent temporarily on the grounds of a declared conflict of interest, such Non-Executive Director as the members of the Board present and voting at the meeting choose shall preside during that period.

5.6.3 If the Chairman and the Deputy Chairman are absent from a meeting of the Council, or are absent temporarily on the grounds of a declared conflict of interest, one of the Non-Executive Directors is to preside at the meeting of the Council. If the person at any such meeting has a conflict of interest in relation to the business being discussed, a Governor appointed by the Council will chair that part of the meeting.

5.6.4 All meetings shall be controlled by the person chairing the meeting and any ruling of the person chairing the meeting in relation to the conduct of the meeting shall be final.

5.7 **Chairman's ruling**

5.7.1 All meetings shall be controlled by the person chairing the meeting and any ruling of the person chairing the meeting in relation to the conduct of the meeting shall be final.

5.7.2 The decision of the person chairing the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and the individual's interpretation of the SOs, at the meeting, shall be final.

5.7.3 In respect of meetings of the Board, statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting of the Board.

5.8 **Conduct at meetings**

5.8.1 The decision of the person chairing the meeting on questions of order, relevance, regularity, appropriateness and any other matters shall be observed at the meeting.

5.8.2 Approval to speak will be given by the person chairing the meeting.

5.8.3 The Council or the Board may agree that its members can participate in the meetings of the Council or the Board (as relevant) by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at a meeting of the Council or the Board.

5.9 **Voting**

5.9.1 When an issue or question at a Board meeting requires a vote, each Director shall have one vote. When an issue or question at a Council meeting requires a vote, each Governor shall have one vote.

5.9.2 Subject to SO 5.9.3 below, every question at a meeting of the Board or the Council shall be determined by a majority of the votes of the Chairman and the Directors or Governors (as relevant) present and voting on the question.

5.9.3 Unless otherwise specified in the Constitution, the person chairing the meeting of the Board or the Council (as relevant) shall not have a vote except in the case of an equality of votes of any question of proposition, when the person chairing the meeting of the Board or the Council shall have a casting vote.

5.9.4 All questions put to the vote shall, at the discretion of the person chairing the meeting, be determined by oral expression or by a show of hands (if all Directors or Governors (as relevant) are present in person). A paper ballot may also be used if a majority of the Directors or Governors (as relevant) present so request.

5.9.5 If at least one-third of the Directors or Governors (as relevant) present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director or Governor (as relevant) present voted or abstained.

5.9.6 If a Director or Governor (as relevant) so requests, the individual's vote shall be recorded by name upon any vote (other than by paper ballot).

5.9.7 A Director or Governor (as relevant) may only vote if present at the time of the vote on which the question is to be decided. In no circumstances may an absent Governor or Director (as relevant) vote by proxy. Absence is defined as being absent at the time of the vote. In respect of Directors or Governors (as relevant) participating in the meeting of the Board or the Council (as relevant) by telephone, video or computer link, those Directors or Governors (as relevant) shall have a vote by oral expression or email confirmation.

5.9.8 In respect of meetings of the Board, no resolution of the Board shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present at a meeting of the Board.

5.9.9 Every Governor must make an annual declaration that he is qualified to vote at meetings of the Council. Such declaration shall be in the form specified at SO 8.8.2 below that they are a member of the constituency which elected them and are not prevented from being a member of the Council by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution.

5.9.10 A Governor may not vote at a meeting of the Council unless, prior to the meeting, he has made the declaration referred to in SO 5.9.9 above.

5.9.11 Each Governor must also notify the Secretary as soon as possible and provide a further declaration at any subsequent meeting if his circumstances have changed.

5.9.12 All Governors shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council, and every agenda for meetings of the Council will draw this to the attention of Governors.

5.9.13 If any matter for consideration at a meeting of the Board relates to the interests of the Chairman or the Non-Executive Directors as a class, neither the Chairman nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. The Directors (excluding the Chairman and the Non-Executive Directors) shall elect one of the number to preside during that period and that person shall exercise all the rights and obligations of the Chairman, including (for the avoidance of doubt) the right to exercise a casting vote where the numbers of votes for and against a motion is equal.

