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 3 May 2022** at **9.00am** by way of a Microsoft Team meeting – below the link.

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 1 MARCH 2022**	**SFT**	**Enclosure A**
	4.	**TO APPROVE THE MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 1 MARCH 2022**	**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**	**Joint**	**Verbal**

9.15	**8.**	**TO RECEIVE THE CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT (plus seal)**	**Joint**	**Enclosure E**
9.25	**9.**	**TO RECEIVE THE Q4 2021/22 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER PROGRESS REPORT**	**SFT**	**Enclosure G**
9.35	**10.**	**TO RECEIVE Q4 2021/22 THE BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER PROGRESS REPORT**	**YDH**	**Enclosure H**
9.45	**11.**	**TO APPROVE THE NHS ENGLAND/ IMPROVEMENT ANNUAL SELF DECLARATIONS** • **YDH** • **SFT**	 **YDH** **SFT**	 **Enclosure I** **Enclosure J**
9.55	**12.**	**TO APPROVE THE CONSTITUTION AND STANDING ORDERS FOR THE MERGED ORGANISATION**	**SFT**	**Enclosure K**
	PERFORMANCE ITEMS			
10.05	**13.**	**TO RECEIVE THE GROUP BOARD OVERVIEW QUADRANT**	**YDH**	**Enclosure L**
	14.	**TO RECEIVE THE QUALITY AND PERFORMANCE REPORT**	**SFT**	**Enclosure M**
10.25	**15.**	**TO RECEIVE THE FINANCE REPORTS AND REVISED COMMITTEE TERMS OF REFERENCES** • **Finance Report - YDH** • **Financial Resilience and Commercial Committee Terms of Reference for 2022/23 - YDH** • **Finance Report – SFT** • **Finance Committee Terms of Reference for 2022/23 – SFT**	**SFT**	 **Enclosure N** **Enclosure N1** **Enclosure O** **Enclosure O1**
10.45	**Coffee Break**			
10.55	**16.**	**TO APPROVE THE 2022/23 BUDGETS** • **YDH** • **SFT**		 **Enclosure P** **Enclosure Q**
11.15	**17.**	**LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT** • **YDH** • **SFT**	 **YDH** **SFT**	 **Enclosure R** **Enclosure S**

11.35	**18.**	**GUARDIAN OF SAFE WORKING FOR JUNIOR DOCTORS REPORT** • **YDH** • **SFT**	**YDH** **SFT**	**Enclosure T** **Enclosure U**
11.55	**19.**	**PATIENT STORY AND CLINICAL TOPIC ON MATERNITY**	**Joint**	**Presentation**
	STRATEGIC ITEMS			
12.35	**20.**	**TO APPROVE THE GOING CONCERN STATEMENTS** • **YDH** • **SFT**	**Joint**	**Enclosure V** **Enclosure W**
12.45	**21.**	**TO APPROVE THE JOINT CAPITAL PROGRAMME FOR 2022/23**	**Joint**	**Enclosure X**
13.00	**22.**	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST** • Name for the merged Trust	**Joint**	**Enclosure Y**
	INFORMATION			
13.10	**23.**	**TO RECEIVE ASSURANCE REPORTS OF THE FOLLOWING BOARD COMMITTEE MEETINGS:** **Audit Committee meetings held on 12 April 2022** • **SFT** • **YDH** • **Quality and Performance Committee meeting held on 23 March 2022** • **Financial Resilience Commercial Committee - Yeovil District Hospital NHS Foundation Trust** • **Mental Health Act Committee meeting held on 8 March 2022** • **People/Workforce Committee meeting held on 8 March 2022**	 **SFT** **YDH** **SFT** **YDH** **SFT** **Joint**	 **Enclosure Z** **Enclosure AA** **Enclosure AB** **Verbal** **Enclosure AC** **Enclosure AD**
	24.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**	**Joint**	
	25.	**ANY OTHER BUSINESS**	**Joint**	
	26.	**RISKS IDENTIFIED**	**Joint**	

	27.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**	
	28.	**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.	
	29.	**WITHDRAWAL OF PRESS AND PUBLIC** To move that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.	
13.30	**30.**	**DATE FOR NEXT MEETING** 5 July 2022	

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

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE MEETINGS HELD ON 1 MARCH 2022 BY MS TEAMS

PRESENT

Colin Drummond	Chairman
Jan Hull	Non-Executive Director (Deputy Chairman)
Barbara Gregory	Non-Executive Director
Kate Fallon	Non-Executive Director
Stephen Harrison	Non-Executive Director
Alexander Priest	Non-Executive Director
Sube Banerjee	Non-Executive Director
Martyn Scrivens	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)
Daniel Meron	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development
Shelagh Meldrum	Chief Officer - Partnerships and Collaboration

IN ATTENDANCE

Fiona Reid	Director of Communications
Graham Hughes	Non-Executive Director, Yeovil District Hospital NHS Foundation Trust
Jane Henderson	Non-Executive Director, Yeovil District Hospital NHS Foundation Trust
Paul Mapson	Non-Executive Director, Yeovil District Hospital NHS Foundation Trust
Meridith Kane	Medical Director for Acute Hospitals
Stacy Barron-Fitzsimmons	Director of Operations, Yeovil District Hospital NHS Foundation Trust
Alison Wootton	Deputy Chief Nurse
Mark Robinson	Deputy Chief Nurse, Yeovil District Hospital NHS Foundation Trust
Victoria Keilthy	Director of Integration
Dawn Sherry	Safeguarding Midwifery lead for YDH and SFT (for item 10)
Paula John	Team leader for WREN team (for item 10)

Kate Hopwood	Deputy Named midwife for Safeguarding (for item 10 only)
Julie Jones	Service Director Integrated and Urgent Care - (for item 14 only)
Maria Heard	Somerset Clinical Commissioning Group (for item 14 only)
Deirdre Molloy	Service Manager Urgent and Emergency Care (for item 14 only)
Caroline Sealey	Freedom to Speak Up Guardian (for item 16 only)
Sallyann King	Interim Director of Midwifery for Somerset (for item 17 only)
Harriet Jones	Head of Inclusion (for item 19 only)
Ian Hawkins	Lead Governor
Kate Butler	Deputy Lead Governor
John Webster	Governor – YDH
Samantha Hann	Corporate Governance and Risk Manager - YDH
Ria Zandvliet	Secretary to the Trust (minute taker)

1.	**APOLOGIES**
1.1	Apologies were received from Hayley Peters (Chief Nurse). Alison Wootton will be deputising for Hayley Peters.
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Martyn Scrivens will be chairing this meeting except for item 14 which will be chaired by Colin Drummond. The Chairman passed the chairmanship of the meeting over to Martyn Scrivens.
1.3	Martyn Scrivens welcomed all Board members and attendees to the meeting and advised that he was privileged to chair the first of the SFT and YDH Board of Directors meetings held in common. He further welcomed members of the public and Governors from both SFT and YDH to the meeting.
1.4	Martyn Scrivens confirmed that both the SFT and YDH meetings were quorate.
2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS**
2.1	Martyn Scrivens advised that questions in relation to the Minehead Minor Injury Unit agenda item had been received and circulated to all members of the Board. These questions will be responded to as part of the relevant agenda item.

3.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 1 FEBRUARY 2022**
3.1	Stephen Harrison proposed, Barbara Gregory seconded and the Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 1 February 2022 as a correct record.
4.	**MINUTES OF THE YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 2 FEBRUARY 2022**
4.1	The approval of the minutes is reflected in the YDH minutes.
5.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**
5.1	The Board received the action log and noted the completed actions.
5.2	The Board noted that the overview of Non-Executive Directors lead roles will be presented to a future Board meeting instead of the March 2022 meeting as indicated in the action log, to enable an overview of lead roles covering both SFT and YDH Executive and Non-Executive Directors to be prepared and presented to the Boards.
5.3	**Learning from Deaths reports - YDH** A reference was made in the minutes that there had been a perceived reduction in senior support and that steps had been taken to remedy this reduction. It was queried whether this had impacted on the working relationship with the Coroner. It was noted that this support related to learning from deaths and was not related to the relationship with the Coroner. The Director of Corporate Services advised that both SFT and YDH had close working relationships with the Somerset Coroner. The Somerset Coroner had not held inquests in person for a period of time and different arrangements had been made. The majority of inquests however related to Coroners out of county and relationships with these Coroners were inevitably slightly different because of the less regular contact.
6.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**
6.1	The Board received the Register of Directors' interest. The Board noted the following changes to the register: • Martyn Scrivens – to add -"Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022); • Phil Brice – to add – "Non-Executive Director of SSL".

7.	**CHAIRMEN'S REMARKS**
7.1	Martyn Scrivens advised that both trusts continued to be under considerable pressure and the impact of these pressures was reflected in the performance reports.
7.2	Colin Drummond advised that the executive team and colleagues were doing excellent work across both trusts to manage the pressures and thanked all colleagues for their commitment and dedication to patients. He highlighted that Sir Gordon Messenger had been commissioned by the Secretary of State for Health and Social Care to carry out a review on the quality of management in the NHS including capability, training and development. In discussions with Sir Gordon Messenger, Colin Drummond had advised him that, from his experience, the quality of NHS management was comparable to the quality of management of FTSE companies. The key difference was that the structure and culture in the NHS was not conducive to letting management manage whilst management in the private sector they were given more freedoms. These comments were welcomed by Sir Gordon Messenger and will be taken into account in the review.
7.3	Colin Drummond further advised that he had also described the merger work in Somerset, including the establishment of a single executive team and the clear chains of command and governance, and Sir Gordon Messenger had accepted this work as excellent examples of good practice and learning.
7.4	Kate Fallon queried whether the review focussed on Board level management or on the culture of leadership in trusts. If the latter, SFT had put significant effort into middle management leadership development over the last few years. It was noted that, due to the short time scale, the review will focus on the top layers of management only.
7.5	Board members agreed that the culture of both trusts over the last few years had very much focussed on self reflection and this will be even more important going forward.
7.6	The Chief of People and Organisational Development advised that the middle management group had performed well in the recent staff survey and this provided a good level of assurance as to the quality of middle management. She advised that the next Joint People/Workforce Committee meeting will discuss culture and engagement and review the baseline position as well as identify actions to be taken to set the right environment for the merged organisation. Paul Mapson asked for a programme for middle and lower management development to be included in the merger programme so that common standards and best practice can be applied across the county. The Chief of People and Organisational Development agreed to follow this up through the People/Workforce Committee. **Action: Isobel Clements.**

7.7	The Board accepted Matthew Bryant's observation that there was an opportunity to explore a number of areas, including continuous improvement, commitment to clinical leadership, team working, inclusion and diversity, and how this will impact on the merged organisation, at a future Board Development Day. The Board agreed to include this item on the Board Development programme. **Action: Ria Zandvliet**.
8.	**CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**
8.1	The Chief Executive presented the report which was received by the Board. The Chief Executive particularly highlighted the ongoing operational pressures across all services and advised that the pressures were exceptionally high even when compared to previous winter pressures. The system continued to be in escalation level OPEL 4 and the position had not changed since declaring OPEL 4 at the end of January 2022. The impact of the continued pressures on colleagues had previously been discussed and were well understood.
8.2	The Chief Executive further highlighted that the Mental Health Unit Use of Force Act will come into place on 31 March 2022 and one of the requirements of the Act was to identify a senior responsible officer. The Board noted that Hayley Peters, Chief Nurse, had been appointed as senior responsible officer, with Paul Townsend leading this work. Oversight will be provided through the Mental Health and Learning Disability Directorate and the Mental Health Act Committee.
8.3	The Board discussed the report and commented/noted that: • some of the pressures were contingent on the easing of the winter pressures and it was queried whether there were projections as to the level of expected pressures in the Spring and Summer. It was further queried whether there were any actions the trusts could take over the Summer to build up capacity or resilience over the next winter. The Chief Executive advised that the trusts were constantly reviewing what further actions could be taken both in the short and medium term. It was currently not clear whether the level of escalation will ease in the Spring as the pressures were not as a result of demand on acute services but related to the ability to discharge patients requiring bedded or home care. The County Council was committed to try to resolve the bottle necks in the discharge pathways but this was difficult due to the domiciliary care capacity issues in Somerset and increasing workforce capacity will need to be a key area of focus. In addition, the discharge pathways were also impacted by an increased demand from community services as some patients' needs had become more complex as a result of the Covid-19 pandemic. All possible solutions were being explored.

The Chief Executive further set out that the Omicron variant had impacted on care homes and a large number of empty care home beds could not be accessed due to the requirement for care homes to remain closed for new admissions until 14 days post Covid-19 outbreak.

The Chief Operating Officer (Mental Health, Families and Neighbourhoods) reiterated the domiciliary care capacity and patient flow issues and highlighted the steps being taken to manage the pressures over the next winter: the launch of a falls service as part of an anticipatory care programme; the implementation of lessons learned nationally from the oximetry community service; the development of a new acute respiratory illness service; and a similar virtual ward for people with frailty. Workforce will be a key challenge but it was hoped that the new initiatives will avoid a large number of patients having to be admitted to hospital.

The Chief Operating Officer (Hospital Services) advised that one of the challenges was the current need to maintain Covid-19 pathways in all services and this made the delivery of particularly acute and emergency services inefficient. Providing planned care had been challenging in view of the pressures and it was recognised that the longer waiting times impacted on patients. Patients presenting to the emergency department were more frail, had a higher acuity, and were diagnosed later in the pathway. It was stressed that the ongoing pressures had also impacted on colleagues.

Some of the actions identified to be able to implement the elective recovery programme included: a new modular theatre at Musgrove Park Hospital (MPH); and investment in West Mendip community hospital to deliver more elective care. However, addressing the discharge pathway issues will be critical for planned care. The large number of patients waiting for intermediate care pathways across Somerset were noted;

- the Boards were effectively accountable for almost all non-primary care healthcare services in the county and it was important not to forget the excellent developments in community services. The Board had to ensure that all relevant colleagues were engaged in the development of a new clinical model and the establishment of the ICS, the merger between the two trusts, and the lessons learned from how patients have managed at home during the Covid-19 pandemic, provided an opportunity to look at the full spectrum of care. This will need to include close working relationships with communities and primary care services. The Board agreed that a discussion on the system strategy will be welcomed;

- workforce planning across the system had been strengthened and international recruitment, led by YDH, was now also focussing on

	the domiciliary care workforce. Other opportunities, including local apprenticeship development, will be pursued.
8.4	The Board thanked the Executive Team for their hard work in managing the pressures and supported the Executive Team in the actions to be taken to mitigate risks.
9.	**BOARD ASSURANCE FRAMEWORK (BAF) – YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST**
9.1	The discussion of this agenda item is reflected in the YDH minutes.
10.	**PATIENT STORY ON MATERNITY SERVICES – WOMEN REQUIRING EXTRA NURTURING (WREN)**
10.1	Meridith Kate introduced Dawn Sherry, Safeguarding Midwifery Lead for both trusts, Paula John, Team Leader for the WREN Team, and Kate Hopwood, Deputy Named midwife for Safeguarding.
10.2	Dawn Sherry advised that the WREN team across both trusts provided enhanced midwifery care across Somerset for women with complex needs and set out the background to the establishment of the teams. The aim was to engage with families in a non-confrontational way and in a way that suits families with the same midwife looking after the family during the pregnancy. Dawn Sherry advised that a number of geographical barriers had been identified and by bringing the SFT and YDH teams together, these barriers had been removed.
10.3	Paula John highlighted the case study of Sarah and set out Sarah's circumstances in 2020 and in 2021. It was noted that the YDH team was unable to deliver post-natal care to Sarah in 2020 but following the merger of the teams – and the removal of the geographical barrier – the midwife was able to deliver care in Sarah's home and the same multi-agency team could continue to provide post natal care to Sarah.
10.4	Kate Hopwood highlighted the benefits of the merged team for Sarah, her baby and the professionals and the wider benefits. One of the benefits was that all members of the team were able to access records across both trusts.
10.5	Dawn Sherry set out the challenges they had experienced, which included IT; increased acuity; and the need for early help. It was noted that access to early help was essential for women not meeting the threshold for WREN services but the early help service was under considerable pressure.
10.6	Dawn Sherry further highlighted examples of feedback the teams had received which demonstrated how well the service had been received and how it had helped vulnerable women managing during and post pregnancy.

10.7	The Board discussed the presentation and commented/noted that: • the WREN teams did fantastic jobs and the benefits of merging the WREN teams showed the importance of continuity of care. This was also one of the reasons for the merger between the trusts and a key recommendation from the Ockenden report. Dawn Sherry advised that continuity of care was important as these groups of women were difficult to engage with and required more midwifery time to build up trust and achieve the best possible outcomes for them. One of the key challenges of continuity of care was the intrapartum element of their care and although every possible effort was being made for the dedicated midwife to be present for the delivery of the baby, this was not always possible; • it was queried whether the IT issues had been addressed. Paula Johns advised that the merger of the teams was felt too important to await the completion of the IT work and interim solutions were found. The changes to the IT systems had been helpful but further improvements could be made; • the work of the teams was impressive and was one of the most thought provoking case studies seen in the last few years. The focus on person centred care and the removal of the barriers to this care was excellent. It was suggested providing a further update to the Board in a year's time and invite colleagues from social care and health visiting services; • the presentation showed a great example of the benefits of integration and highlighted the need to deliver excellent digital services. It was recognised that there was a need to reduce the number of digital system and this will be taking forward as part of the development of the digital strategy. The ambition should be to have one single system which can also be accessed by social care colleagues; • the integration of the WREN teams and the benefits of the integration of the teams had been included in the maternity case study.
10.8	The Board thanked the team for their excellent work.
10.9	Dawn Sherry, Paula John and Kate Hopwood left the meeting.
11.	**GROUP BOARD OVERVIEW QUADRANT – NOVEMBER AND DECEMBER 2021**
11.1	It was agreed to combine items 11, 12 and 13.

	Performance
11.2	The Chief Finance Officer provided an overview of the key performance challenges across both trusts and highlighted: • A&E four hour performance; the number of attendances and actions being taken to address the pressures – four hour performance continued to be below target due to the patient flow pressures; • acute referral to treatment (RTT) times – both YDH and SFT RTT performance remained below the national compliance standard; the number of patients waiting over 52 weeks had decreased in both trusts to 5.3% (SFT) and 6.3% (YDH) of the total waiting lists; the number of patients waiting over 104 weeks showed a small increase in both trusts; • diagnostics – improvements in the number of patients in both trusts waiting under six weeks for their diagnostic test. The areas with the highest over six week waits were: echo and MRI SFT) and Audiology and MRI (YDH) but the overall position was improving; • cancer services – the percentage of patients seen within 14 days of referral showed an increase in both trusts but remained below the national standard. The percentage of cancer patients treated within 62 days of referral by their GP was, in both trusts, below the national compliance standard but above the national average; • cancer services – 62 day backlog – cancer service performance had started to recover in both trusts; • infection control – the number of C. Difficile and E. Coli infections; • slips, trips and falls – the rates of slips, trips and falls; the number of inpatient falls and the number of falls which had resulted in harm. It was noted that particularly SFT had seen an increase in the number of patients with impaired cognition and/or agitation and aggression which could lead to patients being at greater risk of falls; • mandatory training and sickness absence. It was noted that Covid-19 related sickness had significantly increased across both trusts during January 2022.
11.3	The Chief Finance Offer further highlighted SFT specific performance in relation to community physical health services activity; mental health waiting times and activity; and children and young people's eating disorders; out of area placements. Details of the performance issues were set out in the detailed quality and performance report.

11.4	The Board discussed the report and commented/noted that: • the performance overview across both trusts was welcomed; • six weeks waiting times for adult community mental health services had decreased during January 2022 but was improving again in February 2022. It was queried whether this temporary dip in performance was due to the Christmas period. It was noted that the Christmas period was one factor but the service also had some vacancies and high Covid-19 related sickness during January 2022; • delayed discharges had a key impact on patient flow and lot of work was taking place across the whole Somerset system (including Somerset County Council) in terms of improving domiciliary care capacity. It was queried whether the message to members of the public about how they could support patients going home had been effective. The Chief Executive advised that the message had been communicated in different ways, but the effectiveness of the message was difficult to assess. Where possible members of the public had been helping their relative going home but the key issue however was for the system as a whole to ensure an effective discharge pathway. The media had mainly focussed their coverage on the "front door" and ambulance availability and it was queried what further actions could be taken to raise awareness of the wider pressures. The Chief Executive advised that the media was being advised of the wider pressures. Waiting ambulances provided a more visual story and Somerset as a whole was doing well in terms of ambulance handover times. It was noted that messages in relation to A&E attendances and 111 services were coordinated nationally but also on a system basis. As Somerset was in OPEL 4 escalation, communication was coordinated through the Somerset Gold meeting. The Chief Executive stressed that patients with urgent or serious needs should continue to be encouraged to attend A&E services; • it was queried what actions were being taken in relation to reducing the number of falls on inpatient wards. Mark Robinson advised that the number of falls had increased across both trusts but from a YDH perspective, it was reassuring that the number of falls resulting in harm had not increased. The increase in the number patients with impaired cognition or dementia and the level of supervision required made the management of these patients more challenging. The key aim was to support these patients back to their familiar environment where they will be safer. It was noted that performance was reviewed by the Governance and Quality Assurance Committee and all falls resulting in harm were investigated and any lessons learned implemented.

	The staffing establishment report referred to an increase in the acuity and dependency risk and due to the pressure of beds and the Covid-19 separation, not every patient will be in the best possible environment for their needs.
	Finance Reports
11.5	The Chief Finance Officer presented the financial report which was received by the Board. She highlighted the financial position for both trusts: • YDH – a small in month deficit in line with the plan for the period October 2021 to March 2022. The year to date position showed a £686,000 surplus against a forecast breakeven position as at 31 March 2022 and the cost improvement programme was expected to be delivered according to plan. It was noted that the high sickness levels had resulted in an increase in agency expenditure; • SFT - a breakeven position as at 31 January 2022 in line with the plan for the period October 2021 to March 2022. The Trust was on target to deliver the forecast breakeven position as at 31 March 2022 and deliver its cost improvement programme. There had also been an increase in agency expenditure during the month due to high sickness levels.
11.6	The Chief Finance Officer advised that, in view of the significant pressures, both trusts continued to perform well in terms of its financial position. There was however a risk in relation to the delivery of the capital plans and underspending on the financial capital envelope will put additional pressure on the financial position for 2022/23. The reasons for the slippage on the capital programme were noted and it was agreed that these reasons were outside of the control of both trusts. Kate Fallon, Chairman of the SFT Finance Committee, felt that the risk of carrying the underspend on the capital programme forward into 2022/23 was acceptable as it was expected that the 2022/23 capital programme could also experience slippage.
12.	**QUALITY AND PERFORMANCE REPORT**
12.1	The presentation of the report and discussion is set out under item 11.
13.	**FINANCE REPORT**
13.1	The presentation of the report and discussion is set out under item 11.
14.	**MINEHEAD MINOR INJURY UNIT – PERMANENT CHANGE TO OPENING TIMES REPORT -**
14.1	Deirdre Molloy, Julie Jones and Maria Heard joined for this agenda item.
14.2	Colin Drummond chaired this agenda item and advised that a number of questions had been received from members of the public and the questions

	had been circulated to the relevant Directors prior to the meeting to ensure that the questions can be responded to at the meeting.
14.3	The Director of Corporate Services highlighted the key issues and responded to the questions raised as follows: • the executive summary of the report referred to the temporary closure having been in place for four months, but this was incorrect and should have referred to seven months. The four months period referred to the period expired since the most recent detailed discussion at the Board meeting; • a detailed report was provided to the November 2021 Board meeting and the report included the findings from the review into the impact of the overnight closure as well as the findings from the patient and public engagement exercise. That report should be read in conjunction with the report presented to today's Board meeting; • at the November 2021 Board meeting, the Board agreed to extend the temporary closure for a further six month period whilst a review of same day urgent care services was carried out jointly with the Clinical Commissioning Group (CCG) and partner organisations. Although the six month period had not yet passed, the work carried out since the November 2021 Board meeting had reiterated the patient safety issues relating to the current overnight MIU model and the consistent low demand for this service overnight; • recruitment of specialist professionals was challenging but additional recruitment would not address the acute care needs expressed as part of the public engagement exercise as these needs will require services provided at an A&E as they were beyond the expertise of MIU professionals; • the day time MIU service was well regarded and highly valued and the Trust was committed to maintaining the day time service and look at options for expanding services provided at the community hospital; • the questions raised by members of the public could be divided into three categories – the level of local engagement and communication; the accuracy of the data; and the plans for wider same day urgent care services in the West Somerset area. The following responses were provided: - local engagement had been carried out over the summer of 2021 and the engagement events had been advertised in the local press and other media. In addition, the Trust also met with the Local MP, League of Friends and local councillors to explain the position and seek views. It was felt that the events had been advertised through a broad range of social media opportunities and questionnaires. In addition, Maria Heard, CCG, and Julie

	Jones, Somerset FT, had attended the Health and Overview Scrutiny Committee meeting to discuss the options. Discussions had further taken place at the Fit For My Future Programme Board and the CCG's Governing Body, which all supported the Trust's decisions and agreed that the level of engagement had been proportionate for the level of service change proposed. It was felt that further engagement would not have identified any issues which had not already been raised as part of the engagement exercise; - the data was based on service level information collected by the Trust. Further data had been included in the report presented to the November 2021 Board meeting and this data could be shared with members of the public if it was felt to be helpful. The Trust did not hold comprehensive data in relation to ambulance response times, but the information received to date indicated that the response times in West Somerset were in line with the response times in other areas of the county. It was recognised that this may not be the experience of the local population and further information about the ambulance response times was being sought; - plans for wider same day urgent care services – the CCG was leading work with the ambulance service, local GPs and the Trust on same day urgent care services. Work was also taking place with the Local Authority in relation to what transport support can be provided to the local population. It was stressed that the 111 and 999 services will remain the key contact numbers if members of the population have concerns about their health. It was noted that Healthwatch had been commissioned by the CCG to carry out further engagement about same day urgent care services. • members of the public who have submitted questions will receive an individual response to their questions.
14.4	Julie Jones and Deirdre Molloy presented the report which was received by the Board. They highlighted the reasons for the recommendation to permanently close the MIU overnight and further highlighted the data. They particularly highlighted: • the patient and clinical safety concerns – as part of the engagement process members of the public indicated that they would attend the MIU for emergency health care needs and this posed safety concerns as the MIU was not set up as an emergency department. Patients presenting with emergency care needs during daytime was also a concern as patients had to be referred to Musgrove Park Hospital for urgent and acute care management. An initial presentation at MIU could delay time critical interventions. Examples included patients presenting with stroke or heart attack symptoms; head injuries, or acute conditions such as asthma;

	• during the agreed extension to the temporary suspension of the overnight service, the impact of the night-time closure continued to be monitored and no serious safety incidents associated with the night-time closure or a discernible impact had been noted at Minehead MIU or across other healthcare services during this time. The Trust had not been made aware of any significant adverse incidents as a result of the service not being available overnight during the temporary closure; • of the adults from the West Somerset area who attended ED almost 50% required admission to a specialist bed, whilst a proportion of those discharged will have required emergency or specialist intervention not suitable to be delivered in an MIU setting; • the need for a clear communication strategy to communicate the wide range of services available in West Somerset; • the work of the CCG's Task and Finish Group referred to above in relation to the development of a plan for a neighbourhood based integrated urgent care service, included supported travel to Musgrove Park Hospital, multi-agency working, closer working relationships between GP practices and MIU; and a weekend X-ray service.
14.5	The Director of Corporate Services asked the Board to consider the recommendations set out in the report, including the recommendation to permanently close the overnight MIU service, with a particular focus on whether a permanent closure felt safe in the context of the work of the CCG's Task and Finish Group not yet having been completed.
14.6	The Board discussed the recommendations and agreed that the review of the impact of the temporary closure during the last seven months evidenced that a permanent overnight closure felt safe. In addition, the Board agreed that the MIU was not an emergency care centre and that a delay in treatment created considerable clinical and patient safety risks. The Board further agreed that the work of the CCG's Task and Finish Group was important but observed that sufficient details of the future model of urgent care were not yet available. The Board agreed to amend paragraph 9.3 to include a request to the CCG for a clear timeframe for producing this future model of care.
14.7	Stephen Harrison proposed, Jan Hull seconded and the Board approved the recommendations as set out in the report with the request to ask the CCG for a clear timeframe for producing the future model of care for the West Somerset area.
14.8	Colin Drummond thanked members of the public for attending the meeting and for submitting their questions in advance of the meeting. Deirdre Molloy, Maria Heard and Julie Jones left the meeting.

15.	**TO RECEIVE THE STAFFING ESTABLISHMENT REPORTS**
	Yeovil District Hospital NHS Foundation Trust
15.1	The discussion of this agenda item is reflected in the YDH minutes.
	Somerset NHS Foundation Trust
15.2	Alison Wootton, Deputy Chief Nurse, presented the report and highlighted the key challenges and risks. The report was received by the Board.
15.3	The Board discussed the report and commented/noted that: • the report had become very complex due to the wide range of medical and non medical services provided by the Trust but it was recognised that it was important to have clear "Ward to Board" feedback. Work on a single report and on how best to share information with the Board will be carried out over the next few months; • the intermediate care risk had been scored at 25 but this was a whole system risk and was wider than just workforce. The Trust was making every possible effort to support system partners in the mitigation of this risk; • it was queried whether the wellbeing support had been effective or whether more support could be provided. It was noted that the wellbeing support was excellent and it was not envisaged that further support could be provided. The wider wellbeing support was not taken up by all colleagues but every possible action was being taken to ensure that all colleagues were supported on a day to day basis. The Director of People and Organisational Development advised that work was taking place with the wellbeing and network teams, working across both trusts, whether in view of the operational pressures, the current wellbeing support was still valid and relevant. In general, there had been a high uptake of the wellbeing support offered but "buy in" could be improved; • domiciliary care staff recruited overseas were appointed as an NHS employee and their costs were charged to the Local Authority. The aim was for these staff to work in both health and domiciliary care where possible.
15.4	The Board accepted the recommendations set out in the report.
16.	**SIX MONTHLY FREEDOM TO SPEAK UP PROGRESS REPORT**
16.1	Caroline Sealey, Freedom to Speak Up Guardian, presented the report which was received by the Board. Caroline Sealey provided an overview of the Freedom to Speak Up activity over the last six months and highlighted the significant increase in the number of concerns received, the themes of these concerns and the actions taken.

16.2	The Board discussed the report and commented/noted that: • the Freedom to Speak Up Board Self Assessment Tool will be discussed at the April 2022 Board Development Day; • the Freedom to Speak up report, together with information from other reports, enabled data to be triangulated to provide a full overview of patient safety issues and overall colleague wellbeing; • it was queried whether findings from the report will be presented to the People Committee. It was noted that the People Committee will be meeting as a Committee in common with the Workforce Committee in March 2022 and there was a need to consider the areas of focus for the Committees going forward. However, the aim will be to focus on "soft" as well as "hard" data. It was suggested that all relevant Board Committees reviewed the Freedom to Speak Up data to ensure that the full impact of the operational pressures on patients and colleagues was considered; • it was queried whether the civility work had positively impacted on behaviours. Caroline Sealey advised that she was not involved in the delivery of the civility workshops but feedback she had received was that, where the workshops had been delivered to the right colleagues, there had been a positive outcome in terms of behaviours; • the issues raised were in line with the issues raised at Yeovil District Hospital NHS Foundation Trust. The number of medical colleagues using the Freedom to Speak Up route was small and it was queried whether other appropriate mechanisms were in place to enable them to raise any concerns. It was noted that medical colleagues do have other routes through which to raise concerns and this included the medical appraisal process. Meridith Kane advised that medical colleagues traditionally did not raise concerns and work was taking place to remove any cultural barriers to ensure that all colleagues felt able to speak up.
16.3	The Board thanked Caroline Sealey for her excellent work. The Board agreed that the report provided significant assurance in terms of feedback from non medical colleagues but asked for assurance in terms of medical colleagues to be strengthen.
16.4	Caroline Sealey left the meeting.
17.	**OCKENDEN PROGRESS REPORT AND MATERNITY SERVICES WORKFORCE PLANS**
17.1	Sallyann King, Interim Director of Midwifery for Somerset, joined the meeting and presented the report which was received by the Board.

	Sallyann King particularly highlighted the background to the Ockenden report; the compliance rates against the implementation of the Immediate and Essential Actions as at December 2021 (YDH 81% and SFT 74%); the compliance rate as at 18 February 2022 (YDH 88% and SFT 86%); and the recommendations.
17.2	The Board discussed the report and commented/noted that: • the two actions which cannot be fully completed by 24 March 2022 were: twice day consultant ward rounds morning and evenings; and maternal medicine network and pathways. In relation to the latter action, this action cannot be completed until the pathway had been agreed and this was being taken forward at regional level; • in relation to the twice daily consultant ward round action, it was noted that the establishment of an evening round at Musgrove Park Hospital had been complex and difficult but it had been agreed to commence the evening ward rounds from 1 June 2022. It was not possible to implement this at an earlier stage as it was part of a wider set of rota changes and notice periods were required to make adjustments to the rota arrangements; • it was queried whether continuity of a carer was embedded in all teams. Sallyann King advised that continuity of carer was the right way forward and was both right for families and midwifes. Clear criteria had been set how to provide this continuity of care and this will be difficult to implement in rural areas. This had been raised with the national team which had recognised the challenges in rural areas and equitable models of care will be acceptable to the national team. YDH already provided an integrated service but SFT used a traditional hospital based and community based midwife model of care. Changes in working practices in SFT were already being made but further organisational change will be required over the next six months; • it was queried whether digital options could be considered to demonstrate continuity of care in rural areas. Sallyann King advised that conversations had taken place pre Covid how to address rural complexities in a different way. The emphasis on remote working during Covid had demonstrated that digital solutions worked well for outpatient services and digital solutions were very much part of the ongoing discussions.
17.3	The Board thanked Sallyann King for her excellent work across both trusts.
17.4	Sallyann King left the meeting.

18.	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**
18.1	The Director of Strategy and Digital Development provided a verbal update and advised that the populated due diligence templates had been discussed with a wide range of Governors at the end of February 2022. The templates will continue to be updated on an ongoing basis.
18.2	The focus over the next months will also be on the development of the patient case studies and the development of the business case.
19.	**DEVELOPING AN INCLUSIVE CULTURE PROGRESS REPORT**
19.1	The discussion of this agenda item is reflected in the YDH minutes.
20.	**ASSURANCE REPORTS OF THE FOLLOWING BOARD COMMITTEE MEETINGS*:***
	SFT Audit Committee meeting held on 27 January 2022
20.1	Barbara Gregory, Chair of the Audit Committee, presented the report which was received by the Board.
	SFT Quality and Performance Committee meeting held on 26 January 2022
20.2	Jan Hull, Chair of the Quality and Governance Committee, presented the report which was received by the Board.
	YDH Financial Resilience Commercial Committee meeting held on 24 January 2022
20.3	Martyn Scrivens referred to the financial update and advised that there were no further updates.
20.4	The Board welcomed the assurance reports and asked for assurance reports to also be produced for the YDH Board Committee meetings. **Action: Ria Zandvliet.**
21.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
21.1	There were no follow up questions from the Public or Governors.
22.	**ANY OTHER BUSINESS**
22.1	There was no other business.
23*.*	**RISKS IDENTIFIED**
23.1	The Board did not identify any new risks which had not as yet been included on the risk register but noted that a number of the risks, as discussed as part of the Board Assurance Framework and performance

	management agenda items, had increased in intensity and longer term plans will need to be developed to manage these risks.
24.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
24.1	The Board agreed that the meeting had been very effective and in particular the WREN presentation was welcomed. The meeting had been very open and honest with a clear recognition of any shortcomings and actions to be taken to address these shortcomings.
24.2	The meetings held in common provided a side by side overview of both organisations which made it easier to identify any issues across both organisations.
25.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
25.1	The Chairman highlighted the items for discussion at the confidential Board meeting and set out the reasons for including these items on the Confidential Board agenda. These reasons related to contract confidentiality; commercially sensitive items; and draft reports.
26.	**WITHDRAWAL OF PRESS AND PUBLIC**
26.1	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.
27.	**DATE FOR NEXT MEETING**
27.1	3 May 2022

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

PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON

MINUTES OF THE MEETINGS HELD ON 1 MARCH 2022 BY MS TEAMS

PRESENT

Martyn Scrivens	Chairman
Jan Hull	Non-Executive Director
Graham Hughes	Non-Executive Director
Jane Henderson	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)
Daniel Meron	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development
Isobel Clements	Chief of People and Organisational Development
Shelagh Meldrum	Chief Officer - Partnerships and Collaboration

IN ATTENDANCE

Fiona Reid	Director of Communications
Colin Drummond	Chairman – SFT
Barbara Gregory	Non-Executive Director – SFT
Kate Fallon	Non-Executive Director – SFT
Stephen Harrison	Non-Executive Director – SFT
Alexander Priest	Non-Executive Director – SFT
Sube Banerjee	Non-Executive Director - SFT
Meridith Kane	Medical Director for Acute Hospitals
Stacy Barron-Fitzsimmons	Director of Operations
Alison Wootton	Deputy Chief Nurse - SFT
Mark Robinson	Deputy Chief Nurse
Victoria Keilthy	Director of Integration
Dawn Sherry	Safeguarding Midwifery lead for YDH and SFT (for item 10)
Paula John	Team Leader for WREN Team (for item 10)
Kate Hopwood	Deputy Named midwife for Safeguarding (for item 10 only)
Maria Heard	Somerset Clinical Commissioning Group (for item 14 only)

Julie Jones	Service Director Integrated and Urgent Care (for item 14 only)
Deirdre Molloy	Service Manager Urgent and Emergency Care (for item 14 only)
Harriet Jones	Head of Inclusion (for item 19 only)
Caroline Sealey	Freedom to Speak Up Guardian (for item 16 only)
Sallyann King	Interim Director of Midwifery for Somerset (for item 17 only)
Ian Hawkins	Lead Governor - SFT
Kate Butler	Deputy Lead Governor - SFT
John Webster	Governor
Samantha Hann	Corporate Governance and Risk Manager
Ria Zandvliet	Secretary to the Trust – SFT (minute taker)

1.	**APOLOGIES**
1.1	Apologies were received from Hayley Peters (Chief Nurse). Mark Robinson (YDH) will be deputising for Hayley Peters.
1.2	The Chairman advised that, following the establishment of a single executive team across both trusts, the SFT and YDH Boards have agreed to conduct their Board of Directors meetings as meetings held in common. The meetings will be chaired by the Chair of either SFT or YDH Chair on a rotation basis and Martyn Scrivens will be chairing this meeting except for item 14 which will be chaired by Colin Drummond. The Chairman passed the chairmanship of the meeting over to Martyn Scrivens.
1.3	Martyn Scrivens welcomed all Board members and attendees to the meeting and advised that he was privileged to chair the first of the SFT and YDH Board of Directors meetings held in common. He further welcomed members of the public and Governors from both SFT and YDH to the meeting.
1.4	Martyn Scrivens confirmed that both the SFT and YDH meetings were quorate.
2.	**QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS**
2.1	Martyn Scrivens advised that questions in relation to the Minehead Minor Injury Unit agenda item had been received and circulated to all members of the Board. These questions will be responded to as part of the relevant agenda item.
3.	**MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 1 FEBRUARY 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 2 FEBRUARY 2022**
4.1	Jane Henderson proposed, Graham Hughes seconded and the Board approved the minutes of the Yeovil District Hospital NHS Foundation Trust Public Board meeting held on 2 February 2022 as a correct record.
5.	**TO REVIEW THE ACTION LOGS AND MATTERS ARISING**
5.1	The Board received the action log and noted the completed actions.
5.2	The Board noted that the overview of Non-Executive Directors lead roles will be presented to a future Board meeting instead of the March 2022 meeting as indicated in the action log, to enable an overview of lead roles covering both SFT and YDH Executive and Non-Executive Directors to be prepared and presented to the Boards.
5.3	**Learning from Deaths reports - YDH** A reference was made in the minutes that there had been a perceived reduction in senior support and that steps had been taken to remedy this reduction. It was queried whether this had impacted on the working relationship with the Coroner. It was noted that this support related to learning from deaths and was not related to the relationship with the Coroner. The Director of Corporate Services advised that both SFT and YDH had close working relationships with the Somerset Coroner. The Somerset Coroner had not held inquests in person for a period of time and different arrangements had been made. The majority of inquests however related to Coroners out of county and relationships with these Coroners were inevitably slightly different because of the less regular contact.
6.	**TO NOTE THE REGISTERS OF DIRECTORS' INTERESTS AND RECEIVE ANY DECLARATIONS OF INTERESTS RELATING TO ITEMS ON THE AGENDA**
6.1	The Board received the Register of Directors' interest. The Board noted the following changes to the register: • Martyn Scrivens – to add -"Non-Executive Director and Chairman of Wesleyan Bank Limited, a 100% subsidiary of Hampshire Trust Bank Limited" (with effect from 28 February 2022); • Phil Brice – to add – "Non-Executive Director of SSL".
7.	**CHAIRMEN'S REMARKS**
7.1	Martyn Scrivens advised that both trusts continued to be under considerable pressure and the impact of these pressures was reflected in the performance reports.

7.2	Colin Drummond advised that the executive team and colleagues were doing excellent work across both trusts to manage the pressures and thanked all colleagues for their commitment and dedication to patients. He highlighted that Sir Gordon Messenger had been commissioned by the Secretary of State for Health and Social Care to carry out a review on the quality of management in the NHS including capability, training and development. In discussions with Sir Gordon Messenger, Colin Drummond had advised him that, from his experience, the quality of NHS management was comparable to the quality of management of FTSE companies. The key difference was that the structure and culture in the NHS was not conducive to letting management manage whilst management in the private sector they were given more freedoms. These comments were welcomed by Sir Gordon Messenger and will be taken into account in the review.
7.3	Colin Drummond further advised that he had also described the merger work in Somerset, including the establishment of a single executive team and the clear chains of command and governance, and Sir Gordon Messenger had accepted this work as excellent examples of good practice and learning.
7.4	Kate Fallon queried whether the review focussed on Board level management or on the culture of leadership in trusts. If the latter, SFT had put significant effort into middle management leadership development over the last few years. It was noted that, due to the short time scale, the review will focus on the top layers of management only.
7.5	Board members agreed that the culture of both trusts over the last few years had very much focussed on self reflection and this will be even more important going forward.
7.6	The Chief of People and Organisational Development advised that the middle management group had performed well in the recent staff survey and this provided a good level of assurance as to the quality of middle management. She advised that the next Joint People/Workforce Committee meeting will discuss culture and engagement and review the baseline position as well as identify actions to be taken to set the right environment for the merged organisation. Paul Mapson asked for a programme for middle and lower management development to be included in the merger programme so that common standards and best practice can be applied across the county. The Chief of People and Organisational Development agreed to follow this up through the People/Workforce Committee. **Action: Isobel Clements.**
7.7	The Board accepted Matthew Bryant's observation that there was an opportunity to explore a number of areas, including continuous improvement, commitment to clinical leadership, team working, inclusion and diversity, and how this will impact on the merged organisation, at a future Board Development Day. The Board agreed to include this item on the Board Development programme. **Action: Ria Zandvliet**.

8.	**CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT**
8.1	The Chief Executive presented the report which was received by the Board. The Chief Executive particularly highlighted the ongoing operational pressures across all services and advised that the pressures were exceptionally high even when compared to previous winter pressures. The system continued to be in escalation level OPEL 4 and the position had not changed since declaring OPEL 4 at the end of January 2022. The impact of the continued pressures on colleagues had previously been discussed and were well understood.
8.2	The Chief Executive further highlighted that the Mental Health Unit Use of Force Act will come into place on 31 March 2022 and one of the requirements of the Act was to identify a senior responsible officer. The Board noted that Hayley Peters, Chief Nurse, had been appointed as senior responsible officer, with Paul Townsend leading this work. Oversight will be provided through the Mental Health and Learning Disability Directorate and the Mental Health Act Committee.
8.3	The Board discussed the report and commented/noted that: • some of the pressures were contingent on the easing of the winter pressures and it was queried whether there were projections as to the level of expected pressures in the Spring and Summer. It was further queried whether there were any actions the trusts could take over the Summer to build up capacity or resilience over the next winter. The Chief Executive advised that the trusts were constantly reviewing what further actions could be taken both in the short and medium term. It was currently not clear whether the level of escalation will ease in the Spring as the pressures were not as a result of demand on acute services but related to the ability to discharge patients requiring bedded or home care. The County Council was committed to try to resolve the bottle necks in the discharge pathways but this was difficult due to the domiciliary care capacity issues in Somerset and increasing workforce capacity will need to be a key area of focus. In addition, the discharge pathways were also impacted by an increased demand from community services as some patients' needs had become more complex as a result of the Covid-19 pandemic. All possible solutions were being explored. The Chief Executive further set out that the Omicron variant had impacted on care homes and a large number of empty care home beds could not be accessed due to the requirement for care homes to remain closed for new admissions until 14 days post Covid-19 outbreak.

	The Chief Operating Officer (Mental Health, Families and Neighbourhoods) reiterated the domiciliary care capacity and patient flow issues and highlighted the steps being taken to manage the pressures over the next winter: the launch of a falls service as part of an anticipatory care programme; the implementation of lessons learned nationally from the oximetry community service; the development of a new acute respiratory illness service; and a similar virtual ward for people with frailty. Workforce will be a key challenge but it was hoped that the new initiatives will avoid a large number of patients having to be admitted to hospital. The Chief Operating Officer (Hospital Services) advised that one of the challenges was the current need to maintain Covid-19 pathways in all services and this made the delivery of particularly acute and emergency services inefficient. Providing planned care had been challenging in view of the pressures and it was recognised that the longer waiting times impacted on patients. Patients presenting to the emergency department were more frail, had a higher acuity, and were diagnosed later in the pathway. It was stressed that the ongoing pressures had also impacted on colleagues. Some of the actions identified to be able to implement the elective recovery programme included: a new modular theatre at Musgrove Park Hospital (MPH); and investment in West Mendip community hospital to deliver more elective care. However, addressing the discharge pathway issues will be critical for planned care. The large number of patients waiting for intermediate care pathways across Somerset were noted; • the Boards were effectively accountable for almost all non-primary care healthcare services in the county and it was important not to forget the excellent developments in community services. The Board had to ensure that all relevant colleagues were engaged in the development of a new clinical model and the establishment of the ICS, the merger between the two trusts, and the lessons learned from how patients have managed at home during the Covid-19 pandemic, provided an opportunity to look at the full spectrum of care. This will need to include close working relationships with communities and primary care services. The Board agreed that a discussion on the system strategy will be welcomed; • workforce planning across the system had been strengthened and international recruitment, led by YDH, was now also focussing on the domiciliary care workforce. Other opportunities, including local apprenticeship development, will be pursued.
9.4	The Board thanked the Executive Team for their hard work in managing the pressures and supported the Executive Team in the actions to be taken to mitigate risks.