5.9.14 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

Protocol for Voting by e-mail

5.9.15 The Returning Officer is to e-mail a notice of the e-mail vote stating:

a) The details of the issue(s) to be voted upon;

b) The date and time at which the e-mail votes are required to be sent out to the Governors and/or Directors;

c) The e-mail address for return of e-mail votes including the date and time by which they must be received by the Returning Officer ("Deadline Date"); and

d) The contact details of the Returning Officer.

5.9.16 As soon as is reasonably practicable on or after the e-mail of the notice of the e-mail vote, the Returning Officer is to e-mail to the valid e-mail address of every Governor and/or Director, the following information:

a) a ballot paper attachment in accessible electronic format with clear instructions as to how to cast their vote by e-mail;

b) a Declaration of Eligibility form (if required). This form may be combined with the ballot paper;

c) information about the issue(s) to be voted upon; and

d) a covering e-mail providing:

i. the e-mail address for return of the ballot paper;

ii. clear instructions instructing the voter as to how to return their e-mail vote to the Returning Officer by the Deadline Date ("email voting information").

5.10 **Minutes**

5.10.1 The minutes of the proceedings of a meeting of the Board or the Council (as relevant) shall be drawn up and submitted for agreement at the next ensuing meeting of the Board or the Council (as relevant).

5.10.2 No discussion shall take place upon the minutes except upon their accuracy or where the person chairing the meeting considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting of the Board or the Council (as relevant).

5.10.3 Subject to SO 5.10.4, minutes of the proceedings of a meeting of the Council or the Board shall be circulated in accordance with the Governor's or Director's wishes (as relevant).

5.10.4 Minutes of meetings shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of SO 5.1.1 above.

5.11 **Record of attendance**

5.11.1 The names of the Chairman and Directors or Governors (as relevant) present at the meeting shall be recorded in the minutes.

5.12 **Quorum**

5.12.1 At a Board meeting, no business shall be transacted unless at least one third of the total number of Directors, including at least one Executive Director and one Non-Executive Director are present. For the avoidance of doubt, an officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

5.12.2 At a Council meeting, no business shall be transacted unless at least ~~thirteen~~ eleven members of the Governors ~~is~~ are present and the majority of those Governors present are members of the Public Constituency of the Trust.

5.12.3 If at any Board or Council meeting (as relevant) there is no quorum present within thirty minutes of the time fixed for the start of the meeting, the Board or Council meeting (as relevant) shall stand adjourned for a number of days to be fixed by the Chairman and in any event not exceeding thirty days and upon reconvening, those present shall constitute a quorum.

5.12.4 If a Director or Governor (as relevant) has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest the individual shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that Board or Council meeting (as relevant). Such a position shall be recorded in the minutes of the Board or Council meeting (as relevant). The Board or Council meeting (as relevant) must then proceed to the next business.

5.12.5 At all times all questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined in the first instance by oral expression or by a show of hands, unless the Chairman used their discretion under SO 5.9.15 to hold an e-mail vote. At all times, no Governor or Director may vote by proxy.

5.12.6 Chairman's discretion to hold an e-mail vote may be exercised at any time, and for any reason in consultation with the Lead Governor.

5.12.7 If the Chairman exercises their discretion to hold an e-mail vote, then the Governors must vote by e-mail by sending their e-mail vote back to the Returning Officer by the Deadline Date (as prescribed under SO 5.9.15 and as agreed with the Lead Governor). For the

avoidance of doubt, if the Chairman exercises their discretion to hold an e-mail vote, this e-mail vote will form the method of voting.

~~5.12.7~~5.12.8 Individual Governors may only cast one vote on the issue(s) to be voted on unless a second further vote is required owing to any previous vote not being passed in accordance with SO 5.9.2. Once an e-mail vote has been cast by a Governor in accordance with SO 5.9.15, the vote cannot be revoked or altered in any way.

5.13 **Decisions without meetings (Board only)**

5.13.1 The Board may make decisions without meetings of the Board.

5.13.2 The Board may hold meetings by telephone or electronic means. Such meetings shall be conducted under the relevant provisions of the SOs as though an ordinary meeting of the Board was being held.

5.13.3 Authority to employ the provisions of SOs 5.13.1 and 5.13.2 shall be consistent with SO 5.2 and SO 5.4.

5.13.4 Business conducted under the provisions of SOs 5.13.1 and 5.13.2 shall have the same effect and authority as business conducted at an ordinary meeting of the Board.

5.14 **Meetings: electronic communication**

5.14.1 In this SO "communication" and "electronic communication" shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

5.14.2 A Director or Governor (as relevant) in electronic communication with the Chairman and all other parties to a meeting of the Board or the Council (as relevant) or a committee or subcommittee of the Directors or the Governors (as relevant) shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

5.14.3 A meeting at which one or more of the Directors or the Governors (as relevant) attends by way of electronic communication is deemed to be held at such a place as the Directors or the Governors (as relevant) shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors or the Governors (as relevant) attending the meeting are physically present, or in default of such a majority, the place at which the Chairman of the meeting is physically present.

5.14.4 Meetings of the Board or the Council (as relevant) held in accordance with this SO are subject to SO 5.12 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

5.14.5 The minutes of a meeting of the Board or the Council (as relevant) held in this way must state that it was held by electronic communication and that the Directors or the Governors (as relevant) were all able to hear each other and were present throughout the meeting.

5.15 **Repeat Considerations**

5.15.1 When any issue has been dealt with by the Board or the Council (as relevant), it shall not be competent for any member of the Board or the Council (as relevant) other than the Chairman to propose a motion to the same effect within six months. This SO shall not apply

to motions moved in pursuance of a report or recommendations of a committee of the Board or the Council (as relevant) or the Chief Executive.

5.16 **Reports from the Executive Directors (Board only)**

5.16.1 At any meeting of the Board, a Director may ask any question through the Chairman without notice on any report by an Executive Director, or other Officer of the Trust, after that report has been received by or while such report is under consideration by the Board at the meeting. The Chairman may, in his absolute discretion, reject any question which is substantially the same and related to the same subject matter as a question which has already been put to that meeting or a previous meeting.

5.17 **Joint Directors**

5.17.1 Where a post of Executive Director is shared by more than one person:

(a) both persons shall be entitled to attend meetings of the Board;

(b) either of those persons shall be eligible to vote in the case of an agreement between them;

(c) in the case of disagreements between them no vote shall be cast; and

(d) the presence of either or both of those person shall count as one person for the purposes of SO 5.12.

6 ARRANGEMENT FOR THE EXERCISE OF FUNCTIONS BY DELEGATION (BOARD ONLY)

6.1 **Delegation of functions**

6.1.1 Subject to the Regulatory Framework and such guidance, if any, as may be given by NHSI, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee of Directors or sub-committee appointed by virtue of SO 7 below or by a Director or an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit.

6.2 **Emergency powers**

6.2.1 The powers which the Board has reserved to itself within these SOs and the Scheme of Reservation and Delegation may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board for ratification.

6.3 **Delegation to committees**

6.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees or joint-committees, which it has formally constituted and which are made up of Directors. The Constitution and terms of reference of these committees and their specific powers shall be approved by the Board.

6.3.2 When the Board are not meeting as the Board, they shall operate as a committee and may only exercise such powers as have been delegated to them by the Board in public session.

6.4 **Delegation to an Executive Director**

6.4.1 Those functions of the Trust which have not been retained as reserved by the Board, or delegated to a committee or sub-committee, shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions he will perform

personally and shall nominate officers to undertake the remaining functions for which they will retain accountability to the Board.

6.4.2 The Chief Executive shall prepare a Scheme of Reservation and Delegation identifying the individual proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may from time to time propose amendments to the Scheme of Reservation and Delegation which shall be considered and approved by the Board.