9.	**BOARD ASSURANCE FRAMEWORK (BAF)**
9.1	Samantha Hann presented the interim 2021/22 Q4 Board Assurance Framework (BAF) which was received by the Board. It was noted that the two highest scoring risks related to the Care for our Population objective – an increase in the level of demand and the impact of the Covid-19 pandemic – and the Innovative and Collaborate objective – the development of new models of care and a clear clinical strategy across Somerset. The strategic risks will be further updated following discussions at the April 2022 Assurance Committee meetings and a final Q4 BAF will be presented to the May 2022 Board meeting.
9.2	The Board discussed the report and commented/noted that: • the arrows showing movement from the previous quarter were welcomed and demonstrated that the BAF was a "live" document. A request was made to also include arrows in the 2022/23 BAFs; • the majority of strategic risks had not changed and the 'sideways' arrows did not reflect the comprehensive reviews of all strategic risks which were carried out at every Assurance Committee meeting. Consideration will be given as to how best to demonstrate changes as arrows in themselves only provide a limited overview and discussions should focus on what mitigating actions had been identified and on progress on the implementation of these actions; • the increase in the risk ratings was a concern but reflected the current pressures; • a number of actions remained ongoing and it was stressed that it will be important to ensure that the implementation of these actions was kept under close review. The Director of Corporate Services advised that mitigating actions will need to clearly set out what difference they will make to the risk and if the risk cannot be mitigated further, consideration will need to be given as to whether or not the risk can be tolerated; • the joint strategic objectives for 2022/23 will be discussed at the April 2022 Joint Board Development Day.
10.	**PATIENT STORY ON MATERNITY SERVICES – WOMEN REQUIRING EXTRA NURTURING (WREN)**
10.1	Meridith Kate introduced Dawn Sherry, Safeguarding Midwifery Lead for both trusts, Paula John, Team Leader for the WREN Team, and Kate Hopwood, Deputy Named midwife for Safeguarding.
10.2	Dawn Sherry advised that the WREN team across both trusts provided enhanced midwifery care across Somerset for women with complex needs and set out the background to the establishment of the teams. The aim

	was to engage with families in a non-confrontational way and in a way that suits families with the same midwife looking after the family during the pregnancy. Dawn Sherry advised that a number of geographical barriers had been identified and by bringing the SFT and YDH teams together, these barriers had been removed.
10.3	Paula John highlighted the case study of Sarah and set out Sarah's circumstances in 2020 and in 2021. It was noted that the YDH team was unable to deliver post-natal care to Sarah in 2020 but following the merger of the teams – and the removal of the geographical barrier – the midwife was able to deliver care in Sarah's home and the same multi-agency team could continue to provide post natal care to Sarah.
10.4	Kate Hopwood highlighted the benefits of the merged team for Sarah, her baby and the professionals and the wider benefits. One of the benefits was that all members of the team were able to access records across both trusts.
10.5	Dawn Sherry set out the challenges they had experienced, which included IT; increased acuity; and the need for early help. It was noted that access to early help was essential for women not meeting the threshold for WREN services but the early help service was under considerable pressure.
10.6	Dawn Sherry further highlighted examples of feedback the teams had received which demonstrated how well the service had been received and how it had helped vulnerable women managing during and post pregnancy.
10.7	The Board discussed the presentation and commented/noted that: • the WREN teams did fantastic jobs and the benefits of merging the WREN teams showed the importance of continuity of care. This was also one of the reasons for the merger between the trusts and a key recommendation from the Ockenden report. Dawn Sherry advised that continuity of care was important as these groups of women were difficult to engage with and required more midwifery time to build up trust and achieve the best possible outcomes for them. One of the key challenges of continuity of care was the intrapartum element of their care and although every possible effort was being made for the dedicated midwife to be present for the delivery of the baby, this was not always possible; • it was queried whether the IT issues had been addressed. Paula Johns advised that the merger of the teams was felt too important to await the completion of the IT work and interim solutions were found. The changes to the IT systems had been helpful but further improvements could be made; • the work of the teams was impressive and was one of the most thought provoking case studies seen in the last few years. The

	focus on person centred care and the removal of the barriers to this care was excellent. It was suggested providing a further update to the Board in a year's time and invite colleagues from social care and health visiting services; • the presentation showed a great example of the benefits of integration and highlighted the need to deliver excellent digital services. It was recognised that there was a need to reduce the number of digital system and this will be taking forward as part of the development of the digital strategy. The ambition should be to have one single system which can also be accessed by social care colleagues; • the integration of the WREN teams and the benefits of the integration of the teams had been included in the maternity case study.
10.8	The Board thanked the team for their excellent work.
11.	**GROUP BOARD OVERVIEW QUADRANT – NOVEMBER AND DECEMBER 2021 – YDH**
11.1	It was agreed to combine items 11, 12 and 13.
11.2	**Performance** The Chief Finance Officer provided an overview of the key performance challenges across both trusts and highlighted: • A&E four hour performance; the number of attendances and actions being taken to address the pressures – four hour performance continued to be below target due to the patient flow pressures; • acute referral to treatment (RTT) times – both YDH and SFT RTT performance remained below the national compliance standard; the number of patients waiting over 52 weeks had decreased in both trusts to 5.3% (SFT) and 6.3% (YDH) of the total waiting lists; the number of patients waiting over 104 weeks showed a small increase in both trusts; • diagnostics – improvements in the number of patients in both trusts waiting under six weeks for their diagnostic test. The areas with the highest over six week waits were: echo and MRI SFT) and Audiology and MRI (YDH) but the overall position was improving; • cancer services – the percentage of patients seen within 14 days of referral showed an increase in both trusts but remained below the national standard. The percentage of cancer patients treated within 62 days of referral by their GP was, in both trusts, below the national compliance standard but above the national average;

	• cancer services – 62 day backlog – cancer service performance had started to recover in both trusts; • infection control – the number of C. Difficile and E. Coli infections; • slips, trips and falls – the rates of slips, trips and falls; the number of inpatient falls and the number of falls which had resulted in harm. It was noted that particularly SFT had seen an increase in the number of patients with impaired cognition and/or agitation and aggression which could lead to patients being at greater risk of falls; • mandatory training and sickness absence. It was noted that Covid-19 related sickness had significantly increased across both trusts during January 2022.
11.3	The Chief Finance Offer further highlighted SFT specific performance in relation to community physical health services activity; mental health waiting times and activity; and children and young people's eating disorders; out of area placements. Details of the performance issues were set out in the detailed quality and performance report.
11.4	The Board discussed the report and commented/noted that: • the performance overview across both trusts was welcomed; • six weeks waiting times for adult community mental health services had decreased during January 2022 but was improving again in February 2022. It was queried whether this temporary dip in performance was due to the Christmas period. It was noted that the Christmas period was one factor but the service also had some vacancies and high Covid-19 related sickness during January 2022; • delayed discharges had a key impact on patient flow and lot of work was taking place across the whole Somerset system (including Somerset County Council) in terms of improving domiciliary care capacity. It was queried whether the message to members of the public about how they could support patients going home had been effective. The Chief Executive advised that the message had been communicated in different ways, but the effectiveness of the message was difficult to assess. Where possible members of the public had been helping their relative going home but the key issue however was for the system as a whole to ensure an effective discharge pathway. The media had mainly focussed their coverage on the "front door" and ambulance availability and it was queried what further actions could be taken to raise awareness of the wider pressures. The Chief Executive advised that the media was being advised of the wider pressures. Waiting ambulances provided a more visual story and Somerset as a whole was doing well in terms of ambulance

	handover times. It was noted that messages in relation to A&E attendances and 111 services were coordinated nationally but also on a system basis. As Somerset was in OPEL 4 escalation, communication was coordinated through the Somerset Gold meeting. The Chief Executive stressed that patients with urgent or serious needs should continue to be encouraged to attend A&E services; • it was queried what actions were being taken in relation to reducing the number of falls on inpatient wards. Mark Robinson advised that the number of falls had increased across both trusts but from a YDH perspective, it was reassuring that the number of falls resulting in harm had not increased. The increase in the number patients with impaired cognition or dementia and the level of supervision required made the management of these patients more challenging. The key aim was to support these patients back to their familiar environment where they will be safer. It was noted that performance was reviewed by the Governance and Quality Assurance Committee and all falls resulting in harm were investigated and any lessons learned implemented. The staffing establishment report referred to an increase in the acuity and dependency risk and due to the pressure of beds and the Covid-19 separation, not every patient will be in the best possible environment for their needs. **Finance Reports**
11.5	The Chief Finance Officer presented the financial report which was received by the Board. She highlighted the financial position for both trusts: • YDH – a small in month deficit in line with the plan for the period October 2021 to March 2022. The year to date position showed a £686,000 surplus against a forecast breakeven position as at 31 March 2022 and the cost improvement programme was expected to be delivered according to plan. It was noted that the high sickness levels had resulted in an increase in agency expenditure; • SFT - a breakeven position as at 31 January 2022 in line with the plan for the period October 2021 to March 2022. The Trust was on target to deliver the forecast breakeven position as at 31 March 2022 and deliver its cost improvement programme. There had also been an increase in agency expenditure during the month due to high sickness levels.
11.6	The Chief Finance Officer advised that, in view of the significant pressures, both trusts continued to perform well in terms of its financial position. There was however a risk in relation to the delivery of the capital plans and underspending on the financial capital envelope will put additional pressure on the financial position for 2022/23. The reasons for the slippage on the

	capital programme were noted and it was agreed that these reasons were outside of the control of both trusts. Kate Fallon, Chairman of the SFT Finance Committee, felt that the risk of carrying the underspend on the capital programme forward into 2022/23 was acceptable as it was expected that the 2022/23 capital programme could also experience slippage.
12.	**QUALITY AND PERFORMANCE REPORT - SFT**
12.1	The presentation of the report and discussion is set out under item 11.
13.	**FINANCE REPORT – SFT**
13.1	The presentation of the report and discussion is set out under item 11.
14.	**MINEHEAD MINOR INJURY UNIT – PERMANENT CHANGE TO OPENING TIMES REPORT - SFT**
14.1	The discussion of this agenda item is reflected in the SFT minutes.
15.	**TO RECEIVE THE STAFFING ESTABLISHMENT REPORTS** **Yeovil District Hospital NHS Foundation Trust**
15.1	Mark Robinson, Deputy Chief Nurse, presented the report and highlighted the key challenges and risks. The report was received by the Board.
15.2	The Board discussed the report and commented/noted that: • plans were in place to develop more theatres and it was queried whether these theatres can be staffed. Mark Robinson advised that the trusts were working together to identify mutually beneficial solutions and one of the options was to look at international recruitment; • workforce planning was a key strategic issue. The trusts will continue to face skills shortages and will need to develop plans to prepare for the implementation of the elective recovery programme and further future developments. It was noted that the Chief Nurse was working with the Chief of People and Organisational Development and their deputies to develop robust workforce plans for all services across both trusts and good practices from other trusts will be considered; • the last six months had been challenging in terms of safe staffing but in spite of these challenges, the trust had managed the pressures well and there were clear examples of excellent work taking place; • there was evidence that the level of workforce planning between the two trusts was increasing and the variety of career paths will make recruitment easier.

15.3	The Board agreed that the report provided assurance that senior nurses were reviewing staffing levels daily to ensure that there was sufficient nursing and midwifery capacity in line with national guidance relating to the delivery of safe, effective and compassionate care.
15.4	**Somerset NHS Foundation Trust** The discussion of this agenda item is reflected in the SFT minutes.
16.	**SIX MONTHLY FREEDOM TO SPEAK UP PROGRESS REPORT - SFT**
16.1	The discussion of this agenda item is reflected in the SFT minutes.
17.	**OCKENDEN PROGRESS REPORT AND MATERNITY SERVICES WORKFORCE PLANS**
17.1	Sallyann King, Interim Director of Midwifery for Somerset, joined the meeting and presented the report which was received by the Board. Sallyann King particularly highlighted the background to the Ockenden report; the compliance rates against the implementation of the Immediate and Essential Actions as at December 2021 (YDH 81% and SFT 74%); the compliance rate as at 18 February 2022 (YDH 88% and SFT 86%); and the recommendations.
17.2	The Board discussed the report and commented/noted that: • the two actions which cannot be fully completed by 24 March 2022 were: twice day consultant ward rounds morning and evenings; and maternal medicine network and pathways. In relation to the latter action, this action cannot be completed until the pathway had been agreed and this was being taken forward at regional level; • in relation to the twice daily consultant ward round action, it was noted that the establishment of an evening round at Musgrove Park Hospital had been complex and difficult but it had been agreed to commence the evening ward rounds from 1 June 2022. It was not possible to implement this at an earlier stage as it was part of a wider set of rota changes and notice periods were required to make adjustments to the rota arrangements; • it was queried whether continuity of a carer was embedded in all teams. Sallyann King advised that continuity of carer was the right way forward and was both right for families and midwifes. Clear criteria had been set how to provide this continuity of care and this will be difficult to implement in rural areas. This had been raised with the national team which had recognised the challenges in rural areas and equitable models of care will be acceptable to the national team. YDH already provided an integrated service but SFT used a traditional hospital based and community based midwife model of care. Changes in working practices in SFT were already being

	made but further organisational change will be required over the next six months; • it was queried whether digital options could be considered to demonstrate continuity of care in rural areas. Sallyann King advised that conversations had taken place pre Covid how to address rural complexities in a different way. The emphasis on remote working during Covid had demonstrated that digital solutions worked well for outpatient services and digital solutions were very much part of the ongoing discussions.
17.3	The Board thanked Sallyann King for her excellent work across both trusts.
17.4	Sallyann King left the meeting,
18.	**UPDATE ON THE MERGER BETWEEN SOMERSET NHS FOUNDATION TRUST AND YEOVIL DISTRICT NHS FOUNDATION TRUST**
18.1	The Director of Strategy and Digital Development provided a verbal update and advised that the populated due diligence templates had been discussed with a wide range of Governors at the end of February 2022. The templates will continue to be updated on an ongoing basis.
18.2	The focus over the next months will also be on the development of the patient case studies and the development of the business case.
19.	**DEVELOPING AN INCLUSIVE CULTURE PROGRESS REPORT**
19.1	Harriet Jones, Head of Inclusion, joined the meeting. Harriet Jones presented the report which was received by the Board. Harriet Jones further set out the inclusion journey: reflections and next steps and highlighted: • the principles which included: building on progress to date; a new approach - systemic change; and increasing our impact; • inclusion maturity, which showed the journey from one off events (cup cake events), including training sessions, to more inclusive cultures. Mature inclusion teams focussed on workplace culture, changing behaviours, addressing bullying etc and required the development of skills in organisational change and behaviour change; • systemic change and what systemic change looks like – systemic change referred to changing the systems, policies, processes and cultures that create or maintain inequality (fixing the system). It was stressed that systemic change did not relate to changing the people to fit the existing system but was aimed at changed the system, e.g.

	anonymous applications, re-design of promotion criteria, increase transparency etc; • a shift in focus – from focussing on a small part of the problem that can be directly influenced to always being aware of the bigger picture and how our work fits in with the rest of the trust. The aim should be to focus on influencing others and embedding inclusion across the organisation, rather than running 'inclusion projects' in isolation; • how we work systemically – the four tools used to change the approach towards systemic change includes: empowering others; data led; collaboration and influence; and research based.
19.2	The Board discussed the presentation and commented/ noted that: • the joint working with Emma Symonds at YDH, was welcomed; • bringing the inclusion work together under a single heading of systemic change will ensure a clear focus on building a new culture; • there was also considerable work to be carried out at Non-Executive Director and Board level. A number of development sessions had taken place and outcomes had been variable but it was essential to continue this work. Harriet Jones asked Board members to email her if they had development suggestions or needs; • the question to ask was whether everyone in the organisation had the chance to do what they wanted to do, develop and progress. Fundraising had not been reviewed in terms of equal opportunities and Barbara Gregory will follow this up with Harriet Jones outside of the meeting; • it was queried how inclusion will be embedded in the strategic thinking. It was noted that the strategic objectives for 2022/23 will be discussed at the April 2022 Board Development Day and inclusion will need to be considered as part of that discussion, alongside sustainability and digital. It was suggested that all strategies should be tested on inclusivity; • previous stories from disadvantaged colleagues had been very powerful and the Board encouraged Harriet Jones to set up more of such stories; • systemic change was welcomed and was felt to be the right direction of travel. As well as focussing on colleagues, there should also be a focus on patients and carers. Harriet Jones advised that a discussion had been scheduled for 2 March 2022 to look at whether the team's remit should focus on just workforce or wider. If just

	workforce, it will be important to ensure that teams focussing on patients and carers shared the same values and language.
19.3	The Board thanked Harriet Jones for her excellent work.
19.4	Harriet Jones left the meeting.
20.	**ASSURANCE REPORTS OF THE FOLLOWING BOARD COMMITTEE MEETINGS*:***
	Audit Committee meeting held on 27 January 2022 – SFT
20.1	Barbara Gregory, Chair of the Audit Committee, presented the report which was received by the Board.
	Quality and Performance Committee meeting held on 26 January 2022 – SFT
20.2	Jan Hull, Chair of the Quality and Governance Committee, presented the report which was received by the Board.
	Financial Resilience Commercial Committee meeting held on 24 January 2022 – YDH
20.3	Martyn Scrivens referred to the financial update and advised that there were no further updates.
20.4	The Board welcomed the assurance reports and asked for assurance reports to also be produced for the YDH Board Committee meetings. **Action: Ria Zandvliet.**
21.	**FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS**
21.1	There were no follow up questions from the Public or Governors.
22.	**ANY OTHER BUSINESS**
22.1	There was no other business.
23*.*	**RISKS IDENTIFIED**
23.1	The Board did not identify any new risks which had not as yet been included on the risk register but noted that a number of the risks, as discussed as part of the Board Assurance Framework and performance management agenda items, had increased in intensity and longer term plans will need to be developed to manage these risks.
24.	**EVALUATION OF THE EFFECTIVENESS OF THE MEETING**
24.1	The Board agreed that the meeting had been very effective and in particular the WREN presentation was welcomed. The meeting had been very open and honest with a clear recognition of any shortcomings and actions to be taken to address these shortcomings.

24.2	The meetings held in common provided a side by side overview of both organisations which made it easier to identify any issues across both organisations.
25.	**ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING**
25.1	The Chairman highlighted the items for discussion at the confidential Board meeting and set out the reasons for including these items on the Confidential Board agenda. These reasons related to contract confidentiality; commercially sensitive items; and draft reports.
26.	**WITHDRAWAL OF PRESS AND PUBLIC**
26.1	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.
27.	**DATE FOR NEXT MEETING**
27.1	3 May 2022

SOMERSET NHS FOUNDATION TRUST /YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETINGS HELD IN COMMON ON 1 MARCH 2022

AGENDA ITEM	ACTION	BY WHOM	DUE DATE	PROGRESS
7. Chairmen's Remarks	To develop a programme for middle and lower management development as part of the merger programme to ensure that common standards and best practice can be applied across the county	Isobel Clements	Ongoing	This will be followed up at the People and Workforce Committee meetings.
20. Assurance Reports	To produce assurance reports for the YDH Board Committees.	Ria Zandvliet	May 2022	This has been actioned. A report from the Governance and Quality Assurance Committee will be produced after its first meeting held in common with the Quality and Governance Committee meeting in May 2022.

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

BOARD OF DIRECTORS – ACTION SHEET
1 March 2022

Minute	Action	Progress	Due	By
ACTIONS FROM 6 OCTOBER 2021				
1-71/2122 (14.8)	Joint Board to Board Seminar Session on equality, diversity and inclusion and WRES once the new Head of Inclusion is in post to be arranged	Scheduled for June 2022 Joint Board to Board Seminar Session	June 2022	Samantha Hann
ACTIONS FROM 15 DECEMBER 2021				
1-92/2122 (6.11)	Cancer harm reviews presentation to be delivered to a future Joint SFT and YDH QGC/GQAC meeting	This has been added to the work programme for the Joint GQAC/QGC meeting for 2022/23	April 2022	Samantha Hann
ACTIONS FROM 2 FEBRUARY 2022				
1-110/2122 (10.16)	Workforce Committee Terms of Reference to be revised and presented to the Board of Directors for approval	Not yet due	May 2022	Graham Hughes
The actions from 1 March 2022 onwards have been included in the joint action plan.				

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:	3 May 2022

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 26 April 2022.
Recommendation	The Board is asked to: • note the Register of Interests; • declare any changes to the Register of Interests; • declare any conflict of interests in relation to the agenda items.

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

☐ Obj 1 Improve health and wellbeing of population

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

☐ Obj 3 Strengthen care and support in local communities

☐ Obj 4 Reduce inequalities

☐ Obj 5 Respond well to complex needs

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

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

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

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

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

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

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

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

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

REGISTERS OF DIRECTORS' INTERESTS

JOINT EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Chief Executive, Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust • Member of the NHS Confederation Community Network Board • Management Board Member, Yeovil Strategic Estates (YEP) Partner Board • Director, YEP Project Co. Limited • Director, Yeovil Property Operating Company Limited
Phil Brice Director of Corporate Services	• Sister works for Somerset NHS Foundation Trust • Non-Executive Director of the Shepton Mallet Health Partnership • Director of Corporate Services, Yeovil District Hospital NHS Foundation Trust • Non-Executive Director of SSL
Matthew Bryant Chief Operating Officer (Hospital Services)	• Trustee for Hospiscare, Exeter • Visiting Specialist, Plymouth University Peninsula Medical School • Chief Operating Officer (Hospital Services), Yeovil District Hospital NHS Foundation Trust
Isobel Clements Chief of People and Organisational Development	• Daughter works as a registered nurse in the Emergency department at MPH • 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
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
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
Daniel Meron Chief Medical Officer	• Chief Medical Officer, Yeovil District Hospital NHS Foundation Trust
Shelagh Meldrum Chief Officer – Partnerships and Collaboration	• Non-Exec Director Simply Serve Limited • Director Symphony Healthcare Services • Husband Paul Meldrum is Head of Contracting and Business Performance Lead at YDH • Chief Officer – Partnerships and Collaboration, 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 • University of Plymouth (Pro-Chancellor and Chair of Governors) • President of Wadham College Oxford 1610 Society • Deputy Lieutenant for Somerset • Worshipful Company of Water Conservators - Fleet Warden
Jan Hull Non-Executive Director	• Trustee of the Dulverton Abbeyfield Society. • Formerly Managing Director of South, Central and West Commissioning Support Unit

(Deputy Chairman)	• 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 • Daughter has been appointed as the Guardian of Safe Working Hours for Junior Doctors
Stephen Harrison Non-Executive Director	• Trustee, YMCA Brunel Group • Trustee, Lawrence Centre, Wells • Governor, Wookey Primary School
Barbara Gregory Non-Executive Director	• RESEC Research into Elderly and Specialist Care Trustee. • Deloitte Associate – with effect from 6 February 2018. • Chair of the CNL (Chairs, Non Executive and Lay members) Faculty of HFMA • Director of AGRF
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset
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	• Non-Executive Director 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)

Yeovil District Hospital NHS Foundation Trust Non-Executive Directors	
Martyn Scrivens Chairman Non-Executive Director	• Non-Executive Director 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)
Jane Henderson Non-Executive Director Deputy Chairman	• Private Practice Therapeutic Counsellor • Part-time, self-employed counsellor for Frome Birth Talk
Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Volunteer Advisor at Citizens Advice • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	• No declarations
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

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:	3 May 2022

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 March and April 2022.
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)
Yeovil District Hospital NHS FT
☒ 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 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 report is presented to every Board meeting.

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

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

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

JOINT ITEMS

1. PRESSURES ON SERVICES

1.1 Services across the Somerset health and care system continue to be under significant pressure and teams have been working very hard to keep our patients and colleagues as safe as possible while maintaining critical services.

1.2 Although we have seen a steady reduction in the number of reported COVID-19 cases in the community and the number of inpatients testing positive, we are continuing to see very high demand on many of our services in the community, mental health and in the acute hospitals – in particular the number of people attending our emergency and MIU departments. High numbers of ambulance attendances and ongoing significant challenges in discharging patients who are medically fit to leave hospital is also impacting on the availability of inpatient beds across both trusts.

1.3 We are doing everything we possibly can to support and improve patient flow, by working with our health and care partners across the county. In the community, the intermediate care team and our community services are working very hard to support patients.

2. CHANGES TO INFECTION PREVENTION AND CONTROL GUIDANCE

2.1 The UK Health Security Agency (UKHSA), the Department of Heath and Social Care, NHS England and health bodies in the devolved nations recently published revised joint guidance which allows NHS organisations to reduce or remove some of the infection prevention and control (IPC) measures previously put in place as a result of the pandemic.

2.2 This includes:

- Stepping down inpatient COVID-19 isolation precautions.
- Stepping down COVID-19 precautions for exposed patient contacts.
- Returning to pre-pandemic physical distancing in all areas.
- Returning to pre-pandemic cleaning protocols outside of COVID-19 areas.

2.3 The guidance recommends that all healthcare organisations undertake local risk assessments to ensure safe systems of work, balancing risks across the whole patient pathway from home into hospital, in the context of the wider impact of COVID-19 on health services, ensuring they are balancing these risks appropriately and considering the impact on capacity and patient flow.

2.4 It states clearly that all patients, visitors, and staff should continue to practise good hand and respiratory hygiene, including the continued use of face masks by colleagues and face coverings by visitors and patients where clinically tolerated.

2.5 Across Somerset FT and YDH we are working through the guidance, what it means for our sites and services to ensure that we make changes carefully, balancing the benefits of improved flow through our services while continuing to protect our colleagues, patients, and visitors appropriately. Updated local guidance will be issued to our teams. In the meantime, we are emphasising the importance of continuing to wear masks, practicing good hand hygiene and the process for responsible visiting in our ward areas.

2.6 In advance of this guidance being formally issued, a limited review of new and existing national guidance had already been undertaken in line with the guidance for "living with COVID". In anticipation of the new guidance being issued the Boards approved a deviation from the then existing guidance in a limited number of areas around testing protocols and isolation protocols.

Visiting reminder for all inpatient wards across the trust

2.7 A few weeks ago, we re-opened responsible visiting across our hospitals and units, enabling visitors to pre-book visiting slots to see loved ones staying on our wards. Responsible visiting ensures we can continue to protect our patients and our colleagues, as numbers of visitors at any one time on the ward can be managed – limiting the exposure to illness or viruses and having enough space and ventilation.

2.8 Details on the current visiting arrangements are set out on the public websites.

3. PUBLICATION OF THE INDEPENDENT REVIEW OF MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

3.1 The final report of the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (SaTH) was recently published. The review's independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at SaTH between 2000 and 2019. After removing duplication of recording, and excluding cases where there were missing hospital records or consent for participation in the review could not be obtained, the final number of families included in this review is 1,486. Some families had multiple clinical incidents therefore a total of 1,592 clinical incidents involving mothers and babies have been reviewed with the earliest case from 1973 and the latest from 2020.

3.2 The report concluded that catastrophic failures at SaTH may have led to the deaths of more than 200 babies, nine mothers and left other infants with life-changing injuries. The review identifies four pillars for improvement in maternity services at SaTH and in maternity services across England:

- Safe staffing levels properly funded
- A well-trained workforce
- Learning from incidents
- Listening to families

3.3 It sets out more than 60 local actions for learning for SaTH and another 15 key immediate and essential actions to improve all maternity services in England. The report states that trust Boards must have oversight and understanding of their maternity services and must ensure that they listen to and hear local families and their own colleagues. There are strong themes of failures of governance, a bullying and toxic culture, and failure to listen to families throughout the report emphasising the importance of an open and learning culture and listening to and really hearing the voices of women and families.

3.4 We are supporting colleagues within our maternity services and the women, babies and families that we care for. The Board members of both trusts had a discussion about the Freedom to Speak up cultures at the April 2022 Board Development session and we will be working through the actions for our maternity services.

3.5 You can watch this week's address by Donna Ockenden here and the full report is available to read here.

4. THE KING'S FUND AND THE NUFFIELD TRUST REPORT SHOWS PUBLIC SATISFACTION WITH THE NHS, CONCLUDING THAT IT HAS FALLEN TO ITS LOWEST LEVEL SINCE 1997

4.1 The report analyses responses to the 2021 British Social Attitudes survey (BSA). The survey, carried out by the National Centre for Social Research (NatCen) in September and October 2021, is seen as a gold standard measure of public attitudes. It finds that public satisfaction with how the health service runs has fallen sharply to 36 percent – an unprecedented drop of 17 percentage points from 2020 and the lowest level of satisfaction recorded since 1997. Record falls in satisfaction were also seen across all individual NHS services, including GP and hospital services.

4.2 The fall in overall satisfaction with the NHS can be seen across all ages, income groups, sexes and supporters of different political parties. More people (41 percent) are now dissatisfied with the NHS than satisfied. Concerns over long waiting times (65 percent), NHS staff shortages (46 percent) and inadequate government funding (40 percent) remain the top reasons people gave for being dissatisfied with the NHS in 2021.

4.3 Despite this, support for the principles of the NHS is as strong as ever. The overwhelming majority of people expressed high levels of support for the founding principles of the NHS when asked if they should still apply in 2021: that it is free of charge when you need it (94 percent), primarily funded through taxation (86 percent) and available to everyone (84 percent).

4.4 The think tanks' analysis reveals that public satisfaction with GP services – historically the service with the highest levels of public satisfaction – has fallen by an unprecedented 30 percentage points since 2019 to 38 percent, the lowest level of satisfaction recorded for GP services since the survey began in 1983. For the first time the number of people dissatisfied with GP services (42 percent) is higher than those who are satisfied.

4.5 Levels of public satisfaction with hospital inpatient and outpatient services and dentistry are also all at the lowest level since the BSA survey began, and satisfaction with A&E services is at the lowest level since that question was introduced in 1999.

4.6 When asked what the most important priorities for the NHS should be, the top three cited by survey respondents are making it easier to get a GP appointment, improving waiting times for planned operations and increasing the number of staff in the NHS.

4.7 You can read the full report and associated articles here. NHS Providers' response is here.

5. NHS STAFF SURVEY RESULTS PUBLISHED

5.1 The results of the latest NHS Staff Survey results were recently published . An average of over half (45% of colleagues from Somerset FT and 57% of colleagues from YDH) of colleagues across both trusts completed the survey which gives us rich information about our colleagues' experience at work – where we are doing well and where we still need to improve.

5.2 We all know and understand the challenges that we have faced together over the last two years. It is therefore not surprising that morale in both trusts has decreased slightly, but feedback from our colleagues in both trusts is overwhelmingly more positive than from colleagues in comparator trusts. Our results provide many positive areas and a very good platform on which to bring our two trusts together and learn from each organisation's areas of strength. The results for YDH are particularly good.

5.3 The areas where both our trusts benchmark very well are opportunities for flexible working; team working - feeling valued by your team and effective working with other teams; line managers - their interest in colleagues' wellbeing and feeling valued by managers; taking positive action on wellbeing; access to learning and developing; and acting on colleagues' concerns. The areas where we did not benchmark so well and need to improve are ensuring that all colleagues have an annual appraisal and that no colleagues experience harassment.

5.4 Across Somerset FT and YDH we will be working together to continue our wellbeing support for colleagues; encouraging and supporting good management practice; building on the work we have already done on inclusion to ensure all colleagues feel valued and a sense of belonging in our trusts, working to eliminate incidence of harassment, supporting team working

and effectiveness and improving appraisal completion to support colleagues' development.

6. EXPANDING DIAGNOSTIC SERVICES IN SOMERSET

6.1 As part of a national initiative and building on the success of the Rutherford Diagnostic Centre, Somerset wants to develop a second Community Diagnostic Centre in the east of the county. The first Community Diagnostic Centre is the Rutherford Diagnostics Centre that opened in Taunton in September 2021, the first community diagnostics centre of its kind in England. The centre provides diagnostic services including Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Ultrasound and X-Ray.

6.2 The "Fit for My Future" (FFMF) team in Somerset has carried out a survey to gather views on the establishment of a Community Diagnostic Centre which serves the east of the county. The survey closed on 16 April 2022 and feedback from the survey is awaited.

What are Community Diagnostic Centres?

6.3 In November 2020, the Diagnostics: Recovery and Renewal review led by Sir Mike Richards outlined several projects that could be delivered to improve diagnostics across England. The ambitions for diagnostic services had already been recognised by the NHS Long Term Plan published in 2019.

6.4 One of the recommendations from the Richard's review was to create Community Diagnostic Centres (CDCs). These centres aim to achieve:

- Earlier diagnoses for patients through easier, faster, and more direct access to the full range of diagnostic tests needed to understand patients' symptoms
- A reduction in waits by diverting patients away from hospitals, allowing them to treat urgent patients
- A contribution to the NHS's net zero ambitions by providing multiple tests at one visit, reducing the number of patient journeys and helping to cut carbon emissions and air pollution.

7. MATERNITY TEAMS CELEBRATE TOP SURVEY RESULTS FROM MUMS

7.1 Maternity teams at Somerset FT and at Yeovil District Hospital have received outstanding feedback for the care they provide families across the county. Results from the NHS Patient Survey Programme positioned our hospitals among the highest scoring trusts in the region for many areas of maternity care.

7.2 The maternity survey asked questions about antenatal care, labour and birth, and postnatal care, and saw Somerset FT and Yeovil Hospital named best in the South West for antenatal check ups, as well as the care provided at

home after birth. Yeovil Hospital also took the top spot in the region for the care provided during pregnancy.

7.3 Alongside the scored categories, mothers provided key feedback detailing the best experiences as well as areas they felt could be improved.

7.4 The maternity team at Somerset FT was praised by families for the availability of midwives, day and night, for advice about post-pregnancy related issues such as infant feeding. Families also said they were pleased with the level of choice available to them for the actual birth and follow up postnatal care. They said they felt confident in the advice provided by our doctors and midwives.

7.5 There were some areas highlighted by families where improvements could be made, such as the level of information and consultation available before induction.

8. REMEMBERING DR BARRY MOYSE

8.1 Dr Barry Moyse passed away unexpectedly on 11 March 2022, aged 59 years. He was a dearly loved son, brother, husband, father, and friend to many, and had worked as a locum in the Emergency Department (ED) at Musgrove Park Hospital for some time during his career. He was well known as a GP in Somerset, and for his work with the Local Medical Committee (LMC), whose principal role is to support GPs and practices across the county.

8.2 Dr Nick Bray, previous LMC chair and close friend of Barry, has written a tribute to Barry which summarises what a truly amazing person he was.

9. COVID-19 UPDATE

Covid-19 Infection rate

9.1. The seven day Covid-19 infection rate per 100,000 population across Somerset as at 27 April 2022 stands at 252.20 - South Somerset (275.00), Somerset West and Taunton (272.10), Mendip (138.10) and Sedgemoor (246.80).

9.2. As at 27 April 2022, there are 65 COVID-19 positive patients in Musgrove Park Hospital and 41 in Yeovil District Hospital.

10. USE OF THE CORPORATE SEAL

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

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

11. SOMERSET FT SHORTLISTED FOR APPRENTICESHIP AWARD

11.1 We are delighted to have been shortlisted for an apprenticeship award by the Bridgwater and Taunton College. It follows a successful nursing apprenticeship programme that we launched last year in partnership with the college.

11.2 We have been recognised in the Large Employer of the Year category and will find out whether we have on the evening of Thursday 5 May 2022.

12. LOVE MUSGROVE ANNOUNCES 25TH ANNIVERSARY APPEAL

12.1 2022 marks the 25th anniversary of charitable funds across the NHS in Somerset and the work of Love Musgrove. Over the past 25 years the charity has been supporting patients and colleagues in a huge number of ways. From purchasing new items of equipment to supporting staff wellbeing as well as extending efforts to community hospitals, mental health services and other NHS teams across Somerset. Thanks to the Somerset community, the Charity has raised a staggering £20 million in 25 years!

12.2 And so, in the charity's 25th year, to fully recognise the incredible generosity and ongoing support of charitable funds throughout our County, Somerset NHS Foundation Trust has launched Our Charity. As part of the celebrations, we have launched an appeal under the Our Charity umbrella, and in partnership with Love Musgrove, to support projects right across NHS services in Somerset.

12.3 One of the projects is to transform 10 NHS garden spaces across Somerset for the benefit of patients, their families, and staff. This will allow teams to buy garden furniture, plants, and trees and in some cases create allotment spaces to grow fruit and vegetables. This will create lovely spaces for patients to spend precious time with their families.

12.4 The charity is also supplying Dementia Boxes to over 70 clinical spaces across the NHS in Somerset. These boxes will include practical items like hearing aid batteries, glasses wipes and a magnifying glass as well as activities like crossword books, large print cards and sensory items. This will support colleagues to go the extra mile when supporting patients with dementia, regardless of why they've come to seek treatment.

12.5 Other projects being supported include a programme of music therapy and engagement, giving NHS volunteers a polo shirt and supporting stroke rehabilitation units at Williton and South Petherton. To see the full list of projects, head to the charity'swebsite: www.lovemusgrove.org.uk/anniversary-appeal/

12.6 The Charity is also pleased to announce that ToneFM has come on board as the official radio partner for the 25th Anniversary Appeal. Station

Director Patch Jobson had this to say about the partnership, “We’re thrilled to be one of the official partners for this year’s campaign, and with everything that our local NHS teams have done for our community over the last eighteen months, we simply had to step forward and assist with raising awareness for such a vital support line for the NHS.”

12.7 The charity is looking for support for the Appeal from all corners of the County, so if you can support, you can get in touch with the charity via email on fundraising@SomersetFT.nhs.uk or by giving the office a call on 01823 344437. The charity is especially keen to hear from groups and businesses who would be interested in fundraising, and those keen to take on a challenge or organise a fundraising event.

13. HSJ PARTNERSHIP AWARDS

13.1 Colleagues from our trust and from Rutherford Diagnostics attended the HSJ Partnership Awards in London on 3 April 2022. We were shortlisted in the “Best healthcare provider partnership with the NHS” category for our work to establish our partnership which has resulted in NHS patients receiving their imaging scans in the Rutherford Diagnostic Centre Somerset just outside Taunton.

13.2 The team did not win their category, but we are extremely proud of what they have achieved together. The last piece of information that we shared was how The Rutherford Community Diagnostic Centre in Taunton has become the first independent facility in the UK to offer conventional apprenticeship training to student radiographers.

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

14. YEOVIL DISTRICT HOSPITAL AWARDED NEW NHS PASTORAL CARE QUALITY AWARD

14.1. Yeovil Hospital is incredibly proud to announce that the hospital is one of three NHS Trusts within the UK to be awarded the new NHS Pastoral Care Quality Award.

14.2. The award was launched by NHS England and NHS Improvement Nursing International Recruitment Programme to give recognition to NHS trusts who provide excellent care to international nurses and midwives.

14.3. Yeovil Hospital has achieved this fantastic accolade after demonstrating nursing and midwifery colleagues from overseas receive enriched pastoral care at every step of their recruitment and beyond.

14.4. The hospital met a set of standards developed by regional and trust international recruitment leads, and international nursing and midwifery associations that focused on best practice in pastoral care, providing safe arrival, induction training and ongoing support for international staff while they are in post.

14.5. By reaching all standards, Yeovil Hospital can proudly display this award and be recognised for the hospital's commitment to staff wellbeing for both existing and potential employees. The voluntary scheme is now open to all NHS Trusts within the UK.

SOMERSET NHS FOUNDATION TRUST

SEAL REGISTER

26 JANUARY 2022 TO 27 APRIL 2022

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
3 February 2022	23	Angel Place Talkjng Therapies Lease	David Shannon	Peter Lewis
10 February 2022	24	Dorset Dental – Marshes End, Pool, Tenant Agreement	Peter Lewis	Phil Brice
22 February 2022	25	Dorset dental – Marshes End, Safety Drive and Poole Agreement for Lease, Lease, License for Alterations and Deed of Covenant	Peter Lewis	David Shannon

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

SEAL REGISTER
FINANCIAL YEAR 2021/22

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
17/05/2021	495	Joint Services Agreement for the Provision of Nursing Education – Yeovil District Hospital NHS Foundation Trust; Somerset NHS Foundation Trust; and Bridgwater & Taunton College	Shelagh Meldrum Deputy Chief Executive	Ben Edgar-Attwell Company Secretary
30/06/2021	496	Lynton Health Centre – Deed of Guarantee and Indemnity	Jonathan Higman Chief Executive	Sarah James Chief Finance Officer
30/06/2021	497	Lynton Health Centre – Asset Transfer Agreement	Jonathan Higman Chief Executive	Sarah James Chief Finance Officer
28/09/2021	498	Creech Medical Centre – Licence to Assign	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	499	Creech Medical Centre – Deed of Guarantee and Indemnity	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	500	Creech Medical Centre – Deed of Covenant	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	501	Creech Medical Centre – Asset Transfer Agreement	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	503	Lister House Surgery – Asset Transfer Agreement	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	504	Lister House Surgery – Deed of Guarantee and Indemnity	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	505	North Petherton Surgery – Licence to Assign	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	506	North Petherton Surgery – Deed of Covenant	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	507	North Petherton Surgery – Asset Transfer Agreement	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	508	North Petherton Surgery – Deed of Guarantee and Indemnity	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	509	Warwick House Medical Centre – Deed of Guarantee and Indemnity	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	510	Warwick House Medical Centre – Deed of Covenant	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	511	Warwick House Medical Centre – Licence to Assign	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
28/09/2021	512	Warwick House Medical Centre – Asset Transfer Agreement	Sarah James Chief Finance Officer	Ben Edgar-Attwell Associate Director of Integration
20/12/2021	513	St Margaret's Hospice, Yeovil - Lease	Peter Lewis Chief Executive	Sarah James Chief Finance Officer
20/12/2021	514	St Margaret's Hospice, Yeovil - Lease	Peter Lewis Chief Executive	Sarah James Chief Finance Officer
17/03/2022	515	Ilchester Surgery – Licence to Assign – Lease Novation	Peter Lewis Chief Executive	n/a
17/03/2022	516	Ilchester Surgery – Licence to Assign – Lease Novation	Peter Lewis Chief Executive	n/a

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Q4 2021/22 Board Assurance Framework and Corporate Risk Register
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Director of Corporate Services Secretary to the Trust Associate Director of Integrated Governance
PRESENTED BY:	Director of Corporate Services
DATE:	3 May 2022

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	A review of the Trust's strategic objectives was undertaken at the April 2021 Board Development Day, the draft BAF and the Trust's risk appetite were discussed at the June 2021 Board Development Day and the objectives were approved at the July 2021 Board meeting. The objectives are aligned with the system clinical aims which form the basis for the clinical model, and which are set out in the Strategic Outline Case for our merger with Yeovil District Hospital NHS Foundation Trust (YDH). The objectives with the highest risk across the Trust are: • objective 4 - To ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting (Clinical Strategy Aim 2); • objective 9 - To deliver levels of performance that are in line with our operational plans, system ambitions and can demonstrate progress towards the delivery of outstanding care. Recent Board and system-level discussions on the pressures in primary care, social care and other providers - and their impact on the Trust's achievements of its clinical

	and corporate objectives - will need to continue to be reviewed. The draft strategic objectives for 2022/23 were discussed at the April 2022 Board Development Day and will be further considered as part of the review of the BAF. A revised Q1 Assurance Framework will be presented to the Trust Board at its meeting in July 2022.
Recommendation	The Board is asked to: • review the Board Assurance Framework and Corporate Risk Register and note the actions being taken to address the risks identified; • and consider the objectives and risks reserved to the Board.

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

Q4 2021/22 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

1. PURPOSE OF THE REPORT

1.1 To present the Board Assurance Framework and Corporate Risk Register for Q4 2021/22 to the Board.

2. BOARD ASSURANCE FRAMEWORK

2.1 The Board Assurance Framework identifies which of the joint strategic objectives may be at risk because of inadequacies in the operation of controls, or where the Trust have insufficient assurance that the actions and mitigations will deliver the objectives. At the same time it encompasses the control of risk, provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the Trust to determine how to make the most efficient use of resources and address the issues identified in order to improve the quality and safety of care.

2.2 The Assurance Framework is a key element of the governance documents used by the Trust to inform its declaration of compliance with the Essential Standards of Quality and Safety and the Annual Governance Statement. As part of the audit process both the external and internal auditors review the adequacy of the Assurance Framework. Each Trust is expected to have had a framework in place for each full year being reviewed.

2.3 A review of the strategic objectives was undertaken at the April 2021 Board Development Day, the draft BAF and the Trust's risk appetite were discussed at the June 2021 Board Development Day and the objectives were approved at the July 2021 Board meeting. The objectives are aligned with the system clinical aims which form the basis for the clinical model, and which are set out in the Strategic Outline Case for our merger with Yeovil District Hospital NHS Foundation Trust (YDH).

2.4 The draft strategic objectives for 2022/23 were discussed at the April 2022 Joint Board Development Day and will be further considered as part of the review of the BAF. A revised Q1 Assurance Framework will be presented to the Trust Board at its meeting in July 2022.

3. ASSURANCE FRAMEWORK GOVERNANCE ARRANGEMENTS

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

3.2 The Audit Committee oversees the effectiveness of the above processes at each of its meetings and the 2021/22 BAF was last presented to the April 2022 Audit

Committee meeting. The Committee also considered the discussions held at other Board sub-committees.

3.3 The Quality and Governance Committee has responsibility for oversight of objectives 4, 5, 6 and 7. The People Committee has responsibility for oversight of objective 8 and the Finance Committee has responsibility for oversight of objective 10. Objectives 1, 2, 3 and 9 are reserved to the Board.

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

4. GAPS IN CONTROL AND ASSURANCE

4.1 The objectives with the highest risk across the Trust are:

- objective 4 - To ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting (Clinical Strategy Aim 2);

- objective 9 - To deliver levels of performance that are in line with our operational plans, system ambitions and can demonstrate progress towards the delivery of outstanding care (16).

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

4.3 Gaps in controls and assurance are identified in a number of objectives and actions to address these are identified. The Board should consider if there are any further assurances that may be required in respect of any individual areas of risk.

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

5. CORPORATE RISK REGISTER

5.1 The corporate risk register attached is a summary format produced from the "Radar" risk management system.

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

5.3 Following a joint Board discussion at the beginning of April 2022, work is underway to implement newly aligned risk management processes with Yeovil District Hospital NHS Foundation Trust in advance of the planned merger. As part of alignment, there have been minor changes to the current risk scoring tools, and the format for future risk register reports has been updated to provide more clarity on progress

with implementation of controls and other changes. This work is being led by Samantha Hann, who has now been appointed as the Head of Risk across both organisations. The plan is to develop a joint Risk Management Strategy by July 2022, followed by full roll-out of the changes across both organisations during Q2 of 2022/23.

5.4 There are currently nineteen risks on the corporate risk register:

- three risks are rated 25 (overall Covid risk; system finances; intermediate care);
- seven risks are rated 20 (the condition of the estate; increasing demand; RTT risks; waiting times; OT vacancy rate; community hospital staffing; escalation beds);
- five risks are rated 16 (diagnostic waiting times; district nurse staffing; colleague pressures; primary care provision; podiatry vacancies);
- four risks are rated 15 (Dorset dental GA paediatric list; cancer standards; nurse and AHP shortages; disaggregation of RIO).

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

6. CONCLUSION

6.1 Good progress is being made identifying actions to address any gaps in controls and assurances but the position around safe, effective and high quality services, waiting times and recovery remains very challenging, as, increasingly, does workforce issues in a number of core services.

7. RECOMMENDATION

7.1 The Board is asked to review the Board Assurance Framework and Corporate Risk Register and note the actions being taken to address the risks identified; and consider the objectives and risks reserved to the Board.

DIRECTOR OF CORPORATE SERVICES

BOARD ASSURANCE FRAMEWORK SUMMARY

Quarter 4 2021/22

NHS Somerset NHS Foundation Trust

Ref	Executive Owner	Corporate Objective	Current Risk	Target Risk	Strength of Controls	Strength of Assurance	Key Performance Indicators
1	David Shannon	To develop our inclusive culture of learning, research and continuous improvement to improve safety, outcomes, efficiency and effectiveness.	12	12	Amber	Amber	No of Colleagues trained in QI: 27 Gold; No of colleagues engaged in research: On Plan = ; Leadership Capability Index measure: ; earning: Freedom to Speak Up Inde: 0.827; Learning from Deaths measure:
2	Peter Lewis	To work in collaboration with our partners in Somerset to develop an Integrated Care System and deliver the Fit for My Future strategy	12	12	Amber	Amber	ICP and ICB established: ; HSE/I approval of Strat. Outline cas: ; Development of Full Business Case: ; ICS Development Plan: ; FFMF consultation programme:
3	Shelagh Meldrum	To enable people to live healthy independent lives, to prevent the onset of avoidable illness and support active self-management (Clinical Strategy Aim 1)	12	12	Amber	Amber	Establish Prevention Alliance: ; Perioperative care - to be defined: ; Treatment Escalation Plans (TEPs): 100%; PIFU - to be defined: ; arly cancer diagnosis - to be define:
4	Dan Meron Hayley Peters	To ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting (Clinical Strategy Aim 2)	16	9	Amber	Green	Nosocomial transmission: COVID-1: ; Last 1000 Days flagship sub-progs: 42; Patients in adult IP beds / HTT caseload: ; % discharge summaries completed: ; Falls res in harm/1000 acute bed days: 1.42; Falls (harm)/1000 MH+comm bed days: 59.0%; ressure ulcers per 1000 CH bed day: 0.65; Pressure ulcers/1000 acute bed days: 0.63; Pressure ulcers per 1000 DN contacts: 1.4
5	Andy Heron Matthew Bryant	To provide support in neighbourhood areas with an emphasis on self-management and prevention (Clinical Strategy Aim 3)	9	6	Amber	Green	Discharges home on Pathways 0&: 0.904; Rapid Response: Admissions prevented: 247; Comm/MH: % f/u activity by video: 24.8%; 175102; ; 5403
6	Dan Meron Hayley Peters	To value all people alike, addressing inequalities and giving equal priority to physical and mental health (Clinical Strategy Aim 4)	9	9	Green	Green	MCA level 1 training: 93.3%; Waiting times for CAMHS: ; MH patients physical check < 48 hrs: 100.0%; IAPT recovery rate: 58.2%; Waiting times for Learning Disabilitie: 1 = ; afer staffing: Reg nurse MH wards da: 1.101
7	Dan Meron Hayley Peters	To improve outcomes for people through personalised, co-ordinated support (Clinical Strategy Aim 5)	9	9	Green	Amber	Clinical strategy Aim 5 programme: 1100.0% = ; 900.0% = ; Acute inpatients screened: dementia: 94.7%; Connecting Us flagship sub-progs: 200.0% = ; ns in place, monitor:
8	Isobel Clements	To develop a workforce that is: • Safe, with the skills and expertise needed to enable innovation and provision of a high quality service. • Diverse, engaged, motivated and resilient, demonstrating the values and behaviours we expect • Resourced appropriately, flexible and agile to support outstanding care in the most appropriate setting	12	4	Green	Green	Vacancy levels: 5.8%; Sickness Rate: 6.4%; Mandatory Training: 91.8%; Stress / anxiety - days lost: ; Staff turnover: 11.4%
9	Andy Heron Matthew Bryant	To deliver levels of performance that are in line with our operational plans, system ambitions and can demonstrate progress towards the delivery of outstanding care	16	12	Amber	Green	A&E 4 Hour Target: ; Cancer 62 Day GP: ; Countywide waits > 52 weeks: ; District nursing referrals v 2019/20: ; Countywide inpatient activity: ERF: ; Countywide day case activity: ERF: 99.5%; Countywide 1st outpatients: ERF: ; Countywide FU outpatients: ERF: ; Countywide % virtual outpatients: 19.7%
10	Pippa Moger	To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care.	5	5	Green	Green	Position v Plan (YTD): On Plan = ; CIP v Plan (YTD): On Plan = ; Agency v Plan (YTD): +23% =

Board Assurance Framework 2021-22

Exec owner(s)	Corporate Objective	Overseeing Committee
David Shannon	1 To develop our inclusive culture of learning, research and continuous improvement to improve safety, outcomes, efficiency and effectiveness.	Trust Board
		Date of last Committee review
		Feb-22

Key Performance Indicators

No of Colleagues trained in QI	**(Feb 22)**	27 Gold	↓	No of colleagues engaged in research	**(Feb 22)**	On Plan	=	Leadership Capability Index measure	**(date)**		
				Learning: Freedom to Speak Up Index	**(May 21)**	82.70%	↑	Learning from Deaths measure	**(date)**		

Significant risks to achieving this objective	Associated risks on CRR
Lack of management capacity to deliver transformation along with business as usual at a time of response to Covid-19 and restoration services No Detailed R&D Strategy Covering the breadth of services within the Trust. Limited progress has been made in 2020 due to focus on covid studies and response. Capacity across the ICS and delay in ICS implementation delayed the implementation of the collaboration hub.	RSK-000002 (Covid)

Key controls currently in place to manage the risk to achieving this objective	Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)
People Strategy with focus on resourcing, engagement and development (including a range of recruitment and retention plans). Local workforce plans in place, system wide workforce plans in development that relate to the LTP. Colleague Health, Wellbeing & resilience Strategy. Inclusion Strategy and year 1 actions approved by People Committee. Quarterly review of research performance through regional CLRN partnership meetings. Patient Safety Board in place to review safety measures and oversee the programme of improvement. Oversight of the activities of the Somerset Collaboration Hub through the system-wide Collaboration Forum Quarterly Research and Development Executive Group oversees research projects, performance and Risks.	Improvement Board structure monitoring delivery of improvement projects (+) Quarterly Finance Committee reports (+) Quarterly reports to Trust Board on Learning from Deaths (+) Quarterly report to Trust Board on Freedom to Speak up (+) National reporting on WDES and WRES Six monthly freedom to speak up report. National Freedom to Speak Up Guardian Report (+) National Staff Survey (+) Internal Audit of Cultural Maturity (+)

Significant gaps in current controls	Areas where further assurance on effectiveness of controls is required
Detailed R&D strategy not in place to monitor and report through to Trust Board.	Regular Board reports on impact of Research and improvement.