6.4.3 Nothing in these SOs or the Scheme of Reservation and Delegation shall impair the discharge of the direct accountability to the Board or the Chief Finance Officer or other Executive Director to provide information and advise the Board in accordance with statutory requirements or any requirements of NHSI. For all other functions which do not form part of these requirements, the Chief Finance Officer shall be accountable to the Chief Executive.

6.5 Schedule of matters reserved to the Board and Scheme of Reservation and Delegation

6.5.1 The arrangements made by the Board as set out in the Scheme of Reservation and Delegation shall have effect as if incorporated in these SOs.

7 COMMITTEES

7.1 Committees of the Council

7.1.1 The Council may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Council in carrying out its functions. The Council may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties. All decisions taken in good faith at a meeting of the Council or of any committee of the Council shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

7.1.2 In making any recommendations, a committee of the Council must have due regard to the established policies of the Council and shall not depart from them without due reason and consideration. Any such departure and the reason for it shall be drawn to the attention of the Council at the earliest opportunity. The Council requires its committee to refer back to them for a decision.

7.1.3 In consideration of any recommendation a committee of the Council must comply with:

(a) the Trust's Standing Financial Instructions, SOs and written procedures and specific reference to the relevant sections of these documents, should be made, and

(b) any statutory provisions or requirements.

7.2 Committees of the Board

7.2.1 Subject to directions as may be given by NHSI, the Board may appoint committees of the Board, consisting wholly or partly of Directors, or wholly or partly of persons who are not Directors.

7.2.2 The committees established by the Board shall include:

(a) Audit Committee;

(b) Governance and Quality Assurance Committee;

(c) Financial Resilience and Commercial Committee;

(d) Board of Trustees of the Yeovil District Hospital Charitable Fund;

(e) Remuneration Committee; and

(f) any other successor committees to those listed above or any other committees as the Board deem it necessary or appropriate to establish from time to time.

7.2.3 The Board may also establish and dissolve such other committees as required to discharge the responsibilities of the Board.

7.2.4 The Board may appoint committees of the Board consisting wholly or partly of Directors.

7.3 Appointment of Committees

7.3.1 A committee appointed under this SO may, subject to such directions and guidance as may be given by NHSI or the Board or the Council (as relevant), appoint sub-committees consisting wholly or partly of members of the committee, or wholly of persons who are not members of the committee .

7.3.2 Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Board or the Council (as relevant).

7.3.3 Where the Council determines that persons, who are neither Governors nor members of the Board nor Officers of the Trust shall be appointed to a committee of the Council, the terms of such appointment shall be determined by the Council subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board.

7.3.4 Where the Board determines, and legislation, regulations and directions or guidance issued by NHSI permit that persons who are not Directors of the Trust shall be appointed to a committee of the Board, the terms of such appointment shall be determined by the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses.

7.3.5 Where the Board is required to appoint a person to a committee and/or to undertake functions as required by NHSI, and where such appointments are to operate independently of the Board of Directors, such appointment shall be made in accordance with regulations laid down by NHSI.

7.3.6 Committees will normally only make recommendations and provide advice to the Board or the Council unless the Board or the Council (as relevant) has specifically delegated powers to the committee.

7.4 Terms of Reference of Committees

7.4.1 Each such committee shall have such terms of reference and powers and be subject to such conditions the Board or the Council (as relevant) shall decide. Such terms of reference shall be in accordance with the Regulatory Framework and any directions and guidance issued by NHSI, but the Council shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council at a general meeting. The terms of reference shall have effect as if incorporated into these SOs.

7.5 Approval of appointments to Committees

7.5.1 The Board or the Council (as relevant) shall approve the appointments of each of the committees which it has formally constituted.

7.5.2 Except in relation to the Appointment Committee each committee of the Council shall elect its own chairman.

7.5.3 The Board of Directors shall appoint one of the Directors to chair each of its committees.

7.6 Appointments for statutory functions

7.6.1 Where the Board or the Council (as relevant) is required by the Constitution, by any applicable statute or regulations or by any directions or guidance issued by NHSI to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Board or the Council (as relevant), such appointments shall be made in accordance with the Constitution or such applicable statute or regulations or such directions or guidance issued by NHSI.