Risk Assessment	Con	Lik	Risk Score
Initial Risk Assessment **(Apr-20)**	4	3	**12**
Current Risk Assessment **(June-21)**	4	3	**12**
Target Risk **(Plan for Mar-22**)	4	3	**12**

Strength of controls **Amber**

Strength of assurance **Amber**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

Action	Lead	Target Date	Progress

Additional key actions required to mitigate risks or improve assurance

Action	Lead	Target Date	Progress

1	Increase spread of QI training, with an aim to train 80% of colleagues. Launch silver QI training programme and cohort 4&5 of the gold QI training programme	DS	Apr-22	Somerset system Collaboration Hub established across all providers to manage delivery programmes and system-wide roll out of training. Gold and Silver training to be used across ICS. Next round of training launched in September 2021. Gold and Silver training now rolled out across the ICS. Gold training recommenced and increaes in uptake.
2	Develop a Research and Development Strategy for Somerset FT and deliver the year one objectives	DS	~~01/9/2021~~ 01/03/2022	R&D forum established. Currently all resources are focused on priority 1 and Covid studies aligned with national priorities to restart priority and commercial studies. Joint strategy to be developed with the NIHR and YDH supporting exapnsion into social and community care
3	Update and redefine the digital strategy focusing on training and empowering colleagues to utilise technology	DS	Mar-22	Complete Strategic Outline Case Approved by Trust Baord in February 2022
4	Promote the culture of transformation by the development and sharing of the '1000 improvement stories' campaign	DS	Mar-22	QI grand rounds recommence in April 2021 running monthly across the Trust. Trust Awarded Blue Plaque award for QI development and culture.
5	Develop a specific Equality, Diversity and Inclusion Strategy as part of the delivery of the People Strategy.	IC	Mar-21	Complete - EDI maturity report presented to Audit Committee in July 2020. EDS2 report presented to Board in Sept 2020, Inclusion Strategy presented to Board and approved in February 2021.

A	Provision of regular Board updates on Research, Development and Improvement.	DS	~~01/7/2021~~ Apr-22	Current status and forward plan to be discused at future Board development day
B	Establishment of the Operational Steering group & Cultural Board	IC	Apr-21	Cultural Board and Inclusion Steering Group established with first meetings in June 2021. Complete
C	Review governance of Equality, Diversity and inclusion in response to maturity audit.	IC /PB	Mar-21	
D	Undertake cultural maturity audit	IC/PB	Jun-21	Complete. Final audit presented to Audit Committee on 13 July. Action plan in place to support development needs identified
E	Update Governance Arrangements for digital programme, including refocus of digital programme board, Monthly reporting Via Trust Board, quarterly subcommittee reports.	DS	Sep-21	Complete.

6	Establish routine speaking up culture and networking meeting to coordinate feedback and action plan	IC	Dec-20	Complete. Two meetings have been held to review outputs from FTSU, staff governors and trade union colleagues.	F	Annual Report to Trust Board on Quality Improvement programme	DS	Mar-22	Annual report and status being prepared for future Board meeting.
7	Implement arrangements for the collection of regular qualitative workforce data to inform the development of a cultural dashboard for the organisation	IC	Mar-22		G				

Board Assurance Framework 2021-22

Exec owner(s)	Corporate Objective	Overseeing Committee
Peter Lewis	2 To work in collaboration with our partners in Somerset to develop an Integrated Care System and deliver the Fit for My Future strategy	Board
		Date of last Committee review
		Feb-22

Key Performance Indicators

ICP and ICB established	**(Mar 22)**			NHSE/I approval of Strat. Outline case	**(Mar 22)**			Development of Full Business Case	**(Mar 22)**		
ICS Development Plan	**(Mar 22)**			FFMF consultation programme	**(Mar 22)**						

Significant risks to achieving this objective	Associated risks on CRR
Lack of consistent co-ordination and governance arrangements to support optimum system working Individual organisational pressures and reconfiguration programmes impact negatively on implementation of system-wide transformation Delays from any public consultation programmes and any challenges impact negatively on delivery of the strategy	RSK-000005 (System Finance)

Key controls currently in place to manage the risk to achieving this objective	Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)
Fit for My Future strategy and associated governance arrangements	Chief Executive and Chair's reports to the Board (+ / -)
Appropriate representation on key committees - including ICS Shadow Board, ICS Execs, FFMF Programme Board	Integration Update reports to the Board (+)
Merger Programme Board in place	Board to Board meetings with YDH (+)
Provider Collaboration Forum and Provider Development Committee	ICS authorisation (+)
MoU with Yeovil District Hospital NHS FT	Merger Due Diligence reports (+)
Joint Executive Team meetings and action plan	Internal Audit on ICS Governance (+/-)
Strategic Outline Case for merger	Strategic Case for Merger approved by Trust Board (+)
ICS Leadership Forum	NHSE/I Feedback on ICS Development plan (+)
Merger programme and workstreams reports produced for Programme Board bi-weekly and reported to PDC and Trust Board Monthly	Scrutiny Committee oversight of FFMF Strategy (+)
FFMF Programme Board	

Significant gaps in current controls	Areas where further assurance on effectiveness of controls is required
ICS Development Plan Finalisation of governance arrangements to support the ICS and respond to the requirements of upcoming legislation change - there has been a national delay to the implementation of the new ICS arrangements	Merger due diligence and external assurance reports

Risk Assessment	Con	Lik	Risk Score
Initial Risk Assessment **(Apr-20)**	4	4	**16**
Current Risk Assessment **(June-21)**	4	3	**12**
Target Risk **(Plan for Mar-22**)	4	3	**12**

Strength of controls **Amber**

Strength of assurance **Amber**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

	Action	Lead	Target Date	Progress
1	Work with CCG and partner organisations to develop and submit ICS development plan and model constitution	PL	~~01/06/2021~~ July - 22	ICS Development plan submitted and comments received from NHSE/I. Programme management in place to deliver key legal requirements for ICB and ICS Partnership now by 1 July 2022.

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
				Intitial due dilligence completed

2	Work with YDH colleagues to develop Full Business Case for Merger	DS	~~01/11/2021~~ ~~May - 22~~ Oct-22	Workstreams established and integration charters in development. Joint executive team in place from January 2022. Agreed delay of submission of business case to October 2022. Development of integration charters and clinical integration planning in progress.	A	Detailed due diligence programme for merger between SFT and YDH undertaken to asses risks and develop plan to mitigate	DS	~~01/03/2021~~ May - 22	and reported to the Trust Board in January 2022. Quarterly updates to Trust Board and Council of Governors from May 2022.
3	Develop and define Provider Collaborative and Place Based Partnership arrangements for Somerset ICS	SM	~~01/04/2022~~ July-22	Work underway with system partners and ICS Leadership Forum to define structures within Somerset and across county borders. Chief Officer for Collaborations and Partnerships appointed to lead this work	B				
4					C				
5					D				
6					E				

Board Assurance Framework 2021-22

Exec owner(s)

Shelagh Meldrum

Corporate Objective

3	To enable people to live healthy independent lives, to prevent the onset of avoidable illness and support active self-management (Clinical Strategy Aim 1)

Overseeing Committee

Trust Board

Date of last Committee review

Mar-22

Key Performance Indicators

Establish Prevention Alliance	(Mar 22)			Early cancer diagnosis	(Jan 22)	70.3%		Treatment Escalation Plans (TEPs)	(Feb 22)	100%	=
Patient Initiated Follow Up (PIFU)	(Feb 22)	4.7%	↓						(Date)		

Significant risks to achieving this objective

Lack of leadership resource to focus on population health management
Lack of comprehensive data set to inform considerations of inequalities and health population needs
Delivery of our clinical model has a strong interdependency with system development. If there is a lack of system-wide strategy this could impair delivery of our proposed changes
Impact of COVID-19 on capacity and resource across health, public health and social care

Associated risks on CRR

RSK-000002 (Covid)

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

Clinical model developed, aligned to developing ICS clinical strategy priorities.
Continued scrutiny at the Programme Development Board, driving progress through the YDH/SFT Clinical Strategy Group
Joint Strategic Needs Assessments

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

Board merger updates (+)
CQC Insight reports (+)
Clinical model delivery milestones (- / +)
Director of Public Health Annual Report (+ /-)

Significant gaps in current controls

Driver diagram for clinical aim
KPIs for delivery of clinical aim
Shared data set for identifying health inequalities

Areas where further assurance on effectiveness of controls is required

Oversight of clinical aim and flagship priorities through Quality and Governance Committee
Develop focused governance process for implementation of clinical model/strategy across the system

Risk Assessment	Con	Lik	Risk Score
Initial Risk Assessment **(Apr-21)**	3	4	**12**
Current Risk Assessment **(June-21)**	3	4	**12**
Target Risk **(Plan for Mar-22**)	3	3	**9**

Strength of controls **Amber**

Strength of assurance **Amber**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

Action	Lead	Target Date	Progress

Additional key actions required to mitigate risks or improve assurance

Action	Lead	Target Date	Progress

1	Identify leadership within the Trust and at system level to progress this clinical aim	PL	Mar-22	The new role of Chief Officer - Collaborations and Partnerships has a specific responsibility for focus on population health management at the centre of this aim	A	Develop focused governance process for implementation of clinical model/strategy across the system	DM/ HP	Mar-22	ICS strategy being developed by Maria Heard, and Dr Lucy Knight, to be completed in June 2022, oversight of system strategy to be decided through ICS
2	Finalise driver diagrams and KPIs at system level for this strategic aim	LK	Mar-22	System work occuring in the New Year. For YDH/SFT the final versions will follow from system driver diagrams	B	Schedule oversight review(s) through the Board and QGC for this clinical aim	PB	Mar-22	Meeting schedules for 2022/23 being finalised
3	Working with public health and other partners, develop population health datasets at countywide and locality levels to inform care and support priorities	PL	Mar-22	Discussions underway with public health to develop these datasets	C				
3	Implement a Somerset Hub for the management of patients with vague symptoms of cancer or a significant benign condition, to support early diagnosis and management of cancer.	XW	Dec-21	Complete. Service now fully recruited to and all processes in place. Comms out to GPs. Service went live w/c 26th July and accepting referrals. The service was rolled-out to Bridgwater, Sedgemoor and West Somerset at the end of August (i.e. ahead of plan) to increase referral numbers more quickly. It is now fully rolled-out.	D				

4	Pilot an approach to peri-operative management, which establishes which services and pathways are required to optimise patients for surgery and provide alternatives to surgery where this is appropriate.	XW	Jan-22	Pilot underway. Circa 50 long wait surgical patients reviewed. A high proportion of patients with anaemia and diabetes identified. Interventions in terms of using existing services to support patient optimisation. Peri-op diabetes nurse now in post. Workshop held with key stakeholders on the 23rd August to agree priorities and next steps. Business case developed for first phase of longer-term model, which was approved in principle at the Elective Care Board on the 3rd March.	E				
5	Use existing Trust and primary care data-sets to understand differences in the way patients access healthcare from the more socially deprived areas of Somerset.	XW	Mar-22	Initial analysis now complete which shows significant differences between the most and the last socially deprived areas in levels of routine and suspected cancer referrals, DNAs and patient cancellations, and surgical intervention rates. Further analaysis now completed which shows a consistant pattern of higher levels of DNAs across a range of services for patients from more socially deprived areas, along with reduced levels or referral onto surgical pathways (especially T&O, general surgery and ophthalmology). This will shortly be presented to the Somerset steering group and Elective Care Board.	F				
6					G				

Board Assurance Framework 2021-22

Exec owner(s)

Dan Meron/Hayley Peters

Corporate Objective

4 To ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting (Clinical Strategy Aim 2)

Overseeing Committee

Quality & Governance Committee

Date of last Committee review

Mar-22

Key Performance Indicators

Nosocomial transmission: COVID-19	(Sep 21)	5	↑	Last 1000 Days flagship sub-progs	(Mar 22)	42	↑	Patients in adult IP beds / HTT caseload	(Feb 22)	59%	↓
% discharge summaries completed	(Feb 22)	95.0%	↑	Falls res in harm/1000 acute bed days	(Feb 22)	1.42	↓	Falls (harm)/1000 MH+comm bed days	(Feb 22)	2.06	↓
Pressure ulcers per 1000 CH bed days	(Jan 22)	0.65	↑	Pressure ulcers/1000 acute bed days	(Jan 22)	0.63	↓	Pressure ulcers per 1000 DN contacts	(Jan 22)	1.40	↓

Significant risks to achieving this objective

Increasing demand (e.g. elective activity, winter, etc.) potentially leading to reduction in quality of care (outliers, temporary staffing issues, etc.).
Issues relating to recruitment and retention of staff across specific specialties/professional groups.
Age of the estate leading to issues relating to the environment for patient care, with insufficient funds to address them all.
Reduced number/experience of colleagues in some services resulting in dilution of skills and experience
Lack of agreed system high-level clinical strategy
Impact of ongoing COVID-19 effects on safe quality of care leading to adverse outcomes for patients and poor colleague experience

Associated risks on CRR

RSK-000002 (Covid), RSK-000074 (Vaccination Programme), RSK-000003 (Aging Estate), RSK-000017, RSK-000020 (Staffing risks in MH an Community wards)
RSK-000366 (District Nursing)
RSK-000673 (Primary Care Capacity)RSK-000831 (Intermediate Care)

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

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

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

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

Significant gaps in current controls

Effective system-wide workforce plans to deliver staffing capacity in all areas
Backlog maintenance programme and process for new capital planning round

Areas where further assurance on effectiveness of controls is required

Risk Assessment	Con	Lik	Risk Score
Initial Risk Assessment **(Apr-20)**	4	3	**12**
Current Risk Assessment **(Jun-21)**	4	4	**16**
Target Risk **(Plan for Mar-22)**	3	3	**9**

Strength of controls **Amber**

Strength of assurance **Green**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

Action	Lead	Target Date	

Additional key actions required to mitigate risks or improve assurance

Action	Lead	Target Date	Progress

1	Improve performance across all Quality Account priorities.	DM / HP	Apr-22	Flagship programmes linked to QA - progress being made across all, monitored through Q&GC. Needs a refocus after COVID, being reviewed as part of the YDHSFT merger strategy. Plan to review this in early 2022, and have plans by April 2022
2	Maintain safe and effective staffing levels across all our services	DM / HP	Nov-21	Significantly impacted by COVID and current operational pressures. Minimal staffing level SOPs established for all core operational services. Safer Staffing reports to the Board have highlighted risk areas and business cases to address urgent issues developed. Investing in wellbeing, retention and recruitment as well as new types of workforce.
3	Achieve Good or Outstanding in all domains of any CQC inspection	DM / HP	Mar-22	CQC follow meetings underway focused on MUST DO areas from acute inspection in 2020. Positive feedback to date. CQC action plan monitored through Q&GC. CQC consulting on new inspection methodology.
4	Approval of Surgical Centre and AAH Business Case	DS	Nov-21	Complete- Work commenced on site and delivering to programme
5	Develop the Strategic Outline case for Musgrove 2030 redevelopment	DS	~~01/09/2021~~ 01/10/2021	Complete

A	Commission IA to look at the experience of our patients & carers leaving inpatient care (acute & community)	HP	Nov-21	Complete. Audit presented to the Audit Committee and Quality & Governance planning in in October 2021. Moderate assurance with an action plan to address issues identified, although recognising the significant changes there have been to experience in recent months due to system pressures
B	Roll out of HAI Care bundle to reduce HAI	HP	Mar-21	Complete. Review in progress.
C	Completion of revised Six facet survey to assess backlog maintenance priorities	PB	~~01/05/2021~~ Sept-21	Complete - results presented to Q&GC in September 2021
D	System wide workforce sustainability group to be established as part of the system People Board to consider workforce sustainability (inc vaccination programme)	IC	Nov-21	Terms of reference developed with system partners. Work has commenced within the system to support recruitment into roles within social care via a health contract.
E				

Board Assurance Framework 2021-22

Exec owner(s)
Andy Heron
Matthew Bryant

Corporate Objective
5 To provide support in neighbourhood areas with an emphasis on self-management and prevention (Clinical Strategy Aim 3)

Overseeing Committee
Quality & Governance Committee

Date of last Committee review
Mar-22

Key Performance Indicators

% Discharges home on Pathways 0&1	(Feb 22)	90.4%	↓	Rapid Response: Admissions prevented	(Feb 22)	247	↓	Comm/MH: % f/u activity by video	(Dec 21)	24.8%	↓
Clinic-based acute outpatients	(Dec 21)	175,102	↑	Clinic-based f/u (community)	(Dec 21)	93,732	↑	Clinic-based f/u (MH)	(Dec 21)	5,403	↑
Independent Lives flagship projects	(Feb 22)	7	=								

Significant risks to achieving this objective
Development of a comprehensive and robust alternative community model of care offer, which enables the effective reduction of reliance on bed based care and supports the same day urgent care vision.
Failure to have this risks the overall system Neighbourhood and CSOC Programme timeframes due to the impact on consultation timescales.
Lack of focus on community services in the county has included insufficient attention on prevention and health promotion at a community level.
Delay/interruption in model development due to Covid impact

Associated risks on CRR
RSK-000002 (Covid)
RSK-000366 (District Nursing)
RSK-000673 (Primary Care Capacity)

Key controls currently in place to manage the risk to achieving this objective
People Strategy with focus on resourcing, engagement and development (including a range of recruitment and retention plans). Local workforce plans in place, system wide workforce plans in development that relate to the LTP.
Colleague Health, Wellbeing & resilience Strategy. Inclusion Strategy and year 1 actions approved by People Committee.

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)
Fit for My Future Programme Board reports (-)
System reporting via FFMF Programme Board and ICS Execs (+/-)
CQC Inspection reports (+/-). CQC Insight reports
Oversight of flagship Quality Account priorities and clinical strategy through Quality and Governance Committee (+)

Significant gaps in current controls
Develop further KPIs for monitoring performance

Areas where further assurance on effectiveness of controls is required
Develop focused governance process for implementation of clinical model/strategy across the system

Risk Assessment	Con	Lik	Risk Score
Initial Risk Assessment **(Apr-20)**	3	3	**9**
Current Risk Assessment **(June-21)**	3	3	**9**
Target Risk **(Plan for Apr-22)**	3	2	**6**

Strength of controls **Amber**

Strength of assurance **Green**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

Action	Lead	Target Date	Progress

Additional key actions required to mitigate risks or improve assurance

Action	Lead	Target Date	Progress

1	Develop the operational model to support Neighbourhoods	AH	May-22	Work underway to retain the positive aspects of service models implemented at pace during Covid and also the multi-agency working required to deliver the vaccination programme across the county. Project commenced in partnership with the PCN in N Sedgemoor and the CCG to develop a new integrated approach to neighbourhood working in partnership with Primary Care. New Neighbourhoods Board to commence in February 2022 having been delayed by Covid and operational pressures in November/December 2022. New NHS@Home working group to commence February 2022.	A	Develop focused governance process for implementation of clinical model/strategy across the system	DM/HP	May-22	CSOG activity now superseded and taken forward through YDH/SFT clinical strategy development group and ICS.
				Work under way to integrate new virtual ward services for respiratory and frailty within the current framework of community services and new developments within anticipatory care.					
2	Review safe staffing workforce plans across all service areas	HP	Mar-22	Significantly impacted by COVID pressures. Minimal staffing level SOPs established for all core operational services. Safer Staffing reports to the Board have highlighted risk areas and business cases to address urgent issues developed.	B	Develop high level KPIs for key areas	AH	Mar-22	These are being developed for YDH/SFT as part of the clincal strategy work. To be completed March 2022

3	Deliver year 2 plans in the clinical strategy to integrate, streamline and standardise patient pathways - stroke, cardiac rehab and leg ulcers	AH / MB	Apr-22	Work underway through system elective care group. This work has been impacted by the pandemic response and its pressures on teams and services and needs a refocus after COVID, being reviewed as part of the YDHSFT merger strategy. However, progress includes new consultant appointed for ydh service, progress continuing in integration of leg ulcer service. Decision taken to retain South Petherton and Williton Community Hospitals within IUC directorate to further support pathway integration for stroke.	C	Development of the intermediate care dashboard	AH	Apr-22	Complete - now developed
4	Deliver post-COVID new ways of working to support delivery of care closer to home	AH / MB	Apr-22	Policies for agile working and flexible working approved and in place. Making greater use of digital communication. New Neighbourhoods Board agreed and to be established and to take its place alongside A&E DB & Elective Care Board. Continued digital virtual appointments retained across almost all community and mental health services and closely monitored within performance dashboards.	D	Development of the digital dashboard	AH	Apr-22	Complete - now developed
5	Develop plans to implement digital tools for self management	DS	Mar-22	Initial development of plans for self and remote monitoring within covid virtual ward. Further development of patient led applications through Elective recovery fund. Expansion of Oximitary Service and Virtual Ward has expanded in December 2021.	E	Implement short-term measures to mitigate risks associated with Primary Care fragility across a number of areas in Somerset - pending the development of a new neighbourhood partnership model which will be piloted in N Sedgemoor.	AH	Apr-22	

Board Assurance Framework 2021-22

Exec owner(s)

Dan Meron
Hayley Peters

Corporate Objective

6 To value all people alike, addressing inequalities and giving equal priority to physical and mental health (Clinical Strategy Aim 4)

Overseeing Committee

Quality & Governance Committee

Date of last Committee review

Mar-22

Key Performance Indicators

MCA level 1 training	(Feb 22)	93.3%	↓	Waiting times for CAMHS	(Feb 22)	96.9%	↓	MH patients physical check < 48 hrs	(Feb 22)	100.0%	↑
IAPT recovery rate	(Feb 22)	58.2%	↓	Waiting times for Learning Disabilities	(Feb 22)	100.0%	=	Safer staffing: Reg nurse MH wards day	(Feb 22)	110.1%	↓
Stolen Years flagship projects	(Feb 22)	21	=	Clinical strategy Aim 4 programmes	(Feb 22)	13	=				

Significant risks to achieving this objective

-

Associated risks on CRR

RSK-000002 (Covid)

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

Additional in year investment and successful application for transformation funding for core mental health services
Clinical model developed, aligned to Fit For My Future priorities
Open Mental Health delivery forums and performance monitoring

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

Monthly Board updates from Integration Development Board (+)
Monthly Quality and Performance reports (+)
Progress against clinical model milestones (- / +)
Feedback from Healthwatch / CVAG / PALS / Triangle of Care (+ /-)
CQC Inspection reports (+/-). CQC Insight reports (includes SHMI) (+)
Mental Health Act Committee monitoring and reports (+)
Oversight of flagship Quality Account priorities and clinical strategy through Quality and Governance Committee (+)

Significant gaps in current controls

Areas where further assurance on effectiveness of controls is required

Develop focused governance process for implementation of clinical model/strategy across the system

Risk Assessment	Con	Lik	Risk Score
Initial Risk Assessment **(Apr-20)**	3	3	**9**
Current Risk Assessment **(Jun-21)**	3	3	**9**
Target Risk **(Plan for Mar-22)**	3	3	**9**

Strength of controls **Green**

Strength of assurance **Green**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

Action	Lead	Target Date	

Additional key actions required to mitigate risks or improve assurance

Action	Lead	Target Date	Progress

1	Improve performance for our Quality Account priorities	DM / HP	Mar-22	Flagship programme 'stolen years' linked to QA - progress being made across all, monitored through Q&GC. Needs a refocus after COVID, being reviewed as part of YDHSFT merger strategy. Quality Account report presented to the Board in July 2021. Plan to review this in early 2022, and have plans by April 2022	A	Develop focused governance process for implementation of clinical model/strategy across the system	DM/HP	Mar-22	
2	Deliver year 2 plans of the clinical strategy to improve early detection and intervention for health risks in mental health and LD patients	DM / HP	Nov-21	Open Mental Health model developed and operational across the county	B	Schedule oversight review(s) through the Board and QGC for this clinical aim	PB	Mar-22	Meeting schedules for 2022/23 being finalised
3					C				
4					D				
5					E				

Board Assurance Framework 2021-22

Exec owner(s)
Dan Meron
Hayley Peters

Corporate Objective
7 To improve outcomes for people through personalised, co-ordinated support (Clinical Strategy Aim 5)

Overseeing Committee
Quality & Governance Committee

Date of last Committee review
Mar-22

Key Performance Indicators

Clinical strategy Aim 5 programmes	(Feb 22)	11	=	Function First flagship sub-progs	(Feb 22)	9	=	Acute inpatients screened: dementia	(Jan 22)	94.7%	
Connecting Us flagship sub-progs	(Feb 22)	2	=								

Significant risks to achieving this objective
Delivery of our clinical model has a strong interdependency with system development. If there is a lack of system-wide strategy then this could impair delivery of our proposed changes
The flagship programme 'connecting us' currently lacks sufficient detailed implementation plans to deliver this objective at scale
Delivery of this objective is a medium-long term endeavour, if there is a lack of prioritisation in the current climate then delivery could fall behind plan.

Associated risks on CRR
RSK-000002 (Covid)
RSK-000366 (District Nursing)
RSK-000673 (Primary Care Capacity)RSK-000831 (Intermediate Care)

Key controls currently in place to manage the risk to achieving this objective
Clinical model developed, aligned to developing ICS clinical strategy priorities.
Continued scrutiny at the Programme development Board, driving progress through the YDH/SFT Clinical Strategy Group.

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)
Board merger updates from Integration Development Board (+)
Monthly Quality and Performance reports (+)
CQC Insight reports (+)
Clinical model delivery milestones (- / +)
Oversight of flagship Quality Account priorities and clinical strategy through Quality and Governance Committee (+)

Significant gaps in current controls

Areas where further assurance on effectiveness of controls is required
Develop focused governance process for implementation of clinical model/strategy across the system

Risk Assessment	Con	Lik	Risk Score
Initial Risk Assessment **(Apr-20)**	3	3	**9**
Current Risk Assessment **(Jun-21)**	3	3	**9**
Target Risk **(Plan for Mar-22)**	3	3	**9**

Strength of controls **Green**

Strength of assurance **Amber**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

	Action	Lead	Target Date	Progress
1	Deliver year 2 plans in the clinical strategy to improve case management for complex patients	DM / HP	~~01/11/2021~~ May-22	Flagship programme connecting us, and function first' linked to QA - progress being made across all, monitored through Q&GC. Being reviewed as part of YDHSFT merger strategy. Plan to review this in early 2022, and have plans by April 2022
2	Deliver year 2 plans in the clinical strategy to improve care for patients in the last 1000 days	DM / HP	~~01/11/2021~~ Mar-22	Flagship programme 'last 1000 days' linked to QA - progress being made across all, monitored through Q&GC. Being reviewed as part of YDHSFT merger strategy

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress
A	Develop focused governance process for implementation of clinical model/strategy across the system	DM/HP	Mar-22	CSOG activity now superseded and taken forward through YDH/SFT clinical strategy development group and ICS.
B	Schedule oversight review(s) through the Board and QGC for this clinical aim	PB	Mar-22	Meeting schedules for 2022/23 being finalised

3	Deliver year 2 plans in the clinical strategy to support patients to use medication effectively to optimise their health and resilience	DM / HP	~~01/11/2021~~ Mar-22	Pharmacy services across SFT and YDH in the process of integration being reviewed as part of the YDHSFT merger strategy.	C				
4	Extend clinical model work on this objective to include YDH and other system partners	DM / HP	Mar-22	Being reviewed as part of YDHSFT merger	D				
5	Implementation of the NHSE/I personalised care approach	DM/ HP	Mar-23	Already started in areas, needs oversight and co-ordination in new merged trust.	E				

Board Assurance Framework 2021-22

Exec owner(s)	Corporate Objective	Overseeing Committee
Isobel Clements	8 To develop a workforce that is: • Safe, with the skills and expertise needed to enable innovation and provision of a high quality service. • Diverse, engaged, motivated and resilient, demonstrating the values and behaviours we expect • Resourced appropriately, flexible and agile to support outstanding care in the most appropriate setting	People Committee **Date of last Committee review** Mar-22

Key Performance Indicators

Vacancy levels	(Feb 22)	5.8%	↓	Sickness Rate	(Jan 22)	6.4%	↓	Mandatory Training	(Feb 22)	91.8%	↓
Stress / anxiety - days lost	(Jan 22)	383	↑	Staff turnover	(Jan 22)	11.4%	↓				

Significant risks to achieving this objective

Issues relating to supply, recruitment and retention of staff across specific specialties/professional groups.
Failure to develop an organisational inclusive culture that supports the vision and value of the merged trust.
Lack of management capacity to deliver transformation along with business as usual.

Associated risks on CRR

RSK-000002 (Covid); RSK-000017, RSK-000020 (Staffing risks in MH and Community wards) RSK-000690 (Unsustainable pressure on staff)RSK-000831 (Intermediate Care)

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

People Strategy Year 4 priorities with focus on resourcing, engagement and development (including a range of recruitment and retention plans). Local workforce plans in place, system wide workforce plans in development that relate to the LTP. Colleague Health, Wellbeing & resilience Strategy. Inclusion Strategy and year 1 actions approved by People Committee.

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

Oversight of People Strategy via People Committee (+ / -)
Monthly Quality and Performance Reports (+ / -)
National Staff Survey (+)
Pulse Check (+) - newly launched running monthly testing 400 colleagues per month

Significant gaps in current controls

Areas where further assurance on effectiveness of controls is required

Risk Assessment	Con	Lik	Risk Score
Initial Risk Assessment **(Apr-20)**	4	3	**12**
Current Risk Assessment **(Jan 22)**	4	3	**12**
Target Risk **(Plan for Mar-22)**	4	1	**4**

Strength of controls **Green**

Strength of assurance **Green**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

Action		Lead	Target Date	Progress
1	Develop an inclusive culture by supporting network development and ongoing development at Board level	IC	Sep-21	Cultural Board and Inclusion Steering Group established with first meetings in June 2021. Complete
2	Implement the Year 4 priorities of the People Strategy	IC	Mar-22	

Additional key actions required to mitigate risks or improve assurance

Action		Lead	Target Date	Progress
A	Establishment of the Operational Steering group & Cultural Board	IC/MB/JY	Apr-21	Complete. Cultural Board and Inclusion Steering Group established with first meetings in June 2021. Complete
B	System wide workforce sustainability group to be established as part of the system People Board to consider workforce sustainability (inc vaccination programme and social care)	IC	Mar-21	Complete. Terms of reference in development with system partners. Work continues within the system to support recruitment into roles within social care via the use of incentives.

3	Implement the Year 4 priorities of the Colleague Health & Wellbeing Strategy	IC	Mar-22	Implementation in train and monitored through People Committee	C	People Committee support the roll over of the People Strategy into year 4 whilst new people strategy under development for the new provider. Year 4 priorities set & work underway.	IC	Mar-22	Ongoing - delivery monitored through the people committee
4					D	Develop and implement a programme of digital training and development	DS	Mar-22	First phase of digital training programme developed and commenced.
5									

Board Assurance Framework 2021-22

Exec owner(s)

Andy Heron
Matthew Bryant

Corporate Objective

9 To deliver levels of performance that are in line with our operational plans, system ambitions and can demonstrate progress towards the delivery of outstanding care

Overseeing Committee

Trust Board

Date of last Committee review

Mar-22

Key Performance Indicators

A&E 4 Hour Target	(Feb 22)	79.7%	Cancer 62 Day GP	(Jan 22)	60.8%	Countywide waits > 52 weeks	(Feb 22)	2,489
District nursing referrals v 2019/20	(Feb 22)	-0.2%	Countywide inpatient activity: ERF	(Feb 22)	54.3%	Countywide day case activity: ERF	(Feb 22)	99.5%
Countywide 1st outpatients: ERF	(Feb 22)	120.9%	Countywide FU outpatients: ERF	(Feb 22)	110.8%	Countywide % virtual outpatients	(Feb 22)	19.7%

Significant risks to achieving this objective

System plans do not include sufficient capacity to meet demand and bring performance back in line with national targets.
Additional capacity issues relating to staffing and infrastructure in specific specialties.
A range of recruitment and retention plans as part of the People Strategy.
Impact of COVID-19 response on capacity and delivery
Staff shortages in the social care market risk impacting on patient flow from hospitals and intermediate care.

Associated risks on CRR

RSK-00007, RSK-000012 (RTT Risks)
RSK-000008 (Cancer Standards)
RSK-000009 (Diagnostic Waits)
RSK-000015 (Dental Waits)
RSK-000831 (Intermediate Care)

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

Performance monitored through the Monthly Cancer Performance and RTT Steering Groups (both of which cover diagnostics), and the Directorate QOFP process. An enhanced weekly Cancer PTL review is also in place
Directorate Governance, F&P and QOFP processes
COVID Recovery Co-ordination Group reports and plans
Intermediate Care Programme Board
Somerset Elective Care Board

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

Performance monitored through QPOF process (+ /-).
Monthly Quality and Performance reports (+ / -)
External review through quarterly NHSI meetings (+ / -)

Significant gaps in current controls

Insufficient capacity to meet demand.

Areas where further assurance on effectiveness of controls is required

Risk Assessment	Con	Lik	Risk Score
Initial Risk Assessment **(Apr-20)**	4	4	**16**
Current Risk Assessment **(June-21)**	4	4	**16**
Target Risk **(Plan for Mar-22)**	4	3	**12**

Strength of controls **Amber**

Strength of assurance **Green**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

Action	Lead	Target Date	

Additional key actions required to mitigate risks or improve assurance

Action	Lead	Target Date	Progress

1	Implement elective recovery plans for months 1 to 6 (H1), including maximal restoration of recurrent capacity within Covid-19 constraints, and additional capacity through insourcing and other sources.	MB	Sep-21	Complete. In Q1 delivered above planned levels of activity; the system earned additional funding above forecast to reinvest in elective care in the second half of 2021/22. Q2 below plan other than for first outpatients. This is due to: 1) delays in orthopaedic and ophthalmology insourcing activity coming on line (inpatient, day-case and follow-up outpatients), 2) bed pressures as a result of emergency stays increasing by circa one day (intermediate care and patient acuity), and 3) a delay in some outpatient IT system (i.e. I've Arrived) which would increase clinic throughput coming on line. (system being piloted from early December).	A	Establish weekly system performance review meeting, to enable delivery to be monitored and corrective actions to be designed/agreed.	MB	May-21	Complete. Meeting established in May. Action log and monitoring reports in place. Reports in to the Elective Care Board on a monthly basis.
2	Develop and implement plans for reducing echo and MRI diagnostic over 6 week waiters, to support the system-wide ambition of achieving the 99% standard by March 2022.	XW	Mar-22	Changes made to approach to recruitment. 5.4 WTE echo physiologists appointed (4 overseas with lead-in times to arrival). A revised recovery trajectory has been developed, which suggests the backlog will be reduced from the current level of circa 1400 to circa 1150 by the end of June. This is a slower rate of improvement due to more capacity needing to be diverted to manage inpatients and follow-ups. The service is currently interviewing for 2 x band 7 posts. Outsourcing or MRI scans to Alliance Medical (Bridgwater) took place during August to November. The Rutherford MRI van has been retained for the system to support backlog clearance (two days dedicated to SFT). An additional MRI van has been operational 2-3 days a week since October. Rutherford Centre opened in September providing additional static MRI capacity for the more complex scans.	B	Redesign, pilot and implement the process for transferring elective patients to the Independent Sector (IS), to improve uptake of alternative capacity options. Undertake choice survey with patients to understand factors affecting Somerset patient choice.	XW	Sep-21	Complete. Process redesigned. Pilot underway for General Surgery, which has resulted in an improvement in uptake of the offer of earlier surgery in the IS. This process is now being rolled-out to other specialties.

				As a result of the additional capacity MRI over 6 week waiters reduced from 1133 in August to 226 at the end of February. The echo backlog has now reduced from a peak of 1875 in August to 1408 at the end of February.					
3	Implement Rapid Diagnostic Service (RDS) pathways for the high volume / high impact cancer pathways. This will support delivery of the Faster Diagnosis Standard and reduce the number of patients exceeding the 62-day standard.	XW	Dec-21	Prostate one-stop (MRI + outpatients) pathway process commenced in July and plans are now being developed for roll-out. Artificial Intelligence pilot for the on the spot reporting of lung abnormalities on chest x-ray commenced in November, following some technical issues. This will enable patients with potential lung cancers to have a CT either the day of their x-ray or within 72 hours. Upper GI direct access (straight to scope) pathway commenced at the start of December. Funding requested and granted from SWAG Cancer Alliance for colorectal referral hub for Somerset, to support primary care in FIT testing and full referral work-up for suspected cancer referral. This is now operational. Gynae RDS project underway, with changes made to the 2-week wait referral form. A self-referral post-	C	Continue to manage theatre capacity in line with patient need (i.e. clinical priority), with the aid of weekly reports on demand for theatre sessions by priority. Develop an approach for identifying delayed outpatients most at risk of harm due to length of waits for prioritising clinical reviews of these patients. Establish regular communication with long waiting patients to ensure they are aware of who to contact if their condition worsens.	XW	Aug-21	Complete. Protocol under development for routine identification of at risk patients. Agreed at the Clinical Leadership group on the 24th June. YDH has reviewed and will be adopting a similar approach. SFT has now put the process into practice. First letters to patients went out in September. Monitoring/tracking report in place
				menopausal bleed pathway is under development. A navigator has been appointed to speed-up pathway management. A one-stop neck lump clinic for Head & Neck cancers is under development. Work on pathways continuing. However, Faster Diagnosis (28-day) standard achieved October 21 to December 21 (not in January due to the impact of bank holidays).					

4	Implement a pan-Somerset Rapid Diagnostic Service (RDS) hub for patients with vague symptoms of cancer or significant benign disease, to reduce late or emergency presentations.	XW	Aug-21	Complete. Service now fully recruited to and all processes in place. Comms out to GPs. Service went live w/c 26th July and accepting referrals. Rolling-out to Bridgwater, Sedgemoor and West Somerset at the end of August (i.e. ahead of plan) to increase referral numbers more quickly. It has now been fully rolled out.	D	Single waiting list to be established for Somerset	XW	Dec-21	Single Point of Access (SPoA) cataract service for Somerset in place with 69% of all Somerset referrals going through the SPoA and a 17% reduction in referrals to SFT (due to an increase in uptake of the IS) in the latest month's data (April). Options for rolling out to other high volume specialties continue to be developed. Options for rolling out to other high volume specialties now linked with the roll-out of the Advice & Guidance system currently being procured, which has been delayed due to a formal challenge to the procurement process.
5	Design and deliver a programme of outpatient transformation including increased usage of Advice First (Advice & Guidance), expansion of virtual consultations and Patient Initiated Follow-Ups (PIFU), to make best use of available capacity and help to ensure attendances at hospital add value.	MB/XW/ DS	Mar-22	Improvement Team support identified and a programme is now uncder active development. Regional data being used to identify PIFU and virtual consultation opportunities. Services have each developed virtual consultation plans. These have been reviewed to understand a) opportunities for further development, and 2) priorities for support needed to deliver the greatest step-change for the Trust/system. PIFU comms pack developed. A project manager to support Outpatient Transformation now in post. A new Advice & Guidance system is being procured. Roll-out during Q4 2021/22 has been delayed by a formal challenge to the procurement process. An Outpatient Improvement Programme launch is planned in April.	H	Temporary expansion of Rapid Response to be able to offer a contingency alternative to domiciliary care now being developed.	AH		

6	Develop restoration plans for months 7 to 12 (H2), to sustain recovery during the winter and where possible accelerate.	XW	Oct-21	Complete. H2 plans/forecasts developed and bids for investment in additional capacity have been submitted to Region. Confirmation received that the majority of the bids for investment were successful, with Somerset as a system being awarded more than their proportional allocation.	F				
7	Implement additional investment in District Nursing within the night-time service and 7 day working pilot in N. Sedgemoor	AH	Apr-22	Develop business case for further expansion of DN 7 day services within the Taunton and South Somerset areas, closely integrated with new virtual ward and anticipatory care initiatives	G				
8	Support Adult Social Care in the development of new workforce plans for domiciliary care which is vital to maintain flow within the intermediate care service.	AH	Dec-21	Proposals discussed with ICS Chief Execs and senior system leads. Support developed within SFT to recruit to roles that can support social care	H				

Board Assurance Framework 2021-22

Exec owner(s)
Pippa Moger

Corporate Objective
10 To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care.

Overseeing Committee
Finance Committee

Date of last Committee review
Mar-22

Key Performance Indicators

					(Date)						
Position v Plan (YTD)	(Mar 22)	On Plan	=	CIP v Plan (YTD)		(Mar 22)	On Plan	=	Agency v Plan (YTD)	(Mar 22)	+23%	=

Significant risks to achieving this objective
Failure to identify and deliver sufficient CIP schemes.
Increasing demand (e.g. elective activity, winter, COVID etc.) leading to increased costs.
Agency costs to deliver required escalation.
Lack of pace of strategic system-wide changes to address the underlying deficit.

Associated risks on CRR
RSK-000002 (COVID)
RSK-000005 (System Finance)

Key controls currently in place to manage the risk to achieving this objective
Financial control systems and processes.
COVID-19 costs being captured and reported separately
System wide discussions to ensure overall system position is managed within available resources.
Control and oversight of CIP through Quality, Outcomes, Finance and Performance process and CIP Review Group.

Key assurances relating to effectiveness of the controls. Either positive (+) or negative (-)
Internal and external audit programme (+).
Financial oversight via Finance Committee (+/-).
System Finance Assurance Group (+/-).

Significant gaps in current controls

Areas where further assurance on effectiveness of controls is required

	Con	Lik	Risk Score
Initial Risk Assessment **(May-21)**	5	2	**10**
Current Risk Assessment **(May-21)**	5	1	**5**
Target Risk **(Plan for Mar-22)**	5	1	**5**

Strength of controls **Green**

Strength of assurance **Green**

	Controls and Assurances
Green	No gaps in controls or assurances
Amber	Some gaps in controls or assurances
Red	Significant gaps in controls or assurances

Key actions to achieve objective

	Action	Lead	Target Date	Progress
1	Ongoing work to identify additional CIP schemes	PM	Mar-22	Directorates and other service areas continue to deliver schemes to meet their planning target in year Directorates have now scoped and will deliver CIP plans for the value required in 21/22. Work has now started scoping 2022/23 schemes.
2	Identify additional opportunities, through the use of available benchmarking, Model Hospital, GIRFT and other data sources to identify further efficiencies and improve productivity.	PM	Mar-22	CIP workshop planned for July to share approaches and ideas and to explore further opportunities The model hospital has recently been updated for the 20/21 reference costs so this will be an area for direcotrates to review as part of the scoping for 2022/23 plans.
4				

Additional key actions required to mitigate risks or improve assurance

	Action	Lead	Target Date	Progress

Risk Register List report

Report Date: **20-Apr-2022**

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

Reference	Category	Scope	Description	Owner	Last review	Next review	Original score	Current score	Risk response	Target score	Latest comment
RSK-000002	Corporate Risk	Organisation	COVID - Risks associated with Covid 19 Pandemic.	Peter Lewis	15-Mar-22	30-Apr-22	25	25	Tolerate	25	Risk score increased based on current impact on services of some admissions on top of current pressures and significant staff absence.
RSK-000003	Corporate Risk	Organisation	Aging Estate - if the Trust is not able to invest sufficiently in backlog maintenance on the acute hospital site, then there is a risk to the sustainability of high quality care in some specialties.	David Shire	11-Apr-22	31-Oct-22	20	20	Tolerate	20	Regardless of plans for some buildings (e.g. critical care, theatres, maternity) and other smaller departments (breast care, haematology) to be replaced, some service disruption will be inevitable. The risk has been further increased due to the need for the Trust to identify further controls on capital which mean less funding available for reducing maintenance backlog.
RSK-000005	Corporate Risk	Organisation	Somerset STP system finances - risk of being unable to reduce demand for services to allow the system savings required to be delivered to meet the overall control total.	Pippa Moger	23-Mar-22	30-Jun-22	20	25	Treat	15	The financial outlook will be challenging and system partners are committed to resolving the underlying deficit. Planning guidance for 2022/23 is expected in Mid Dec and will be used to update the funding assumptions alongside the ongoing work to refresh expenditure run rate information. System partners have discussed how to progress the development of recovery plan to move the system back into financial balance in a realistic timescale.
RSK-000007	Corporate Risk	Organisation	RTT - if we do not have sufficient capacity and resource currently allocated to meet the demand for non-admitted and admitted care then waiting times will continue to lengthen.	Matthew Bryant	20-Apr-22	30-Jun-22	16	20	Treat	20	All aspects of acute trust RTT performance continue to be heavily impacted by the recent COVID-19 outbreak, exacerbated by the Omicron variant. There is an active programme of system-wide actions to support long term recovery, which includes the shared use of capacity across the system, ways of re-routing demand to available capacity, full use of available Independent Sector capacity, and ways of managing demand differently.
RSK-000008	Corporate Risk	Organisation	Cancer Standards - if we continue to fail to meet the 62-day referral from GP Cancer Standard, then this could result in adverse patient experience.	Matthew Bryant	20-Apr-22	30-Jun-22	16	15	Treat	15	Patients are continuing to be prioritised for cancer treatment, in line with the national prioritisation codes and timescales established during Covid. Patients treated for a colorectal cancer made-up 50% of all the breaches of the 62-day standard. A review has been undertaken of the colorectal pathway and a working group has been established to identify interventions.
RSK-000009	Corporate Risk	Organisation	Diagnostic Waiting Times Performance - if we continue to experience growth in demand greater than our ability to supply capacity for key diagnostic modalities, then we will fail to meet national standards.	Matthew Bryant	20-Apr-22	30-Jun-22	16	16	Treat	12	Social distancing, PPE and cleaning measures put in place to manage patient care during the COVID-19 outbreak continue to impact on throughput. Additional MRI capacity is now being utilised at a local Independent Sector provider and Rutherford diagnostic centre in Taunton has opened, providing an additional CT and MRI scanner.
RSK-000012	Corporate Risk	Organisation	Waiting Times - if we are unable to provide sufficient capacity to enable us to meet clinically acceptable waiting times for patients for non-admitted and admitted care, including follow up intervals then this has the potential to impact on the clinical outcomes for patients.	Matthew Bryant	20-Apr-22	30-Jun-22	20	20	Treat	15	Detailed discussion on elective care recovery at Quality & Governance Committee throughout 2021/22, including review of actions taken and planned for Outpatients, Inpatients / Day-Case, Diagnostics, RTT and cancer.

RSK-000015	Corporate Risk	Dental Services	Dorset Dental General Anaesthetic Paediatric List - if the waiting list exceeds waiting targets then health outcomes and patient experience will be adversely affected	Alison Ficarotta	28-Oct-21	30-Nov-21	15	15	Treat	12	Numbers of GA lists available to the service have now returned to pre COVID levels at MPH, YDH and Dorset with one additional list in Dorset. However, the number of patients treated per list in Dorset is reduced by 20%. Additional ad hoc lists are sourced wherever possible and all children waiting more than 18 weeks for a GA appointment continue to be clinically reviewed prior to their appointment as dental needs may have changed during the length of time waiting.
RSK-000831	Corporate Risk	Intermediate Care	If social care are unable to commission sufficient capacity/obtain sufficient workforce and deliver in line with system plans and to meet demand in a timely way then we will see patients delayed in acute and community hospital beds. This will lead to adverse outcomes for individual patients, high occupancy rates (which also lead to poor outcomes for a much larger group of patients), a need for escalation beds, compromising colleague experience in a significant way and resulting in high levels of unplanned overspend. It will cause poor ED performance, and cancellation of elective patients causing further patient safety risks, as well as a reputation and regulatory risk associated with this.	Matthew Bryant	05-Apr-22	30-Apr-22	15	25	Treat	15	Strategic and regional action is being taken to address the difficulties in the domiciliary care market, which account for two thirds of the current delays on the D2A pathway.
RSK-000017	Corporate Risk	Community Hospitals Wards	Community Hospital staffing levels - if the current problems with community staffing levels and the national and local recruitment market for nurses persists, there is a risk of failing to meet safer staffing levels in Community Hospitals.	Jayne Cooper	29-Nov-21	30-Apr-22	15	20	Treat	12	Risk score increased based on current position.
RSK-000673	Corporate Risk	Organisation	Issues with the current capacity and future resilience of primary care in Somerset are significantly impacting on capacity across the Trust in areas already under pressure (including ED, MIUs, district nursing, etc.)	Andy Heron	16-Mar-22	30-Mar-22	16	16	Tolerate	16	Discussed at Quality & Governance Committee in October 2021.
RSK-000366	Corporate Risk	District Nurses	There is an ongoing shortfall in staffing levels within the District Nursing Teams.	Tracy Evans	29-Mar-22	30-Jun-22	16	16	Treat	12	The impact of this staffing shortfall has resulted in: • Patients being prioritised on a daily basis with appointments being cancelled and rebooked for another day • Delay in assessments for example, wound assessments, leg ulcer assessments (to include ABPI measurements), continence and health needs assessments • District Nurses not having time to undertake varied and comprehensive clinical assessments
RSK-000004	Corporate Risk	Organisation	Demand - if demand for services continues to increase in-line with demographic trends then the Trust will not have sufficient capacity.	Peter Lewis	10-Jan-22	01-Apr-22	20	20	Tolerate	16	Work to address this risk is currently limited due to the COVID-19 pandemic.
RSK-000399	Corporate Risk	Therapies	Increased vacancy rate in Occupational Therapy across the organisation impacting on patient outcomes and flow	Clare Boobyer-Jones	20-Apr-22	31-Jul-22	16	20	Treat	12	Increased risk due to avoidable harm through deconditioning. Workforce position remains constrained. Unmet need P1 daily
RSK-000588	Corporate Risk	Podiatry	Community podiatry services are under significant pressure due to high levels of demand and high vacancy rates.	Toni Hall	16-Mar-22	31-May-22	16	16	Treat	12	
RSK-000690	Corporate Risk	Organisation	Ongoing unsustainable pressure to colleagues in the Trust	Isobel Clements	15-Mar-22	31-May-22	16	16	Treat	12	

RSK-000862	Corporate Risk	Acute Hospital Wards	Escalation Beds - risks to patient safety and patient experience from increased need for escalation beds at MPH, including doubling up in single rooms in the Jubilee Building	Alison Wootton	20-Apr-22	30-May-22	16	20	Tolerate	20	Linked to a large number of risks in specific departments, including medical and surgical wards, cardiology, theatres and ED.
RSK-000082	Corporate Risk	Organisation	Nurse and AHP Staffing Shortage and increased activity across all services - Risk of impact on quality of patient care and increased pressure on colleagues	Alison Wootton	04-Apr-22	29-Apr-22	20	15	Treat	6	This risk is linked to an increasing number of risks in individual departments across acute wards and community services.
RSK-001046	Corporate Risk	Safeguarding	Rio disaggregation (separation of systems) - key risk is missing key information that informs safeguarding action or risk assessment	Richard Painter	11-Apr-22	03-Aug-22	20	16	Tolerate	15	RiO disaggregation is due to go live in August 2022 at the request of Somerset County Council (SCC). Public Health Nursing (PHN) under the jurisdiction of SCC are setting up their own independent version of the RiO patient record system. The head of PHN has provided assurance that IG arrangements for the transfer of information is safe.