7.7 Applicability of SOs and Standing Financial Instructions to committees and sub-committees

7.7.1 The SOs and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees and sub-committees established by the Board or the Council. In which case the term “Chairman” is to be read as a reference to the chairman of the committee or sub-committee as the context permits, and the term “member of the Board” or "member of the Council" (as relevant) is to be read as a reference to a member of the committee or sub-committee also as the context permits.

7.8 Confidentiality

7.8.1 A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or the Council (as relevant) or shall otherwise have concluded on that matter.

7.8.2 A Director or Governor member of a committee shall not disclose any matter reported to the Board or the Council (as relevant) or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or the Council (as relevant) or committee shall resolve that it is confidential.

8 DECLARATION OF INTEREST

8.1 Interests

8.1.1 Interests which should be regarded as relevant and material for the purposes of this SO are:

(a) Directorships, including non-executive directorships held in private companies or listed companies (with the exception of those of dormant companies).

8.1.2

(a) Ownership or part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

(b) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

(c) A position of authority in a charity or voluntary organisation in the field of health and social care.

(d) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.

(e) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks.

(f) Any pecuniary interest, direct or indirect in a contract which the Trust has entered into or proposed to enter into.

(g) Any direct or indirect interest in a proposed transaction or arrangement with the Trust.

(h) Any relationship, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

8.1.3 For the avoidance of doubt, the following shall not be considered relevant and material for the purposes of these SOs:

(a) Shares not exceeding 2% of the total share in issue held in any company whose shares are listed on any public exchange;

(b) An employment contract held by Staff Governors;

(c) An employment contract with the relevant local authority held by a Local Authority Governor;

(d) An employment contract with a Partnership Organisation held by a Partnership Governor.

8.2 A Director or a Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

8.2.1 of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body; or

8.2.2 of an interest in any company, body or person with which he is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director or a Governor (as relevant) in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.3 Where a Director or a Governor:

8.3.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

8.3.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company of body, whichever it the less, and

8.3.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that clause,

8.4 This SO 8 shall not prohibit him from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his duty to disclose his interest.

8.5 All individuals in their capacity as a Governor or a Director of the Trust shall be required to report to the Secretary all gifts, hospitality and conflicts of interest in line with the Trust's relevant policy.

8.6 Directorship by a Director or Governor of companies likely to or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. This information should be kept up to date for inclusion in succeeding Annual Reports.

8.7 This SO 8 applies to a committee or sub-committee of the Board or the Council as it applies to the Board and the Council and applies to any member of such committees or sub-committees (whether or not he is also a Director or Governor) as it applies to a Director or a Governor.

8.8 **Declarations by Governors**

8.8.1 All Governors must declare any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust, or proposed transaction involving the Trust (before the Trust enters into the transaction or arrangement).

8.8.2 Any relevant and material interests shall be declared either at the time of the Governor's election or appointment or as soon as thereafter as the interest arises, but within five (5) days of the Governor becoming aware of the existence of that interest. The declaration upon appointment or election shall be in the following form:

To the Secretary of Yeovil District Hospitals NHS Foundation Trust:

I hereby declare that I am at the date of this declaration a member of the [Public/Staff Constituency], and I am not prevented from being a member of the Council of Governors by reason of any provision in the Constitution.

8.8.3 In addition, if a Governor is present at a meeting of the Council and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement, disclose the fact and shall:

(a) withdraw from the meeting and play no part in the relevant discussion or decision; and

(b) shall not vote on the issues (and if by advertence they do remain and vote, their vote shall not be counted).

8.8.4 At the time the interest is declared, it should be recorded in the minutes of the Council meeting. Any changes in interests should be officially declared at the next relevant meeting of the Council following the change occurring.

8.8.5 The Secretary shall be responsible for compiling and maintaining the register of interests of Governors in accordance with the Constitution. In establishing, maintaining, updating and publicising the register of interest, the Trust shall comply with all guidance issued from time to time by NHSI. The details of the Governors' interests recorded in the register of interests of Governors will be kept up to date by means of a regular review as necessary.

8.8.6 The above list of potential interests applies to the Governors, their partner, and to their immediate family (parent, spouse, child or sibling).

8.8.7 If a Governor fails to declare an interest required to be disclosed in accordance with the Constitution and the provisions of this SO 8.8, the Governor shall permanently vacate their office if required to do so by 75% of the remaining Governors present and voting at a meeting of the Council.

8.8.8 If a Governor has any doubt about the relevant of an interest then they should discuss it with the Secretary.

8.9 **Declaration by Directors**

8.9.1 All Directors of the Trust are under the following duties:

(a) A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

(b) A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

8.9.2 At the time Directors' interests are declared, they should be recorded in the minutes of the Board meeting. Any changes in interests should be officially declared at the next Board meeting following the change occurring. It is the obligation of the Director to inform the Secretary in writing within seven (7) days of becoming aware of the existence of a relevant or material interest.

8.9.3 Directors' directorships of companies in SO 8.1.1 above likely or possibly seeking to do business with the NHS (SO 7.1.2 above) should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

8.9.4 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chairman having the casting vote.

8.9.5 The Secretary shall be responsible for compiling and maintaining the register of interests of Directors. In establishing, maintaining, updating and publicising the register of interest, the Trust shall comply with all guidance issued from time to time by NHSI. The details of the Directors' interests recorded in the register of interests of Directors will be kept up to date by means of a regular review as necessary.

8.9.6 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chairman.

8.10 **Canvassing of, and recommendations by, Directors or Governors in relation to appointments**

8.10.1 Canvassing of Directors, Governors or members of any committee, sub-committee or joint committee of the Board or the Council directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this SO 8.10.1 shall be included in application forms or otherwise brought to the attention of candidates.

8.10.2 A Director or a Governor (as appropriate) shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this SO 8.10.2 shall not preclude a Director or a Governor (as appropriate) from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.10.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

8.11 **Registers of Interests**

8.11.1 Registers of Interests shall be maintained in accordance with paragraph 20 of Schedule 7 of the 2006 Act to first record formally declarations of interests of Directors and secondly to record formally the interests of Governors. The Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors and by all Governors.

8.11.2 The details set at SO 8.11.1 will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve (12) months will be incorporated.

8.11.3 The Register of Interests will be available for public inspection in accordance with the Constitution.

9 SUSPENSION OF SOs

Suspending SOs for practice and procedure of the Board

9.1 Except where this would contravene any statutory provision or guidance issued by NHSI or the rules relating to the quorum, any one or more of the SOs may be suspended at any meeting of the Board, provided that at least two-thirds of the whole number of the members of the Board are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension. The decision and reason to suspend the SOs shall be recorded in the minutes of the Board meeting.

Suspending SOs for practice and procedure of the Council

9.2 Except where this would contravene any statutory provision or guidance issued by NHSI or the rules relating to the quorum, any one or more of the SOs may be suspended at any meeting of the Council, provided that at least two-thirds of the whole number of the members of the Council are present, including one Public Governor and one Staff Governor, and that a majority of those present vote in favour of suspension. The decision and reason for the suspension shall be recorded in the minutes of the Council meeting.

SOs applicable to both the Board and the Council

9.3 A separate record of matters discussed by the Board or the Council (as relevant) during the suspension of SOs shall be made and shall be available to the Chairman and members of the Board or Governors (as relevant).

9.4 No formal business may be transacted while the SOs are suspended.

9.5 The Audit Committee shall review every decision to suspend SOs.

10 CUSTODY OF SEAL AND SEALING OF DOCUMENTS (BOARD ONLY)

10.1 Custody of seal

10.1.1 The common seal of the Trust shall be kept by the Secretary in a secure place.

10.2 Sealing of Documents

10.2.1 The common seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board, or of a committee thereof or where the Board has delegated its powers.