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Q4 2021/22 Board Assurance Framework and Corporate Risk Register
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Head of Risk
PRESENTED BY:	Director of Corporate Services
DATE:	3 May 2022

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

Executive Summary and Reason for presentation to Committee/Board	The Board Assurance Committees carry out detailed monitoring and review of the principal risks that relate to the organisation's strategic objectives and priorities. These risks are proactively managed and reported on as a minimum requirement quarterly to the Board Assurance Committees and to the Board of Directors through the BAF. The Board Assurance Committees provides assurance to the Board with regard to the continued effectiveness of the Trust's system of integrated governance, risk management and internal control. Committees continue to review the extent to which they are assured by the evidence presented for each risk. The BAF includes all principal risks that represent higher levels of opportunity/threat, which may have a major, or long-term impact on benefits realisation or organisation objectives and which may also impact upon the strategic objectives and outcomes positively or negatively. The BAF was reviewed and updated by the Executive Leads for each Principal Risk to the organisation. Scrutiny of the risks takes place within the following Board Assurance Committees: Finance Committee in Common, Audit Committee, Governance and Quality Assurance Committee and Workforce Committee. The draft strategic objectives for 2022/23 were discussed at the April 2022 Board Development Day and will be further considered as part of the review of the BAF. A revised Q1

	Assurance Framework will be presented to the Trust Board at its meeting in July 2022.
Recommendation	The Board is asked to: • review the Board Assurance Framework and Corporate Risk Register and note the actions being taken to address the risks identified; • and consider the objectives and risks reserved to the Board.

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

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

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

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

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

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

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

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

Q4 2021/22 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

1. INTRODUCTION

1.1 The Department of Health provided guidance on Assurance Frameworks in 2003. The document states that, '*the Assurance Framework provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives*'. The Board Assurance Framework (BAF) forms part of the Trust's risk management strategy and is the framework for identification and management of strategic risks.

1.2 In line with the Trust's Risk Management Strategy and the revised monitoring arrangements therein, the Board will receive the BAF on a quarterly basis (April, July, October and January). The BAF provides evidence to support the Annual Governance Statement.

2. BOARD ASSURANCE FRAMEWORK

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

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

2.3 The identified high-level objectives for Yeovil District Hospital are:

- Care for our Population
- Develop our People
- Innovate and Collaborate
- Develop a Sustainable System.

2.4 Underneath each high-level objectives are various key priorities to be achieved.

3. WHAT IS ASSURANCE?

3.1 Assurance:

Provides: Evidence/Confidence/Certainty

To: Board/Managers/Stakeholders
That: Action is taken as required

3.2 In order to make this assessment, Board Assurance Committees consider the following questions, based on the evidence provided on the BAF for each risk:

- To what extent are the key controls (i.e. existing controls) effective?
- What are the gaps in the controls, how significant are they in relation to the current risk score?
- What internal assurances and *independent* external assurances are in place? Are they sufficient/adequate and are there any gaps? Are additional assurances required?
- Are there any areas where assurance is duplicated, repeated or excessive when compared with the activity undertaken?
- What actions are in place to further mitigate the risk to the agreed 'tolerated' level? Are they current and active? Are they adequate? Does more need to be done?

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

Risk Quantification Matrix

3.4 As per the Trust's current Risk Management Strategy, risks are scored using the 5x5 matrix:

Consequence	**Likelihood**				
	Rare - 1	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Certain - 5**
Negligible - 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

Updates and Changes to the Board Assurance Framework

3.5 One of the purposes of the BAF is to ensure that all principal risks are mitigated to an appropriate or acceptable level. It is expected that not all risks will be able to have mitigating controls that reduce the risk to the target level. The attached BAF details the total number of risks to the four Trust strategic objectives that are scored as follows (based on current risk score).

3.6 The financial risk assessments for Quarter 4 confirm achievement of targets in year and would be rated below the level of the corporate risk register on that basis for 2021/22. However, the risks looking to 2022/23 have been subsequently assessed and are reflected in the risk ratings identified in this report.

Objective	High Risk (16-25)	Significant Risk (12-15)	Moderate Risk (8-10)	Low Risk (1-6)
	Current Risk Score			
Care for our Population – *We will seek and seize opportunities to continually improve the quality, accessibility and safety of our services, and the experience we provide. We will support and encourage our local population to live healthier lives.*	**1**	**2**	**0**	**0**
Develop our People - *We will ensure our teams have the skills, capacity and environment to enable them to provide the care that they aspire to. We will make our hospital an employer of choice.*	**0**	**3**	**0**	**0**
Innovate and Collaborate - *As part of a sustainable Somerset care system, and working with our partners, we will develop and deliver outstanding services, employing new models of care and innovative technology.*	**1**	**0**	**4**	**0**
Develop a Sustainable System - *We will manage our resources responsibly to ensure the sustainability of our services and the local care system, without compromising on safety and quality.*	**0**	**3**	**0**	**1**

Headline information by Objective (BAF)

3.6 The principal risks identified and monitored by the Board of Directors and Board Assurance Committees through the BAF are:

Care for our Population – *We will seek and seize opportunities to continually improve the quality, accessibility and safety of our services, and the experience we provide. We will support and encourage our local population to live healthier lives.*	**Current Risk Rating** Likelihood x Impact	**Target Risk Rating** Likelihood x Impact
SR1: There is a risk that increasing levels of demand and the COVID-19 pandemic would exceed capacity leading to challenges in maintaining the safety of our services, leading to deteriorating operational performance	**4x5**	**2x4**
SR2: There is a risk to the Trust of static or decreasing population health if the wider system is adversely affected by the COVID-19 pandemic and is unable to prioritise prevention and healthy living activities	**4x3**	**2x3**
SR3: There is a risk that our scale (or other factors, including COVID-19) results in us not being able to continue to achieve nationally mandated quality standards leading to vulnerability in the services we provide	**3x4**	**1x3**

Develop our People - *We will ensure our teams have the skills, capacity and environment to enable them to provide the care that they aspire to. We will make our hospital an employer of choice.*	**Current Risk Rating** Likelihood x Impact	**Target Risk Rating** Likelihood x Impact
SR4: There is a risk that we fail to recruit and retain key staff with the skills required resulting in us being	**4x3**	**2x3**

Develop our People - *We will ensure our teams have the skills, capacity and environment to enable them to provide the care that they aspire to. We will make our hospital an employer of choice.*	**Current Risk Rating** Likelihood x Impact	**Target Risk Rating** Likelihood x Impact
unable to maintain service continuity, increasing costs and negatively impacting on the quality of service we provide		
SR5: There is a risk that the Trust does not develop a future workforce strategy resulting in a workforce that is not aligned with the Phase 1-4 COVID-19 recovery and ICS development	**4x3**	**2x3**
SR6: There is a risk that the Trust does not have an engaged workforce performing at the required level in order achieve its ambition of becoming an employer of choice	**4x3**	**2x2**

Innovate and Collaborate - *As part of a sustainable Somerset care system, and working with our partners, we will develop and deliver outstanding services, employing new models of care and innovative technology.*	**Current Risk Rating** Likelihood x Impact	**Target Risk Rating** Likelihood x Impact
SR7: There is a risk that we do not deliver our digital strategy and sufficiently transform our services leading to poor patient experience and increased benchmarked costs	**3x3**	**2x3**
SR8: There is a risk that in a digital age heavy reliance on electronic systems may expose the Trust to risks around business continuity, data protection and internal systems reliance	**3x3**	**2x3**
SR9: There is a risk of failure to agree and adopt new models of care and a clear clinical strategy across Somerset leading to increased demand and unsustainable services at YDH	**4x4**	**2x3**
SR10: There is a risk of ineffective partnership working (and other factors) slowing the development of an Integrated Care System within Somerset	**2x4**	**2x4**
SR11: There is a risk that the volume of change activity leads to an inability to focus and deliver on priorities	**3x3**	**2x3**

Develop a Sustainable System - *We will manage our resources responsibly to ensure the sustainability of our services and the local care system, without compromising on safety and quality.*	**Current Risk Rating** Likelihood x Impact	**Target Risk Rating** Likelihood x Impact
SR12: There is a risk that we fail to address and reduce our underlying deficit by not achieving our financial plans due to non-delivery of our cost improvement and transformation programmes and inability to secure adequate income	**3x4**	**1x4**

SR13: There is a risk that we take decisions that compromise quality and safety in order to achieve financial balance	**2x3**	**2x3**
SR14: There is a risk of not delivering our strategic capital programme and therefore not continuing to develop and to maximise the effectiveness of our facilities, infrastructure and equipment	**3x4**	**2x3**
SR15: There is a risk that the group's subsidiary companies fail to deliver their plans which could undermine the Trust's strategic and financial plans and performance	**3x4**	**2x3**

4. CORPORATE RISK REGISTER

Overview

4.1 This risk report aims to provide details of the key risks detailed on the Trust's corporate risk register at the end of Quarter 4 2021/22. The report focuses on those risks scoring significant or higher (12+) on the risk matrix.

4.2 The top 6 risks to the organisation during Quarter 4 2021/22 were:

- Risk 331 – Continued high level of over 21 day length of stay and those patients waiting for care at alternative providers due to insufficient intermediate care capacity. This results in patients not being cared for in the most appropriate place; delay in patients onward care and treatment; adverse outcomes for individual patients; high occupancy rates leading to poorer outcomes for larger groups of patients; reduction in patient flow; Trust's ability to maintain performance standards; financial risk to opening additional escalation areas; compromised colleague experience; poor ED performance; cancellation of elective patients; patient safety risks; and reputational and regulatory risks to the organisation *Risk Score – 25 (High Risk)*

- Risk 100 – Risk of breaching National RTT Standards at aggregate and specialty level. This is due to performance deterioration following the direct impact of Covid as well as the residual "catch up" in referrals missed during the pandemic period and other operational limitations. This could result in patients waiting longer than expected resulting in poorer health outcomes *Risk Score – 20 (High Risk)*

- Risk 198 - Reduced staff resilience including staff burn out due to stress/anxiety related to workplace pressures, prolonged increased demand on services, prolonged impact of the pandemic on staff resilience to cope, changes in personal circumstances for staff e.g. financial impacts, anxiety regarding new variants of COVID19, anxiety relating to the potential merger with SFT and working conditions staff are being expected to work within particularly in areas undergoing building works *Risk Score – 20 (High Risk)*

- Risk 405 - Inability to safely deliver the Acute Oncology Service with the required nursing skills and expertise to manage this cohort of patients. Due to 0.6WTE currently in post with a shortfall in the funded establishment of 2xWTE (1xWTE long-term sickness and 1xWTE vacancy). To meet the needs of the service, a further 1xWTE is also required to bring the

establishment to 3.6Xwte. Resulting in a limited Acute Oncology Service, inability to follow up patients, inability to provide training to ward nurses and ED staff, impact on staff wellbeing and continued non-compliance with mandatory national audits. *Risk Score – 20 (High Risk)*

- *SHS Risk* - Risk 728 - Reduced staff resilience including staff burn out due to stress/anxiety related to workplace pressures, increased demand on services, impact of the pandemic on staff resilience to cope, changes in personal circumstances for staff, anxiety of contracting COVID19 *Risk Score – 20 (High Risk)*

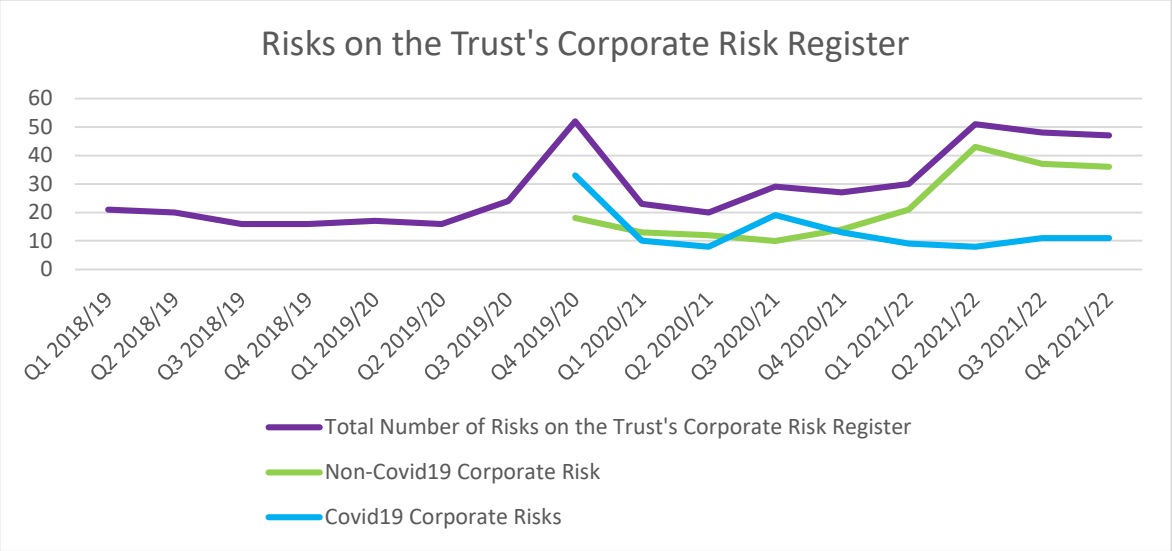
- Risk 738 - Not delivering in year Financial Improvement Trajectory due to a failure to deliver savings which would result in a breach of financial targets and duties of the Organisation with potential regulatory and audit actions being taken *Risk Score – 20 (High Risk)*

Quarter 4 2021/22 Corporate Risk Register Changes

4.3 Since 1 January 2022, the changes within the Corporate Risk Register are noted below:

Quarter 4 2021/22 Corporate Risk Register Update	Total Number of Risks	Risk Numbers
Total number of **new** significant or high risks added	**4**	790, 793, 815, 840
Total number of risks previously scoring less than 12 which have **increased** within the Quarter & now form part of the Corporate Risk Register	**3**	97, 238, 687
Total number of risks previously scoring 12 or above which have **increased** within the Quarter	**8**	21, 492, 542, 646, 737, 738, 739, 741
Total number of risks that have **remained the same** within the Quarter in terms of risk score (12 or above)	**32**	45, 49, 91, 100, 198, 221, 235, 236, 331, 349, 357, 372, 405, 483, 497, 515, 549, 556, 607, 613, 638, 652, 659, 683, 691, 696, 697, 728, 729, 734, 736, 742
Total number of risks which have **reduced** but still form part of the Corporate Risk Register	**1**	705
Total number of risks which have **reduced** and no longer form part of the Corporate Risk Register	**4**	716, 753, 755, 783
Total number of risks which have been **archived** and no longer are on the live risk register	**4**	617, 746, 782, 790

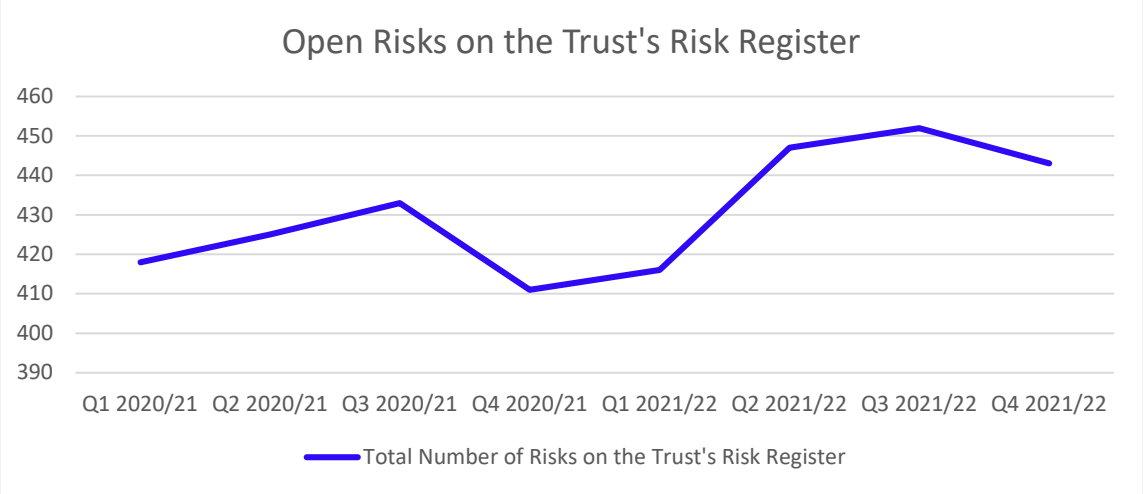
4.4 The total number of risks on the Corporate Risk Register has decreased slightly reducing from 48 risks in Quarter 3 2021/22, to 47 risks in Quarter 4 2021/22. However, despite this small reduction, when compared to Quarter 4 2020/21 there has been a 74.07% increase on the number of risks on the Corporate Risk Register with the number of high risks continuing to increase each quarter.



This risk report provides the necessary information for the Audit Committee that is a fundamental part of the Governance arrangements required by NHS Improvement, NHS England and the Care Quality Commission. The Executive Committee is asked to NOTE the report and the corporate risk register.

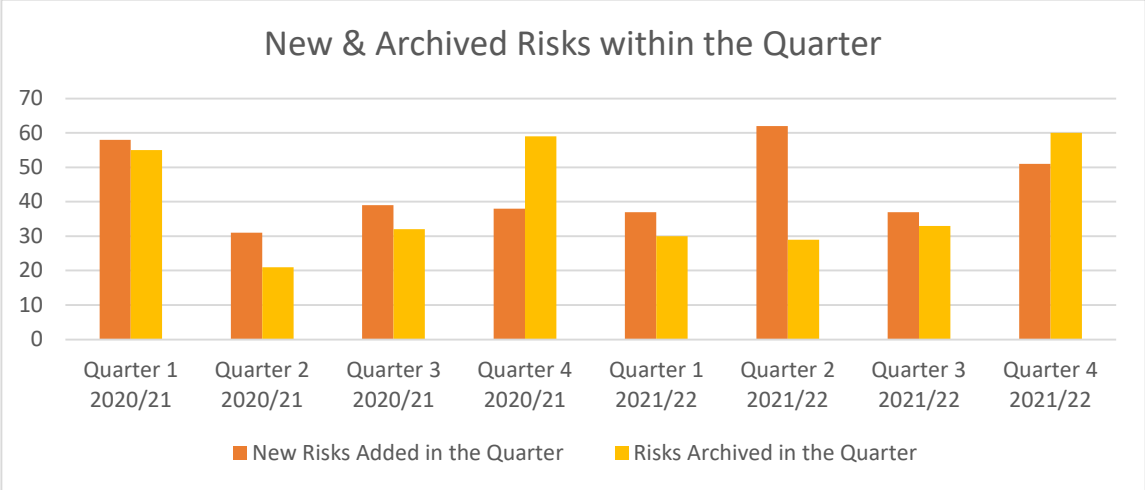
General Quarterly Risk Register Update

4.5 As of 31 March 2022, there were 443 open risks on the Trust's risk register, which includes risks for the YDH Group subsidiary organisations.



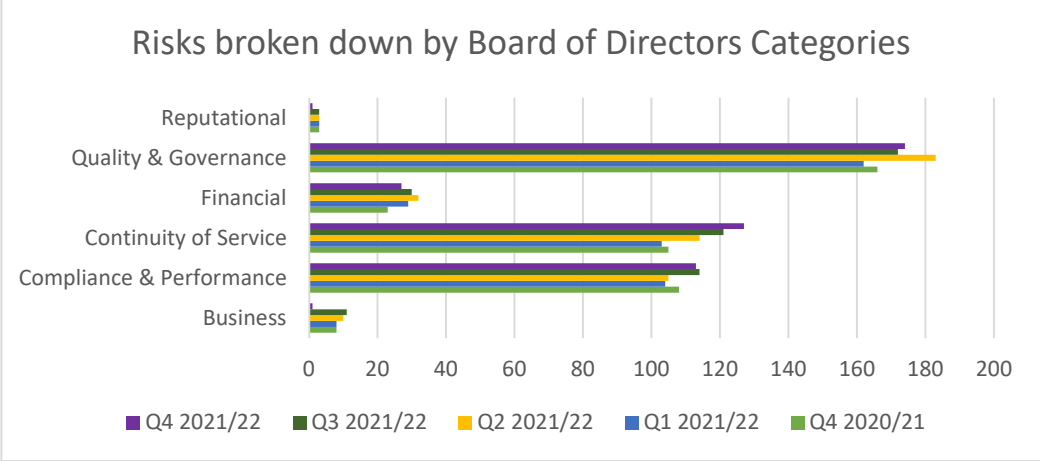
4.6 51 new risks have been added to the risk register within Quarter 4 2021/22, 50 of these were risks not associated with COVID19 and 1 was directly associated within COVID19. This is an increase of 37.84% when compared to the total number of new risks added in Quarter 3 2021/22.

4.7 60 risks have been archived within Quarter 4 2021/22, 50 of these were risks not associated with COVID19 and 10 were associated with COVID19. This is an increase of 81% when compared to the total number of risks archived in Quarter 3 2021/22.



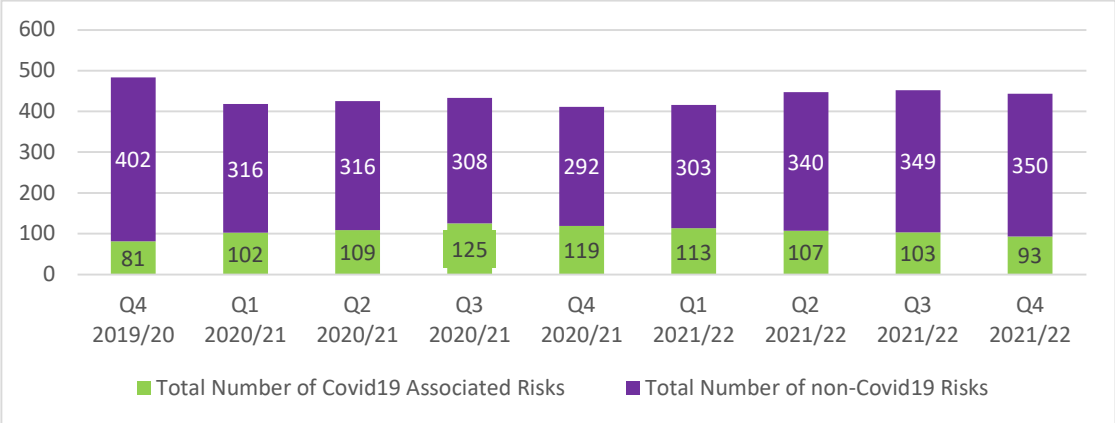
Board of Directors Categories of Risk Quarterly Update

4.8 All risks on the risk register are recorded under the Board of Directors categories of risk. Although the majority of risks could fall into more than one category, the risks are recorded against the primary category for the purposes of the register e.g. a risk may have a secondary financial impact but the primary impact is the patient safety risk so it would be recorded under Quality and Governance. As represented in the chart below, the highest number of risks continue to fall within the Quality and Governance category.



COVID19 Quarterly Risk Register Update

4.9 As of the 31 March 2022 there were 93 open risks on the Trust's COVID19 risk register. The number of risks on the COVID19 risk register have continued to reduce within the quarter. Of the 93 live risks on 31 March 2022, 8 of these are significant risks and 6 are high risks.



4.10 COVID19 associated risks represent 20.99% of the Trust's full risk register reported risks at the end of Quarter 4 2021/22. The number of COVID19 associated risks is continuing to decrease each quarter since Quarter 4 2020/21. Since 31 December 2021:

- There have been 1 newly identified risk added to the Trust's risk register associated with COVID19. This risk did not form part of the COVID19 corporate risk register

- 5 risks increased within the quarter. 2 of the risks now form part of the COVID19 corporate risk register:
  - 1 significant risk (scoring 12) increased to a high risk (scoring 16)
  - 1 significant risk (scoring 12) further increased to a significant risk (scoring 15)
  - 3 moderate risks increased to significant risks
  - 1 low risk increased to a moderate risk

- 5 risks reduced within the quarter
  - 1 significant risk reduced to a moderate risk
  - 3 moderate risks reduced to a low risk
  - 1 low risk (scoring 6) further reduced to a low risk (scoring 3)
- 10 risks from the COVID19 risk register were archived within Quarter 4 2021/22, none of these from the COVID19 corporate risk register

4.11 A breakdown by risk score is shown below:

Risk Rating Scores	New Risks ADDED during Quarter 4 2021/22	Risks which have been ARCHIVED during Quarter 4 2021/22	Total Number of LIVE COVID19 Risks on 31 March 2022
High (16+)	0	0	6
Significant (12-15)	0	0	8
Moderate (8-10)	0	6 (Risks 462, 478, 482, 558, 570 & 608)	56
Low (1-6)	1 (Risk 789)	4 (Risks 56, 489, 647, 789)	23
Total Number of Risks:	**1**	**10**	**93**

Quarter 4 2021/22 Corporate Risk Register

Board of Directors Categories	Low	Moderate	Significant	High	Totals	% of all risks
Business	1	0	0	0	1	0.26 ↓
Compliance & Performance	48	58	5	2	113	25.50 ↑
Continuity of Service	30	75	14	8	127	28.67 ↑
Financial	7	14	2	4	27	6.09 ↓
Quality & Governance	63	99	9	3	174	39.28 ↑
Reputational	1	0	0	0	1	0.26 ↓
Totals	**150**	**246**	**30**	**17**	**443**	
% of all risks	33.86 ↑	55.53 ↓	6.77 ↓	3.84 ↑		

Compliance & Performance

High (20)	100	Breach of RTT standards
High (16)	687	Inability to comply with Cancer standards due to lack of outpatient capacity
Significant (15)	646	Non-compliance with national Stroke standards
Significant (15)	652	Deteriorating cancer performance and poor data quality
Significant (12)	97	Harm to patients awaiting cardiac surgery
Significant (12)	683	Lack of Trust policy to govern the exchange of patient information and data via uncontrolled and insecure means
Significant (12)	696	Fire compartmentation breaches

Financial Risks

High (20)	738	Failure to deliver savings
High (16)	737	Failure to control costs
High (16)	739	Failure to secure appropriate levels of income
High (16)	741	Programmes and projects fail to deliver savings
Significant (12)	497	Financial sustainability of SHS
Significant (12)	742	Premium rate staffing costs

Reputational Risks

There are no high or significant reputational risks on the Corporate Risk Register

Quality & Governance Risks

High (25)	331	Insufficient intermediate care capacity
High (16)	21	Inability to safely manage increasing numbers of mental health patients
High (16)	542	Unsafe numbers of attendances in ED
Significant (15)	49	Increased demand – opening of escalation areas
Significant (15)	492	Inability to discharge patients – no designated discharge organisation
Significant (12)	91	Inequitable 7 day Therapy service
Significant (12)	238	Clinical results and information not actioned in timely fashion
Significant (12)	349	Inadequate planning for patient deterioration
Significant (12)	372	Preventable sight loss for patients lost to follow up or insufficient capacity
Significant (12)	613	Cross transmission of nosocomial infections
Significant (12)	45	Delay in evacuating patients cross level on wards 6 to 9
Significant (12)	691	Delayed communication and follow up care with specialties and/or primary care following an AEC episode of care

Business Risks

There are no high or significant business risks on the Corporate Risk Register

Continuity of Service Risks

High (20)	198	Reduced staff resilience including staff burn out
High (20)	405	Inability to safely deliver the Acute Oncology Service
High (20)	728	Reduced staff resilience including staff burn out (SHS)
High (16)	736	Disruption to service provision, business continuity and progress with the merger
High (16)	236	Reduced GP cover within SHS Practices
High (16)	483	Reduction in primary care provision for SHS patients
High (16)	607	Compromised care provided to patients due to inadequate levels of staffing on wards
High (16)	729	Violence & aggression towards Practice Staff (SHS)
Significant (15)	840	Safe and effective change of use for the Gynae Recovery room
Significant (12)	705	Maintaining a sustainable recruitment & retention programme for HCAs
Significant (12)	815	Inability to match capacity to demand (SHS)
Significant (12)	357	Cyber security risk
Significant (12)	221	Failure by Ezec Medical Services (Provider) to deliver timely Non-Emergency Patient Transport Service (NEPTS) for discharge and transfer of patients
Significant (12)	235	Simultaneous bed lift failure
Significant (12)	515	Inability to retain and recruit critical care medical staff
Significant (12)	549	Lack of fire barrier containment
Significant (12)	556	Insufficient specialist nurse inpatient care provision for diabetes patients
Significant (12)	638	Inability to deliver the endoscopy service
Significant (12)	659	Failing and limited functionality of Cardiology IT system EchoPAC web server and Imagevault storage system
Significant (12)	793	Cancellation of clinics due to Ophthalmology Nurse & HCA vacancies
Significant (12)	697	Delay in the treatment of ENT patients
Significant (12)	734	Loss of emergency power supply in the event of a mains power cut

Key: 12-15 = Significant Risk **16-25 = High Risk** 01 = Unique Risk Reference

Summary of Principal Risks

Innovate and Collaborate

	Executive owner(s)	Principal Risk	Monitoring Group(s)	Overall risk rating	Movement	Risk target	Strength of controls	Movement	Strength of assurance	Movement
SR10	Chief Officer – Partnerships and Collaboration	**SR10: There is a risk of ineffective partnership working (and other factors) slowing the development of an Integrated Care System within Somerset**	Board of Directors	**8: Moderate Risk**	⇔	**8: Moderate Risk**	**Green**	⇔	**Amber**	⇔

Key:

Risk rating		Likelihood of Occurrence				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
Impact	1 Negligible	1	2	3	4	5
	2 Minor	2	4	6	8	10
	3 Moderate	3	6	9	12	15
	4 Major	4	8	12	16	20
	5 Catastrophic	5	10	15	20	25

Controls and Assurances	
Red	Assurance indicates poor effectiveness of controls/assurances
Amber	Some assurances in place or controls are still maturing.
Blue	Reasonable assurance. Some issues which could increase likelihood of risk materialising.
Green	No gaps in controls or assurances

Board Assurance Framework 2021-22

Strategic Objective: **Innovate and Collaborate**
As part of a sustainable Somerset care system, and working with our partners, we will develop and deliver outstanding services, employing new models of care and innovative technology.

Monitoring group(s): Board of Directors

Date last reviewed: 22/03/2022

Executive Owner(s): Chief Officer – Partnerships and Collaboration

Strategic Priorities:
P16: Complete the formal business case for collaboration with SFT
P17: Refresh and align our digital transformation strategy with both the system digital and clinical strategy
P18: Implement EPMA & radiology Order Comms
P19: Enhance and use our business intelligence capability to inform Trust and system planning
P20: Support the development of local 'Neighbourhoods'
P21: Further develop virtual outpatients, virtual ward and other digital solutions developed during the pandemic
P22: Fully engage and collaborate in the formation of the Somerset ICS ensuring the voice of YDH and SHS is heard

What is the risk to delivery? SR10: There is a risk of ineffective partnership working (and other factors) slowing the development of an Integrated Care System within Somerset

What controls are in place to manage the risk to delivering the objective?

1) Membership of System Leadership Board and ICS Executive Group
2) Provider Development Committee (PDC) in place with ICS and LA attendance
3) New role of Chief Officer Partnership & Development established
4) Implementation of single Executive team as part of the merger programme and to enable Provider Collaboration
5) Appointment of Chief Executive to lead the merger programme
6) Single Executive Team appointed and started in post on 10 January 2022

What assurance do we have that our controls are working?

1) Updates to Board of Directors
2) Somerset system designation as an Integrated Care System in November 2020
3) Reciprocal NED representation on all provider Boards to challenge partnership working
4) Regular Board to Board and Exec to Exec meetings
5) YDH/SFT merger case
6) Joint Board and Council of Governors meetings
7) Seat at ICS Board and all ICS Development meetings
8) Formal Provider Collaborative Agreement in development
9) Lead role in the formation of a new Provider Collaboration Forum

Are there any gaps in our controls (and what are we doing about them)? Relate to the actions below

1) Standardised reporting across the Somerset system
2) Maturity of ICS and new ICB Governance structure
3) Developing personal relationships between key leaders and impact of organisational change processes on personal commitments to system working
4) Delays in the development of the ICS & ICB delayed as a result of the COVID-19 pandemic

Are there any gaps in our assurance (and what are we doing about them)? Relate them to the actions below

1) Standardised reporting across the Somerset system
2) ICS Governance structure is in its infancy

Likelihood	Consequence
2: Unlikely	4: Major

Overall risk rating	**8: Moderate Risk**
Overall target risk rating	**8: Moderate Risk**
Strength of controls	**Green**
Strength of assurance	**Amber**

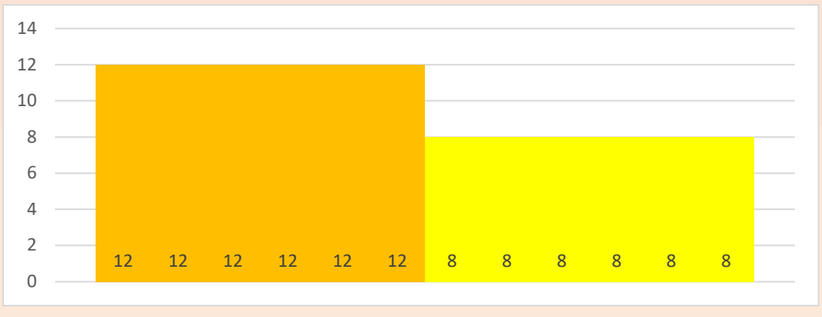
Rationale for overall risk rating:
The ICS designation process has enabled progress to be made in defining the high level ICS structure but there remains continued uncertainty about the impact of legislative change and the impact that this will have on our aspiration to key the Somerset ICS as simple as possible. Good progress is being made relating to the YDH/SFT formal collaboration. The delay in ICS legislative changes and the formation of the ICB along with system pressures places risk on conducive partnership and collaboration.

Risk Appetite	Moderate - Risks Rated 8-10

Key:	Controls and Assurances
Low	Assurance indicates poor effectiveness of controls. Immediate action is required for ongoing management of the risk
Medium	Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed at this moment but should improve.
High	Reasonable assurance provided over the effectiveness of controls. However, there are some issues identified that if not addressed, could increase the likelihood of the risk materialising.
Strong	No gaps in controls or assurances

Change in Risk - Overall risk rating

Dec 2020	Apr 2021	Jul 2021	Oct 2021	Dec 2021	March 2022
8	8	8	8	8	8



Actions to mitigate risk and to fill the gaps in controls and assurance

	Action	By who?	By when?	Progress
1	Complete the Assurance Process for the YDH/SFT strategic case and start work on the Full Business Case for submission in November 2021	Director of Strategy and Digital Development	October 2022	Strategic Case signed off by the Boards of both YDH and SFT. Feedback received from NHSEI. Work commencing on Full Business Case but agreement reached by both Boards to extend the timetable for this in response to operational pressures and the NHSEI feedback
2	Formal Provider Collaborative MOU to be in place leading up to merger	Chief Officer Partnership and collaboration	April 2022	Draft MOU produced undergoing consultation
3	Re-launch Provider Collaboration Forum within emerging ICS/ICB Governance Framework	Chief Officer Partnership and collaboration	April 2022	Draft ToR complete and undergoing consultation and working with ICS Governance Development Team on fit in organisational structure.

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Yeovil District Hospital NHS Foundation Trust Board Declarations Relating to the Provider Licence and the Health and Social Care Act
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust – SFT
PRESENTED BY:	Director of Corporate Services
DATE:	3 May 2022

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	NHS foundation trusts are required to make the following declarations after the end of the financial year: • systems for compliance with licence conditions – in accordance with General condition 6 of the NHS provider licence; • availability of resources and accompanying statement – in accordance with the Continuity of service condition 7 of the NHS provider licence; • Corporate Governance Statement – in accordance with the FT 4 condition of the NHS provider licence • certification on training of Governors – in accordance with s151(5) of the Health and Social Care Act. The Trust is now no longer required to submit the declarations to NHS England/Improvement but the Board is required to sign off the declarations and publish the self certifications. The Trust intends to also make positive confirmations on all declarations. The Board is required to seek the views of Governors in relation to Conditions 4 and 6 and the certification on training

	of Governors. Due to the earlier date of the Board meeting, Governors views will be sought by email. It is proposed that the declarations are approved pending feedback from Governors and that any changes to the declarations are approved by the Board by email following the receipt of any comments from Governors.
Recommendation	To discuss and approve compliance with the required declarations pending feedback from Governors and to agree that any significant changes to the declarations are approved by the Board by email.

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)

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]
Annual 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

YEOVIL DISTRICT NHS FOUNDATION TRUST

NHS PROVIDER LICENCE DECLARATIONS

1. GENERAL CONDITIONS 6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

1.1 Paragraphs 1 and 2 of General Conditions 6 state that:

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   (a) the Conditions of this Licence;

   (b) any requirements imposed on it under the NHS Acts, and;

   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and;

   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

1.2 The Trust is intending to declare full compliance with the following statement:

"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution**."**

The basis for confirming this statement is set out below

1.3 The Trust has processes and systems in place to identify risks to compliance, which are outlined in the wording of the Annual Report. This report is audited by the Trust's external auditors. These systems and processes have been strengthened following further refinement of the Risk Management processes within the organisation. The formal Executive Committee scrutinises the full Corporate Risk Register and Board Assurance Framework prior to the end of the reporting quarter; this provides an opportunity for a sense-check of the corporate risks and scoring.

1.4 In addition, the Risk Management Strategy was approved in 2021/22. A comprehensive Risk Management Arrangements document has also been created, which provides details of the operational arrangements for the management of risk within Yeovil District Hospital.

1.5 The Trust implemented the Ulysses Risk Management Module, which provides robust methods for the monitoring and recording of actions against risks identified

and how these risks are to be mitigated to safeguard against these occurring. This system is now fully embedded across the organisation for risk management and action plan recording and monitoring.

1.6 The principles of the NHS Constitution are at the core of everything the Trust does and are well embedded throughout all processes.

1.7 The Trust completed a full review of the various constitutional documents, (Standing Financial Instructions, Scheme of Reservation and Delegation and Standing Orders). These were updated in line with best practice and approved by the Board in early 2021/22.

1.8 The Trust undertakes continued review processes of systems in place within the Trust, through both internal reviews, audits completed by the Internal Audit function and through external reviews completed by relevant parties, such as the Care Quality Commission and NHS England and Improvement.

1.9 An internal audit of the Trust's Risk Management Processes in place within YDH was undertaken and this provided substantial assurance for Design and Moderate assurance was provided for Operational Effectiveness. The report also outlined a several areas of good practice and the actions outlined in the report were implemented.

2. GENERAL CONDITIONS 6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

2.1 The Trust is intending to declare full compliance with the following statement*:*

"The Board declares that the Licensee continues to meet the criteria for holding a licence."

3. CONTINUITY OF SERVICES CONDITION 7 – AVAILABILITY OF RESOURCES

3.1 The Trust is required to make one of the following statements:

EITHER

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors

which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

3.2 The Trust will declare compliance with statement 3a. The basis for this compliance statement is the 2021/22 year end position, the rigorous cost improvement programmes, the ongoing integration of services and close working arrangements with Somerset NHS Foundation Trust, and the presentation of the budgets for 2022/23 to the May 2022 Board meeting.

4. CONDITION FT4 - CORPORATE GOVERNANCE STATEMENT

4.1 It is recommended that the Board declares compliance with the standards marked in italics below.

4.2 *The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS*.

4.3 *The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.*

4.4 *The Board is satisfied that the Trust has established and implements*

(a) Effective board and committee structures;

(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

(c) Clear reporting lines and accountabilities throughout its organisation.

4.5 *The Board is satisfied that the Trust has established and effectively implements systems and/or processes:*

(a) To ensure compliance with the Trust's duty to operate efficiently, economically and effectively;

(b) For timely and effective scrutiny and oversight by the Board of the Trust's operations;

(c) To ensure compliance with health care standards binding on the Trust including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the

Trust's ability to continue as a going concern);

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) To ensure compliance with all applicable legal requirements.

4.6 *The Board is satisfied that the systems and/or processes referred to above should include but not be restricted to systems and/or processes to ensure:*

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that it receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

4.7 *The Board is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.*

The basis for confirming this statement is set out below

4.8 The statement provided above is standard wording provided by NHS Improvement.

4.9 The Trust has structured governance arrangements in place with clear lines of reporting from "ward to Board" across operational, quality, safety, patient experience and finance, through assurance committees, to the Board.

4.10 The Trust is subject to the recommendations of the NHS Foundation Trust Code of Governance (which is modelled on best practice UK governance principles) and the

Well-Led framework, which encourages Boards to conduct formal evaluations of its performance and that of its committees and directors.

4.11 A previous internal audit review on the effectiveness of governance, have highlighted several areas of good practice, including the Trust having a clearly documented Governance Framework in place, which outlines the responsibilities of the key Board Assurance Committees, as well as the sub-groups and committees that feed into them. The recommendations from this review were completed, including the amendment to membership of the various Board assurance committees to improve their effectiveness.

4.12 The Board schedule for YDH includes the rotation between Operational and Strategic focussed meetings providing a suitable framework for the review and consideration of strategic developments, both within the hospital, the Somerset ICS and the wider healthcare system. On a quarterly basis, the Board makes use of Board Development Days to strengthen the focus of the Board.

4.13 In addition, the Trust is able to rely upon the following evidence/sources of assurance:

- Internal Audit and External plans that include a full range of audits to give assurance in this area (via Audit Committees to Board)
- Head of Internal Audit Opinion
- Annual Audit Letter 2020/21
- Monthly quality, performance, and finance reports to Committees and Board
- Board Assurance Framework and Corporate Risk Register
- Care Quality Commission inspections report and action plans
- BDO Effectiveness of Governance report
- Accountability Framework for the monitoring of performance and quality
- Risk Management Strategy and Risk Management Arrangements
- Processes in place to ensure this is flagged (usually via the Audit Committee), with additional guidance from internal and external audits
- New guidance is also flagged through NHS Providers
- Board Assurance Committees terms of reference
- Governance Framework
- Counter Fraud work plan and reports
- Various Board Assurance Reports (e.g. Safer Staffing, Learning from Deaths, Freedom to Speak Up, Guardian of Safe working etc.)
- Patient Experience Reports to Governance and Quality Assurance Committee
- Annual Report, Quality Report, Annual Accounts and Annual Governance Statement
- Going Concern Statement

5. TRAINING OF GOVERNORS

5.1 The Trust is required to confirm compliance with the following statement:

"The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the

Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."

5.2 The Trust is intended to declare full compliance with the above statement on the basis that a development programme has been put in place by way of Governor Development Days. The agenda for the Development Days is set by Governors and takes account of the skills and knowledge needs of Governors. Governors are also invited to attend specific training events, including NHS Providers events

The basis for confirming this statement is set out below

5.3 All governors attend mandatory induction to the Trust, which provides training across a range of topics, including Safeguarding, Information Governance etc. In addition, the Council of Governors receive annual reminders, key updates and an overview of their responsibilities from KPMG. Regular development sessions have been scheduled.

5.4 Governors also have the opportunity to attend both regional and national Governor events, such as the NHS Providers Governor Focus Conference. Training may also be provided at these events.

DIRECTOR OF CORPORATE SERVICES

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Somerset NHS Foundation Trust Board Declarations Relating to the Provider Licence and the Health and Social Care Act
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Director of Corporate Services
DATE:	3 May 2022

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	NHS foundation trusts are required to make the following declarations after the end of the financial year: • systems for compliance with licence conditions – in accordance with General condition 6 of the NHS provider licence; • availability of resources and accompanying statement – in accordance with the Continuity of service condition 7 of the NHS provider licence; • Corporate Governance Statement – in accordance with the FT 4 condition of the NHS provider licence • certification on training of Governors – in accordance with s151(5) of the Health and Social Care Act. The Trust is now no longer required to submit the declarations to NHS England/Improvement but the Board is required to sign off the declarations and publish the self certifications. The Trust intends to also make positive confirmations on all declarations. The Board is required to seek the views of Governors in relation to Conditions 4 and 6 and the certification on training

	of Governors. Due to the earlier date of the Board meeting, Governors views will be sought by email. It is proposed that the declarations are approved pending feedback from Governors and that any changes to the declarations are approved by the Board by email following the receipt of any comments from Governors.
Recommendation	To discuss and approve compliance with the required declarations pending feedback from Governors and to agree that any significant changes to the declarations are approved by the Board by email.

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)

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]
Annual 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

NHS PROVIDER LICENCE DECLARATIONS

1. GENERAL CONDITIONS 6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

1.1 Paragraphs 1 and 2 of General Conditions 6 state that:

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   (a) the Conditions of this Licence;

   (b) any requirements imposed on it under the NHS Acts, and;

   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and;

   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

1.2 The Trust is intending to declare full compliance with the following statement:

"Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution**."**

2. GENERAL CONDITIONS 6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

2.1 The Trust is intending to declare full compliance with the following statement*:*

"The Board declares that the Licensee continues to meet the criteria for holding a licence."

3. CONTINUITY OF SERVICES CONDITION 7 – AVAILABILITY OF RESOURCES

3.1 The Trust is required to make one of the following statements:

EITHER

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

3.2 The Trust will declare compliance with statement 3a. The basis for this compliance statement is the 2021/22 year end position, the rigorous cost improvement programmes, the ongoing integration of services and close working arrangements with Yeovil District Hospital NHS Foundation Trust, and the presentation of the budgets for 2022/23 to the May 2022 Board meeting.

4. CONDITION FT4 - CORPORATE GOVERNANCE STATEMENT

4.1 It was recommended that the Board declares compliance with the standards marked in italics below. The sources of evidence for the standards are set out in Appendix 1.

4.2 *The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS*.

4.3 *The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.*

4.4 *The Board is satisfied that the Trust has established and implements*

(a) Effective board and committee structures;

(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

(c) Clear reporting lines and accountabilities throughout its organisation.

4.5 *The Board is satisfied that the Trust has established and effectively implements systems and/or processes:*

(a) To ensure compliance with the Trust's duty to operate efficiently, economically and effectively;

(b) For timely and effective scrutiny and oversight by the Board of the Trust's operations;

(c) To ensure compliance with health care standards binding on the Trust including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Trust's ability to continue as a going concern);

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) To ensure compliance with all applicable legal requirements.

4.6 *The Board is satisfied that the systems and/or processes referred to above should include but not be restricted to systems and/or processes to ensure:*

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that it receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as

appropriate views and information from these sources; and

(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

4.7 *The Board is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.*

5. TRAINING OF GOVERNORS

5.1 The Trust is required to confirm compliance with the following statement:

"The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."

5.2 The Trust is intended to declare full compliance with the above statement on the basis that a development programme has been put in place by way of Governor Development Days. The agenda for the Development Days is set by Governors and takes account of the skills and knowledge needs of Governors. Governors are also invited to attend specific training events, including NHS Providers events

DIRECTOR OF CORPORATE SERVICES

Appendix 1 – Sources of assurance for Condition FT4 – Corporate Governance Statement

Text of the Statement	Evidence / Sources of assurance on which Board members may choose to rely
The board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS.	• Internal Audit (BDO) and External Audit (KPMG) plans include full range of audits to give assurance in this area (via Audit Committees to Board) • Annual Governance Statement. • Head of Internal Audit Opinion. • Annual Audit Letter 2020/21. • Monthly quality, performance, and finance reports to the Board. • Board Assurance Framework and Corporate Risk Register. • Care Quality Commission inspection reports and action plans. • Financial Plan 2021/22. • Implementation of new directorate structures. • Risk Management strategy and implementation of new risk management system
The board has regard to such guidance on good corporate governance as may be issued by NHS England/ Improvement from time to time.	• Processes in place to ensure this is flagged (usually via Audit Committees), with back up provided by regular updates on new guidance from internal and external audit. • New guidance is also flagged through NHS Providers.
The board is satisfied that the Trust implements: (a) effective board and committee structures (b) clear responsibilities for its board, for committees reporting to the board and for staff reporting to the board and those committees (c) clear reporting lines and accountabilities throughout its organisation.	• Review of the effectiveness of the Board, and the use of Development Days to strengthen the strategic focus of the Board. • Assurance reports from the Committees to the Board. • The Trust's Constitution (including Standing Orders). • Standing Financial Instructions. • Scheme of Delegation. • Committee and Governance Group Terms of Reference and annual review of the Terms of References. • Development of Board of Directors' Terms of References and review of compliance with the Terms of References • Committee Governance structure • Directorate Governance internal audit report

Text of the Statement	Evidence / Sources of assurance on which Board members may choose to rely
The board is satisfied that Somerset NHS Foundation Trust effectively implements systems and/or processes: (a) to ensure compliance with the licence holder's duty to operate economically, efficiently and effectively (b) for timely and effective scrutiny and oversight by the board of the licence holder's operations (c) to ensure compliance with healthcare standards binding on the licence holder including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions (d) for effective financial decision-making, management and control including, but not restricted to, appropriate systems and/or processes to ensure the licence holder's ability to continue as a going concern (e) to obtain and disseminate accurate, comprehensive, timely and up-to-date information for board and committee decision-making (f) to identify and manage (with, but not restricted to, forward plans) material risks to compliance with the conditions of its licence (g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery (h) to ensure compliance with all applicable legal requirements.	• Well-led reviews (3 years) and action plan. • Review of Board and committee effectiveness. • Committee and Governance Group terms of reference. • Constitutional documents (standing orders, standing financial instructions, scheme of reservation and delegation and Constitution). • Governance framework, including internal audit of governance processes. • Internal audit plan, reports and opinion. • External audit plan and Annual Audit Letter. • Counter-fraud work plan and reports. • Risk management processes (including corporate risk register, board assurance framework and risk management strategy). • Regular Board and committee meetings' cycle (e.g. Audit Committee, and Quality and Governance Committee, Finance Committee oversight and progress reports from the Committees to the Board). • Operational plan, business action plan and monitoring arrangements. • Performance reports to the Board (monthly) • Staffing establishment reports, including review of Safer Staffing arrangements to the Board. • Financial performance report to the Board (monthly) and to the Finance Committee; approval of the revenue and capital budgets by the Board and close monitoring arrangements of the cost improvement programme. • Performance monitoring process and review by the directorates. • Patient experience reports to the Council of Governors and Quality and Governance Committee, including feedback from the Friends and Family Tests, and patient story to the Board. • Implementation of the People Strategy. • Annual report, quality report, annual account and annual governance statement. • System working

Text of the Statement	Evidence / Sources of assurance on which Board members may choose to rely
	• CQC inspection report ('Good' overall) and action plan; Care Quality Commission Mental Health Act compliance reports. • Going Concern statement to the Audit Committee and Board. • Alliance work with Yeovil District Hospital NHS Foundation Trust. • Performance review meetings with regulators. • System financial plan. • Leadership Walkrounds.
The board is satisfied: (a) there is sufficient capability at board level to provide effective organisational leadership on the quality of care provided (b) the board's planning and decision-making processes take timely and appropriate account of quality of care considerations (c) accurate, comprehensive, timely and up-to-date information on quality of care is collected (d) it receives and takes into account the accurate, comprehensive, timely and up-to-date information on quality of care (e) Somerset NHS Foundation Trust including its board actively engages on quality of care with patients, staff and other relevant stakeholders, and takes into account, as appropriate, views and information from these sources (f) there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues, including escalating them to the board where appropriate.	• Annual performance review of the Chief Executive by the Chairman; • Annual performance review of each Executive Director by the Chief Executive and feedback provided to the Remuneration Committee. • Annual personal development plan agreed for the Chief Executive and Executive Directors. • Annual review of the Chairman by the Council of Governors and Board members. • Annual review of Non-Executive Directors by the Chairman and Nomination and Remuneration Committee. • Chief Medical Officer and Chief Nurse as Executive members of the Trust Board.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Draft constitution and standing orders for the merged organisation
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Director of Corporate Services/Secretary to the Trust
DATE:	3 May 2022

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	A Joint Constitution Review Group was set up to prepare a draft Constitution for the merged organisation. The draft Constitution, including Standing Orders, is attached and any proposed changes are highlighted in red. Proposals to change the number of public governor seats in some of the constituencies from 1 May 2022, from the date of the merger and from 1 May 2023 were approved at the November 2021 Board meeting. These changes have been incorporated into the current Constitution and are therefore not highlighted as a change in the attached Constitution. Two areas still need to be finalised and these relate to: • the name of the Trust; • the location of the Headquarters for the merged organisation. In addition, the names of the Board Committees may be subject to change. The draft Constitution was approved at the December 2021 Council of Governors meeting.

Recommendation	The Board is asked to approve the Constitution, including Standing Orders, for the merged organisation and to note that approval of the Constitution also constitutes approval of the insertion of the name of the Trust, its Headquarters and changes to the name of the Board Committees in the Constitution and Standing Orders, when confirmed.

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

Yeovil District Hospital NHS FT

- ☐ 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 current Constitution was last considered at the November 2021 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

DRAFT CONSTITUTION AND STANDING ORDERS FOR THE MERGED ORGANISATION

1. PURPOSE

1.1 To present the draft Constitution, including Standing Orders, for the post merger organisation to the Board.

2. BACKGROUND

2.1 A Joint Constitution Review Group was set up to prepare a draft Constitution for the merged organisation. Membership of the Group consisted of the following:

- Ria Zandvliet, Secretary to the Trust SFT (Chairman of the Group);
- Ben Edgar-Attwell, Associate Director of Integration (SFT/YDH);
- Alison Whitman, Lead Governor YDH;
- Anthony Robinson, Deputy Lead Governor YDH;
- Fiona Rooke, Staff Governor YDH;
- Ian Hawkins, Lead Governor SFT;
- Kate Butler, Deputy Lead Governor SFT;
- Neil Thomas, Staff Governor SFT.

2.2 The following executive directors were invited to attend the meetings:

- Phil Brice, Director of Governance and Corporate Development;
-
- David Shannon, Director of Strategic Development and Improvement;
- Jeremy Martin, Director of Transformation

2.3 The Group met on 15 June 2021, 12 July 2021, 26 July 2021 and 31 August 2021.

2.4 The draft Constitution was approved at the December 2021 Council of Governors meeting.

3. CHANGES TO THE CONSTITUTION

3.1 The approach taken in the development of the Constitution was to start from the model Constitution and insert the relevant wording of each Trust's Constitution to be able to identify any areas of commonality and differences.

3.2 This approach identified differences in the way the Constitution and Standing Orders in both trusts were structured and the draft Constitution has been structured in the same way as the Yeovil District Hospital NHS Foundation Trust (YDH)'s Constitution as it was felt that this structure better grouped relevant sections together. This restructuring means that some of the content included in Annexes to the Constitution has been included in the main Constitution but the wording, unless indicated to the contrary, has not changed.

3.3 In addition, the Standing Orders have been separated from the main Constitution to be able to clearly distinguish between the main Constitution and Standing Orders and to make the size of the documents easier to manage. This change does not affect the approval process for changes to the Standing Orders for the Council of Governors and Board of Directors.

3.4 Further key changes relate to:

- the alignment of content with the YDH Constitution;
- the clarification or simplification of processes or wording;
- changes to reflect the new name of NHS Improvement (Monitor);
- changes in the reference to the NHS Foundation Trust Network;
- a change in the maximum number of other Non-Executive Directors from eight to nine to reflect the increase in the number of post merger Non-Executive Directors;
- wording to reflect the agreed process in relation to the Staff Governor elections from the date of merger;
- the inclusion of a reference to wholly and partially owned corporate entities (subsidiaries).

4. AREAS STILL TO BE FINALISED

4.1 The name of the Trust and the location of the Headquarters for the merged organisation still need to be confirmed and it is proposed that approval of the Constitution and Standing Orders also constitutes approval of the insertion of the name of the Trust and headquarter location, when this information becomes available, in the main Constitution and in the Standing Orders.

4.2 The Board Committees are referenced in Annex 2 of the Standing Orders – 5.1.9 – and as the names of the Committees may be subject to change, it is also proposed that approval of the Constitution and Standing Orders constitute approval of changes to the name of the Board Committees.

5. RECOMMENDATION

5.1 The Board is asked to approve the Constitution, including Standing Orders, for the merged organisation and to note that approval of the Constitution also constitutes approval of the insertion of the name of the Trust, its Headquarters and changes to the name of the Board Committees in the Constitution and Standing Orders, when confirmed.

SECRETARY TO THE TRUST

XXXXX NHS FOUNDATION TRUST

CONSTITUTION

XXXXXNHS Foundation Trust Constitution

TABLE OF CONTENTS

Paragraph

1. INTRODUCTION

1.1 An NHS Foundation Trust is a Public Benefit Corporation which is authorised under the National Health Service Act 2006 to provide goods and services for the purposes of the health service in England. A Public Benefit Corporation is a body corporate which is constituted in accordance with Schedule 7 of the 2006 Act. The Constitution provides, inter alia, for the Trust to have Members, Governors and Directors, and determines who may be eligible for membership and how Governors and Directors are appointed and defines their respective roles and powers. Further, Members of the Trust may vote in elections to, and stand for election for the Council of Governors, as provided in this Constitution.

2. INTERPRETATION AND DEFINITIONS

2.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012

2.2 Words importing the singular shall import the plural and vice-versa.

2.3 Any reference to any organisation shall include a reference to any successor in title or any organisation or entity which has taken over its functions or responsibilities.

2.4 References in this Constitution to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder.

2.5 References to legislation also includes all regulations, orders, statutory guidance or directives.

2.6 Headings are for ease of reference only and are not to affect interpretation.

2.7 All Annexes referred to in this Constitution form part of it.

2.8 References to paragraphs are to paragraphs in this Constitution save that where there is a reference to a paragraph in an annex to this Constitution it shall be a reference to a paragraph in that annex unless the contrary is expressly stated or the context otherwise so requires.

2.9 In this Constitution:

the **2006 Act** is the National Health Service Act 2006.

the **2012 Act** is the Health and Social Care Act 2012.

the "**Accounting Officer"** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

"Annex"
followed by a number, means the Annex to this Constitution so numbered;

"Annual Accounts"
means those accounts prepared by the Trust pursuant to paragraph 25 of Schedule 7 to the 2006 Act;

Annual Members Meeting is defined in paragraph 15 of the constitution and has the same meaning as the Annual General Meeting;

"Appointed Governor"
means a Somerset Clinical Commissioning Group Governor, a Local Authority Governor, or a Partnership Organisation Governor as specified in paragraph 4 of Annex 3;

"Appointments Panel"
means a Panel of the Council of Governors appointed pursuant to Annex 8;

"Annual Report"
means a report prepared by the Trust pursuant to paragraph 26 of Schedule 7 to the 2006 Act;

"Area of the Trust"
means the area, consisting of all the areas, specified in Annex 1, as an area for the Public Constituencies;

"Audit Committee"
means a committee of the Board of Directors as established pursuant to paragraph 40 of this Constitution;

"Auditor"
means the auditor of the Trust appointed by the Council of Governors pursuant to paragraph 39 of this Constitution;

"Authorisation"
means the authorisation issued to the Trust by Monitor under section 35 of the 2006 Act;

"Board of Directors"
means the Board of Directors as constituted in accordance with this Constitution;

"British Islands"
means the United Kingdom, the Channel Islands and the Isle of Man as defined in the Interpretation Act 1978. The Republic of Ireland is not included in this definition.

"Chairman"
means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression "the Chairman" shall be deemed to include the Deputy Chairman or any other Non-Executive Director appointed if the Chairman is absent from the meeting or is otherwise unavailable.

"Chief Executive"
means the Chief Executive of the Trust;

"Constitution"
means this Constitution together with the Annexes attached hereto;

"Council of Governors"
means the Council of Governors as constituted in this Constitution, which has the same meaning as the "Board of Governors" in paragraph 7 of Schedule 7 to the 2006 Act;

"Deputy Chairman"
means the Deputy Chairman of the Trust appointed in accordance with paragraph 27 of this Constitution;

"Designated Organisation"
means an organisation registered as such in the register of Governors which provides staff who exercise functions on behalf the Trust;

"Director"
means a member of the Board of Directors and includes both Executive and Non-Executive Directors;

"Directors' Code of Conduct"
means the Code of Conduct for Directors of the Trust, as adopted by the Trust and as amended from time to time by the Board of Directors; which all Directors must subscribe to.

"District Councils"
means:

(a) Mendip District Council, Council Offices, Cannards Grave Road, Shepton Mallet, Somerset BA4 5BT;

(b) Sedgemoor District Council, Bridgwater House, Kings Square, Bridgwater TA6 3AR;
(c) South Somerset District Council, Council Offices, Brympton Way, Yeovil, Somerset BA20 2HT;
(d) Somerset West and Taunton District Council, The Deane House, Belvedere Road, Taunton, Somerset, TA1 1HE

or their successor bodies;

"Elected Governor"
means a Public Governor or a Staff Governor;

"Election Scheme"
means the election rules set out at Annex 4 of the Constitution**;**

"Executive Director"
means an Executive ~~Director of the Trust~~ member of the Board of Directors of the Trust. An executive member of the Board of Directors can be a voting or a non voting Director'

"Finance Director"
means the Finance Director of the Trust;

"Financial Year"
means each period of twelve months beginning with 1 April;

"Forward Plan"
means the document prepared by the Foundation Trust pursuant to paragraph 27 of Schedule 7 to the 2006 Act;

"**Governor"**
means a member of the Council of Governors and includes both Appointed Governors and Elected Governors;

"Governors' Code of Conduct"
means the Code of Conduct for Governors of the Trust, as adopted by the Trust and as amended from time to time by the Council of Governor, which all governors must subscribe to.

"**Health Overview and Scrutiny Committee"**
means a local authority overview and scrutiny committee established pursuant to section 21 of the Local Government Act 2000.

"Health Service Body"
Shall have the meaning ascribed to it in Section 275 of the 2006 Act and includes the following organisations, or their successors:

- strategic health authority;
- clinical commissioning group;

- NHS trust,
- special health authority; and
- NHS foundation trust.

"Immediate Family Member"
means either:

(a) A partner (of whatever gender), whether married, in a civil partnership (if defined in the Civil Partnership Act 2004), or some other similar arrangement, whether or not residing together in the same household, or;

(b) A child or adopted child; including a biological child of one or both of two parties to a marriage or relationship or any other child who has been treated by one or both of those parties as a child of their family; or

(c) A sibling or step-sibling; or

(d) A parent or step-parent; or

(e) A partner (as defined in sub-paragraph (a) above, of a person identified in sub-paragraphs (b), (c), or (d).;

“HealthWatch”
means the independent consumer champion for health and social care in England**,** or any statutory successor

“Licence”
means the Trust’s Provider Licence issued by NHS Improvement (Monitor). The Licence includes licence conditions and standards which will need to be adhered to by the Trust.

“Local Authority”
means a local authority that may appoint a Local Authority Governor and which is listed in Annex 3;

"Local Authority Governor"
means a Governor of the Council of Governors appointed by one or more Local Authority whose area includes the whole or part of the Area of the Trust;

"Local Authority Partnership Agreement"
means an agreement made under section 75 of the 2006 Act;

"Member"
means a member of the Trust;

"Model Rules for Elections"
means the election rules set out in Annex 4;

"Monitor"
means the body corporate known as Monitor, as provided by section 61 of the 2012 Act;

"NHS England/Improvement (NHSE/I)" is the body corporate known as NHS England/NHS Improvement (Monitor), as provided by Section 61 of the 2012 Act.

"NHS Foundation Trust Code of Governance"
means the best practice advice published by Monitor on 4 July 2014 ~~10 March 2010~~, and as may be amended, varied or replaced by NHS England/Improvement (Monitor) or its successor body from time to time;

"Non-Executive Director"
means a Non-Executive Director of the Trust. For the avoidance of doubt, the Chairman is a Non-Executive Director;

"Officer"
means an employee of the Trust or any other person holding a paid appointment or office with the Trust;

"Partnership Organisation"
means an organisation that may appoint Partnership Governors and which is listed in Annex 3 to this Constitution;

"Partnership Organisation Governor"
means a Governor of the Council of Governors appointed by a Partnership Organisation other than: a Public Governor, Staff Governor, CCG Governor; or Local Authority/District Council Governor.

"Public Constituency"
has the meaning ascribed to it in paragraph 8 of this Constitution;

"Public Governor"
means a Governor of the Council of Governors elected by the Members of a Public Constituency;

"Secretary"
means the Secretary of the Trust or any other person other than a Governor, the Chief Executive or the Finance Director of the Trust, appointed by the NHS Foundation Trust or (as the case may be) the Trust or body corporate appointed to perform the roles and responsibilities of the Secretary as set out in Annex 8 and Appendix A of the NHS Foundation Trust Code of Governance;

"Sex Offenders Order"
means ~~a Sexual Offences Preventative Order made under section 104 of the Sexual Offences Act 2003, or a Risk of Sexual Harm Order made under section 123 of the Sexual Offences Act 2003;~~

a) a Sexual Offences Prevention Order made under either Section 104 or 105 of the Sexual Offences Act 2003; or

b) an Interim Sexual Offences Prevention Order made under Section 109 of the Sexual Offences Act 2003; or

c) a Risk of Sexual Harm Order made under Section 123 of the Sexual Offences Act 2003; or

d) the Interim Risk of Sexual Harm Order made under Section 126 of the Sexual Offences Act 2003; or

e) a Sexual Harm Prevention Order made under Section 103A of the Sexual Offences Act 2003; or

f) an Interim Sexual Harm Prevention Order made under Section 103F of the Sexual Offences Act 2003; or

g) a Sexual Risk Order made under Section 122A of the Sexual Offences Act 2003; or

h) an Interim Sexual Risk Order made under Section 122E of the Sexual Offences Act 2003; or

i) a Foreign Travel Order made under Section 114 of the Sexual Offences Act 2003.

"Sex Offenders Register"
means the notification requirements, set out in Part 2 of the Sexual Offences Act 2003, commonly known as the "Sex Offenders Register" ~~Register of Sex Offenders maintained under Part I of the Sex Offenders Act 1997 (as amended by the Sexual Offences Act 2003);~~

"Somerset Clinical Commissioning Group Governor"
means a Governor of the Council of Governors appointed by Somerset Clinical Commissioning Group;

"Staff Constituency"
has the meaning ascribed to it in paragraph 9 of this Constitution;

"Staff Governor"
means a member ~~Governor~~ of the Council of Governors elected by the members of the Staff Constituency;

"Standing Orders"

means the Standing Orders of the Council of Governors or the Board of Directors;

"Trust"
means XXXXXX NHS Foundation Trust;

“Trust Premises”
means any premises owned, leased or occupied under licence by the Trust for the purposes of providing or supporting its services as specified within the Trust’s Provider Licence and the schedules to the Licence.

“Vexatious Complainant” is someone who persists in pursuing a complaint where the NHS Complaints procedure at the NHS Trust or (as the case may be) the Trust, has been fully implemented and exhausted (as defined in the Trust’s policy for managing unsatisfied complaints);

"Voluntary Organisation"
means a body other than a public or local authority, the activities of which are not carried on for profit;

"Volunteer"
means a person who provides goods or services to the NHS Trust or (as the case may be) the Trust, but who is not employed to do so by the NHS Trust or (as the case may be) the Trust.

3. NAME

3.1 The name of the foundation trust is XXXXXXX (the Trust).

4. PRINCIPAL PURPOSE

4.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

4.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

4.3 The Trust may provide goods and services for any purposes related to:

4.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

4.3.2 the promotion and protection of public health.

5. POWERS

5.1 The powers of the Trust are set out in the 2006 Act, as amended by the Health and Social Care Act 2012, subject to any restrictions in the Terms of its Licence.

5.2 In the exercise of its powers, the Trust shall have regard to the principles of the NHS and the Trust as set out in Annex 4 of the Standing Orders.

5.3 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

5.4 Subject to any restriction contained in this Constitution, in the 2006 Act, ~~and to paragraph 5.5 below~~ or in Annex 2 of the Standing Orders, any of these powers may be delegated to a committee of directors or to an executive director.

5.5 Where the Trust is exercising functions of managers pursuant to Section 23 of the Mental Health Act 1983 (as amended), those functions may be exercised by any three or more persons authorised by the Board of Directors, each of whom must be neither an Executive Director of the Trust, nor an employee of the Trust. For the avoidance of doubt a Non -Executive Director is not an employee of the Trust.

6. OTHER PURPOSES

6.1 The purpose of the Trust may include education, training and research and other facilities for purposes related to the provision of health care, in accordance with its statutory duties and the terms of its Licence.

~~The Trust may carry out research in connection with the provision of health care and make facilities and staff available for the purposes of education, training or research carried on by others.~~

6.2 The Trust may fulfil the social care functions of any local authority as specified by an agreement made under Section 75 of the 2006 Act or otherwise.

6.3 The Trust may also carry on activities other than those mentioned above, subject to the regulatory framework, for the purpose of making additional income available in order to carry out its principal purpose better.

7. MEMBERSHIP AND CONSTITUENCIES

7.1 It is a requirement that the Trust, in deciding membership constituencies, shall have regard to the need for those eligible to be representative of those to whom the Trust provides services.

7.2 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

7.2.1 a public constituency

7.2.2 a staff constituency

8. PUBLIC CONSTITUENCY

8.1 An individual who lives in an area specified in Annex 1, and is not a member of staff, as an area for a public constituency may become or continue as a member of the trust.

8.2 Those individuals who live in an area specified for a public constituency are referred to collectively as the "Public Constituency".

8.3 The minimum number of members in each Public Constituency is specified in Annex 1.

9. STAFF CONSTITUENCY

9.1 An individual who is employed by the Trust under a contract of employment with the Trust (the Non-Executive Directors of the Trust shall not be regarded as employees for this purpose) may become or continue as a member of the trust provided:

9.1.1 they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

9.1.2 they have been continuously employed by the Trust under a contract of employment for at least 12 months.

9.2 Individuals ~~who are employed by a designated organisation or designated Trust subcontractor, and~~ who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt, this does not include voluntary organisations or

those who assist or provide services to the Trust on a voluntary basis.

9.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the "Staff Constituency".

9.4 The Staff Constituency shall not be divided into classes.

9.5 The minimum number of members in the Staff Constituency is specified in Annex 2.

9.6 An individual who is:

9.6.1 eligible to become a member of the Staff Constituency, ~~and~~ or

9.6.2 invited by the Trust to become a member of the Staff Constituency;

shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless they inform the Trust that they do not wish to do so.

9.7 An eligible individual under paragraph 9.1 who has previously informed the Trust that they do not wish to become a member of the Staff Constituency under paragraph 9.6 above may become a Member upon entry to the membership register pursuant to an application by them.

9.8 On receipt of an application for membership as set out in paragraph 9.7 above, and subject to being satisfied that the applicant is eligible, the Secretary shall cause the applicant's name to be entered in the Trust's Register of Members.

9.9 An individual who is no longer employed by the Trust shall have their Membership of the Trust transferred to the Public Constituency upon termination of their employment unless they inform the Trust they do not wish to continue their Membership.

10. NOT USED

11. NOT USED

12. APPLICATION FOR MEMBERSHIP

12.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust.

~~Subject to paragraph 8.7 below, applicants for membership of the Trust must complete and sign a hard copy of an application or submit an electronic copy of an application form and may be required to provide such further evidence as the Secretary may reasonably require in determining eligibility. Application for membership is subject to the provisions set out in Annex 8.~~

12.2 On receipt of an application for membership and subject to being satisfied that the applicant is eligible, the Secretary shall cause the applicant's name to be entered in the Trust's register of Members.

13. DISQUALIFICATION AND EXPULSION FROM MEMBERSHIP OF THE TRUST

~~*An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.*~~

~~*An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.*~~

13.1 An individual shall not become or continue as a Member of the Trust if they:

13.1.1 are a Member of any other constituency or class within a constituency;

13.1.2 are a member or are eligible to be a member of the Staff Constituency;

13.1.3 fail or cease to fulfil the criteria for membership of the Public Constituencies, or the Staff Constituency under the provisions of this Constitution to be a Member;

13.1.4 are less than 12 years of age at the ~~time~~ date of their application to become a Member;

13.1.5 were formerly employed by the Trust or the NHS Trust and were dismissed for gross misconduct;

13.1.6 have been identified as a Vexatious Complainant in line with the relevant policy.

13.1.7 have been placed on the Sex Offenders Register and/or is subject to a Sex Offenders Order;

13.1.8 have been involved as a perpetrator in a serious incident of violence or abuse within the last five years at any NHS

hospital or facility or against any NHS employee or other persons who exercise functions for the purpose of a Health Service Body;

13.1.1 have been previously expelled as a member by the Council of Governors or by another NHS foundation trust, and has not been subsequently re-admitted by the Council of Governors;

13.1.2 have demonstrated aggressive or violent behaviour at any Hospital and following such behaviour they have been asked to leave, have been removed or excluded from any Hospital in accordance with the relevant Trust policy for withholding treatment from violent/aggressive patients.

13.1.3 have deemed to have acted in a manner contrary to the interests of the Trust; or

13.2 do not agree to abide by the Trust's principles (as set out in Annex 4 of the Standing Orders.

14. TERMINATION OF MEMBERSHIP

14.1 An individual shall cease to be a Member ~~if they~~ on:

14.1.1 Resignation by;

14.1.1.1 giving notice in writing to the Trust, or

14.1.1.2 telephoning the Trust and confirming their wish to resign, with such resignation to take effect on written confirmation of their resignation by the Trust;

14.1.2 Disqualification or expulsion from membership under this Constitution pursuant to paragraph 13 above.

14.1.3 ~~die/~~ Death.

~~cease to fulfil the requirements of paragraphs 5, 6, 7 or 8 of this Constitution, as the case may be; be specific~~

14.1.4 or if they have not provided a current postal address.

14.2 It is the responsibility of each Member to ensure their eligibility at all times and not the responsibility of the Trust to do so on their behalf. A Member who becomes aware of their ineligibility shall be under a duty to inform the Secretary as soon as practicable and that person shall thereupon be removed forthwith from the Register of Members and shall cease to be a Member.

~~Where the Secretary has reason to believe that a Member is ineligible for membership or may be disqualified from membership under this Constitution, the Secretary shall carry out reasonable enquiries to establish if this is the case.~~

~~Where the Secretary considers that there may be reasons for concluding that a Member or an applicant for membership may be ineligible or be disqualified from membership, the Secretary shall advise that individual of those reasons in summary form and invite representations from the Member or applicant for membership within 28 days or such other reasonable period as the Secretary may in their absolute discretion determine. Any representations received shall be considered by the Secretary and a decision made on the Member's or applicant's eligibility or disqualification as soon as reasonably practicable and notice in writing of that decision shall be given to the Member or applicant within 14 days of the decision being made.~~

~~If no representations are received within the said period of 28 days or longer period (if any) permitted under the preceding paragraph, the Secretary shall be entitled nonetheless to proceed and make a decision on the member's or applicant's eligibility or disqualification notwithstanding the absence of any such representations from them.~~

~~Upon a decision being made under paragraphs 14.4 or 14.5 above that the Member is ineligible for or disqualified from membership the Member's name shall be removed from the Register of Members forthwith and they shall thereupon cease to be a Member.~~

~~Any decision made under this Constitution to disqualify a Member or an applicant for membership may be referred by the Member or applicant concerned to the Dispute Resolution Procedure under paragraph XX of this Constitution.~~

14.3 Where the Trust is on notice that a Member may be disqualified from membership, or may no longer be eligible to be a Member, it shall give the Member 14 days' written notice to show cause why his name should not be removed from the register of Members. On receipt of any such information supplied by the Member, the Secretary may, if they consider it appropriate, remove the Member from the register of Members. In the event of any dispute the Secretary shall refer the matter to the Council of Governors to determine.

15. ANNUAL MEMBERS' MEETING

15.1 The Trust shall hold an annual meeting of its members (referred to

as either ‘Annual Members’ Meeting or ‘Annual General Meeting’) ~~so that there is no more than fifteen calendar months between one meeting and the next.~~ The Annual Members’ Meeting shall be open to members of the public.

15.2 The following documents are to be presented to Members of the Trust at the Annual Members’ Meeting by at least one member of the Board of Directors in attendance:

15.2.1 the Annual Accounts;

15.2.2 any report of the Auditor on them; and

15.2.3 the Annual Report;

15.3 Where an amendment is made to the constitution as per paragraph 53.3 in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust).

15.3.1 At least one member of the Council of Governors must attend the next Annual Members’ Meeting and present the amendment, and

15.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

15.4 The Council of Governors shall present to the Annual Members Meeting:

15.4.1 A report on the proceedings of its meetings held since the last annual meeting;

15.4.2 A report on the progress since the last annual meeting in developing the membership strategy is fully representative of the persons who are eligible to be members under the Constitution;

15.4.3 A report on any change to the Governors which has taken place since the last annual meeting; and

15.4.4 A report containing such comments as it wishes to make regarding the performance of the Trust and the accounts of the Trust for the preceding Financial Year and the future service development plans of the Trust.

~~*Further provisions about the Annual Members’ Meeting are set out in Annex 9 – Annual Members’ Meeting.*~~

16. COUNCIL OF GOVERNORS

16.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors. It is to be chaired by the Chairman of the Trust and it is to consist of Public Governors, Staff Governors, Local Authority Governors, and Other Partnership Governors.

17. COUNCIL OF GOVERNORS – COMPOSITION

17.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed governors. It is to be chaired by the Chairman of the Trust and is to consist of Public Governors, Staff Governors and Appointed Governors.

17.2 The composition of the Council of Governors is specified in Annex 3.

17.3 The aggregate number of Public Governors is to be more than half of the total membership of the Council of Governors.

17.4 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 1.

17.5 The organisations currently specified that may appoint a member of the Council of Governors are:

17.5.1 NHS Somerset Clinical Commissioning Group;

17.5.2 Somerset County Council

17.5.3 District Councils (until 1 May 2023 only)

17.5.4 Somerset Primary Care Board

17.5.5 Voluntary, Community and Social Enterprise (VCSE)

17.5.6 Universities

17.5.7 Symphony Healthcare Services Ltd

17.5.8 Simply Serve Limited

18. COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

18.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules. Elections for Elected Governors shall be conducted using the First Past the Post (FPP) system.

18.2 The Model Election Rules as published from time to time by the Department of Health, NHS Providers ~~Foundation Trust Network~~ or its successor body, form part of this constitution. The Model Election Rules are attached at Annex 4.

18.3 A subsequent variation of the Model Election Rules by the Department of Health, NHS Providers ~~Foundation Trust Network~~ or its successor body, shall not constitute a variation of the terms of this constitution for the purposes of paragraph 46 of the constitution (amendment of the constitution). For the avoidance of doubt, the Trust cannot amend the Model Rules for Elections.

18.4 An election, if contested, shall be by secret ballot.

18.5 Paragraph 18.1 and 18.4 above shall apply to all elections for Public and Staff Governors.

18.6 Members of each Public and Staff Constituencies may elect any of their members who are eligible to be a Public or Staff Governor.

18.7 A person may not vote at an election for or stand for election as an Elected Governor unless within the specified period stated in the Model Rules for Elections they have made a declaration as set out in paragraph 18.7 below. It is an offence ~~(other than in relation to the Staff Constituency)~~ to knowingly or recklessly make such a declaration which is false in a material particular.

18.8 The specified form regarding the declaration to stand for election as an Elected Governor shall be as set out on the nomination paper referred to in the Model Rules for Elections at Annex 4 and shall state as follows:

"I declare that I am resident at the address detailed in Section 1 of this form. I declare that to the best of my knowledge I am eligible to stand for election to the Council of Governors for the seat named in Section 2 of this form. I declare that to the best of my knowledge I am not de-barred from standing for election by any of the provisions detailed at Section 3 of this form. I declare that I have stated details of any financial interests I have in the NHS Trust (or, as the case may be, the Foundation Trust) at Section 4 of this form. I understand that if any of these declarations are later found to be false I will if elected lose my seat on the Council of Governors and may also have my membership withdrawn. I endorse the principles of the National Health Service and in particular that healthcare should be available to everyone regardless of age, income or ethnicity and is based on

need, not the ability to pay, as well as being free at the point of delivery".

18.9 The procedure for nominating Appointed Governors is set out in Annex 3.

19. COUNCIL OF GOVERNORS - TENURE

19.1 Elected Governors

19.1.1 An elected governor may hold office for a period of up to 3 (three) years.

19.1.2 An elected governor shall cease to hold office if they cease to be a member of the constituency or class by which they were elected.

19.1.3 An elected governor shall be eligible for re-election at the end of their term, ~~subject to the Terms of Office set out in Annex 6~~ subject to paragraph 19.1.4 and paragraph 20.

19.1.4 An Elected Governor may hold office for a maximum of 9 (nine) consecutive years.

~~An Elected Governor may hold office for a maximum of 9 (nine) consecutive years, except when the end of their final term occurs when the Trust is in the process of a major transaction for which the Council of Governors are due to vote on the appropriateness of the transaction. In this case, the Elected Governor will be eligible to stand for election for a maximum of one additional year.~~

19.2 Appointed Governors

19.2.1 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them by notice in writing to the Trust or if they cease to be employed by or associated with the appointing organisation.

19.2.2 An appointed governor shall be appointed for a period of up to 3 (three) years.

19.2.3 An appointed governor shall be eligible for re-appointment at the end of their term subject to paragraph 19.2.4.

19.2.4 An Appointed Governor may hold office for a maximum of 9 (nine) consecutive years.

20. TERMINATION OF TERMS OF OFFICE

20.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary.

20.2 A Governor shall cease to hold office if their term of office is terminated in accordance with paragraph 20.1 above and/or they are disqualified from or are otherwise ineligible to hold office as a Governor.

20.3 If a Governor fails to attend any meeting of the Council of Governors for a consecutive period of twelve months or alternatively for three successive meetings of the Council of Governors, their tenure of office is to be immediately terminated by the Council of Governors unless the Council of Governors is satisfied that:

20.3.1 The absence was due to reasonable cause; and

20.3.2 That the Governor will be able to start attending meetings of the Council of Governors within such a period as it considers reasonable.

20.4 The Council of Governors may by a resolution of at least three quarters of the Governors present at the meeting, terminate a Governor's tenure of office if for reasonable cause it considers that:

20.4.1 They are disqualified from becoming or continuing as a Member under this Constitution;

20.4.2 They have knowingly or recklessly made a false declaration for any purpose provided for under this Constitution or in the 2006 Act; or

20.4.3 Their continuing as a Governor would or would be likely to prejudice the ability of the Trust to discharge its duties and functions or adversely affect public confidence in the services provided by the Trust or otherwise bring the Trust into disrepute.

20.5 If a Governor is considered to have acted in a manner inconsistent with:

20.5.1 the core principles as set out in Annex 4 of the Standing Orders.

20.5.2 the Provider Licence, Authorisation; or

20.5.3 the Standing Orders for the Practice and Procedure of the Council of Governors, as set out in Annex 1 of the Standing Orders for; or

20.5.4 the Governor's Code of Conduct, or

20.5.5 they have failed to declare an interest as required by this Constitution or the Standing Orders for Governors or, they have spoken or voted at a meeting on a matter in which they have an interest contrary to this Constitution or the Standing Orders Governors, and in this paragraph "interest" includes a pecuniary and a non-pecuniary interest and in either case whether direct or indirect, and they are adjudged to have so acted by a majority of not less than 75% of the Council of Governors then the Governor shall vacate their office immediately.

20.5.6 The Standing orders for the Council of Governors shall provide for the process to be adopted in cases relating to the termination of a Governor's tenure.

20.5.7 A Governor whose office is terminated under this paragraph 20.5 and paragraph 21 below shall not be eligible to stand for re-election of re-appointment to the Council of Governors for a period of three years from the date of their removal from office.

21. COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL

21.1 The following may not become or continue as a member of the Council of Governors:

21.1.1 In the case of an Elected Governor they cease to be a Member of the constituency or part of a constituency by which they were elected;

21.1.2 In the case of an Appointed Governor the appointing organisation withdraws its ~~appointment~~sponsorship of them.

21.1.3 A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

21.1.4 The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

21.1.5 A person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;

21.1.6 They are a person who is a subject of a disqualification order made under the Company Directors' Disqualification Act 1986;

21.1.7 A person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them;

21.1.8 They are under 16 years of age at the date they are nominated for election or appointment.

21.1.9 They are a Director of the Trust, or executive director, non-executive director, chairman, chief executive officer of another Health Service Body (unless he is appointed by a Partnership Organisation which is a Health Service Body), or a body corporate whose business involves the provision of health care services, including for the avoidance of doubt those who have a commercial interest in the affairs of the Trust;

21.1.10 NHS England/Improvement (Monitor) has exercised its powers to remove that person as a Governor of the Trust or has suspended them from office or has disqualified them from holding office as a Governor of the Trust for a specified period or NHS England/Improvement (Monitor) has exercised any of those powers in relation to the person concerned at any other time whether in relation to the Trust or some other NHS foundation trust;

21.1.11 They have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body;

21.1.12 They are a person whose tenure of office as the chairman or as a member or director of a Health Service Body has been terminated on the grounds that their appointment was not in the interests of the health service, for non attendance at meetings, or for non-disclosure of a pecuniary interest;

21.1.13 They have had their name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service

(Wales) Act 2006, and has not subsequently had their name included in such a list;

21.1.14 They have failed or refused to confirm in writing that they will abide by any Code of Conduct for Governors which the Trust shall have published from time to time;

21.1.15 They have refused without reasonable cause to undertake any training which the Trust and/or Council of Governors requires all Governors to undertake;

21.1.16 They are a member of a local authority Health Overview and Scrutiny Committee;

21.1.17 They are the subject of a Sex Offenders Order and/or their name is included in the Sex Offenders Register;

21.1.18 They are an occupant of the same household and/or they are an Immediate Family Member of a Director of the Trust;

21.1.19 They are a person who by reference to information revealed by a Disclosure and Barring Service check is considered by the Trust to be inappropriate on the grounds that their appointment might adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

21.1.20 They have failed to make, or has falsely made, any declaration as required by paragraph 18.8 of this Constitution;

21.1.21 They have been removed as a Governor or equivalent by any foundation trust within the last five (5) years;

21.1.22 They are a person who is a subject of a disqualification order made under the Company Directors' Disqualification Act 1986;

21.1.23 They are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

21.1.24 They have failed to repay (without good cause) any amount of monies properly owed to the Trust,

21.1.25 They have received a written warning from the Trust for abuse of any type or;

21.1.26 The Partnership Organisation which they represent ceases to exist or withdraws its entitlement to appoint a Governor.

21.2 The provisions of paragraph 21.1 above apply to both Elected Governors and Appointed Governors and to anyone seeking election or appointment.

21.3 Where a Governor's membership of the Council of Governors ceases for one of the reasons set out in paragraph 21 of the Constitution ~~or in paragraphs 1 and 2 above of this Annex 5~~, they shall notify the Secretary in writing of such disqualification and/or (as the case may be), removal as soon as is practicable and, in any event, within 14 days of first becoming aware of those matters which rendered them disqualified or removed.

21.4 If it comes to the notice of the Secretary at the time of their taking office or later that the Governor is so disqualified, the Secretary shall immediately declare that the person in question is disqualified and notify them in writing to that effect as soon as is practicable.

21.5 Upon despatch of any such notification under paragraphs 21.3 or 21.4 above, that person's tenure of office, if any, shall be terminated and they shall cease to act as a Governor, and the Secretary shall cause their name to be removed from the register of Governors of the Council of Governors.

21.6 The Trust will make, from time to time, policy on the grounds, processes and procedures for the removal of Governors. Such policies shall be presented to the Council of Governors for comments and approval and any changes shall be reflected in the Standing Orders.

~~*Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 8.*~~

22. VACANCIES

22.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of a term of office, the following provisions will apply.

22.2 Elected Governors shall be replaced using the following provisions:

22.2.1 The Council of Governors shall offer the candidate who secured the next highest number of votes in the last election for the Constituency (or part of Constituency, as the case may be) in which the vacancy has arisen the opportunity to assume the vacant office for the unexpired balance of the retiring

Governor's term of office. If that candidate does not wish to fill the vacancy it will then be offered to that candidate who secured the next highest number of votes until the vacancy is filled.

22.2.2 If no reserve candidate is available or willing to fill the vacancy, a by-election will be held in accordance with the Model Rules for Elections save that if an election is due to be held within 12 months of the vacancy having arisen, the office will stand vacant until the next scheduled election.

22.2.3 The Returning Officer shall maintain a record of votes cast at each election for the above purposes and the Returning Officer shall conduct or shall oversee the conducting of the process set out in paragraphs 22.2.1 and 22.2.2 above.

22.3 Notwithstanding the provisions above, where any termination of a Governor's term of office causes the total number of Governors elected from the Public Constituency to be less than half the total membership of the Council of Governors', a by-election will be held in accordance with paragraph 18 of this Constitution as soon as reasonably practicable.

22.4 Where an Appointed Governor's membership of the Council of Governors ceases for whatever reason, the Council of Governors shall invite the relevant appointing bodies to appoint a new Governor as soon as practicable. Appointed Governors shall be replaced in accordance with the processes agreed pursuant to paragraph 4 of Annex 3 of this Constitution.

22.5 No proceedings of a Council of Governors shall be invalidated by any vacancy in its membership or any defect in the appointment or election of any Governor.

23. COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS

23.1 The general duties of the Council of Governors are:

23.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

23.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

23.1.3 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

23.2 Each Governor shall exercise their own skill and judgement in the conduct of the Trust's affairs and shall in their stewardship of the Trust's affairs bring as appropriate the perspective of the constituency or organisation by which they were elected or appointed as the case may be.

24. COUNCIL OF GOVERNORS: ROLES AND RESPONSIBILITIES

24.1 The ~~general~~ roles and responsibilities of the Council of Governors at a general meeting or otherwise shall be:

24.1.1 To assist the Board of Directors in setting the strategic direction of the trust and targets for the Trust's performance;

24.1.2 To monitor the Trust's performance in achieving strategic objectives and performance targets that have been set;

24.1.3 To be presented with the annual accounts, any report of the Auditor on them and the annual report;

24.1.4 To consider disputes as to membership referred to it pursuant to paragraph 54; and/or

24.1.5 To consider resolutions to remove a Governor pursuant to paragraph 20.4 of this Constitution.

24.1.6 To act as guardians to ensure that the Trust operates in a way that is consistent with NHS and Trust principles (as set out in Annex 4 of the Standing Orders) and the terms of the Trust's Authorisation;

24.1.7 To exercise such other powers and to discharge such other duties as may be conferred on the Council of Governors under this Constitution.

24.1.8 To respond as appropriate when consulted by the Board of Directors.

24.2 The Council of Governors shall appoint the Chairman and other Non-Executive Directors of the Trust at a general meeting. The appointment and re-appointment process for the Chairman and other Non-Executive Directors is set out in Annex 4 of the Standing Orders.

24.3 The Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of officed, of the non-Executive Directors.

24.4 The Council of Governors may remove the Chairman and other Non-Executive Directors of the Trust at a general meeting. The removal of the Chairman and other Non-Executive Directors of the Trust requires the approval of at least three quarters of the Governors.

24.5 The Council of Governors shall approve (by a majority of the Council of Governors voting) the appointment of the Chief Executive by the Non-Executive Directors of the Trust at a general meeting.

24.6 The Council of Governors will agree with the Audit Committee the criteria for appointing, reappointing and removing external Auditors and shall appoint, reappoint or remove the Trust's external Auditor, following a written recommendation from the Audit Committee.

24.7 This written recommendation must include the reason(s) for the appointment, reappointment or removal of the external Auditors. Should the Council of Governors disagree with the Audit Committee's recommendation, the Council of Governors will provide the Audit Committee with the reasons for the disagreement and the Audit Committee will be required to consider these reasons and to present any further recommendations to the Council of Governors. The recommended appointment term for the appointment or reappointment of external auditors is three to five years.

24.8 The Council of Governors may establish sub-committees (as set out in Annex 1 of the Standing Orders) of its members to discharge its duties under this Constitution or in order to more effectively meet its roles and responsibilities.

24.9 The Governors also have the specific role and function of:

24.9.1 developing membership and representing the interests of the Members and holding the Board of Directors to account in relation to the Trust's performance;

24.9.2 representing the interests of the Members of the Trust as a whole and the interests of the public;

24.9.3 holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors;

24.9.4 approving an application by the Trust to enter into a merger, acquisition, separation or dissolution.

24.10 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

25. COUNCIL OF GOVERNORS – REMUNERATION AND TRAVEL EXPENSES

25.1 Governors are not to receive remuneration, provided that this shall not prevent the remuneration of Governors by their employer (such as in the instance of staff governors).

25.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust, in accordance with the rates paid to employees and the Trust's policy on travelling and subsistence expenses as may be varied from time to time.

26. COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS

26.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 33.1 below) or, in their absence the Deputy Chairman (appointed in accordance with the provisions of paragraph 37.1 below) shall chair at meetings of the Council of Governors and the person chairing the meeting shall have a casting vote.

26.2 If the Deputy Chairman is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director ~~as shall be appointed by the Council of Governors~~ shall preside.

26.3 Where it has been determined by the Chair that it is inappropriate for the Chairman or any non-executive director to chair the meeting, the Lead Governor shall preside.

26.4 Meetings of the Council of Governors shall be open to members of the public unless the Council of Governors decides otherwise in accordance with the exclusions identified in Annex 1 of the Standing Orders.

26.5 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

27. COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS

27.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under

consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

27.2 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed. These provisions are set out in Annex 1 of the Standing Orders.

28. LEAD GOVERNOR

28.1 The Governors may (at their discretion) appoint a Lead and Deputy Lead Governor at any general meeting of the Council of Governors thereafter. The method of appointment shall be determined by agreement of the Council of Governors.

28.2 If the Governors make the appointments specified in Standing Order 28.1 above, then the following provisions of this Standing Order shall apply:

28.2.1 Without prejudice to the rights of any Governor to communicate directly with the Chairman, the Lead Governor shall be responsible for receiving from Governors observations and concerns expressed to them by Governors regarding a potential significant breach of the Trust's Licence.

28.2.2 Subject to paragraph 28.1, the Lead and Deputy Lead Governor so appointed shall hold office for a period of 12 calendar months but shall be eligible for reappointment at that time.

28.2.3 The contact details of the Lead and Deputy Lead Governor shall be provided to NHS England/Improvement (Monitor) on appointment. The Lead Governor shall then be responsible for receiving and communicating to the Council of Governors any correspondence from NHS England/Improvement (Monitor).

28.2.4 The Lead or Deputy Lead Governor shall chair the meeting of the Council of Governors when it is inappropriate for the Chair or a Non-Executive Director to do so.

28.3 Notwithstanding the tenure provisions set out at in paragraph 28.2.2 above, if the Lead and/or Deputy Lead Governor is considered to have acted in a manner inconsistent with paragraph 28.2.1 above and they are adjudged to have so acted by a majority of not less than 75% of the Council of Governors, then the Lead and/or Deputy Lead Governor shall stand down and cease to fulfil the role of Lead or Deputy Lead Governor.

29. COUNCIL OF GOVERNORS – STANDING ORDERS

29.1 The standing orders for the practice and procedure of the Council of Governors and further additional provisions are set out in Annex 1 of the Standing Orders.

30. BOARD OF DIRECTORS – GENERAL DUTY

30.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

31. BOARD OF DIRECTORS – COMPOSITION

31.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

31.2 The Board of Directors is to comprise:

31.2.1 a non-executive Chairman

31.2.2 up to a maximum of 9 other non-executive directors; and

31.2.3 up to a maximum of 8 executive directors.

31.3 One of the executive directors shall be the Chief Executive.

31.4 The Chief Executive shall be the Accounting Officer.

31.5 One of the executive directors shall be the Finance Director.

31.6 One of the executive directors is to be a registered medical practitioner (within the meaning of the Medical Act 1983) or a registered dentist (within the meaning of the Dentists Act 1984).

31.7 One of the executive directors is to be a registered nurse or a registered midwife (within the meanings of the Nursing and Midwifery Order (SI2002/253).

31.8 The post of an Executive Director may be held by two individuals on a job-share basis (the executive positions of registered medical practitioner/registered dental practitioner and nurse/midwife cannot be shared between the two professions), but where such an arrangement is in force and the post carries voting rights, the two individuals may only exercise one vote between them at any meeting of the Board of Directors.

31.9 In the event that the number of Non-Executive Directors (including the Chairman) is equal to the number of Executive Directors, the Chairman (and in their absence, the Deputy Chairman), shall have a second or casting vote at meetings of the Board of Directors in accordance with the Standing Orders for the Board of Directors.

31.10 If, in spite of the Chairman's casting or second vote, there remained an imbalance at Board meetings between the number of Executive and Non Executive Directors, if a formal vote is required, the maximum number of Executive votes to be counted will be equivalent to the number of Non Executive Directors present at the meeting of the Board of Directors in accordance with the Standing Orders for the Board of Directors.

31.11 The validity of any act of the Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Director.

31.12 Subject to the provisions of paragraphs 31.2 to 31.7 above, the Board of Directors shall determine any change in the number of Directors, provided that any change in the number of Directors is within the range set out in paragraph 31.2 above.

32. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIRMAN AND OTHER NON-EXECUTIVE DIRECTORS

32.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the Trust and the other Non-Executive Directors.

32.2 Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

32.3 Without prejudice to paragraph 32.1 above and subject to the provisions of paragraph 31, the process for appointing new Non-Executive Directors and the Chairman will be as set out in Annex 4 of the Standing Orders.

33. BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other Non-Executive Directors.

33.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

34. BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR

34.1 A person may be appointed as a non-executive director only if:

34.1.1 They are a member of a Public Constituency,

34.2 Where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university, and

34.3 They are not disqualified by virtue of paragraph 35 below.

35. BOARD OF DIRECTORS – DISQUALIFICATION

35.1 The following may not become or continue as a member of the Board of Directors:

35.1.1 A person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

35.1.2 The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

35.1.3 The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

35.1.4 A person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it.

35.1.5 The person is included in the children's barred list or the adults' barred list maintained under section 2 of the

Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

35.1.6 The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

35.1.7 A person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

35.1.8 A person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

35.1.9 The person has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

35.1.10 A person whose tenure of office as a chairman or member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the health service.

35.1.11 A person who has had their name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list;

35.1.12 A person who has within the preceding (2) two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a Health Service Body.

35.1.13 A person who is a governor of another NHS foundation trust (unless they are appointed by a Partnership Organisation which is a Health Service Body). Any executive or non-executive director who has a pecuniary or other interest in another health or social care related organisation must make this known to the Chairman and must excuse themselves from Board discussion and proceedings if they believe that a conflict of interest exists

at any time during the business of the Board.

35.1.14 A person who holds an office or paid work with HealthWatch.

35.1.15 A person who is a member of a local authority Health Overview and Scrutiny Committee.

35.1.16 A person who has failed without reasonable cause to fulfill any training requirements established by the Board of Directors.

35.1.17 A person who is a subject of a disqualification order made under the Company Directors' Disqualification Act 1986.

35.1.18 A person who has failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the Directors' Code of Conduct.

35.1.19 A person who is the subject of a Sex Offenders Order and/or their name in included in the Sex Offenders Register.

35.1.20 A person who by reference to information revealed by a Disclosure and Barring Service check is considered by the Trust to be inappropriate on the grounds that their appointment may adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute or

35.1.21 A person who is unable or unwilling to sign an annual declaration that they continue to meet the Care Quality Commission's Fit and Proper Person regulations.

35.1.22 In the case of a Non-Executive Director, they no longer satisfy paragraph 35.1 above.

35.1.23 They do not meet the criteria set out in Regulation 5(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (including any modification or re-enactment).