10.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer (or an Officer nominated by them) and authorised and countersigned by the Chief Executive (or an Officer nominated by them) provided that any Officer nominated is not from the same directorate as the person nominating them.

10.3 Register of sealing

10.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose. A report of all sealings shall be made to the Board at least once a year.

The report shall contain details of the seal number, the description of the document and date of sealing.

10.4 **Signature of documents**

10.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

10.4.2 The Chief Executive or nominated Officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee or sub-committee to which the Board has delegated appropriate authority.

11 TRUST SECRETARY

11.1 The Trust shall have a Secretary who may be an employee, but may not be a Governor, or the Chief Executive or the Chief Finance Officer. The Secretary shall be appointed and removed by the Board.

11.2 The Secretary's functions shall include:

11.2.1 acting as Secretary to the Council and the Board, and any committees of the Council or the Board;

11.2.2 summoning and attending all meetings of the Council and the Board, and keeping the minutes of those meetings;

11.2.3 keeping the register of members and other registers and books required by the Constitution to be kept;

11.2.4 having charge of the Trust's seal;

11.2.5 publishing to Members in an appropriate form information which they should have about the Trust's affairs; and

11.2.6 oversight of the preparation and sending to NHSI and any other statutory body all returns which are required to be made in conjunction with the Management Information Team and Finance Department.

12 MISCELLANEOUS

12.1 **SOs to be given to members of the Board and Governors**

12.1.1 It is the duty of the Chief Executive to ensure that existing members of the Board and the Council and all new appointees are notified of and understand their responsibilities within the SOs and the SFIs. Updated copies shall be issued to staff designated by the Chief Executive.

12.1.2 New Designated Officers shall be informed in writing and shall receive copies where appropriate of the SOs.

12.2 The Trust's SFI and Scheme of Reservation and Delegation to the Board shall have the effect as if incorporated into the SOs.

12.3 **Amendment of the SOs**

12.3.1 The SOs may only be amended in accordance with paragraph 20 of the Constitution (Amendment of the Constitution).

12.4 **Duty to report non-compliance with the SOs**

12.4.1 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance, and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board or the Council (as relevant) for action or ratification. All members of the Board or the Council (as relevant) and Officers have a duty to disclose any non-compliance with these SOs to the Secretary as soon as possible.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Amendments to constitution
SPONSORING EXEC:	Phil Brice, Director of Corporate Services
REPORT BY:	Ria Zandvliet, Secretary to the Trust
PRESENTED BY:	Phil Brice, Director of Corporate Services
DATE:	7 March 2023

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

Executive Summary and Reason for presentation to Committee/Board	The Constitution for the post merger organisation has been reviewed by NHS England as part of the review of the merger business case and two small amendments have been requested. The proposed changes are set out in the attached report.
Recommendation	The Board is asked to approve the amendments as set out in the report.

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

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

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

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

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

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

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

AMENDMENTS TO THE CONSTITUTION

1. INTRODUCTION

1.1. The Constitution for the post merger organisation, as approved at the May 2022 Board meeting, has been reviewed by NHS England as part of the review of the merger business case and two small amendments have been requested.

1.2. The first amendment relate to membership and clarifying the general disqualification provision.

1.3. The second amendment relate to mergers etc and extending the "significant transaction" definition to specifically state that mergers etc are included in the definition.

2. PROPOSED AMENDMENTS

2.1. The proposed amendments to the Constitution are highlighted in red below:

13. Disqualification and expulsion from membership of the trust

13.1.1 are a Member of any other constituency or class within a constituency as an individual cannot be a member of more than one constituency or class of a constituency;

13.1.2 are a member or are eligible to be a member of the Staff Constituency as an individual cannot be a member of the public constituency if they are also eligible to be a member of the staff constituency;

50. Mergers etc and significant transactions

"An application for a merger, acquisition, dissolution, separation etc. as defined in the NHS Act 2006."

3. RECOMMENDATION

13.2 The Board of Directors is asked to **approve** the proposed changes to the Constitution.

13.3 The proposed changes are to be presented to the Council of Governors on 9 March 2023.