36. BOARD OF DIRECTORS – APPOINTMENT OF DEPUTY CHAIRMAN

36.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a deputy chairman, on the recommendation of the Chairman. ~~in accordance with SO 3.11 of Annex 7.~~

~~Fit and Proper Persons Regulation: Care Quality Commission Regulation 5~~

~~The Trust is required to comply with the Fit and Proper Persons Regulation which state that unless an individual satisfies all the requirements set out in 29.2, the Trust must not appoint or have in place an individual:~~

~~(a) As a director, or~~

~~(b) Performing the functions of, or functions equivalent to the functions of, such a director.~~

~~The Trust has determined that the individuals referred to in (a) and (b) include: Executive Directors, Non-Executive Directors, Associate Directors and Deputy Directors.~~

~~The requirements referred to in paragraph 29.1 are that:~~

~~(a) The individual is of good character;~~

~~(b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;~~

~~(c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;~~

~~(d) The individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and~~

~~(e) None of the grounds of unfitness specified in Part 1 of Schedule 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and included in paragraph 29 of the Constitution, apply to the individual.~~

In assessing the individual's character for the purposes of paragraph 29.2(a), the matters considered must include those listed in Part 2 of Schedule 4 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which have been included in paragraph 29 to the Constitution.

The following information must be available to be supplied to the Care Quality Commission in relation to each individual who holds an office or position referred to in paragraph (28.1)(a) or (28.1)(b):

1. Proof of identity including a recent photograph;

2. Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997, a copy of a Disclosure and Barring certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request);

3. Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2(b) of the Police Act 1997, a copy of an enhanced Disclosure and Barring certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults;

4. Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to:

   (a) Health or social care, or;

   (b) Children or vulnerable adults,

5. Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended;

6. In so far as it is reasonably practicable to obtain, satisfactory evidence of any qualification relevant to the duties for which the person is employed or appointed to perform;

~~7. A full employment history, together with a satisfactory written explanation of any gaps in employment;~~

~~8. Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purpose of the regulated activity;~~

~~9. For the purposes of this section:~~

~~(a) "the appointed day" means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;~~

~~(b) "satisfactory" means satisfactory in the opinion of the Commission;~~

~~(c) "suitability information relating to children or vulnerable adults" means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.~~

~~10. Such other information as is required to be kept by the Trust under any enactment which is relevant to that individual.~~

~~Where an individual who holds an office or position referred to in paragraph 29.1(a) or (b) no longer meets the requirements in paragraph 29.2 the Trust must:~~

~~(a) Take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements; and;~~

~~(b) If the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.~~

37. BOARD OF DIRECTORS - APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER EXECUTIVE DIRECTORS

37.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

37.2 The appointment of the Chief Executive shall require the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

37.3 A committee consisting of the Chairman, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other executive directors.

38. BOARD OF DIRECTORS – MEETINGS

38.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

38.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

38.3 Further provisions are set out in Annex 2 of the Standing Orders.

39. BOARD OF DIRECTORS – STANDING ORDERS

39.1 The standing orders for the practice and procedure of the Board of Directors are attached ~~at Annex 8~~ to the Constitution as a separate document.

40. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

40.1 The duties that a director of the Trust has by virtue of being a director include in particular:

40.1.1 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.

40.1.2 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.

40.2 The duty referred to in sub-paragraph 40.1.1 is not infringed if:

40.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

40.2.2 The matter has been authorised in accordance with the constitution.

40.3 The duty referred to in sub-paragraph 40.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

40.3.1 In sub-paragraph 40.1.2, “third party” means a person other than –

40.3.2 The Trust, or

40.3.3 A person acting on its behalf.

40.4 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

40.5 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

40.6 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

40.7 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

40.8 A director need not declare an interest:

40.8.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

40.8.2 If, or to the extent that, the directors are already aware of it;

40.8.3 If, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered –

40.8.4 By a meeting of the Board of Directors, or

40.8.5 By a committee of the directors appointed for the purpose under the constitution.

40.9 A matter shall have been authorised for the purposes of paragraph 40.2.2 above if:

40.9.1 the Directors, in accordance with the requirements set out in this paragraph 40.9, authorise any matter or situation proposed to them by any Director which would, if not authorised, involve a Director (an "Interested Director") breaching his duty under paragraph 40.1.1 above to avoid Conflicts:

40.9.1.1 the matter in question shall have been proposed by any Director for consideration in the same way that any other matter may be proposed to the Directors under the provisions of this Constitution;

40.9.1.2 any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interest Director; and

40.9.1.3 the matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

40.9.2 Any authorisation of a Conflict under this paragraph 40.9 may (whether at the time of giving the authorisation or subsequently):

40.9.2.1 extend to any actual or potential conflict of interest which may reasonably be expected to arise out of the Conflict so authorised;

40.9.2.2 provide that the Interested Director be excluded from the receipt of documents and information and the participation in discussions (whether at meetings of the Directors or otherwise) related to the Conflict;

40.9.2.3 impose upon the Interested Director such other terms for the purposes of dealing with the Conflict as the Directors think fit;

40.9.2.4 provide that, where the Interested Director obtains, or has obtained (through his involvement in the Conflict and otherwise than through his position as a Director of the Trust) information that is confidential to a third party, he will not be obliged to disclose that information to the Board of Directors, or to use it in relation to the Trust’s affairs where to do so would amount to a breach of that confidence; and

40.9.2.5 permit the Interested Director to absent himself from the discussion of matters relating to the Conflict at any meeting of the Directors and be excused from reviewing papers prepared by, or for, the Directors to the extent they relate to such matters.

40.10 Where the Directors authorise a Conflict, the Interested Director will be obliged to conduct himself in accordance with any terms imposed by the Directors in relation to the Conflict.

40.11 The Directors may revoke or vary such authorisation at any time, but this will not affect anything done by the Interested Director, prior to such revocation or variation in accordance with the terms of such authorisation.

40.12 A Director is not required, by reason of being a Director, to account to the Trust for any remuneration, profit or other benefit which he derives from or in connection with a relationship involving a Conflict which has been authorised by the Directors (subject in each case to any terms, limits or conditions attaching to that authorisation) and no contract shall be liable to be avoided on such grounds.

41. REGISTERS

41.1 The Trust shall have:

41.1.1 a register of members showing, in respect of each member, the constituency to which they belong and, where there are classes within it, the class to which they belong;

41.1.2 a register of members of the Council of Governors;

41.1.3 a register of interests of governors;

41.1.4 a register of directors; and

41.1.5 a register of interests of the directors.

42. ADMISSION TO AND REMOVAL FROM THE REGISTERS

Register of Members

42.1 The Secretary shall maintain the Register of Members in two parts. Part one, which shall be the register referred to in the 2006 Act, shall include the name of each member and the constituency or class to which they belong, and shall be open to inspection by the public in accordance with paragraph 43 below. Part two shall contain all the information from the application form and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third party. Notwithstanding this provision the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual membership of the Trust is representative of those eligible for membership and for the administration of the provisions of this Constitution.

Register of Governors

42.2 The Register of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted which may be that of the Secretary.

Register of Interests of the Governors

42.3 The Register of Interests of the Governors shall contain the names of each Governor, whether they have declared any interests and, if so, the interests declared in accordance with this Constitution or the Standing Orders for the Council of Governors.

Register of Directors

42.4 The Register of Directors shall list the names of Directors, their capacity on the Board of Directors and an address through which they may be contacted which may be the Secretary.

Register of Interests of Directors

42.5 The register of interests of Directors shall contain the names of each Director, whether they have declared any interests and, if so, the interests declared in accordance with this Constitution or the Standing Orders for the Board of Directors.

~~Further arrangements for admission to and removal from the registers are set out in Annexes 5 and 8.~~

43. REGISTERS – INSPECTION AND COPIES

43.1 The Trust shall make the registers specified in paragraph 42 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

43.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.

43.3 So far as the registers are required to be made available:

43.3.1 they are to be available for inspection free of charge at all reasonable times; and

43.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

43.4 If the person requesting a copy or extract is not a member of the trust, the Trust may impose a reasonable charge for doing so.

44. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

44.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

44.1.1 a copy of the current constitution,

44.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

44.1.3 a copy of the latest annual report

44.1.4 a copy of any notice given under section 52 of the 2006 Act.

44.2 The Trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:

44.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

44.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

44.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

44.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

44.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

44.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

44.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

44.2.8 a copy of any final report published under section 65I (administrator's final report),

44.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

44.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

44.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

44.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

45. EXTERNAL AUDITOR

45.1 The Trust shall have an auditor and the Trust agrees to provide the Auditor with every facility and all information which he may reasonably require for the purposes of his functions under Schedule 10 of the 2006 Act.

45.2 The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

45.3 The external auditor is to carry out its duties in accordance with Schedule 10 of the 2006 Act and in accordance with any directions given by NHS England/Improvement (Monitor), or its successor body, on standards, procedures and techniques to be adopted.

~~The Board of Directors may resolve that the "external auditor" be appointed to provide a non-audit review and publish a report on any other aspects of the Trust's performance. Any such "external auditor" is to be appointed by the Council of Governors.~~

45.4 The external auditor may provide services which are outside of the scope of the annual accounts external audit process (non-audit services). The Council of Governors may agree to delegate the approval of non-audit services to the Audit Committee.

46. AUDIT COMMITTEE

46.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

47. ACCOUNTS

47.1 The Trust must keep proper accounts and proper records in relation to the accounts.

47.2 NHS England/Improvement (Monitor) may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

47.3 The accounts are to be audited by the Trust's auditor.

47.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England/Improvement (Monitor) may with the approval of the Secretary of State direct.

47.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

48. ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

48.1 The Trust shall prepare an Annual Report and send it to NHS England/Improvement (Monitor).

48.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England/Improvement (Monitor).

48.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

48.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

48.5 Each forward plan must include information about:

48.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

48.5.2 the income it expects to receive from doing so.

48.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 48.5.1 the Council of Governors must:

48.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the Trust of its principal purpose or the performance of its other functions, and

48.6.2 notify the directors of the Trust of its determination.

A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.

49. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

49.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

49.1.1 the annual accounts

49.1.2 any report of the auditor on them

49.1.3 the annual report.

49.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

49.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 49.1 with the Annual Members' Meeting.

50. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

50.1 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

50.2 A "Significant transaction" means a transaction ~~for anything other than the service contract with the Somerset Clinical Commissioning Group~~ that meets any of the criteria set out below:

- assets – the gross asset value (total of the fixed assets and current assets) of the asset which is subject to the transaction is greater than 25% of the Trust Gross Assets prior to the transaction at the time the Board seeks approval from the Governors;

- income – either the forecast annual income attributable to the Asset associated with the transaction or the contract value associated with the transaction is greater than 25% of the Trust's gross annual income forecast by the Trust for the

current financial year prior to the transaction at the time the Board seeks approval from the Governors;

- capital – the gross capital of the company or business being acquired/divested is greater than 25% of what would be the Trust forecasted total capital following completion of the transaction or the effects on the total capital of the Trust resulting from a transaction greater than 25% of that total capital. For this purpose Gross Capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets. Total Capital of the Trust equals taxpayers' equity in the Trust.

50.3 Notwithstanding the above provisions and for the avoidance of doubt, a Significant Transaction does not include:

50.3.1 transaction pursuant to: Sections 56, 56A 56B and 57A of the 2006 Act; or

50.3.2 contracts in place, from time to time, with NHS Somerset Clinical Commissioning Group (or its successor organisation); or

50.3.3 contracts in place, from time to time, with any other Clinical Commissioning Groups, or the NHS Commissioning Board (or its successor organisation); or

50.3.4 contracts in place, from time to time, with Public Health England (or its successor organisation) and local authorities

51. INDEMNITY

51.1 Governors of the Council of Governors and Board of Directors and Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

51.2 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangement for its own benefit and for the benefit of the Council of Governors, Board of Directors and the Secretary.

52. INSTRUMENTS

52.1 The Trust shall have a seal.

52.2 The seal shall not be affixed except under the authority of the Board of Directors.

52.3 An overview of the sealings is to be presented to the Board of Directors on a quarterly basis.

53. DISPUTE RESOLUTION PROCEDURES

53.1 **Dispute about entitlement to membership**

53.1.1 In the event of any dispute about the entitlement to membership, the dispute shall be referred to the Secretary who shall make a determination on the point in issue. If the Member or applicant (as the case may be) is aggrieved at the decision of the Secretary they may appeal in writing within 14 days of the Secretary's decision to the Council of Governors or a delegated committee or sub-committee of the Council of Governors whose decision shall be final.

53.2 **Dispute in relation to this Constitution** (other than about membership)

53.2.1 In the event of any dispute in relation to this Constitution that concerns anything other than membership, the dispute shall be referred to the Chairman who shall make a determination on the point in issue. If the Member or complainant (as the case may be) is aggrieved at the decision of the Chairman they may appeal in writing within 14 days of the Chairman's decision to the Board of Directors whose decision shall be final**.**

13.2 **Dispute between the Council of Governors and Board of Directors**

4.3.1 In the event of dispute between the Council of Governors and the Board of Directors the Raising Concern Policy will apply.

13.2.1 In the first instance the Chairman on the advice of the Secretary, and such other advice as the Chairman may see fit to obtain, shall seek to resolve the dispute.

13.2.2 If the Chairman is unable to resolve the dispute they shall appoint a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to

make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute.

13.2.3 If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chairman may refer the dispute back to the Board of Directors who shall make the final decision.

54. AMENDMENT OF THE CONSTITUTION

54.1 The Trust may make amendments of its constitution only if:

54.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and

54.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

54.2 Amendments made under paragraph 54.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

54.3 Where an amendment is made to the constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

54.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

54.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

54.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

54.5 Amendments by the Trust of its constitution are to be notified to NHS England/Improvement (Monitor), or its successor body. For the avoidance of doubt, NHS England/Improvement (Monitor)'s, or its successor body's, functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

55. DISSOLUTION OF THE TRUST

55.1 The Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the provisions of the 2006 Act.

56. NOTICES

56.1 Save where a specific provision of the Constitution otherwise requires or permits, any notice required by this Constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose.

56.2 In paragraph 56.1 “electronic communication" shall have the meaning set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

56.3 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice served pursuant to paragraph 56.1 above shall be deemed to have been received 48 hours after the envelope containing it was posted, or in the case of a notice contained in an electronic communication, 48 hours after it was sent.

57. THE ROLE AND RESPONSIBILITIES OF THE SECRETARY

57.1 The Trust shall have a Secretary who may be an employee of the Trust, but may not be a Governor, the Chief Executive or the Finance Director of the Trust.

57.2 Notwithstanding the specific functions of the Secretary, as set out in this Constitution, the Secretary will be expected to:

57.2.1 Ensure good information flows within the Board of Directors and its committees and between senior management and the Council of Governors and Members;

57.2.2 Ensure that the procedures of the Board of Directors (as set out in this Constitution and the Standing Orders for the Board of Directors) are complied with;

57.2.3 Ensure that the procedures of the Council of Governors (as set out in this Constitution and the Standing Orders for Governors) are complied with;

57.2.4 Advise the Board of Directors and the Council of Governors (through the Chairman or the Deputy Chairman, as the case may be) on all governance matters; and

57.2.5 Be available to give advice and support to individual Directors and assistance with professional development.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Ref. Paragraph 8)

Table 1 - Current seats on the Council of Governors

Name of Constituency	For residents of	Minimum number of members	Elected Governors
Mendip	Mendip District Council area	150	4
Sedgemoor	Sedgemoor District Council area	150	4
South Somerset	South Somerset District Council area	200	8
Somerset West and Taunton	Somerset West and Taunton District Council	200	7
Dorset	Dorset	50	1
Outside Somerset and Dorset	England and Wales outside Somerset and Dorset	50	1
Totals	**Minimum Membership**	**800**	
	Governors		**25**

Table 2 - Seats on the Council of Governors from 1 May 2023

Name of Constituency	For residents of	Minimum number of members	Elected Governors
Mendip	Mendip District Council area	150	4
Sedgemoor	Sedgemoor District Council area	150	4
South Somerset	South Somerset District Council area	200	6
Somerset West and Taunton	Somerset West and Taunton District Council	200	5
Dorset	Dorset	50	1
Outside Somerset and Dorset	England and Wales outside Somerset and Dorset	50	1
Totals	**Minimum Membership**	**800**	
	Governors		**21**

1.1 Table 1 will be replaced with the table showing the seats from 1 May 2023 on 1 May 2023 and this paragraph will be deleted.

ANNEX 2 – THE STAFF CONSTITUENCY

(Ref. Paragraph 9)

1. MINIMUM NUMBER OF MEMBERS

1.1 There will be a single Staff Constituency with at least 1,200 members.

2. NUMBER OF SEATS ON COUNCIL OF GOVERNORS

2.1 The number of Governors to be elected by the Staff Constituency is 12 (twelve).

3. STAFF GOVERNOR ELIGIBILITY

~~Only staff members with a substantive contract will be able to stand for election as a Staff Governor.~~

3.1 Subject to the provisions set out in paragraphs 3.2 and 3.3 below, members of the Staff Constituency may elect any of the members of the Staff Constituency who are eligible to be a Staff Governor.

3.2 The provision set out below in paragraph 3.3 will apply only for the elections for the two new staff governor seats which will become available from 1 October 2022 and for the two staff governor seats which have remained vacant from 1 May 2022.

3.3 Only staff who transferred to XXXXXX from the date of the merger and who had a substantive contract with Yeovil District Hospital NHS Foundation Trust on the date of the merger will be eligible to stand for election for the two new and two vacant staff governor seats referred to in paragraph 3.2. In the case of a by-election to be held, all staff members will be eligible to stand for election.

3.4 Paragraphs 3.2, 3.3. and 3.4 will be removed from the Constitution following the October 2022 staff governor election process without the need for further Council of Governors or Board of Directors' approval.

~~4. EXERCISE OF FUNCTIONS~~

~~4.1 For the purposes of paragraph XX of the Constitution it shall be for the Trust in its absolute discretion to determine:~~

~~(a) The Designated Organisations; and~~

~~(b) Whether an individual exercises functions for the purposes of the Trust.~~

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraph 17)

1. OBJECTIVES

1.1 The Trust shall seek to ensure, subject to the requirements of the 2006 Act, that the composition of the Council of Governors meets the following objectives:

1.1.1. The interests of the community served by the Trust are appropriately represented and the NHS and Trust principles (as set out in Annex 4 of the Standing Orders) are upheld; and

1.1.2. The level of representation of the Public Constituencies, the Staff Constituency, and the Appointing Organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs and, to this end, the Council of Governors'.

1.2 The Council shall at all times maintain a policy for the composition of the Council of Governors which takes account of the Trust's membership strategy.

1.3 Shall from time to time, and not less than every three years, review the policy for the composition of the Council of Governors and the membership strategy.

1.4 When appropriate, shall propose amendments to this Constitution.

1.5 Shall provide to the Members relevant information concerning the performance and forward plans of the Trust; and

1.6 Shall act in an advisory capacity when the Board of Directors has to make challenging or difficult decisions including those that affect the strategic direction of the Trust.

2. COMPOSITION

2.1 The Composition of the Council of Governors shall be as follows:

	Electing/Appointing Body		Elected Governors	Appointed Governors
1.1	**Public Governors**			
	1.1.1	Mendip District Council area	4	
	1.1.2	Sedgemoor District Council area	4	
	1.1.3	South Somerset District Council area	8	
	1.1.4	Somerset West and Taunton District Council	7	
	1.1.5	Dorset	1	
	1.1.6	England and Wales outside Somerset and Dorset	1	
1.2	**Staff Governors**			
	Staff Constituency		12	
Appointed Governors				
1.3	**CCG Governor**			
	1.3.1	Somerset Clinical Commissioning Group		1
1.4	**Local Authorities' Governors**			
	1.4.1	Somerset County Council		1
	1.4.2	District Councils		2
1.5	**Partnership Organisations' Governors**			
	1.5.1	Somerset Primary Care Board		1
	1.5.2	Voluntary, Community and Social Enterprise (VCSE)		2
	1.5.3	Universities		1
	1.5.4	Symphony Healthcare Services Ltd		1
	1.5.5	Simply Serve Limited		1
	Total		**37**	**10**

2.2 The Composition of the Council of Governors from 1 May 2023 shall be as follows:

	Electing/Appointing Body		Elected Governors	Appointed Governors
1.1	**Public Governors**			
	1.1.1	Mendip District Council area	4	
	1.1.2	Sedgemoor District Council area	4	
	1.1.3	South Somerset District Council area	6	
	1.1.4	Somerset West and Taunton District Council	5	
	1.1.5	Dorset	1	

	1.1.6	England and Wales outside Somerset	1	
1.2	**Staff Governors**			
	Staff Constituency		12	
Appointed Governors				
1.3	**CCG Governor**			
	Somerset Clinical Commissioning Group (or successor organisation)			1
1.4	**Local Authorities' Governors**			
	1.5.1	Somerset County Council		2
1.5	**Partnership Organisations' Governors**			
	1.6.1	Somerset Primary Care Board		1
	1.6.2	Voluntary, Community and Social Enterprise (VCSE)		2
	1.6.3	Universities		1
	1.6.4	Symphony Healthcare Services Ltd		1
	1.6.5	Simply Serve Limited		1
	Total		**33**	**9**

2.3 The table showing the current composition will be replaced with the table showing the position as at 1 May 2023 on 1 May 2023 and this paragraph and all relevant sections in the Constitution and this Annex will be amended accordingly without the need for further approval from the Council of Governors or the Board of Directors.

2.4 The Council of Governors shall comprise Governors who are:

2.4.1 Elected by the respective constituencies in accordance with the provisions of this Constitution; or

2.4.2 Appointed in accordance with paragraph 3 of this Annex 3 below.

2.5 The Council of Governors shall at all times be constituted so that more than half the Governors are elected by members of the Trust other than those who are members of the Staff Constituency.

3. APPOINTED GOVERNORS

3.1 The following organisations, as listed in paragraph 17.5 shall be entitled to appoint Governors:

3.1.1 **Clinical Commissioning Group Governor**

3.1.1.1 **Somerset Clinical Commissioning Group** or its successor organisation shall be entitled to appoint 1 (one) Governor by notice in writing signed by the

Chief Executive or the Chairman of such Trust and delivered to the Secretary.

3.1.2 **Local Authorities' Governors**

3.1.2.1 **Somerset County Council** or its successor organisation shall be entitled to appoint 1 (one) Governor by notice in writing signed by the Leader of the Council or a member of the Council executive and delivered to the Secretary.

3.1.2.2 The **District Councils** in Somerset or their successor organisations shall agree between themselves which of them may appoint 2 (two) Governors by notice in writing signed by the leaders of the nominating District Councils, copied to all the other District Councils in Somerset and delivered to the Secretary. In the absence of any such agreement as to which District Council will appoint a Governor, the Trust may nominate two of the District Councils.

3.1.3 **Partnership Organisations' Governors**

3.1.3.1 **Somerset Primary Care Board** shall be entitled to appoint 1 (one) Governor by notice in writing signed by an authorised officer of the Board and delivered to the Secretary.

3.1.3.2 **Voluntary, Community and Social Enterprise (VCSE)** shall be entitled to co-ordinate the appointment of 2 (two) Governors by notice in writing and delivered to the Secretary.

3.1.3.3 **Bournemouth University** (established under Section 216(1) of the Education Reform Act 1988 by virtue of the Educational (Recognised Bodies) (England) Order 2003), whose address is Fern Barrow, Talbot Campus, Poole, Dorset, BH12 5BB; **University of Bristol**, (established under Royal Charter granted on 17 May 1909) whose address is Senate House, Tyndall Avenue, Bristol, BS8 1TH; **University of Plymouth** (established under Section 216(1) of the Education Reform Act 1988 by virtue of the Educational (Recognised Bodies) (England) Order 2003) whose address is Drake Circus, Plymouth, PL4 8AA; **University of Exeter**, (established under Section 216(1) of the Education Reform Act 1988 by virtue of the Educational (Recognised Bodies) (England) Order 2003), whose address is Stocker Rd, Exeter EX4 4PY, (together the "Universities") or their respective

successor organisations shall be entitled to appoint 1 (one) Governor between them by notice in writing signed by a Vice Chancellor or a pro Vice Chancellor from each university, and delivered to the Secretary.

3.1.3.4 **Symphony Healthcare Services Ltd** shall be entitled to appoint 1 (one) Governor by notice in writing signed by an authorised officer of the Board and delivered to the Secretary.

3.1.3.5 **Simply Serve Limited** shall be entitled to appoint 1 (one) Governor by notice in writing signed by an authorised officer of the Board and delivered to the Secretary.

3.2 All Appointed Governors shall be named individuals. The organisations entitled to appoint Governors shall agree one named deputy to attend meetings in the absence of the appointed governor by notice in writing signed by an authorised officer of the organisation and delivered to the Secretary.

3.3 The Council of Governors retains the right to review and amend the organisations entitled to appoint a Governor.

3.4 Notwithstanding the provisions of paragraphs 3.1 above, the Chairman may veto the appointment of any Appointed Governor by serving notice in writing on the relevant Organisation where they believe that the appointment in question is unreasonable, irrational, or otherwise inappropriate.

ANNEX 4 - MODEL ELECTION RULES

Model Rules for Elections
to the Council of Governors

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PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

Publicity

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

PART 12: MISCELLANEOUS

PART 1: INTERPRETATION

1. INTERPRETATION

1.1 In these rules, unless the context otherwise requires:

"2006 Act" means the National Health Service Act 2006;

"corporation" means the public benefit corporation subject to this constitution;

"council of governors" means the council of governors of the corporation;

"declaration of identity" has the meaning set out in rule 21.1;

"election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"e-voting" means voting using either the internet, telephone or text message;

"e-voting information" has the meaning set out in rule 24.2;

"ID declaration form" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"lead governor" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"list of eligible voters" means the list referred to in rule 22.1, containing the information in rule 22.2;

"method of polling" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"NHS England/Improvement" means the corporate body known as NHS England/Improvement (Monitor) as provided by section 61 of the 2012 Act;

"numerical voting code" has the meaning set out in rule 64.2(b)

"polling website" has the meaning set out in rule 26.1;

"postal voting information" has the meaning set out in rule 24.1;

“telephone short code” means a short telephone number used for the purposes of submitting a vote by text message;

“telephone voting facility” has the meaning set out in rule 26.2;

“telephone voting record” has the meaning set out in rule 26.5 (d);

“text message voting facility” has the meaning set out in rule 26.3;

“text voting record” has the meaning set out in rule 26.6 (d);

“the telephone voting system” means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

“the text message voting system” means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

“voter ID number” means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

“voting information” means postal voting information and/or e-voting information.

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. TIMETABLE

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. COMPUTATION OF TIME

3.1 In computing any period of time for the purposes of the timetable:

(a) A Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) A day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. RETURNING OFFICER

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. STAFF

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as they consider necessary for the purposes of the election.

6. EXPENDITURE

6.1 The corporation is to pay the returning officer:

(a) Any expenses incurred by that officer in the exercise of their functions under these rules;

(b) Such remuneration and other expenses as the corporation may determine.

7. DUTY OF CO-OPERATION

7.1 The corporation is to co-operate with the returning officer in the exercise of their functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. NOTICE OF ELECTION

8.1 The returning officer is to publish a notice of the election stating:

(a) The constituency, or class within a constituency, for which the election is being held;

(b) The number of members of the council of governors to be elected from that constituency, or class within that constituency;

(c) The details of any nomination committee that has been established by the corporation;

(d) The address and times at which nomination forms may be obtained;

(e) The address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer;

(f) The date and time by which any notice of withdrawal must be received by the returning officer;

(g) The contact details of the returning officer;

(h) The date and time of the close of the poll in the event of a contest.

9. NOMINATION OF CANDIDATES

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) Is to supply any member of the corporation with a nomination form, and;

(b) Is to prepare a nomination form for signature at the request of any member of the corporation;

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in

an electronic format.

10. CANDIDATE'S PARTICULARS

10.1 The nomination form must state the candidate's:

(a) Full name;

(b) Contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and;

(c) Constituency, or class within a constituency, of which the candidate is a member.

11. DECLARATION OF INTERESTS

11.1 The nomination form must state:

(a) Any financial interest that the candidate has in the corporation.

12. DECLARATION OF ELIGIBILITY

12.1 The nomination form must include a declaration made by the candidate:

(a) That they are not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and;

(b) For a member of the public or patient constituency, of the particulars of their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. SIGNATURE OF CANDIDATE

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) They wish to stand as a candidate;
(b) Their declaration of interests as required under rule 11, is true and correct, and;

(c) Their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. DECISIONS AS TO THE VALIDITY OF NOMINATION

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) Decides that the candidate is not eligible to stand;

(b) Decides that the nomination form is invalid;

(c) Receives satisfactory proof that the candidate has died, or;

(d) Receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) That the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election;

(b) That the paper does not contain the candidate's particulars, as required by rule 10;

(c) That the paper does not contain a declaration of the interests of the candidate, as required by rule 11;

(d) That the paper does not include a declaration of eligibility as required by rule 12, or

(e) That the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after they have received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a

nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. PUBLICATION OF STATEMENT OF CANDIDATES

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) The name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and;

(b) The declared interests of each candidate standing, as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. INSPECTION OF STATEMENT OF NOMINATED CANDIDATES AND NOMINATION FORMS

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. WITHDRAWAL OF CANDIDATES

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate

and attested by a witness.

18. METHOD OF ELECTION

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) The candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and;

(b) The returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by them in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. POLL TO BE TAKEN BY BALLOT

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) If internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) Configured in accordance with these rules; and

(ii) Will create an accurate internet voting record in respect of any voter who casts their vote using the internet voting system;

(b) If telephone voting is to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) Configured in accordance with these rules; and

(ii) Will create an accurate telephone voting record in respect of any voter who casts their vote using the telephone voting system;

(c) If text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) Configured in accordance with these rules; and

(ii) Will create an accurate text voting record in respect of any voter who casts their vote using the text message voting system.

20. THE BALLOT PAPER

20.1 The ballot of each voter (other than a voter who casts their ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) The name of the corporation;

(b) The constituency, or class within a constituency, for which the election is being held;

(c) The number of members of the council of governors to be elected from that constituency, or class within that constituency;

(d) The names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) Instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available;

(f) If the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and;

(g) The contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. THE DECLARATION OF IDENTITY (PUBLIC AND PATIENT CONSTITUENCIES)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) That the voter is the person:

(i) To whom the ballot paper was addressed, and/or

(ii) To whom the voter ID number contained within the e-voting information was allocated,

(b) That they have not marked or returned any other voting information in the election, and

(c) The particulars of their qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return their declaration of identity with their ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

ACTION TO BE TAKEN BEFORE THE POLL

22. LIST OF ELIGIBLE VOTERS

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) A postal address; and,

(b) The member's e-mail address, if this has been provided

to which their voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. NOTICE OF POLL

23.1 The returning officer is to publish a notice of the poll stating:

(a) The name of the corporation;

(b) The constituency, or class within a constituency, for which the election is being held;

(c) The number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) The names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(e) That the ballot papers for the election are to be issued and returned, if appropriate, by post;

(f) The methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3;

(g) The address for return of the ballot papers;

(h) The uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) The telephone number where, if telephone voting is a method of polling, the telephone voting facility is located;

(j) The telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located;

(k) The date and time of the close of the poll;

(l) The address and final dates for applications for replacement voting information, and;

(m) The contact details of the returning officer.

24. ISSUE OF VOTING INFORMATION BY RETURNING OFFICER

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) A ballot paper and ballot paper envelope;

(b) The ID declaration form (if required);

(c) Information about each candidate standing for election, pursuant to rule 61 of these rules, and;

(d) A covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast their vote by an e-voting method of polling:

(a) Instructions on how to vote and how to make a declaration of identity (if required);

(b) The voter's voter ID number;

(c) Information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate;

(d) Contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) Only be sent postal voting information; or;

(b) Only be sent e-voting information; or'

(c) Be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by

e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. BALLOT PAPER ENVELOPE AND COVERING ENVELOPE

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) The address for return of the ballot paper printed on it, and

(b) Pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:

(a) The completed ID declaration form if required, and

(b) The ballot paper envelope, with the ballot paper sealed inside it.

26. E-VOTING SYSTEMS

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) Require a voter to:

(i) Enter their voter ID number; and

(ii) Where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) Specify:

(i) The name of the corporation;

(ii) The constituency, or class within a constituency, for which the election is being held;

(iii) The number of members of the council of governors to be elected from that constituency, or class within that constituency;

(iv) The names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates;

(v) Instructions on how to vote and how to make a declaration of identity,

(vi) The date and time of the close of the poll, and

(vii) The contact details of the returning officer;

(c) Prevent a voter from voting for more candidates than they are entitled to at the election;

(d) Create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of:

(i) The voter's voter ID number;

(ii) The voter's declaration of identity (where required);

(iii) The candidate or candidates for whom the voter has voted; and

(iv) The date and time of the voter's vote;

(e) If the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) Prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) Require a voter to

(i) Enter their voter ID number in order to be able to cast their vote; and

(ii) Where the election is for a public or patient constituency, make a declaration of identity;

(b) Specify:

(i) The name of the corporation;

(ii) The constituency, or class within a constituency, for which the election is being held;

(iii) The number of members of the council of governors to be elected from that constituency, or class within that constituency;

(iv) Instructions on how to vote and how to make a declaration of identity;

(v) The date and time of the close of the poll, and

(vi) The contact details of the returning officer;

(c) Prevent a voter from voting for more candidates than they are entitled to at the election;

(d) Create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) The voter’s voter ID number;

(ii) The voter’s declaration of identity (where required);

(iii) The candidate or candidates for whom the voter has voted; and

(iii) The date and time of the voter’s vote

(e) If the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) Prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) Require a voter to:

(i) Provide their voter ID number; and

(ii) Where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast their vote;

(b) Prevent a voter from voting for more candidates than they are entitled to at the election;

(c) Create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) The voter's voter ID number;

(ii) The voter's declaration of identity (where required);

(iii) The candidate or candidates for whom the voter has voted; and

(iii) The date and time of the voter's vote

(d) If the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(e) Prevent any voter from voting after the close of poll.

THE POLL

27. ELIGIBILITY TO VOTE

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. VOTING BY PERSONS WHO REQUIRE ASSISTANCE

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

29. SPOILT BALLOT PAPERS AND SPOILT TEXT MESSAGE VOTES

29.1 If a voter has dealt with their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a “spoilt ballot paper”), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless they:

(a) Are satisfied as to the voter’s identity; and

(b) Have ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”):

(a) The name of the voter, and

(b) The details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) The details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with their text message vote in such a manner that it cannot be accepted as a vote (referred to as a “spoilt text message vote”), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if they can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless they are satisfied as to the voter’s identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt

text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) The name of the voter, and

(b) The details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) The details of the replacement voter ID number issued to the voter.

30. LOST VOTING INFORMATION

30.1 Where a voter has not received their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless they:

(a) Are satisfied as to the voter's identity;

(b) Have no reason to doubt that the voter did not receive the original voting information;

(c) Have ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) The name of the voter;

(b) The details of the unique identifier of the replacement ballot paper, if applicable, and;

(c) The voter ID number of the voter.

31. ISSUE OF REPLACEMENT VOTING INFORMATION

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, they are also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has

already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) The name of the voter;

(b) The unique identifier of any replacement ballot paper issued under this rule;

(c) The voter ID number of the voter.

32. ID DECLARATION FORM FOR REPLACEMENT BALLOT PAPERS (PUBLIC AND PATIENT CONSTITUENCIES)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

POLLING BY INTERNET, TELEPHONE OR TEXT

33. PROCEDURE FOR REMOTE VOTING BY INTERNET

33.1 To cast their vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter their voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast their vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast their vote.

33.5 The voter will not be able to access the internet voting system for an election once their vote at that election has been cast.

34. VOTING PROCEDURE FOR REMOTE VOTING BY TELEPHONE

34.1 To cast their vote by telephone, the voter will need to gain access to

the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter their voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast their vote by keying in the numerical voting code of the candidate or candidates, for whom they wish to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once their vote at that election has been cast.

35. VOTING PROCEDURE FOR REMOTE VOTING BY TEXT MESSAGE

35.1 To cast their vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain their voter ID number and the numerical voting code for the candidate or candidates, for whom they wish to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

PROCEDURE FOR RECEIPT OF ENVELOPES, INTERNET VOTES, TELEPHONE VOTES AND TEXT MESSAGE VOTES

36. RECEIPT OF VOTING DOCUMENTS

42.1 Where the returning officer receives:

(a) A covering envelope, or

(b) Any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) The candidate for whom a voter has voted, or

(b) The unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. VALIDITY OF VOTES

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, they are to:

(a) Put the ID declaration form if required in a separate packet, and;

(b) Put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, they are to:

(a) Mark the ballot paper “disqualified”;

(b) If there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper;

(c) Record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and;

(d) Place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, they are to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, they are to:

(a) Mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”;

(b) Record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and;

(c) Place the document or documents in a separate packet.

38. DECLARATION OF IDENTITY BUT NO BALLOT PAPER (PUBLIC AND PATIENT CONSTITUENCY)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) Mark the ID declaration form “disqualified”;

(b) Record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and;

(c) Place the ID declaration form in a separate packet.

39. DE-DUPLICATION OF VOTES

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election they shall:

(a) Only accept as duly returned the first vote received that was cast using the relevant voter ID number; and;

(b) Mark as “disqualified” all other votes that were cast using the relevant voter ID number

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) Mark the ballot paper “disqualified”;

(b) If there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) Record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(c) Place the document or documents in a separate packet; and

(e) Disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) Mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”;

(b) Record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) Place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) Disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. SEALING OF PACKETS

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) The disqualified documents, together with the list of disqualified documents inside it;

(b) The ID declaration forms, if required,

;

(b) The list of spoilt ballot papers and the list of spoilt text message votes;

(d) The list of lost ballot documents;

(e) The list of eligible voters, and;

(f) The list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV 41. NOT USED

42. ARRANGEMENTS FOR COUNTING OF THE VOTES

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) The board of directors and the council of governors of the corporation have approved:

(i) The use of such software for the purpose of counting votes in the relevant election, and

(ii) A policy governing the use of such software, and

(b) The corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) Count and record the number of:

(iii) Ballot papers that have been returned; and;

(iv) The number of internet voting records, telephone voting records and/or text voting records that have been created, and;

(b) Count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

44 (FPP). REJECTED BALLOT PAPERS AND REJECTED TEXT VOTING RECORDS

44.1 Any ballot paper:

(a) Which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced;

(b) On which votes are given for more candidates than the voter is entitled to vote;

(c) On which anything is written or marked by which the voter can be identified except the unique identifier, or;

(d) Which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

44.3 A ballot paper on which a vote is marked:

(a) Elsewhere than in the proper place;

(b) Otherwise than by means of a clear mark;

(c) By more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that they can be identified by it.

44.4 The returning officer is to:

(a) Endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and;

(b) In the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) Does not bear proper features that have been incorporated into the ballot paper;

(b) Voting for more candidates than the voter is entitled to;

(c) Writing or mark by which voter could be identified, and;

(d) Unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

44.6 Any text voting record:

(a) On which votes are given for more candidates than the voter is entitled to vote;

(b) On which anything is written or marked by which the voter can be identified except the voter ID number, or;

(c) Which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

44.8 A text voting record on which a vote is marked:

(a) Otherwise than by means of a clear mark;

(b) By more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that they can be identified by it.

44.9 The returning officer is to:

(a) Endorse the word “rejected” on any text voting record which under this rule is not to be counted, and;

(b) In the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) Voting for more candidates than the voter is entitled to;

(b) Writing or mark by which voter could be identified, and;

(c) Unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. NOT USED.

STV46. NOT USED.

STV47. NOT USED.

STV48. NOT USED.

STV49. NOT USED.

STV50. NOT USED.

STV51. NOT USED.

51(FPP) Equality of votes

51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

52(FPP). DECLARATION OF RESULT FOR CONTESTED ELECTIONS

52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) Declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected;

(b) Give notice of the name of each candidate who they have declared elected:

(i) Where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or;

(ii) In any other case, to the chairman of the corporation; and

(c) Give public notice of the name of each candidate whom they have declared elected.

52.2 The returning officer is to make:

(a) The total number of votes given for each candidate (whether elected or not), and;

(b) The number of rejected ballot papers under each of the headings in rule 44.5,

(c) The number of rejected text voting records under each of the headings in rule 44.10,

available on request.

STV52. NOT USED.

53. DECLARATION OF RESULT FOR UNCONTESTED ELECTIONS

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) Declare the candidate or candidates remaining validly nominated to be elected;

(b) Give notice of the name of each candidate who they have declared elected to the chairman of the corporation, and;

(c) Give public notice of the name of each candidate who they have declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. SEALING UP OF DOCUMENTS RELATING TO THE POLL

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) The counted ballot papers, internet voting records, telephone voting records and text voting records;

(b) The ballot papers and text voting records endorsed with "rejected in part";

(c) The rejected ballot papers and text voting records, and;

(d) The statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) The disqualified documents, with the list of disqualified documents inside it;

(b) The list of spoilt ballot papers and the list of spoilt text message votes;

(c) The list of lost ballot documents, and;

(d) The list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) Its contents;

(b) The date of the publication of notice of the election;

(c) The name of the corporation to which the election relates, and;

(d) The constituency, or class within a constituency, to which the

election relates.

55. DELIVERY OF DOCUMENTS

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. FORWARDING OF DOCUMENTS RECEIVED AFTER CLOSE OF THE POLL

56.1 Where:

(a) Any voting documents are received by the returning officer after the close of the poll, or;

(b) Any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or;

(c) Any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. RETENTION AND PUBLIC INSPECTION OF DOCUMENTS

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. APPLICATION FOR INSPECTION OF CERTAIN DOCUMENTS RELATING TO AN ELECTION

58.1 The corporation may not allow:

(a) The inspection of, or the opening of any sealed packet containing:

(i) Any rejected ballot papers, including ballot papers rejected in part;

(ii) Any rejected text voting records, including text voting records rejected in part;

(iii) Any disqualified documents, or the list of disqualified documents;

(iv) Any counted ballot papers, internet voting records, telephone voting records or text voting records, or;

(v) The list of eligible voters, or

(b) Access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage, by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) Persons;

(b) Time;

(c) Place and mode of inspection;

(d) Production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) In giving its consent, and;

(b) In making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established:

(i) That their vote was given, and

(ii) That NHS England/Improvement (Monitor) has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

59(FPP). COUNTERMAND OR ABANDONMENT OF POLL ON DEATH OF CANDIDATE

59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) Countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and;

(b) Order a new election, on a date to be appointed by them in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

59.3 Where a poll is abandoned under rule 59.1(a), rules 59.4 to 59.7 are to apply.

59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

59.5 The returning officer is to:

(a) Count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) Seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

59.6 The returning officer is to endorse on each packet a description of:

(a) Its contents,

(b) The date of the publication of notice of the election,

(c) The name of the corporation to which the election relates, and

(d) The constituency, or class within a constituency, to which the election relates.

59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. NOT USED.

PART 10: ELECTION EXPENSES AND PUBLICITY

ELECTION EXPENSES

60. ELECTION EXPENSES

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS Improvement (Monitor) under Part 11 of these rules.

61. EXPENSES AND PAYMENTS BY CANDIDATES

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) Personal expenses,

(b) Travelling expenses, and expenses incurred while living away from home, and

(c) Expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. ELECTION EXPENSES INCURRED BY OTHER PERSONS

62.1 No person may:

(a) Incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) Give a candidate or their family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

PUBLICITY

63. PUBLICITY ABOUT ELECTION BY THE CORPORATION

63.1 The corporation may:

(a) Compile and distribute such information about the candidates, and

(b) Organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) Objective, balanced and fair;

(b) Equivalent in size and content for all candidates;

(c) Compiled and distributed in consultation with all of the candidates standing for election, and;

(d) Must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. INFORMATION ABOUT CANDIDATES FOR INCLUSION WITH VOTING INFORMATION

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) A statement submitted by the candidate of no more than 250 words;

(b) If voting by telephone or text message is a method of polling

for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and;

(c) A photograph of the candidate.

65. MEANING OF "FOR THE PURPOSES OF AN ELECTION"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of their own services voluntarily, on their own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. APPLICATION TO QUESTION AN ELECTION

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS Improvement (Monitor) for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS Improvement(Monitor) by:

(a) A person who voted at the election or who claimed to have had the right to vote, or;

(b) A candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) Describe the alleged breach of the rules or electoral irregularity, and;

(b) Be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHS Improvement (Monitor) will refer the application to the independent election arbitration panel appointed by NHS Improvement (Monitor).

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS Improvement (Monitor) shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. SECRECY

67.1 The following persons:

(a) The returning officer,

(b) The returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) The name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) The unique identifier on any ballot paper;

(iii) The voter ID number allocated to any voter;

(iv) The candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as they think fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. PROHIBITION OF DISCLOSURE OF VOTE

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom they have voted.

69. DISQUALIFICATION

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) A member of the corporation,

(b) An employee of the corporation,

(c) A director of the corporation, or

(d) Employed by or on behalf of a person who has been nominated for election.

70. DELAY in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) The delivery of the documents in rule 24, or

(b) The return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as they consider appropriate.

XXXXX NHS FOUNDATION TRUST

STANDING ORDERS

XXXXX NHS FOUNDATION TRUST

STANDING ORDERS

1. INTRODUCTION

1.1. The XXXXX NHS Foundation Trust (the "Trust") (previously known as the Somerset NHS Foundation Trust) became a Public Benefit Corporation on 1 May 2008 following authorisation by Monitor pursuant to the National Health Service Act 2006 (the "2006 Act") and this Authorisation is of unlimited duration.

1.1. The principal place of business of the Trust is currently at XXXXX

1.2. The Trust is governed by the 2006 Act, its Constitution and the terms of its Provider Licence granted by NHS Improvement (Monitor) (the Regulatory Framework). The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Trust Board and the Council of Governors of the Trust to adopt SOs for the regulation of its proceedings and business ~~and to adhere at all times to the Code of Conduct for Governors~~.

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. The SOs, Scheme of Delegation and SFIs provide a comprehensive business framework. All Executive Directors and Non-Executive Directors, all members of staff, and Governors should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1.5. As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.6. 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.

1.7. The Chairman, Chief Executive or any other person giving information to the public on behalf of the Trust shall ensure that they follow the principles set out by the Committee on Standards in Public Life (the Wicks Committee) and that they will adhere to the principles set out within the Independent Commission's Good Governance Standard for Public Service, and the Care Quality Commission's Fit and Proper Person regulations. They will also ensure that they follow the best practice advice set out in the NHS Foundation Trust Code of Governance 2006 (the "Code") published by Monitor that sets out the overarching framework for compliance with the Regulatory Framework.

1.8. The Trust shall deal with NHS England/Improvement (Monitor) in an open and co-operative manner and shall promptly notify NHS England/Improvement (Monitor) of anything relating to the Trust of which NHS England/Improvement (Monitor) would reasonably expect prompt notice, including, without prejudice to the foregoing generality, any anticipated failure or anticipated prospect of failure on the part of the Trust to meet its obligations under its Provider Licence or any financial or performance thresholds which NHS England/Improvement (Monitor) may specify from time to time.

ANNEX 1 - STANDING ORDERS FOR THE COUNCIL OF GOVERNORS

(Ref. Paragraphs 19, 20 and 21)

CONTENTS:

1. DEFINITIONS

1.1. In these Standing Orders:

Annual Meeting
means a general meeting of the Council of Governors at which the annual accounts, annual report and external auditors' opinions are presented to the Council of Governors.

Clear Day
means a day of the week not including Saturday, Sunday or a public holiday.

Code of Conduct
means any code which the Trust may publish from time to time to govern or guide the conduct of the Council of Governors, Directors and Officers of the Trust.

Appointments Panel
means the Panel established in accordance with Annex 3.

Officer
means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

Returning Officer
means an employee of the Trust or any other person holding a paid appointment or office with the Trust who is administering and counting the e-mail votes for the issue(s) to be voted upon.

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 COUNCIL OF GOVERNORS

3.1. The roles and responsibilities of the Governors as set out in paragraph 24 of the Constitution also have effect as if incorporated into the SOs. Certain powers and decisions may only be exercised by the Council of Governors in formal session. These powers and decisions are set out in paragraphs 23, 24, 26 and 50.

3.2. The roles and responsibilities of the Council are to be carried out in accordance with the Regulatory Framework include the following:

3.2.1. to hold the Board to account for the performance of the Trust;

3.2.2. to respond as appropriate when consulted by the Board in accordance with the Constitution; and

3.2.3. to prepare and from time to time review the Trust's membership strategy.

3.3. 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. MEETINGS OF THE COUNCIL OF GOVERNORS

4.1. Admission of the Public

4.1.1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors except where it resolves by special resolution that members of the public and representatives of the press be excluded from all or part of a meeting on the grounds that:

4.1.1.1. any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

4.1.1.2. for other reasons stated in the resolution and arising from the nature of the business or the proceedings that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the Constitution.

4.1.2. 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).

4.1.3. Nothing in these SOs shall require the Council of Governors to allow members of the public and representatives 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 Chairman.

4.1.4. Matters to be dealt with by the Board or the Council following the exclusion of the public and representatives of the press

under SO 4.1.1 above shall be confidential to the Governors. Members of the Council 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.

4.1.5. The Chairman (or Deputy Chairman) will decide what arrangements and terms and conditions they feel 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.

4.2. Calling Meetings

4.2.1. Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine and there shall be at least 4 (four) meetings in any year including:

4.2.1.1. an annual meeting no later than the 30 September in each year~~, apart from the first year,~~ when the Council of Governors are to receive and consider the Annual Accounts, any report by the Auditor and the Annual Report; and

4.2.1.2. any other meetings required of the Governors in order to fulfil their functions in accordance with the Constitution.

4.2.2. ~~The Secretary may call a meeting of the Council of Governors at any time. If the Secretary refuses to call a meeting after a requisition for that purpose, signed by at least 8 (eight) Governors and specifying the business to be transacted at the meeting, has been presented to them, or if, without so refusing, the Secretary does not call a meeting within 5 (five) Clear Days after such requisition has been presented to them at the Trust's Headquarters, such one third or more of the Governors may forthwith call a meeting for the purpose of conducting that business.~~
Not less than 8 (eight) Governors may by notice in writing to the Secretary requisition an extraordinary meeting of the Council of Governors and on receipt of such notice the Secretary shall cause such a meeting to be called within 5 (five) working days of receipt of the notice.

4.2.3. The Council of Governors may invite the Chief Executive, member of the Board of Directors or a representative of the

financial auditor or other advisors to attend a meeting of the Council of Governors.

4.2.4. The Council of Governors may agree that its Governors can participate in its meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to be exceptional but shall constitute presence in person at the meeting for the purposes of SO 4.16 (Quorum).

4.3. Notice of Meetings

4.3.1. Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf, shall be delivered to, or sent by post to the usual place of residence of every Governor, so as to be available to them at least ~~10 (ten) Clear Days~~ four (4) Clear Days before the meeting save in the case of emergencies.

4.3.2. Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and if possible the public part of the agenda, shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least ~~10 (ten)~~ four (4) Clear Days before the meeting, save in the case of emergencies.

4.3.3. Want of service of the notice on any one Governor shall not affect the validity of a meeting but failure to serve such a notice on more than five Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of posting or in the case of a notice being sent electronically, on the date of transmission.

4.3.4. In the case of a meeting called by Governors in default of the Secretary, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the requisition.

4.4. Setting the Agenda

4.4.1. The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2. A Governor of the Council of Governors desiring a matter to be included on an agenda, including a formal proposition for discussion and voting on at a meeting, shall make their request in writing to the Chairman at least 10 (ten) Clear Days before the meeting. 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 10 (ten) Clear Days before a meeting may be included on the agenda at the discretion of the Chairman.

4.5. **Petitions**

4.5.1. Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting of the Council of Governors.

4.6. **Written Motions**

4.6.1. In urgent situations and with the consent of the Chairman, business may be effected by a Governor's written motion to deal with business otherwise required to be conducted at a meeting of the Council of Governors.

4.6.2. If all Governors of the Council of Governors have been notified of the proposal and a simple majority of Governors entitled to attend and vote at a meeting of the Council of Governors confirms acceptance of the written motion either in writing or electronically to the Secretary within 5 (five) Clear Days of dispatch then the motion will be deemed to have been resolved, notwithstanding that the Governors have not gathered in one place.

4.6.3. The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date, a Governor who has previously indicated acceptance can withdraw, and the motion shall fail.

4.6.4. Once the resolution has been passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

4.6.5. 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.

4.6.6. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.6.7. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor or Director (as relevant) to move:

4.6.7.1. An amendment to the motion.

4.6.7.2. The adjournment of the discussion or the meeting.

4.6.7.3. That the meeting proceed to the next business (*).

4.6.7.4. The appointment of an ad hoc committee to deal with a specific item of business.

4.6.7.5. That the motion be now put to a vote (*).

4.6.7.6. That the public be excluded from the meeting in relation to the discussion concerning the proposition under SO 4.1.1.

4.6.8. 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.

4.6.9. 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.

4.6.10. 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.

4.7. **Chairman of Meeting**

4.7.1. At any meeting of the Council of Governors, the Chairman, if present, shall preside.

4.7.2. If the Chairman is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chairman shall preside.

4.7.3. If the Deputy Chairman is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director ~~as shall be appointed by the Council of Governors~~ shall preside.

4.7.4. Where it has been determined by the Chair that it is inappropriate for the Chairman or any non-executive director to chair the meeting, the Lead or Deputy Lead Governor shall preside.

4.8. **Agenda**

4.8.1. Where a Governor has requested inclusion of a matter on the agenda in accordance with SO 4.4.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this SO 4.8 shall apply in respect of the proposition.

4.8.2. 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").

4.8.3. Agendas will be sent to Governors before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than 3 (three) Clear Days before the meeting, save in the case of emergencies. It is the responsibility of the Chairman to ensure that sufficient information is provided to Governors to ensure that rational discussion can take place.

4.8.4. 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 SO 4.3 shall not prevent the calling of or invalidate such meeting provided that every effort is made to contact Governors of the Council of Governors who are not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

4.8.5. No business may be transacted at any meeting of 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 Council 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.

4.9. **Report from the Board of Directors**

4.9.1. Unless otherwise agreed in writing, at each meeting of the Council of Governors, the Board of Directors is required to report to the Council of Governors on the Trust's general progress ~~forward~~ and forward planning unless it is agreed in writing they will not do so.

4.10. **Chairman's Ruling**

4.10.1. Statements of Governors made at meetings of the Council of Governors 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 final.

4.11. **Voting**

4.11.1. A Governor may not vote at a meeting of the Council of Governors unless, within ~~7 (seven) Clear Days~~ the 12 months prior to the commencement of the meeting they have:

4.11.2. made a declaration that they are a member of the constituency which elected them; ~~and~~ or

4.11.3. if the Governor is an Appointed Governor, they are not prevented from being a governor of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution.

4.11.4. Such declaration will be in the form as set out in paragraph 18 of the Constitution.

4.11.5. Subject to SO 4.11.7 below, every question at a meeting shall be determined by a majority of the votes of the Chairman of the meeting and the Governors present and voting on the question.

4.11.6. Whoever is Chairman of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal have a second or casting vote.

4.11.7. A resolution for the removal of the Chairman or a Non-Executive Director shall be passed only if three quarters of the total number of Governors vote in favour of it.

4.11.8. If at least one-third of the Governors present so request, the voting (other than by paper ballot or e-mail vote) on any question may be recorded to show how each Governor present voted or abstained.

4.11.9. If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot or e-mail vote).

4.11.10. Subject to SO 4.17, a Governor may only vote if present at the time of the vote on which the question is to be decided; no Governor may vote by proxy but a Governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote. For the avoidance of doubt, SO 4.11.11 does not apply if an e-mail vote is required under SO 4.17.

4.11.11. In certain circumstances, the Chairman may specify in a notice of a meeting any matter which requires approval by a written resolution and such a matter may be approved in writing provided that at least three quarters of the Governors, and a majority of the elected Governors, approve the resolution in writing within the timescale imposed in such a notice.

4.12. **Minutes**

4.12.1. The minutes of the proceedings of a meeting shall be drawn up by the Secretary or a Nominated Officer and submitted for agreement at the next ensuing meeting of the Council of Governors where they will be signed by the Chairman presiding at it.

4.12.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.12.3. 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 4.1.1 above.

4.13. **Suspension of Standing Orders**

4.13.1. Except where this would contravene any statutory provision or any guidance or best practice advice issued by NHS England/Improvement (Monitor), any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Governors are present, there is a majority of Governors who are members of the Public Constituency of the Trust, and that a majority of those present vote in favour of suspension.

4.13.1.1. A decision to suspend the SOs shall be recorded in the minutes of the meeting.

4.13.1.2. A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Chairman and Governors.

4.13.1.3. No formal business may be transacted while the SOs are suspended.

4.13.1.4. The Audit Committee shall review every decision to suspend SOs.

4.14. **Variation and Amendment of Standing Orders**

4.14.1. Subject always to paragraph 54 of the Constitution, these SOs shall be amended only if:

4.14.1.1. a notice of proposal under SO 4.4.2 has been given; and

4.14.1.2. no fewer than half the total number of Governors vote in favour of amendment; and

4.14.1.3. no fewer than half of the total number of Governors is present; and

4.14.1.4. the variation proposed has been approved by the Council of Governors and does not contravene a statutory provision or guidance issued by NHS England/Improvement (Monitor) or the Constitution.

4.15. **Record of Attendance**

4.15.1. The names of the Chairman and Governors present at the meeting shall be recorded in the minutes.

4.16. **Quorum**

4.16.1. No business shall be transacted at a meeting unless at least half of the Governors are present, and of these not less than half shall be Governors elected from the Public or appointed by non Health Service Bodies.

4.16.2. If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for a minimum period of 5 (five) Clear Days and upon reconvening, those present shall constitute a quorum.

4.16.3. If a Governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest as provided in SO 6, they 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 meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.16.4. 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 uses their discretion under SO 4.17 to hold an e-mail vote. At all times, no Governor may vote by proxy.

4.16.5. 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.

4.16.6. 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 4.17 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 only method of voting.

4.16.7. Individual Governor may only cast one vote on the ~~Proposed Transaction~~ 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 4.11.5. Once an e-mail vote has been cast by a Governor in accordance with SO 4.17, the vote cannot be revoked or altered in any way.

4.17. **Protocol for Voting by e-mail**

4.17.1. The Returning Officer is to e-mail a notice of the e-mail vote stating:

4.17.1.1. The details of the issue(s) to be voted upon.

4.17.1.2. The date and time at which the e-mail votes are required to be sent out to the Governors.

4.17.1.3. 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

4.17.1.4. The contact details of the Returning Officer.

4.17.2. 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, the following information:

4.17.2.1. A ballot paper attachment in accessible electronic format with clear instructions as to how to cast their vote by e-mail.

4.17.2.2. A Declaration of Eligibility form (if required). This form may be combined with the ballot paper.

4.17.2.3. Information about the issue(s) to be voted upon.

4.17.2.4. A covering e-mail providing:

4.17.2.4.1. The e-mail address for return of the ballot paper.

4.17.2.4.2. Clear instructions instructing the voter as to how to return their e-mail vote to the Returning Officer by the Deadline Date ("e-mail voting information").

5. COMMITTEES

5.1. Subject to any guidance as may be issued by NHS England/Improvement (Monitor), the Council of Governors may and, if directed by NHS England/Improvement (Monitor), shall appoint committees of the Council of Governors consisting wholly or partly of its members to assist it in the proper performance of its functions under the Regulatory Framework, ~~consisting wholly or partly of the Chairman and Governors.~~

5.2. 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.

5.3. All decisions taken in good faith at the meeting of the Council of Governors or at any meeting of a committee shall be valid even if it is subsequently discovered that there was a defect in the calling of the meeting or the appointment of the Governors attending the meeting.

5.4. A committee appointed under SO 5 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.5. These SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms “Chairman” to be read as a reference to the Chairman of the committee, and the term “Governor” to be read as a reference to a member of the committee as the context permits.

5.6. Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the Regulatory Framework and any guidance or best practice advice issued by NHS England/Improvement (Monitor), but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.

5.7. Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.8. Any committee or sub-committee established under this SO 5 may call upon outside advisers to assist them with their tasks, subject to the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the Dispute Resolution Procedure as set out ~~at Annex 8~~ in paragraph 53 of the Constitution.

5.9. The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.10. Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with guidance issued by NHS England/Improvement (Monitor).

5.11. Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors or NHS England/Improvement (Monitor).

5.12. The Council of Governors may appoint Governors to serve on joint committees with the Board of Directors or committees of the Board of Directors.

5.13. 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.

5.14. In consideration of any recommendation, a committee of the Council must comply with:

5.14.1. The Trust's Standing Financial Instructions, SOs and written procedures and specific reference to the relevant sections of these documents should be made.

5.14.2. Any statutory provisions or requirements.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1. Declaration of Interests

6.1.1. The Regulatory Framework requires each Governor to declare to the Secretary:

6.1.1.1. any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust, as described in SO 6.2.1; and

6.1.1.2. any actual or potential pecuniary interest, direct or indirect, in any matter concerning the Trust, as described in SOs 6.2.3 and 6.2.4; and

6.1.1.3. any actual or potential family interest, direct or indirect, of which the Governor is aware, as described in SO 6.2.6.

6.1.2. Such a declaration shall be made either at the time of the Governor's election or appointment or as soon thereafter as the interest arises, and in a form prescribed by the Secretary which shall be included as Schedule A to these SOs.

6.1.3. In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement

disclose the fact and shall not vote on any question with respect to the matter.

6.1.4. If a Governor has a pecuniary interest, whether direct or indirect, or any material non-financial interest in any contract, proposed contract or other matter which is under consideration by the Council of Governors, they shall disclose that to the rest of the Council of Governors as soon as they are aware of it.

6.1.5. At the time the interests are declared, they should be recorded in the Council of Governors meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

6.1.6. Subject to SO 6.2.5, if a Governor has declared a pecuniary interest (as described in SO 6.2.3 and 6.2.4 they shall not take part in the consideration or discussion of the matter.

6.1.7. This SO 6 applies to any committee, sub-committee or joint committee of the Council of Governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not they are also a Governor).

6.1.8. The interests of Governors in companies likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

6.2. **Nature of Interests**

6.2.1. Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by NHS England/Improvement (Monitor):

6.2.1.1. directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies); or

6.2.1.2. ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS; or

6.2.1.3. majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS; or

6.2.1.4. a position of authority in a charity or voluntary organisation in the field of health and social care; or

6.2.1.5. any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services; or

6.2.1.6. any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

6.2.2. For the avoidance of doubt, the following shall not be considered relevant and material for the purposes of these SOs:

6.2.2.1. Shares not exceeding 2% of the total share in issue held in any company whose shares are listed on any public exchange.

6.2.2.2. An employment contract held by Staff Governors.

6.2.2.3. An employment contract with the relevant local authority held by a Local Authority Governor.

6.2.2.4. An employment contract with a Partnership Organisation held by a Partnership Governor.

6.2.3. A Governor shall be treated as having indirectly a pecuniary interest in a matter, if:

6.2.3.1. They, or a nominee of them, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

6.2.3.2. They are a partner of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

6.2.4. A Governor shall not be treated as having a pecuniary interest in any matter by reason only:

6.2.4.1. of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

6.2.4.2. of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

6.2.4.3. of any travelling or other expenses or allowances payable to a Governor in accordance with the Constitution.

6.2.5. Where a Governor:

6.2.5.1. has an indirect pecuniary interest in a matter by reason only of a beneficial interest in securities of a company or other body, and

6.2.5.2. 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 or body, whichever is the less, and

6.2.5.3. if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

the Governor shall not be prohibited 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 their duty to disclose their interest.

6.2.6. A family interest is an interest of an Immediate Family Member of a Governor which if it were the interest of that Governor would be a personal interest or a pecuniary interest of them.

6.2.7. If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.3. **Register of Governors**

6.3.1. The register of Governors shall list the names of Governors, their category of membership of the Council of Governors

and an address through which they may be contacted which may be the Secretary.

6.4. **Register of Governors' Interests**

6.4.1. The Secretary shall keep a register of interests of Governors which shall contain the names of each Governor, whether he has declared any interest, and if so, the interest declared.

7. STANDARDS OF BUSINESS CONDUCT

7.1. Governors of the Council of Governors shall comply with the NHS Foundation Trust Code of Governance, the Council of Governors' Code of Conduct and any guidance or best practice advice issued by NHS England/Improvement (Monitor).

8. APPOINTMENTS AND RECOMMENDATIONS

8.1. A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment but this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.2. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

8.3. Candidates for any staff appointment under the Trust shall, when making such an application, disclose in writing to the Trust whether they are related to any Governor or the holder of any office within the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4. The Chairman and every Governor shall disclose to the Chief Executive or their delegated officer any relationship between themselves and a candidate of whose candidature that Governor or Officer is aware. It shall be the duty of the Chief Executive or their delegated Officer to report to the Council of Governors any such disclosure made.

8.5. On appointment, Governors of the Council of Governors should disclose to the Council of Governors whether they are related to any other Governor of the Council of Governors or holder of any office in the Trust.

8.6. Where the relationship to a Governor of the Council of Governors of the Trust is disclosed, SO 6 shall apply.

9. MISCELLANEOUS

9.1. The Secretary shall provide a copy of these SOs to each Governor and endeavour to ensure that each Governor understands their responsibilities within these SOs.

9.2. These SOs including all documents having effect as if incorporated in them shall be reviewed annually by the Board of Directors and the Council of Governors.

9.3. 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 Council of Governors for action or ratification. All Governors have a duty to disclose any non-compliance with these SOs to the Chairman as soon as possible.

Schedule A

Prescribed Form of Declaration of Interests

Declaration to the Secretary of XXXX NHS Foundation Trust

Date [insert]

To the Secretary of XXX NHS Foundation Trust

Dear [insert]

In fulfilment of the obligations imposed on me by paragraph 16 of the Constitution of the XX NHS Foundation Trust and the provisions of Standing Order X of the Standing Orders for the Council of Governors generally, and in particular Standing Order xxx, I hereby give notice to the Trust of my interest in **[**insert details of the nature and extent of the relevant interest(s) (e.g. pecuniary, non pecuniary, direct, indirect, actual, potential, etc.)**]** as of the date posted above.

I require the nature and extent of my interest(s) to be recorded in the Trust's register of interests of the Governors of the Council of Governors.

Yours faithfully

[name]

ANNEX 2 - BOARD OF DIRECTORS STANDING ORDERS

(Ref. Paragraph 32)

CONTENTS:

1 INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of SOs (on which they should be advised by the Chief Executive and Secretary).

1.2 Any expression to which a meaning is given in the 2006 Act or any regulations or orders made under the 2006 Act shall have the same meaning in these SOs and, in addition, defined terms used in these SOs have the same meaning as in the Constitution unless the context requires otherwise, or a contrary intention is evident.

1.3 Words importing the singular shall include the plural and vice-versa.

1.4 In these SOs:

"Accounting Officer"
means the Officer responsible for discharging the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For this Trust is shall be the Chief Executive.

"Board of Directors"
means the Board of Directors as constituted in accordance with the Constitution.

"Budget"
means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Chairman"
means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression "the Chairman" shall be deemed to include the Deputy Chairman or any other non-executive appointed in accordance with paragraph 26 of the Constitution if the Chairman is absent from the meeting or is otherwise unavailable.

"Chief Executive"
means the Chief Executive officer of the Trust.

"Clear Days"
means a day of the week not including a Saturday, Sunday or Public Holiday.

"Concode"
means a code of procedure for building and engineering contracts for the NHS.

“Constitution”
means the Constitution of the Trust, together with the Annexes and Appendices attached hereto as approved by NHS England/Improvement (Monitor).

“Council of Governors”
means the Council of Governors as constituted in this Constitution, which has the same meaning as the “Council of Governors” in the 2006 Act.

“Director”
means a member of the Board of Directors appointed in accordance with the Constitution and includes both executive and non-executive Directors and the phrase “member of the Board” shall be construed accordingly.

“Finance Director”
means the Director of Finance of the Trust.

"Funds held on Trust"
means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Section 14 of Part 2, Schedule 4 to the 2006 Act. Such funds may or may not be charitable.

“Member”
means a member of the Trust.

"Motion”
means a formal proposition to be discussed and voted on during the course of a meeting.

“NHS England/Improvement”
means the body corporate known as NHS England/Improvement (Monitor), the successor body of Monitor, as provided by Section 61 of the 2012 Act.

"Nominated Officer"
means an Officer charged with the responsibility for discharging specific tasks within the SOs and the SFIs.

“Officer”
means an employee or any other person holding a paid appointment or office with the Trust.

“Scheme of Delegation”
means the Reservation of Powers to the Board of Directors and Delegation of Powers.

“Secretary to the Trust”
means a person appointed by the Trust to act independently of the Board of Directors to provide advice on corporate governance issues to the Board of Directors and the Chairman and to monitor the Trust’s compliance with the Regulatory Framework, the Standing Orders, and regulatory guidance.

"SFIs”
means Standing Financial Instructions.

“SOs”
means these Standing Orders.

“the 2006 Act”
means the National Health Service Act 2006.

“Trust”
means the Somerset NHS Foundation Trust.

“Trust Headquarters”
means Musgrove Park Hospital, Taunton, Somerset, TA1 5DA

“Vice Chairman”
means a non-executive Director appointed by the Council of Governors to undertake the Chairman’s duties in the event that the Chairman is absent for any reason.

2 THE TRUST BOARD

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee.

2.3 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 Trust.

2.4 The Trust has the functions conferred on it by its Provider Licence issued by NHS Improvement (Monitor). Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees. Accountability for charitable Funds held on Trust is to the Charity Commission. Accountability for non-charitable Funds held on Trust is only to NHS England/Improvement (Monitor).

2.5 The powers of the Trust established under statute shall be exercised by the Board of Directors meeting in public/ private session except as otherwise provided for in SO 4.

2.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation and have effect as if incorporated into the SOs.

2.7 **Composition of the Board of Directors**

2.7.1 In accordance with the Constitution, the Board of Directors is to comprise:

2.7.1.1 The following Non-Executive Directors:

2.7.1.1.1 the Chairman, and up to a maximum of 9 (nine) other Non-Executive Directors.

2.7.1.2 the following Executive Directors:

2.7.1.2.1 the Chief Executive who shall be the Accounting Officer, the Finance Director, and up to a maximum of 6 (six) other Directors as set out in paragraph 31 of the Constitution.

2.7.2 At meetings of the Board of Directors, in the event that the number of Non-Executive Directors (including the Chairman) is equal to the number of Executive Directors, the Chairman (and in their absence, the Deputy Chairman) shall have a second or casting vote.

2.7.3 A person may only be appointed as a Non-Executive Director if:

2.7.3.1 They are a member of the Public Constituency, and

2.7.3.2 They are not eligible by virtue of paragraph 34 of the Constitution or disqualified by virtue of paragraph 35.

2.7.4 The validity of any act of the Board of Directors is not affected by any vacancy among the Directors or any defect in the appointment of a Director.

2.7.5 The Chairman (in consultation with the Council of Governors) will appoint a Non-Executive Director as the "senior independent director", for such period not exceeding the remainder of their term as a Non-Executive Director as they may specify on appointing them.

2.7.6 Any Non-Executive Director so appointed may at any time resign from the office of "senior independent director" by

giving notice in writing to the Chairman. The Chairman (in consultation with the Council of Governors) will thereupon appoint another Non-Executive Director as "senior independent director" in accordance with the provisions in SO 2.7.5.

2.7.7 The "senior independent director" shall perform the role set out in the Code of Governance.

2.8 Register of Directors

2.8.1 In accordance with paragraphs 41 and 42 of the Constitution, the Trust shall keep and maintain a register of Directors which shall list the names of the Directors, their capacity on the Board of Directors and an address through which they may be contacted which may be the Secretary.

2.9 Appointment and Removal of the Chairman and other Non-Executive Directors

2.9.1 The Chairman and other Non-Executive Directors are to be appointed by the Council of Governors following a formal, rigorous and transparent procedure. The current Chairman or a Non-Executive Director may stand for reappointment. Six months before the end of the term of office of the Chairman or a Non-Executive Director (as the case may be), the Council of Governors will adopt a procedure as set out in Annex 3 for appointing the Chairman and the Non-Executive Directors.

2.9.2 The provisions of paragraph 32 of the Constitution apply to the removal of the Chairman or other Non-Executive Directors.

2.10 Remuneration and Terms of Office of the Chairman and Non-Executive Directors

2.10.1 The Chairman and the Non-Executive Directors are to be appointed for a period of office determined by the Council of Governors at a general meeting of the Council of Governors.

2.10.2 At the general meeting of the Council of Governors referred to at SO 2.10.1 the Council of Governors shall decide the:

2.10.2.1 period of office;

2.10.2.2 remuneration and allowances; and

2.10.2.3 other terms and conditions of office, including the job description, of the Chairman and other Non-Executive Directors.

2.11 Appointment and Powers of Deputy Chairman

2.11.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairman and in accordance with paragraph 36 of the Constitution, the Council of Governors shall appoint a Non-Executive Director to be Deputy Chairman for such period, not exceeding the remainder of their term as Non-Executive Director, as the Council of Governors may specify on appointing them.

2.11.2 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Council of Governors. The Council of Governors may thereupon appoint another Non-Executive Director as Deputy Chairman in accordance with the provisions of SO 2.11.1.

2.11.3 Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Deputy Chairman will be "acting chairman" until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these SOs shall, so long as there is no Chairman able to perform their duties, be taken to include references to the Deputy Chairman. Where both the Chairman and Deputy Chairman are unable to perform their duties owing to illness, conflict of interest or any other cause, another Non-Executive Director as may be appointed by the Council of Governors shall act as Chairman.

2.12 Remuneration and Terms of Office of the Chief Executive and Executive Directors

2.12.1 The Trust shall establish a committee of Non-Executive Directors in accordance with SO 33 to decide the:

2.12.1.1 remuneration and allowances; and

2.12.1.2 the other terms and conditions of office of the Chief Executive and other Executive Directors.

2.13 Disqualification

2.13.1 Directors are subject to the disqualification criteria included at paragraphs 34 and 35 of the Constitution.

3 MEETINGS OF THE TRUST

3.1 Admission of the Public and the Press

3.1.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons, to be determined by the Board of Directors.

3.1.2 Before holding a public meeting, the Board of Directors will send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding the meeting, the Board of Directors will send a copy of the minutes of the meeting to the Council of Governors. Want of service of the agenda and minutes of the Board meeting on any Governor shall not affect the validity of a meeting.

3.1.3 The public and representatives of the press shall be afforded facilities to attend public meetings of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

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

3.1.4 The Chairman shall give such directions as they thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public.

3.1.5 Nothing in these SOs shall require the Board of Directors 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 Board of Directors.

3.1.6 Matters to be dealt with by the Board following the exclusion of the public and representatives of the press under SO 3.1.4

above shall be confidential to the Directors. Members of the Board 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.

3.1.7 The Chairman (or Deputy Chairman) will decide what arrangements and terms and conditions they feel are appropriate to offer in extending an invitation to observers, advisors and others to attend and address any meeting of the Board, and may change, alter or vary these terms and conditions as they deem fit.

3.2 Calling Meetings

3.2.1 Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.2.2 The Chairman may call a meeting of the Board of Directors at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Board of the Directors, and this has been presented to them, or if, without so refusing, the Chairman does not call a meeting within 7 (seven) days after such requisition has been presented to them, such one third or more members of the Board of Directors may forthwith call a meeting.

3.3 Notice of Meetings

3.3.1 Before each meeting of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman, or by an Officer of the Trust authorised by the Chairman to sign on their behalf, shall be delivered to every Director, or sent by post and where possible by email to the usual place of residence of every Director, so as to be available to them at least ~~6 (six~~) 4 (four) Clear Days before the meeting.

3.3.2 Want of service of the notice on any member of the Board of Directors shall not affect the validity of a meeting.

3.3.3 In the case of a meeting called by the Directors in default of the Chairman, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.3.4 Failure to serve such a notice on more than 3 (three) Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.3.5 In the event of an emergency giving rise to the need for an immediate meeting, SOs 3.3.1 to 3.3.4 shall not prevent the calling of such a meeting without the requisite ~~6 (six)~~ 4 (four) Clear Days' notice provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.4 Agendas

3.4.1 Agendas will be dispatched by post and by email to members of the Board of Directors ~~6 (six)~~ 4 (four) Clear Days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than 3 (three) Clear Days before the meeting, save in emergency. Failure to serve such a notice on more than three members of the Board of Directors will invalidate the meeting. A notice shall be presumed to have been served one day after dispatch.

3.4.2 Before each meeting of the Board of Directors (where SO 3.1.2 applies), a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's Headquarters at least 3 (three) Clear Days before the meeting.

3.4.3 No business may be transacted at any meeting of the Board of Directors 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 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.

3.5 Setting the Agenda

3.5.1 The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

3.5.2 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chairman at least 10 (ten) Clear Days before the meeting, subject to SO 3.3. Requests

made less than 10 (ten) Clear Days before a meeting may be included on the agenda at the discretion of the Chairman. Agendas will be sent to Directors before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than 3 (three) Clear Days before the meeting, save in the case of emergencies. 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.

3.6 **Petitions**

3.6.1 Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting of the Board of Directors.

3.7 **Chairman of Meeting**

3.7.1 At any meeting of the Board of Directors, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and they are present, shall preside. If the Chairman and Deputy Chairman are absent such Non-Executive Director as the members of the Board of Directors present shall choose, shall preside.

3.7.2 If the Chairman is absent temporarily on the grounds of a declared conflict of interest, the Deputy-Chairman, if present, shall preside. If the Chairman and Deputy-Chairman are absent, or are disqualified from participating, such Non-Executive Director as the members of the Board of Directors present shall choose shall preside.

3.8 **Chairman's Ruling**

3.8.1 Statements of Directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time, and subject to SO 1.1 the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.9 **Notices of Motion**

3.9.1 Subject to the provisions of SO 3.11 ('Motions: procedure at and during a meeting') and SO 3.12 ('Motion to rescind a resolution'), a member of the Board of Directors wishing to move or amend a motion shall send a written notice to the Chairman.

3.9.2 The notice shall be delivered at least 10 (ten) Clear Days before the meeting. The Chairman shall include in the agenda

for the meeting all notices so received that are in order and permissible under these SOs. Subject to SO 3.3.3, this SO shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meeting.

3.10 Emergency Motions and Written Motions

3.10.1 Emergency Motions

3.10.1.1 Subject to the agreement of the Chairman, and subject also to the provision of SO 3.11 ('Motions: procedure at and during a meeting'), a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.10.2 Written Motions

3.10.2.1 In urgent situations and with the consent of the Chairman, business may be effected by a Director's written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.

3.10.2.2 If all members of the Board of Directors have been notified of the proposal and a simple majority of Directors entitled to attend and vote at a meeting of the Board of Directors confirms acceptance of the written motion either in writing or electronically to the Secretary within 5 (five) Clear Days of dispatch then the motion will be deemed to have been resolved notwithstanding that the Directors have not gathered in one place.

3.10.2.3 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date a Director who has previously indicated acceptance can withdraw and the motion shall fail.

3.10.2.4 Once the resolution is passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

3.11 Motions: Procedure at and during a meeting

3.11.1 Who may propose

3.11.1.1 A motion may be proposed by the Chairman of the meeting or any member of the Board of Directors present. It must also be seconded by another member of the Board of Directors.

3.11.2 Contents of motions

3.11.2.1 The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

3.11.2.1.1 the reception of a report;

3.11.2.1.2 consideration of any item of business before the Board of Directors;

3.11.2.1.3 the accuracy of minutes;

3.11.2.1.4 that the Board of Directors proceed to next business;

3.11.2.1.5 that the Board of Directors adjourn;

3.11.2.1.6 that the question be now put.

3.11.3 Amendments to motions

3.11.3.1 A motion for amendment shall not be discussed unless it has been proposed and seconded.

3.11.3.2 Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board of Directors.

3.11.3.3 If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.11.3.4 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.

3.11.4 **Rights of reply to motions**

3.11.4.1 Amendments

3.11.4.1.1. The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment but may not otherwise speak on it.

3.11.4.2 Substantive/original motion

3.11.4.2.1. The Director who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.11.5 **Withdrawing a motion**

3.11.5.1 A motion or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

3.11.6 **Motions once under debate**

3.11.6.1 When a motion is under debate, no motion may be moved other than:

3.11.6.1.1. an amendment to the motion;

3.11.6.1.2. the adjournment of the discussion, or the meeting;

3.11.6.1.3. that the meeting proceed to the next business;

3.11.6.1.4. that the question should be now put;

3.11.6.1.5. the appointment of an 'ad hoc' committee to deal with a specific item of business;

3.11.6.1.6. a motion under SO 3.1.3 resolving to exclude the public (including the press); and

3.11.6.1.7. that a member be not further heard.

3.11.6.2 In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

3.11.6.3 If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.11.6.4 The mover of a motion shall have a maximum of 5 (five) minutes to move and 5 (five) minutes to reply. Once a motion has been moved, no member of the Board of Directors shall speak more than once or for more than 5 (five) minutes.

3.12 Motion to Rescind a Resolution

3.12.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 (six) calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of 4 (four) other members of the Board of Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate committee or the Chief Executive for recommendation.

3.12.2 When any such motion has been dealt with by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chairman to propose a motion to the same effect within 6 (six) months however the Chairman may do so if he considers it appropriate. This SO shall not apply to motions moved in pursuance of a report or recommendations of a committee or the Chief Executive.

3.13 **Voting**

3.13.1 Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the chairman of the meeting shall have a second or casting vote. For any avoidance of doubt, for voting, there must not be more Executive Directors voting than Non-Executive Directors.

3.13.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.13.3 If at least one-third of the members of the Board of Directors present so request, the voting (other than by paper ballot), on any question may be recorded to show how each Director present voted or abstained.

3.13.4 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.13.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.13.6 An Officer who has been appointed formally by the Board of Directors 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 of Directors 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.

3.14 **Minutes**

3.14.1 The minutes of the proceedings of a meeting shall be drawn up by the Secretary and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.

3.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting. Minutes shall be retained in the Chief Executive's office.

3.14.3 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.15 Suspension of Standing Orders

3.15.1 Except where this would contravene any statutory provision or any guidance or best practice advice issued by NHS England/Improvement (Monitor), any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

3.15.2 A decision to suspend the SOs shall be recorded in the minutes of the meeting.

3.15.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

3.15.4 No formal business may be transacted while the SOs are suspended.

3.15.5 The Audit Committee shall review every decision to suspend the SOs.

3.16 Variation and Amendment of Standing Orders

3.16.1 Subject always to paragraph 38 of the Constitution, these SOs shall be amended only if:

3.16.1.1 relevant notice of a meeting has been served in accordance with SO 3.3;

3.16.1.2 a notice of motion under SO 3.9 has been given;

3.16.1.3 no fewer than half the total of the Non-Executive Directors vote in favour of amendment;

3.16.1.4 at least two-thirds of the Directors are present; and

3.16.1.5 the variation proposed does not contravene the Regulatory Framework, any statutory provisions or any guidance issued by Monitor.

3.17 Record of Attendance

3.17.1 The names of the Directors present at the meeting shall be recorded in the minutes.

3.18 Quorum

3.18.1 No business shall be transacted, where a vote is required, at a meeting of the Board of Directors unless at least two Executive Directors, two Non-Executive Directors and the Chairman, or nominated Deputy Chairman for the purpose of this meeting, are present and to be properly constituted the number of Non-Executive Directors (including the Chairman) voting must exceed the number of Executive Directors. This paragraph should be read in conjunction with paragraph 3.13.1 ~~of Annex 7 of this constitution~~.

3.18.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.18.3 If a Director 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 (see SO 7)7 they 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 meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Nomination and Remuneration Committee).

3.19 Joint Directors

3.19.1 Where a post of Executive Director is shared by more than one person:

3.19.1.1 both persons shall be entitled to attend meetings of the Board;

3.19.1.2 either of those persons shall be eligible to vote in the case of an agreement between them;

3.19.1.3 in the case of disagreements between them no vote shall be cast; and

3.19.1.4 the presence of either or both of those person shall count as one person for the purposes of SO 3.13.

3.20 **Meetings: Electronic Communication**

3.20.1 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.

3.20.2 A Director in electronic communication with the Chairman and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.20.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors 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 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.

3.20.4 Meetings held in accordance with this SO are subject to SO 3.18 (Quorum). For such a meeting to be valid, a quorum MUST be present and maintained throughout the meeting.

3.20.5 The minutes of a meeting held in this way MUST state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to SO 2.6 and such guidance as may be issued by NHS England/Improvement (Monitor), the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee appointed by virtue of SO 4.3 below or by a Director or an Officer in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

4.2 **Emergency Powers**

4.2.1 The powers which the Board of Directors has retained to itself within these SOs may in emergency 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 the Chairman shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 Delegation to committees

4.3.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or subcommittees, or joint committees, which it has formally constituted. The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

4.3.2 When the Board is not meeting as the Trust in formal session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in formal session.

4.4 Delegation to Officers

4.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or subcommittee or joint-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Officers to undertake the remaining functions for which they will still retain accountability to the Board of Directors.

4.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Finance Director or other Executive Director to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the Finance Director shall be accountable to the Chief Executive for operational matters.

4.4.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these SOs.

4.5 Delegation of Powers – Scheme of Delegation

4.5.1 Under the SOs relating to the Arrangements for the Exercise of Functions by Delegation (SO 4) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5.1.1 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit. Delegated Powers are covered in a separate document (the Scheme of Delegation). That document has effect as if incorporated into the SOs.

4.6 Duty to Report Non-Compliance with Standing Orders

4.6.1 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 of Directors for action or ratification. All members of the Board of Directors and all Officers have a duty to disclose any non-compliance with these SOs to the Secretary as soon as possible.

5 COMMITTEES

5.1 Appointment of Committees

5.1.1 Subject to SO 2.6, the Regulatory Framework and such guidance issued by NHS England/Improvement (Monitor), the Board of Directors may and, if directed by NHS England/Improvement (Monitor), shall appoint committees of the Trust consisting wholly or partly of Directors or other Health Service Bodies or wholly of persons who are not Directors of the Trust or other Health Service Bodies.

5.1.2 A committee appointed under SO 5.1.1 may, subject to the Regulatory Framework and such guidance and/or best practice advice as may be issued by NHS England/Improvement (Monitor) or the Board of Directors or other Health Service Bodies in question, appoint sub-committees or sub-groups consisting wholly or partly of Directors or wholly of persons who are not Directors of the Trust, the committee of the Trust or the other Health Service Bodies in question.

5.1.3 The SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-

groups established by the Board of Directors, in which case the term “Chairman” is to be read as a reference to the Chairman of the committee as the context permits, and the term “member" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Trust in public.)

5.1.4 Each such committee, sub-committee or sub-group shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide in accordance with any legislation, and/or regulations and/or such guidance or best practice advice issued by Monitor. Such terms of reference shall have effect as if incorporated into the SOs.

5.1.5 Where committees are authorised to establish sub-committees or sub-groups they may not delegate executive powers to the sub-committee/group unless expressly authorised by the Board of Directors.

5.1.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the Regulatory Framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.1.7 Where the Board of Directors is required to appoint persons to a committee and/or undertake statutory functions as required by the Secretary of State and/or NHS England/Improvement (Monitor), and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations and guidance made by NHS England/Improvement (Monitor).

5.1.8 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.

5.1.9 The committees established by the Board of Directors are:

5.1.9.1 Audit Committee;

5.1.9.2 Nomination and Remuneration Committee;

5.1.9.3 Charitable Funds Committee;

5.1.9.4 Finance Committee;

5.1.9.5 Quality and Governance Committee;

5.1.9.6 People Committee; and

5.1.9.7 Mental Health Act Committee

5.1.10 The terms of reference of those committees and sub-groups shall be agreed by the Board of Directors.

5.1.11 Notwithstanding the provisions of SO 5.1.9 above, the Board of Directors may establish other committees and sub-groups from time to time at its discretion.

5.2 **Confidentiality**

5.2.1 A member of a committee, sub-committee or joint 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 of Directors or shall otherwise have concluded on that matter.

5.2.2 A Director or a member of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6 INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

6.1 The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution.

6.2 The Directors, having regard to the views of the Council of Governors, are to prepare the Forward Plan in respect of each Financial Year to be given to NHS England/Improvement (Monitor).

6.3 The Directors are to present to the Council of Governors at a general meeting the Annual Accounts, any report of the Auditor on them, and the Annual Report.

6.4 The Annual Report is to give:

6.4.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its Public Constituency is representative of those eligible for such membership;

6.4.2 information on each non-executive director determining whether each is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement, with particular reference to paragraph 40 of the Constitution; and

6.4.3 any other information which NHS England/Improvement (Monitor) requires.

6.5 In order to comply with the Regulatory Framework in all respects and in particular in relation to the matters which are set out above, the Council of Governors may request that a matter which relates to paragraphs 42 – 44 of the Constitution is included on the agenda for a meeting of the Board of Directors.

6.6 If the Council of Governors so desires such a matter as described within SO 6.5 to be included on an agenda item, they shall make their request in writing to the Chairman at least 10 (ten) Clear Days before the meeting of the Board of Directors, subject to SO 3.3. The Chairman shall decide whether the matter is appropriate to be included on the agenda. Requests made less than 10 (ten) Clear Days before a meeting may be included on the agenda at the discretion of the Chairman.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 The Regulatory Framework requires members of the Board of Directors to declare to the Secretary:

7.1.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter which is under

consideration concerning the Trust or is to be considered by the Board of Directors; and

7.1.2 any interests including but not limited to any personal or family interests which are relevant and material to the business of the Trust, irrespective of whether those interests are direct or indirect, actual or potential'

7.2 Directors should declare such interests as soon as the Director in question becomes aware of it. Any members of the Board of Directors appointed subsequently should do so on appointment.

7.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the Constitution or the SOs and delivering it to the Secretary on appointment or as soon thereafter as the interest arises, but within 7 (seven) Clear Days of becoming aware of the existence of a relevant and material interest.

7.4 If a declaration under SO 7.1 or 7.2 above provided to be, or becomes, inaccurate or incomplete, the Director must make a further declaration before the Trust enters into the transaction or arrangement. This does not require a declaration of an interest of which the Director is not aware or whether the director is not aware of the transaction or arrangement in question.

7.5 A Director need not declare an interest:

7.5.1 if, it cannot reasonably be regarded as likely to give rise to a conflict of interest;

7.5.2 if, or to the extent that, the Directors are already aware of it;

7.5.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered by:

7.5.4 a meeting of the Board of Directors, or

7.5.5 by a committee of the Directors appointed for the purpose.

7.6 In addition, if a Director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

7.7 If a Director has declared a pecuniary interest in accordance with SO 7.8 below they shall not take part in the consideration or discussion of the matter in respect of which an interest has been disclosed and

shall be excluded from the meeting whilst that proposed contract is under consideration. At the time the interests are declared, they should be recorded in the Director's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

7.8 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by NHS England/Improvement (Monitor):

7.8.1 Directorships, including Non-Executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

7.8.2 ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

7.8.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

7.8.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

7.8.5 any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;

7.8.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

7.9 Any travelling or other expenses or allowances payable to a Director in accordance with the Constitution shall not be treated as a pecuniary interest.

7.10 Members of the Board of Directors of companies likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

7.11 A Director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.11.1 they, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

7.11.2 they are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

7.12 For the avoidance of doubt, the following shall not be considered relevant and material for the purposes of these SOs:

7.12.1.1 Shares not exceeding 2% of the total share in issue held in any company whose shares are listed on any public exchange;

7.12.1.2 An employment contract held by Staff Governors;

7.12.1.3 An employment contract with the relevant local authority held by a Local Authority Governor;

7.12.1.4 An employment contract with a Partnership Organisation held by a Partnership Governor.

7.13 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.13.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

7.13.2 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.14 Where a Director:

7.14.1 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

7.14.2 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 or body, whichever is the less, and

7.14.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

the Director shall not be prohibited 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 their duty to disclose their interest.

7.15 In the case of Immediate Family members, the interest of one Immediate Family member shall, if known to the other, be deemed for the purposes of the Constitution and the SOs to be also an interest of the other.

7.16 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.17 Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 to Schedule 7 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this SO.

7.18 SO 7 applies to any committee, sub-committee of the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a Director) and will need to be read in conjunction with the applicable policy.

7.19 **Register of Interests**

7.19.1 The register of interests of Directors shall contain the names of each Director, whether they have declared any interests and, if so, the interests declared in accordance with the Constitution or these SOs.

7.19.2 It is the obligation of the Director to inform the Secretary in writing within 7 (seven) Clear Days of becoming aware of the existence of a relevant or material interest. The Secretary must amend the appropriate register of interests of Directors upon receipt of new or amended information as soon as is practical and, in any event, within 14 (fourteen) days.

7.19.3 The register of interests of Directors will be available to the public and the Chairman will take reasonable steps to bring the existence of the register of interests of Directors to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the register of interests of Directors must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register of Interests.

7.19.4 The details of Directors' interests recorded in the register of interests of Directors will be kept up to date by means of a

regular review as necessary of the register of interests of Directors by the Chief Executive or Secretary during which any changes of interests recently declared will be incorporated.

8 STANDARDS OF BUSINESS CONDUCT

8.1 Policy

8.1.1 Directors and Officers should comply with the NHS Foundation Trust Code of Governance, the Nolan Principles, Standards for Members of NHS Boards and Clinical Commissioning Group governing bodies in England and any guidance and best practice advice issued by NHS England/Improvement (Monitor). This section of the SOs should be read in conjunction with these documents.

8.1.2 Directors and Officers should also comply with provisions of the Trust's Fraud Response Plan and Anti Bribery Policy.

8.2 Interest of Directors and Employees in Contracts

8.2.1 If it comes to the knowledge of Director or an Officer that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or Secretary of the fact that they are interested therein. In the case of Immediate Family Members, the interest of one Immediate Family Member shall, if known to the other, be deemed to be also the interest of that Immediate Family Member.

8.2.2 A Director or Officer must also declare to the Chief Executive or Secretary any other employment or business or other relationship of their, or of an Immediate Family Member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust in accordance with SO 7. The Trust shall require such interests to be recorded in the register of interests of Directors.

8.3 Canvassing of, and Recommendations by, Directors in Relation to Appointments

8.3.1 Canvassing of Directors or members of any committee, sub-committee or joint committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these SOs shall be included in application forms or otherwise brought to the attention of candidates.

8.3.2 A Director of the Board of Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

8.4 Relatives of Directors or Officers

8.4.1 Directors and Officers shall bear in mind that candidates for any staff appointment shall when making an application disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4.2 The Directors and Officers shall disclose to the Chief Executive any relationship between themself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board of Directors whether they are related to any other member of the Board of Directors or holder of any office in the Trust.

8.4.4 Where the relationship to an Officer or another Director to a Director of the Trust is disclosed, SO 7 shall apply.

8.5 External Consultants

8.5.1 SO 8 will apply equally to all external consultants or other agents acting on behalf of the Trust. The Scheme of Delegation should be adhered to at all times.

9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 Custody of Seal

9.1.1 The Common Seal of the Trust shall be kept by the Secretary to the Trust or Nominated Officer in a secure place.

9.2 **Sealing of Documents**

9.2.1 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 of Directors or of a committee thereof or where the Board of Directors has delegated its powers.

9.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an Officer nominated by them) and authorised and countersigned by the Chief Executive (or an Officer nominated by them who shall not be within the originating directorate).

9.3 **Register of Sealing**

9.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

10 SIGNATURE OF DOCUMENTS

10.1 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 of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or Nominated Officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

11 MISCELLANEOUS

11.1 **Standing Orders to be given to Members and Officers**

11.1.1 It is the duty of the Chief Executive to ensure that existing Directors and Officers 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. New designated Officers shall be

informed in writing and shall receive copies, where appropriate, of the SOs.

11.2 Documents having the standing of Standing Orders

11.2.1 The SFIs and the Scheme of Delegation shall have the effect as if incorporated into the SOs.

11.3 Review of Standing Orders

11.3.1 The SOs shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs. For the avoidance of doubt, any changes to the SFIs and Scheme of Delegation only requires Board of Directors' approval.

11.4 Corporate Documents

11.4.1 Any corporate documents specific to the setting up of the Trust shall be held in a secure place by the Chief Executive.

ANNEX 3 - STANDING ORDERS

TENDERING AND CONTRACT PROCEDURE

CONTENTS*:*

1 DUTY TO COMPLY WITH STANDING ORDERS

1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and the Trust's Standing Financial Instructions (SFIs) (except where SO 3.15. (Suspension of SOs) is applied).

1.2 EU Directives and Acts Governing Public Procurement

1.2.1 Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SOs.

1.2.2 The Bribery Act 2010, which came into effect on 1 July 2011, makes it a criminal offence to give promise or offer a bribe, and to request, agree to receive or accept a bribe, either at home or abroad. The Bribery Act 2010 shall have effect as if incorporated in these SOs.

1.2.3 The Trust shall adopt as good practice the requirements of the NHS England Business Case Approvals Process for Capital Investment, Property, Equipment and ICT 14 August 2013 Publications Gateway Reference: 00324 and Health Building Note 00-08 Part A: Strategic framework for the efficient management of healthcare estates and facilities and associated relevant guidance issued by Monitor/NHS England/Improvement (Monitor) in respect of capital investment and estate and property transactions, including the "Capital Regime, Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts November 2016.

1.2.4 In the case of management consultancy contracts the Trust shall adopt, as far as is practicable, the NHS Executive guidance "The Procurement and Management of Consultants within the NHS". The Trust will also comply with the Guidance from NHS England/Improvement (Monitor) entitled "Best Practice in Making Investments" and the Regulatory Framework.

1.2.5 The Trust should have policies and procedures in place for the control of all tendering activity.

1.3 Formal Competitive Tendering

1.3.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and

for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health or other regulatory organisations); for the design, construction and maintenance of building and engineering works (including construction and concession contracts); and for disposals.

1.3.2 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive where:

1.3.2.1 the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 excl VAT (this figure to be reviewed annually); Or

1.3.2.2 the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with;

1.3.2.3 where the requirement is covered by an existing national, regional or local contract or framework

1.3.2.4 where provided for in regulatory guidance.

1.3.3 Formal tendering procedures may be waived by Officers to whom powers have been delegated by the Chief Executive:

1.3.3.1 in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstance are detailed in an appropriate Trust record;

1.3.3.2 where the timescale genuinely precludes competitive tendering (failure to plan the work properly is not a justification for single tender);

1.3.3.3 where it is apparent from the specification that specialist expertise is required to meet it and the expertise is only available from one source;

1.3.3.4 where the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

1.3.3.5 where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

1.3.4 The waiving of competitive tendering procedures should not be used:

1.3.4.1 to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure;

1.3.4.2 for building and engineering construction works, and maintenance (other than in accordance with Concode or other relevant regulatory guidance) without Departmental of Health approval.

1.3.5 Where it is decided that competitive tendering is not applicable and should be waived by virtue of SO 1.3.3.1 to SO 1.3.3.4 above the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported by the Chief Executive to the Audit Committee.

1.3.6 Except where SO 1.3.2 and SO 10.3.3, or a requirement under SO 1.2, applies, the Board of Directors shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and where possible, no less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

1.3.7 Items estimated to be below the limit set in this Standing Order for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

1.3.8 The Board of Directors shall review the Tendering Procedure at least every two years.

1.4 Invitation to tender

1.4.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

1.4.2 All invitations to tender shall be by an e-tendering software

package. The suppliers response shall be completed on-line and uploaded into a secure electronic mailbox until the opening time.

1.4.3 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in SO 1.4.4 and 1.4.5 below.

1.4.4 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

1.4.5 Every tender for building or engineering works (except for maintenance work, when Estatecode or other relevant regulatory guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the DH or modified and/or amplified to accord with guidance issued by NHS England/Improvement (Monitor) and the Department of Health and, in minor respects, to cover special features of individual projects.

1.4.6 Each significant member of Trust staff involved in the tendering process must declare any interests relating to the project they are overseeing.

1.5 Receipt and safe custody of Formal tenders

1.5.1 The tender documents will be stored in the electronic mailbox until the closing date and time. An audit log within the e-tendering system will record the data and time the offer documents are received.

1.6 Opening Formal tenders

1.6.1 Where an electronic tendering package is used the tender documents will be opened electronically by two independent professionals from the procurement service.

1.6.2 Each significant member of staff involved in the tendering process is to declare any interests relating to the project they are overseeing. Where an electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening.

1.6.3 All actions by both procurement staff and suppliers shall be recorded within the system audit reports.

1.7 Admissibility

1.7.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

1.7.2 Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

1.8 Late tenders

1.8.1 Tenders received after the due time and date, but before the opening of the other tenders, may be considered only if the Chief Executive or their Nominated Officer decides that there are exceptional circumstances, eg where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned.

1.8.2 The Chief Executive or Nominated Officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender shall be reported to the Board at its next meeting.

1.8.3 Technically late tenders (ie those despatched in good time but delayed through no fault of the tenderer) may at the discretion

of the Chief Executive be regarded as having arrived in due time.

1.8.4 Incomplete tenders (ie those from which information necessary for the adjudication of the tender is missing) and amended tenders (ie those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt) will be dealt with in the same way as late tenders.

1.8.5 Where examination of tenders reveals errors or incompleteness which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

1.8.6 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, and the process of evaluation shall not be started.

1.9 Acceptance of formal tenders

1.9.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

1.9.2 A tender other than the lowest whole life cost (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless for good and sufficient reason and the decision and reason recorded as a written record using the appropriate Tender Acceptance Authorisation Form.

1.9.3 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

1.9.4 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive.

1.9.5 The use of these procedures must demonstrate that the award of the contract was:

1.9.5.1 not in excess of the going market rate/price current at the time the contract was awarded, and

1.9.5.2 achieved best value for money.

1.9.6 In considering which tender to recommend, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. This will take the form of an official evaluation process involving a consideration of both commercial and technical aspects, any key stakeholders involved in the tender process. In cases of doubt they shall consult the Chief Executive via the completion of a Recommendation Report. The Chief Executive or Director of Finance, see SO 1.16.1.1 for authorisation levels, shall approve acceptance of the tender in writing to the responsible officer. (Larger tenders ie those exceeding a total value of £1,000,000 (inc Vat) shall be referred to the Trust Board for approval).

1.9.7 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.

1.9.8 All tenders shall be treated as confidential and shall be retained for inspection.

1.10 Tender reports to the Trust Board

1.10.1 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

1.11 List of approved firms

1.11.1 Building and Engineering Construction Works

1.11.1.1 Invitations to tender shall be made only to firms included on either an approved list of tenderers compiled by the Trust or by neighbouring Trusts or on the Construction Line, NHS Supply Chain or other national or regional purchasing framework list.

1.11.1.2 Firms included on approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person and shall act in accordance with all relevant employment legislation and guidance.

1.11.1.3 Firms shall conform at least with the requirements of the Health and Safety at Work Act 1974 (as amended) and any amending and/or other related legislation concerned with the health, safety and

welfare of workers and other persons, and to any relevant British standard code of practice issued by the British Standard Institution. Firms must provide to the appropriate Officer a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

1.11.2 Financial Standing and Technical Competence of Contractors

1.11.2.1 The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

1.12 Exceptions to using approved contractors

1.12.1 If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from a list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on a list), or where a list for whatever reason has not been prepared, the Chief Executive shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

1.12.2 An appropriate record in the contract file shall be made of the reasons for inviting a tender or quote other than from an approved list.

1.13 Competitive Quotations

1.13.1 Quotations are required to be obtained where formal tendering procedures have been waived under SOs 1.3.2 or 1.3.3 and where the intended expenditure or income exceeds, or is reasonably expected to exceed the limits defined in the Scheme of Delegation and/or the SFIs.

1.13.2 Where quotations are obtained under SO 1.14 they shall be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board of Directors.

1.13.3 Quotations shall be in writing.

1.13.4 All quotations shall be treated as confidential and shall be retained for inspection.

1.13.5 The Chief Executive or their Nominated Officer shall evaluate the quotations and select the one which gives value for money. If this is not the lowest quotation then this fact and the reasons why the lowest quotation was not chosen shall be recorded in a permanent record and a Quotation Acceptance Authorisation Form completed.

1.14 Non-Competitive Quotations

1.14.1 Non-competitive quotations in writing may be obtained, in exceptional circumstances, for the following purposes:

1.14.1.1 the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their Nominated Officer, possible or desirable to obtain competitive quotations;

1.14.1.2 the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts. The Trust shall use National Contracts awarded by such Government Bodies as Government Procurement or NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

1.14.1.3 the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts, the approvals required for these courses of action will be by reference to the financial limits set out in Appendix 1 of the Standing Financial Instructions.

1.14.1.4 miscellaneous services, supplies and disposals;

1.14.1.5 where the goods or services are for building and engineering maintenance the responsible works manager must verify that the first two conditions of this Standing Order eg SO 1.14.1.1 and SO 1.14.1.2 apply)

1.14.1.6 where tenders or quotations are not required, because expenditure is below the limits set in Appendix 1 of the Standing Financial Instructions, the Trust shall procure goods and services in

accordance with procurement procedures approved by the Board of Directors.

1.15 Quotations to be within Financial Limits

1.15.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these SOs except with the authorisation of either the Chief Executive or Director of Finance.

1.16 Authorisation of Tenders and Competitive Quotations

1.16.1 Providing all the conditions and circumstances set out in these SOs have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Contracts **awarded to the lowest bidder.**

1.16.1.1 Below £50,000 - main list authorised signatory

1.16.1.2 £50,000 - £1,000,000 – main list authorised signatory and an Executive Director

1.16.1.3 Above £1,000,000 – Trust Board - to be recorded in minutes.

~~**The Finance Director or the Chief Executive must approve any contracts not awarded to lowest bidder.**~~

Contracts not awarded to the lowest bidder:

1.16.1.4 Below £50,000 - Director of Finance or Chief Executive

1.16.1.5 £50,000 - £1,000,000 Chief Executive and Chairman

1.16.1.6 Above £1,000,000 – Trust Board – to be recorded in minutes.

Contracts above £1,000,000 incl VAT (over the full period of the contract) must be approved by the Board of Directors.

1.16.2 These levels of authorisation may be varied or changed from time to time by the Board of Directors and need to be read in conjunction with the Scheme of Delegation and/or SFIs.

1.16.3 Formal authorisation must be put in writing. In the case of

authorisation by the Board of Directors this shall be recorded in their minutes.

1.17 Instances where formal competitive tendering or competitive quotation is not required

1.17.1 Where competitive tendering or a competitive quotation is not required, the Trust should adopt one of the following alternatives:

1.17.1.1 the Trust shall use the NHS supply chain for procurement of all goods and services unless the Chief Executive or their Nominated Officer deem it inappropriate. The decision to use alternative sources must be documented;

1.17.1.2 if the Trust does not use the NHS supply chain (where tenders or quotations are not required, because expenditure is below £5,000), the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

1.18 Private Partnership

1.18.1 The Trust should normally market-test for "Private Partnership" funding when considering a capital procurement. When the Board of Directors proposes, or is required, to use finance provided by the private sector the following shall apply:

1.18.1.1 The Chief Executive and Finance Director shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

1.18.1.2 Where the sum exceeds delegated limits, a business case must be referred to NHS England/Improvement (Monitor) and/or Department of Health for approval or treated as per current guidelines.

1.18.1.3 The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

1.18.1.4 The selection of a contractor/finance company must be on the basis of competitive tendering or

quotations.

1.19 Compliance Requirements for all Contracts (including lease contracts)

1.19.1 The Board of Directors may only enter into contracts on behalf of the Trust within its statutory powers and within the Regulatory Framework and shall comply with:

1.19.1.1 these SOs;

1.19.1.2 the SFIs;

1.19.1.3 the Trust's Provider Licence;

1.19.1.4 statutory provisions including those giving effect to EU Directives;

1.19.1.5 such of the NHS Standard Contract Conditions as are applicable;

1.19.1.6 appropriate NHS guidance;

1.19.2 Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

1.19.3 Contracts shall include lease and hire purchase agreements.

1.19.4 In all contracts made by the Trust, the Board of Directors shall endeavour to obtain value for money by use of all systems in place. The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.

1.20 Personnel and Agency or Temporary Staff Contracts

1.20.1 The Chief Executive shall nominate Officers with delegated authority to enter into contracts for the employment of other Officers and to enter into contracts for the employment of agency staff or temporary staff service contracts.

1.21 Healthcare Services Agreements

1.21.1 Healthcare Services contracts made between two Health Service Bodies for the supply of healthcare services, will be legally binding contracts and are subject to the provisions of the 2006 Act and any other relevant legislation.

1.21.2 The Chief Executive shall nominate Officers with power to negotiate for the provision of healthcare services from providers of healthcare services.

1.22 Cancellation of Contracts

1.22.1 Except where specific provision is made in model forms of contracts or standard schedules of conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if:

1.22.1.1 the contractor has offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust; or

1.22.1.2 the contractor has shown or foreborne favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by them or acting on their behalf (whether with or without the knowledge of the contractor); or

1.22.1.3 in relation to any contract with the Trust the contractor or any person employed by them or acting on their behalf shall have committed any offence under the Prevention of Corruption Acts 1989 and 1916,the Prevention of Corruption (Amendment) Act 2018, Bribery Act 2010, and other appropriate legislation.

1.23 Determination of Contracts for Failure to Deliver Goods or Material

1.23.1 There shall be inserted in every written contract for the supply of goods or materials entered into by the Trust a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may (without prejudice) determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good such default.

1.23.2 The clause referred to at SO 1.23.1 shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

1.24 **Contracts Involving Funds held on Trust**

1.24.1 Contracts involving Funds held on Trust shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

1.24.2 SO 1.24.1 shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

2 DISPOSALS

2.1 **Competitive** Tendering or Quotation procedures shall not apply to the disposal of:

2.1.1 any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their Nominated Officer;

2.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

2.1.3 items to be disposed of with an estimated sale value as set out in the Scheme of Delegation;

2.1.4 items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; or

2.1.5 land or buildings concerning which Department of Health guidance has been issued but subject to compliance with such guidance; or

2.1.6 any matter which NHS England/Improvement (Monitor) has issued alternate specific guidance and/or best practice advice in relation to.

3 IN-HOUSE SERVICES

3.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

3.2 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

3.2.1 "specification group", comprising the Chief Executive or Nominated Officer(s) and specialist(s).

3.2.2 "in-house tender group", comprising representatives of the in-house team, a nominee of the Chief Executive and appropriate technical support.

3.2.3 "evaluation group", comprising normally a specialist Officer, a supplies Officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £500,000 a non-Officer member should be a member of the evaluation team.

3.3 All groups referred to in SO 3.2.1 to 3.2.3 should work independently of each other but individual Officers may be a member of more than one group. No member of the "in-house tender group" may, however, participate in the evaluation of tenders.

3.4 The "evaluation group" shall make recommendations to the Board of Directors.

4. REVIEW OF THE TENDERING AND CONTRACT PROCEDURE

4.1 For the avoidance of doubt, the Tendering and Contracting Procedure form part of the Standing Orders but any changes to the procedure only require Board of Directors' approval.

ANNEX 4 - FURTHER PROVISIONS

1. REPRESENTATIVE MEMBERSHIP

1.1. The Trust shall at all times strive to ensure that, taken as a whole, its actual membership is representative of those eligible for membership. To this end:

1.1.1. The Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors and shall be reviewed by them from time to time at least every three years.

1.1.2. The Council of Governors shall present to each Annual Meeting:

1.1.2.1. a report on steps taken to secure that, taken as a whole, the actual membership of its constituencies and the classes of constituencies is representative of those eligible for such membership;

1.1.2.2. the progress of the membership strategy; and

1.1.2.3. any changes to the membership strategy.

2. CO-OPERATION WITH HEALTH SERVICE AND OTHER BODIES

2.1. In exercising its functions, the Trust shall co-operate with Health Service Bodies and any local authority with which the Trust has a Local Authority Partnership Agreement.

2.2. Notwithstanding the provisions of paragraph 2.1 above, the Trust shall co-operate with any specific third party body that it has a duty (statutory, contractual, or otherwise) to co-operate with.

3. RESPECTS FOR RIGHTS OF PEOPLE

3.1. In conducting its affairs, the Trust shall respect the rights of the members of the community it serves, its employees and people dealing with the Trust as set out in the Human Rights Act 1998.

4. APPOINTMENT OF CHAIRMAN AND NON-EXECUTIVE DIRECTORS

4.1. Decisions and processes regarding the appointment and reappointment of the Chairman and Non-Executive Directors of the Trust are solely within the purview of the Council of Governors.

4.2. The Nominations and Remuneration Committee has delegated powers from the Council of Governors to consider the Non-Executive Director or Chairman

vacancies due in the next 12 months and make recommendations to the Council of Governors.

4.3. The Nominations and Remuneration Committee shall:

4.3.1. recommend the re-appointment of an existing Non-Executive Director/Chairman or if applicable the recruitment process for the Chairman and Non-Executive Directors (as may be the case).

4.3.2. take advice, as necessary, from the Director of People and Organisational Development and the Trust Secretary or other internal or external sources

4.3.3. report its recommendations regarding the re-appointment of the Non-Executive Director or Chairman as an agenda item in a timely manner at a Council of Governors meeting for decision, or:

4.3.4. report its recommendations regarding the recruitment process for the Non-Executive Director or Chairman post as an agenda item in a timely manner to the Council of Governors meeting for decision.

4.3.5. make recommendations to the Council of Governors meeting in relation to pay and tenure of Non-Executive Directors/Chairman for the Council of Governors' decision. Each period of appointment (or re-appointment) will be to a maximum of three years, and any re-appointment over six years will be subject to particularly rigorous review. Any re-appointment over six years will be subject to annual re-appointment to provide assurance that the Non-Executive Director seeking re-appointment retains their independence of character and judgement.

4.3.6. ensure that a formal, rigorous and transparent procedure is followed, which takes into account the needs of the organisation, the balance of expertise and experience on the Board, eligibility of existing Non-Executive Directors or Chairman to stand for a further term, and any other relevant factors. This is not an exhaustive list of the matters which may need to be considered by the Nominations and Remuneration Committee, but is merely intended to act as a guide.

4.4. Subject to the provisions of paragraph 4.3.1 above, the process for appointing new Non-Executive Directors and the Chairman, including the potential re-appointment of the Chairman and Non-Executive Directors, will be as follows:

4.4.1. No later than six months before the end of the term of office of the Chairman or a Non-Executive Director (as the case may be), the Nominations and Remuneration Committee will consider, paying due regard to the provisions set out in paragraph 4.3.1, the formal performance evaluation for the Non-Executive Director or Chairman for the previous two years, skills and experience and eligibility of existing Non-Executive Directors prepared to stand for re-appointment. The

reason for considering the performance of existing Non-Executive Directors will be to inform the decisions made regarding the re-appointment of the Non-Executive Director or Chairman, or the recruitment process to be followed. However, nothing within this paragraph will preclude the Nominations and Remuneration Committee from considering other relevant circumstances when deciding on the recruitment process as outlined in paragraph 4.3.1 above. Having due regard to the needs of the composition of the Board, the Nominations and Remuneration Committee may either 1) recommend to the Council of Governors that 1) an external recruitment process is followed or 2) recommend the re-appointment, pay, length of term of an existing Non-Executive Director. For the avoidance of doubt, if the recommendation to re-appoint a Non-Executive Director or Chairman is approved by the Council of Governors, there is no requirement to set up an Appointments Panel, unless this is specifically requested by the Council of Governors.

4.4.2. Following a recommendation to follow an external recruitment process, and subject to the Council of Governors' agreement, the Council of Governors will appoint an Appointments Panel to undertake the recruitment process. The Appointments Panel will be constituted in accordance with paragraphs 4.4.4 and 4.4.5 below.

4.4.3. The current Chairman or a Non-Executive Director may stand for reappointment, subject to the conditions at paragraph 4.4 above.

4.4.4. The Appointments Panel for the Chairman will consist of the Senior Independent Director, or if the Senior Independent Director is standing for appointment a Non-Executive Director who is not standing for appointment, two Elected Governors, and one Appointed Governor. If the number of Elected/Appointed Governors prepared to serve on the Appointments Panel is greater than the number of places available, the Panel members will be selected by election by the Elected/Appointed Governors respectively. A Public Governor will chair the Appointments Panel. Each member of the Appointments Panel will have one vote. The chairman of another NHS foundation trust will be invited to act as an independent assessor to the Appointments Panel.

4.4.5. The Appointments Panel for Non-Executive Directors will consist of the Chairman, two Elected Governors, and one Appointed Governor. If the number of Elected/Appointed Governors prepared to serve on the Appointments Panel is greater than the number of places available, the Panel members will be selected by election by the Elected/Appointed Governors respectively. The Chairman will chair the Appointments Panel. Each member of the Appointments Panel will have one vote.

4.4.6. Appropriate candidates (not more than 5 (five) for each vacancy) will be identified by an Appointments Panel.

4.4.7. The Appointments Panel constituted under paragraphs 4.4.4 and 4.4.5 above will be supported by appropriate advice from the Trust's Director of People and Organisational Development on the qualifications, skills and experience required for each position. They may also work with an external organisation recognised as expert at appointments to identify the qualifications, skills and experience required for Non-Executive Directors.

4.4.8. The Council of Governors will not consider nominations for the Chairman and other Non-Executive Directors other than those made by the appropriate Appointments Panel.

4.4.9. The Appointments Panel will make recommendations to the Council of Governors meeting about the preferred candidate to be appointed to the Non-Executive Director or Chairman post for the Council of Governors' decision.

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Performance Quadrant
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Performance and Reporting Manager
PRESENTED BY:	Chief Finance Officer
DATE:	3 May 2022

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 performance quadrant sets out performance in relation to: • Safety and Patient Experience • People • Performance • Finance A detailed overview of performance will be presented at the meeting.
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:					

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

YEOVIL DISTRICT HOSPITAL FOUNDATION TRUST PERFORMANCE QUADRANT

FINANCE — Mar-22

£0.037m in month deficit → **£0.256m fav to in month plan** → **£0.254m year to date surplus** → **£0.254m to date fav to financial trajectory**

	In Month (£'000s)		YTD (£'000s)	
Category - Core items	Actual	Variance to Trust Plan	Actual	Variance to Trust Plan
Income (Including Top funding from NHSE/I)	26,358	6,518	235,324	8,431
SIREN and COVID referred testing	343	181	3,112	2,137
Pay - Substantive, Bank & Agency	(20,181)	(6,862)	(155,532)	(6,412)
Non-pay - Consumables, Drugs, Other	(6,535)	(348)	(75,391)	(4,778)
Depreciation, Interest, PDC, Impairments	(23)	768	(7,258)	877
Financial Improvement Trajectory basis	(37)	256	254	254
Donated Assets and Impairment	3	4	(465)	(218)
I&E surplus/(deficit)	(34)	260	(210)	36

Additional items	Actual	Variance	Actual	Variance
CIP Achievement (to draft new year budget)	520		3,841	
CIP % achieved recurrent			33%	
Pay - Agency	(1,073)	221	(11,955)	(1,510)
Capital expenditure	(6,451)		(10,587)	
Working cash balance*	28,455		28,455	
Better Payment Practice Code (BPPC)			95%	

**Cash balance after deducting funding received in advance or held for committed spend.*

SAFETY AND PATIENT EXPERIENCE — Mar-22

Indicators	Mar-22	Mar-20	6 Month Avg	Movement
HSMR (Latest available - Jan-2021 to Dec-2021)	0.919	0.846	--	↓
Patient Falls	108	70	85.7	↑
Pressure Ulcers	12	7	11.0	↓
C.Diff (Lapse in Care)	0	0	0	→
E.Coli Gram Negative Blood Stream Infections	1	2	0.83	↑
MRSA	0	0	0	→
Incidents reported	1102	656	948.3	↑
Number of never events	0	1	0	→
Number of prescribing errors causing harm	0	0	1	↓
VTE risk assessment completed on admission	95.00%	94.20%	--	↑
Complaints	8	3	8	↑
PALS Concerns	49	71	49	↑
Inpatients Friends and Family Test Response Rate (Statutory Return)	17.33%	23.73%		↑
Inpatients Friends and Family Test Likely to Recommend (Statutory Return)	95.12%	95.79%		↓
Rate of readmissions for the same clinical condition (% of total number of admissions)	4.32%	4.31%	--	↓
Number of same day cancelled operations for non-clinical reasons	34	22	--	↑
Safe Staffing nurse fill rate (Number of wards at < 80% establishment)	0	0	--	→

PERFORMANCE — Mar-22

Indicators	Actual	Local Target	National Standard	Movement	RAG (Local)
A&E 4 hour Waiting Times	77.68%	95.0%	95.0%	↓	
Ambulance Handover Times	88.48%	98.0%	98.0%	↓	
RTT - Incomplete Pathways Waiting Times	64.53%	--	92.0%	↓	
Diagnostics - 6 Weeks Waiting Times	82.76%	99.0%	99.0%	↑	
Cancer - 2WeekWait - Waiting Times (Feb-22)	82.26%	93.0%	93.0%	↑	
Cancer - 2WeekWait - Breast Symptoms (Feb-22)	93.75%	93.0%	93.0%	↑	
Cancer - 28 Day Diagnosis - 2WeekWait (Feb-22)	76.46%	75.0%	75.0%	↑	
Cancer - 28 Day Diagnosis - Breast (Feb-22)	91.18%	--	TBC	↓	
Cancer - 31 day Treatment Waiting Times (Feb-22)	99.00%	96.0%	96.0%	↑	
Cancer - 62 day Standard Waiting Times (Feb-22)	63.71%	85.0%	85.0%	↓	

RAG Status: Local Target achieved, Target failed - within 1% of local target, Target failed - more than 1% away from achieving local target

PEOPLE — Mar-22

Indicators	Mar-22	Mar-20	Target	Movement	RAG
Turnover	17.50%	18.19%	12%-17%	↑	
Registered Nursing Vacancies (% of Whole Time Equivalent)	1.78%	1.31%	5.00%	↓	
Medical & Dental Vacancies (% of Whole Time Equivalent)	2.45%	3.69%	5.00%	↓	
Other Vacancies (% of Whole Time Equivalent)	4.02%	3.94%	2.00%	↓	
Total Vacancies (% of Whole Time Equivalent)	3.03%	3.02%	2.00%	↓	
12 month Absence Rate (month in arrears)	4.12%	3.26%	3.00%	↑	
Mandatory Training Rate	88.71%	86.89%	85.00%	↓	
Staff Appraisal Rate	85.77%	85.32%	90.00%	↑	
Agency Spend in Month against ceiling (£000's)	£1,074	£575	£470	↓	
Agency Spend YTD against ceiling (£000's)	£11,955	£6,194	£5,639		

Somerset NHS Foundation Trust 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:	3 May 2022

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 in respect of Adult, Older persons and Children and Young People's mental health services. • the percentage of IAPT (Talking Therapies) patients moving to Recovery.

	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, 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 18 weeks from referral to treatment with our acute services; • 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/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]
.

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: MARCH 2022

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, which relate to our two predecessor organisations, 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.

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**
• during March 2022 we continued successfully to meet the challenges presented by COVID-19 to patients and colleagues. • 'Attend Anywhere' technology continues to enable patients to be seen remotely and receive advice and support, and continues to be well received. • urgent and emergency patients continue to receive the treatments they need. • the percentage of patients waiting under six weeks for mental health services remains high. • there has been a significant reduction in the number of patients waiting over 104 weeks from Referral to Treatment. • our Talking Therapies (IAPT) service continues to maintain recovery rates which are significantly above the national standard. • compliance in respect of mandatory training 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 and rising levels of demand. • continuing 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. • continue the rollout of the mass vaccination programme.
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 free car parking, accommodation provision, and nutrition. • continue with new ways of working, particularly through the use of technology; this presents an opportunity for us to consider how we provide care appropriately and effectively to patients following the COVID-19 outbreak. • 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 the Trust's 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 (IP&C) 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): 24 cases, MSSA BSIs: 15 cases E. coli BSIs: 95 cases, Klebsiella BSIs: 28, Pseudomonas aeruginosa BSIs: 13.

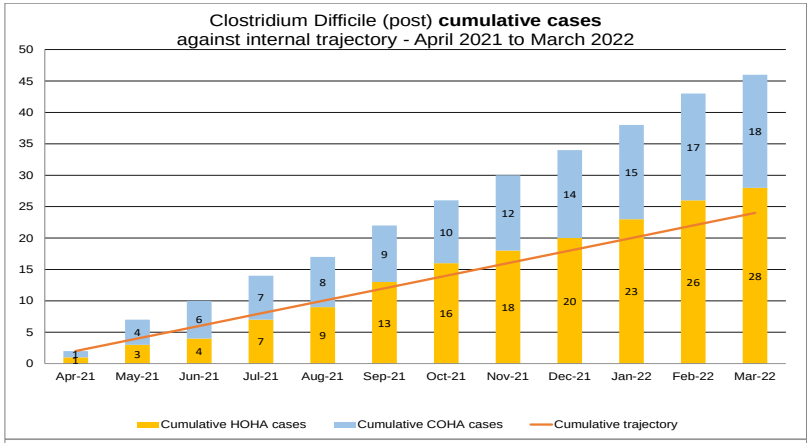
Current performance (including factors affecting this)

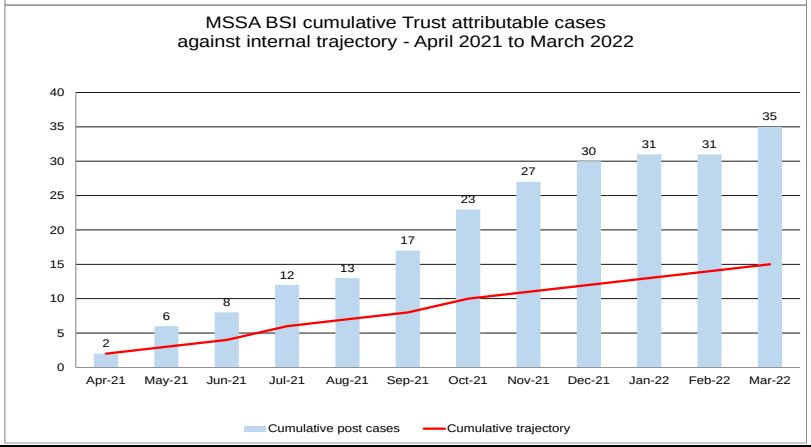
- **MRSA –** There were no Trust attributed MRSA bloodstream infections (BSIs) reported during March 2022. The total number of cases for 2021/22 was four. Post infection reviews (PIRs) have been completed on all cases, with lapses in care identified in two, relating to peripheral vascular cannula. Confirmation is awaited on the case reassignment of one of these cases to University Hospitals Bristol & Weston NHS Foundation Trust.
- **C. diff** – There were three Trust-attributed cases in March 2022, two HOHA (Hospital-onset, healthcare associated) and one COHA (Community-onset, healthcare associated). The total number of cases for 2021/22 was 46 against a threshold of 24. The final PIRs are in progress but of those completed, lapses in care were identified in nine, relating to antimicrobial prescribing, hand hygiene and environmental cleanliness.
- **MSSA –** Four Trust-attributed MSSA BSIs were reported in March 2022. The total number of cases for 2021/22 was 35 against an internal threshold of 15. The final PIRs are in progress but of those completed, lapses in care were identified in six, relating to peripheral vascular cannula.
- **E. coli -** Three Trust-attributed E. coli BSIs were reported in March 2022. The total number of cases for 2021/22 was 46 against a threshold of 95. The final PIRs are in progress but of those completed, lapses in care were identified in four, related to urinary catheters, delay in treatment and hand hygiene.
- **Klebsiella –** Two Trust attributed Klebsiella BSI were reported in March 2022, bringing the total to 16 against a threshold of 28. The final PIRs are in progress but of those completed no lapses in care have been identified.
- **Pseudomonas –** No Trust attributed Pseudomonas aeruginosa BSIs were reported in March 2022. The total number of cases for 2021/22 was seven against a threshold of 13. Final PIRs are in progress but of those completed, no lapses in care have been identified.
- **COVID-19 –** There were 524 inpatient cases of COVID-19 identified during March 2022. A total of 178 were healthcare associated. There were 27 outbreaks of COVID affecting inpatient wards, restrictions have been lifted in all but one of these wards.

Focus of improvement

- To respond to the latest COVID-19 guidance in relation to healthcare setting and balance recovery of services with infection control management of COVID-19.
- To implement the new definitions of healthcare attributed cases of bloodstream infections from the new financial year.

Line/Bar Charts





Recent performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
MRSA	0	0	1	1	0	0
C.Diff	5	3	4	4	5	3
MSSA	6	4	3	1	0	4
E.coli	4	2	5	6	3	3

Safe

Fall incidents: monthly rates of falls incidents across all of our inpatient wards, reported via our RADAR reporting system, per 1000 occupied bed days. Our aims are to maintain high rates of reporting, and have a low proportion of incidents which result in harm.

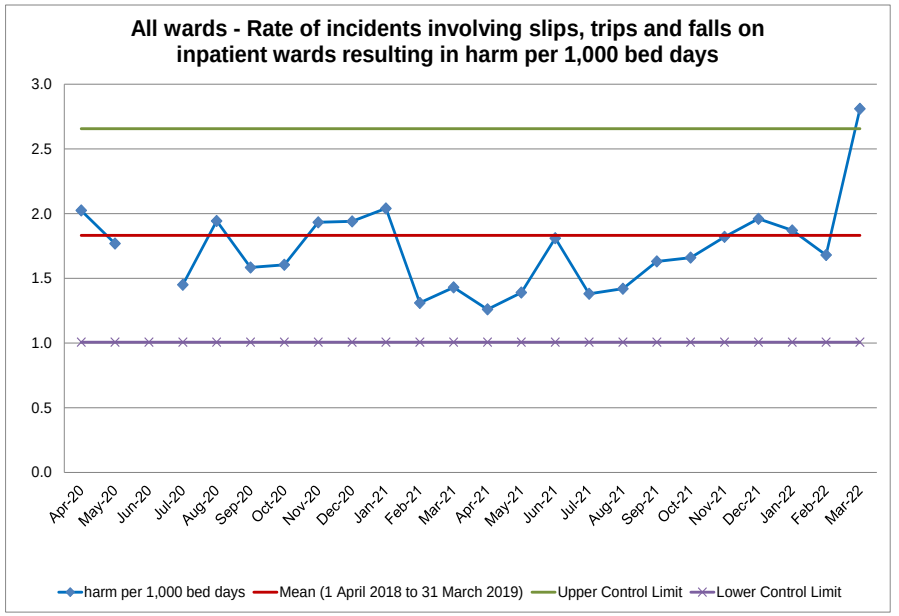
Current performance (including factors affecting this)

- During March 2022, of 283 reported falls, a total of 83 resulted in harm, a rate of 2.81 per 1,000 occupied bed days. This is the highest rate reported since April 2020.
- Recent operational pressures have continued, with unprecedented demands relating to emergency patients requiring admission and increases in the number of medical patients with complex needs who have been placed on surgical or other medical wards, which do not always have the appropriate skill mix or experience of such patients. It has also been necessary to accommodate additional patients by increasing bed capacity in several areas.
- The average length of stay in community hospitals is increasing, and patients have higher levels of acuity and dependency on admission.
- Exacerbating factors have included reduced staffing due to absences, particularly impacting on the ability to provide one-to-one care, along with the increased acuity and dependency of patients.

Focus of improvement work

- The falls improvement group will meet again following an extended period due to covid pressures. Key actions have been identified for implementation in the next three months.
- The recently appointed falls lead has commenced various audits (including bedrail, lying and standing blood pressures). The results from each audit will be fed back to the wards and the identified actions will be monitored.
- The falls lead is reviewing educational needs for all clinical colleagues. They also continue to work with the Quality and Improvement team on a ward-based pilot for post-falls debriefs, which will also help to identify themes and inform necessary actions.
- An overarching action plan for falls is being developed and will be reviewed at the next falls meeting in May 2022.

SPC Chart



How do we compare

The number of falls resulting in harm per 1,000 occupied bed days in March 2022 increased compared to February 2022.

Recent Performance

The monthly numbers of incidents since October 2021 were as follows:

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number of falls	239	254	251	250	200	283
Falls rate per 1,000 occupied bed days	8.46	9.08	8.95	8.64	7.45	9.60
Falls resulting in harm	47	51	55	54	45	83
Harm rate per 1,000 occupied bed days	1.66	1.82	1.96	1.87	1.68	2.81

Safe

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

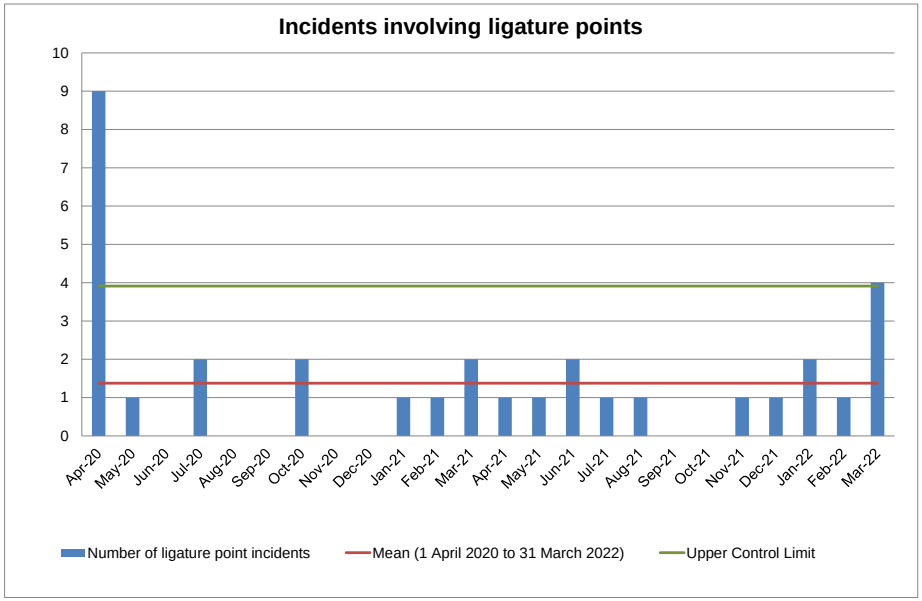
Current performance (including factors affecting this)

- **Ligature incidents:** During March 2022 there were four fixed ligature incidents, all relating to a patient on Rowan ward.
- None of the reported incidents resulted in any harm to the patient.

Focus of improvement work

- All incidents involving ligatures are reviewed to ensure that assessments and care plans accurately reflect observation levels and the management of identified risk. A review of risks and observation levels is also discussed at all handovers for each individual patient.
- The Environmental Risks group continues to review all fixed-point ligatures as part of the ongoing work to improve patient safety within inpatient services. Potential technological solutions are currently available including door-top alarms, and room monitors which will continue to be evaluated as part of this working group, to be used as an addition to evidenced-based risk assessment and appropriate observation and engagement.
- The ligature incidents which occurred during March 2022, and which involved radiator fins, were discussed at the Environmental Risk Group in April 2022. Historical work had been undertaken to install a fine mesh grill underneath the fins, which were then secured in place with anti-tamper screws, which should have prevented any ligature from being inserted to create an anchor point. A process has been initiated across all mental health wards to check the integrity of the radiators to make sure the fins and grill are securely held in place and that a ligature cannot be inserted. Where these types of radiator covers are in place wards have been asked to add to their local risk register and to update their annual ligature point assessment to include this risk.

SPC Chart



How do we compare

The latest NHS Benchmarking Network report, covering the year 2020/21, showed that Somerset Partnership had comparatively lower levels of ligature incidents than peer providers nationally.

Recent Performance

The monthly numbers of incidents since October 2021 were as follows:

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number of Ligature point incidents	0	1	1	2	1	4
Number resulting in harm	0	1	0	0	0	0

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.

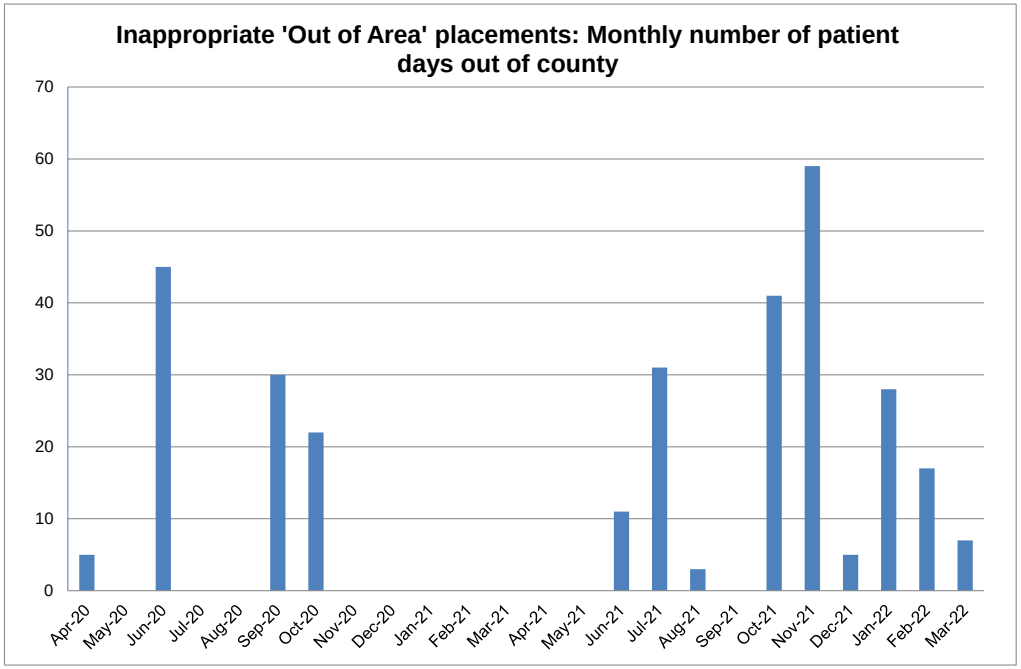
Current performance (including factors affecting this)

- During March 2022 one patient was placed out of area, for a total of seven days.
- At the time when the patient required admission, both Pyrland wards, for older persons, were unable to accept the patient due to a COVID outbreak, and this was also true of our other acute mental health wards at the time.
- The patient was admitted into a Somerset bed once Infection Prevention Control (IPC) restrictions had been lifted.

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 majoirty 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 daily 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 posssible.
- 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.

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 since October 2021 were:

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number of Days	41	59	5	28	17	7
Number of patients	3	3	2	2	1	1

Responsive

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

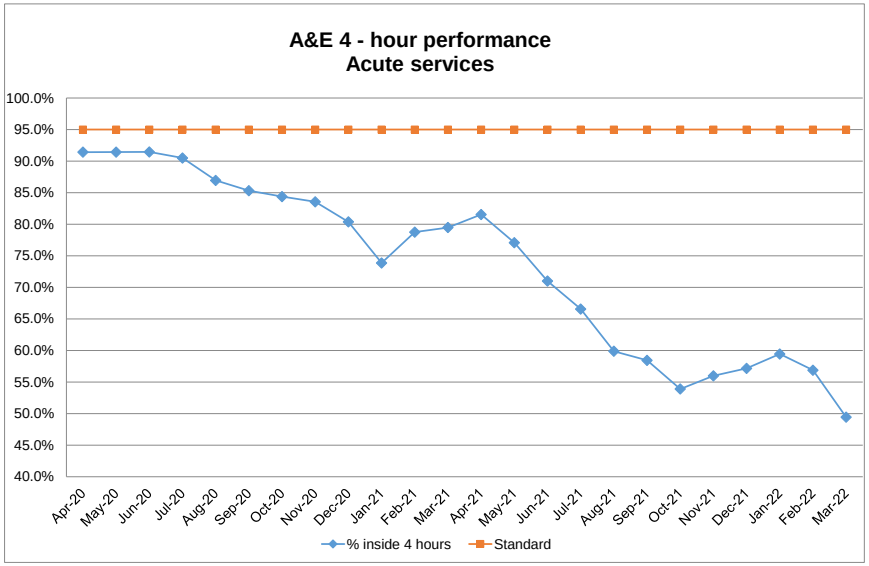
Current performance (including factors affecting this)

- A&E 4-hour performance was 49.4% for the Musgrove site in March 2022, down from 56.9% in February 2022.
- COVID-19 admissions were higher than in previous months but remain lower than levels seen during the second wave of the pandemic. Most patients being admitted with COVID-19 are admitted because of other conditions they have.
- With the Minor Injury Unit (MIU) contribution included, the overall performance was 76.8% in March 2022, and hence still below the 95% national standard.
- A&E attendances in March 2022 were 4.7% above March 2020 levels, likely reflecting a restoration to more normal levels of A&E attendances, with two years' worth of growth. Overall, emergency admissions were 21% down on the forecast for the month, with a 39% reduction in zero length of stay admissions and a 12% reduction in 1+ day admissions, compared with pre-COVID levels. Those patients being admitted to an inpatient bed continue to have longer stays. This is consistent with a slowing of the 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

- Work continues with Intermediate Care to support an increase in domiciliary care capability through recruitment, an increase in pay rates and retention payments.
- The reinstated Discharge Lounge remains open. Portman ward is to focus on medically fit for discharge patients.
- Patients continue to be triaged on arrival and segregated into COVID and non-COVID areas within the Emergency Department until a full clinical assessment has been completed.
- Trust escalation beds remain fully activated to support inpatient flow. The current Escalation Standard Operating Procedure was revised and implemented in mid-February 2022.

Line Chart



How do we compare

National average performance for Trusts with a major Emergency Department was 58.6% in March 2022. Our performance was 49.4%. We were ranked 91 out of 111 trusts. With Minor Injury Unit attendances included, we were ranked 27, with performance of 76.8%.

Recent performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
Actual	53.9%	56.0%	57.2%	59.4%	56.9%	49.4%

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.

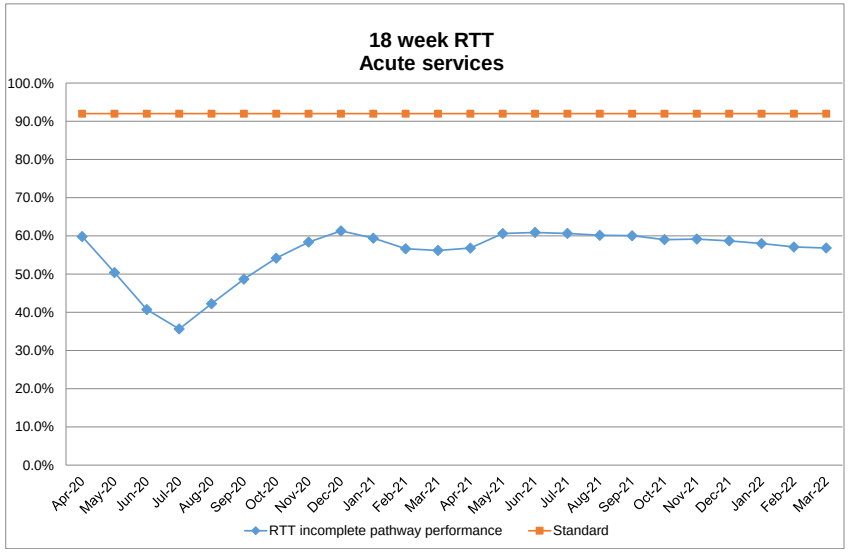
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT reduced slightly, to 59.0% (acute + community) in March 2022, from 59.3% in February 2022.
- The over 18-week backlog increased by 272 pathways. The total waiting list size increased by 467 pathways and was 408 below (i.e. better than) trajectory (33,196 actual vs. 33,604). There was an increase in both acute and community pathways, with acute pathways increasing from 30,938 to 31,365.
- RTT clock starts (i.e. referrals) in March 2022 were 3.6% below average pre-COVID levels (working days adjusted).
- 52-week waiters increased in March 2022 by five to 1,741 pathways. The number of 78+ week waiters reduced from 418 in February to 359 in March 2022. We reported 86 patients waiting over 104 weeks (against a revised trajectory of 88), which is significant reduction on the February 2022 position of 145. We expect to report a further improvement in performance next month.

Focus of improvement work

- Until November 2021 the Trust remained one inpatient theatre's worth of capacity down due to the conversion of a theatre into critical care. This has resulted in a backlog of more complex, longer routine cases on the waiting list.
- Significant bed pressures and theatre staff sickness and shortages are preventing full restoration of inpatient activity.
- There is an active programme of system-wide actions to support long term recovery, which includes the shared use of capacity across the system, ways of re-routing demand to available capacity, full use of available Independent Sector capacity, physical capacity expansion and ways of managing demand differently (e.g., Advice First and Peri-Operative pathways).

Line Chart



How do we compare

The national average performance was 62.6% in February 2022 – the latest data available. Our performance was 59.3%. National performance deteriorated by 0.2% between January and February 2022, and the number of 52-week waiters across the country decreased by 12,050 to 299,478 (representing 4.8% of the national waiting list).

Performance trajectory: 52 week wait performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	1,749	1,880	2,015	2,148	2,203	2,233
Actual	1,800	1,772	1742	1,693	1,736	1,741

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

Responsive

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.

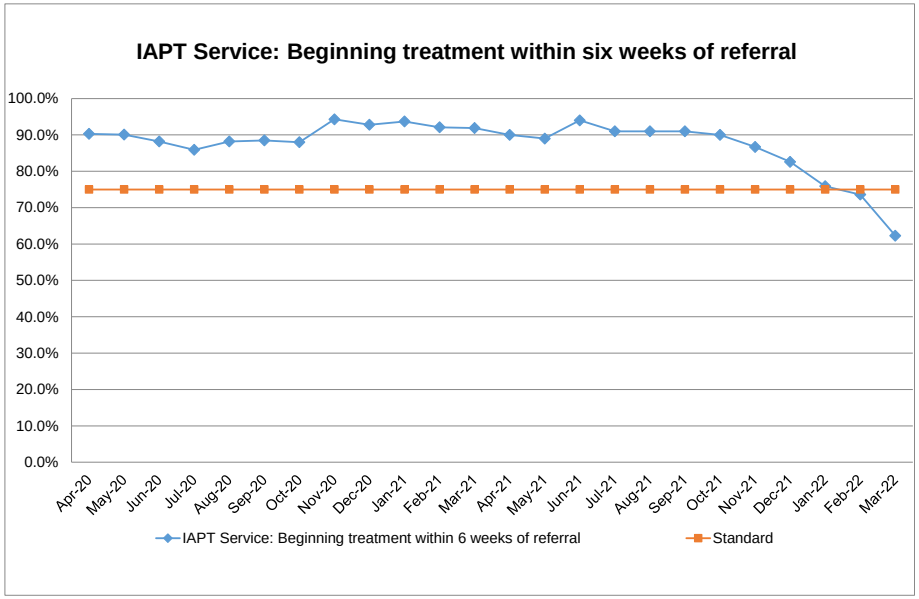
Current performance (including factors affecting this)

- During March 2022, compliance decreased further below the 75% national standard, to 62.3%.
- The fall in compliance over recent months 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.
- This was exacerbated by high vacancy levels, long term sickness and maternity leave.
- The service currently has a higher level of vacancies than at any time in the past six years.

Focus of improvement work

- Recruitment continues to be challenging, although numerous recent appointments have been made with variable 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.
- The service is converting a Step 3 (High Intensity Cognitive Behavioural Therapy) vacancy into an Assessment Worker role, to help move more people into treatment within six weeks.
- The service is also employing locums, and is continuing to use external online providers creatively
- The service manager continues to work with the management team and other colleagues to identify areas of concern and formulate actions to address them.

SPC Chart



How do we compare

National average performance against the six-week standard in January 2022 (the latest published data) was 89.7%; our performance was 75.9%.

Recent Performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
Total Discharges	340	315	345	395	371	422
First treatment inside of six weeks	305	273	285	300	273	263
Compliance %	89.7%	86.7%	82.6%	75.9%	73.6%	62.3%

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.

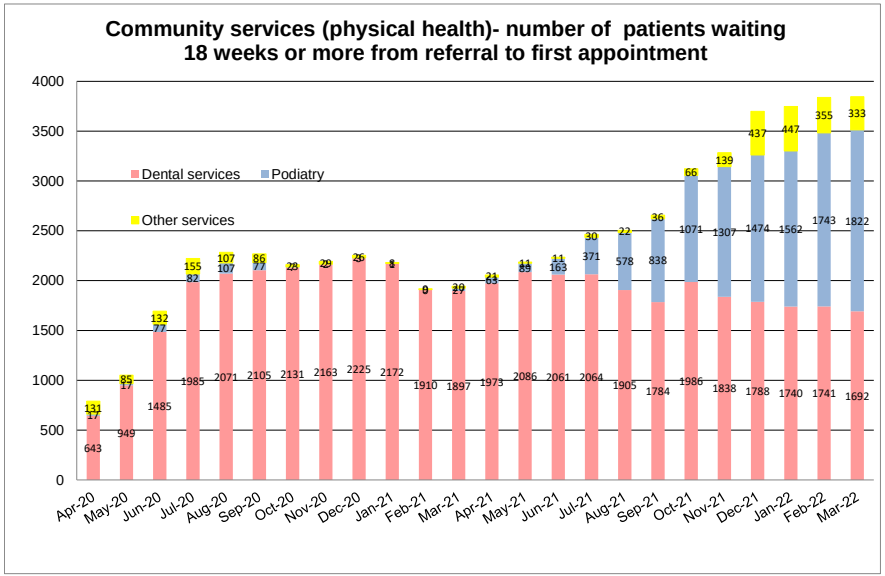
Current performance (including factors affecting this)

- As at 31 March 2022, the number of patients waiting 18 weeks or more totalled 3,847, an increase of eight patients compared to the position as at 28 February 2022.
- The number of people waiting 18 weeks or more to be seen by our Podiatry service increased to 1,822 patients, from 1,743 as at 28 February 2022. The Podiatry service continues to have significant levels of vacancies, which is a national issue.
- Our Somerset and Dorset dental service had 1,692 patients waiting 18 weeks or more to be seen, down from 1,741 as at 28 February 2022 (Somerset: 1,514 patients, down from 1,531 and Dorset: 178 patients, down from 210).
- The recent increases in the number of patients recorded within 'Others' relate mainly to our MSK Physiotherapy service, in respect of which patients waiting 18 weeks or more decreased to 151 as at 31 March 2022, from 235 as at 28 February 2022. The recent growth in numbers was primarily due to increased referral levels, sickness absence, and vacancies.

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 service has developed new triage pathways and adapted the referral form to enable more clinically-driven decision making for the identification of urgent patients. New appointments to the team have recently been made but there remain ongoing challenges to recruit additional podiatrists.
- Air exchange units now installed in various dental clinics should significantly reduce the fallow time between appointments. Work is ongoing to improve the efficiency of these units.
- The MSK Physiotherapy service continues to develop a waiting list initiative plan to manage increases in referrals, and also plans to address vacancies and long-term sickness levels.

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 March 2022 increased by eight when compared to 28 February 2022.

Recent performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number waiting	3,123	3,284	3,699	3,749	3,839	3,847

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).

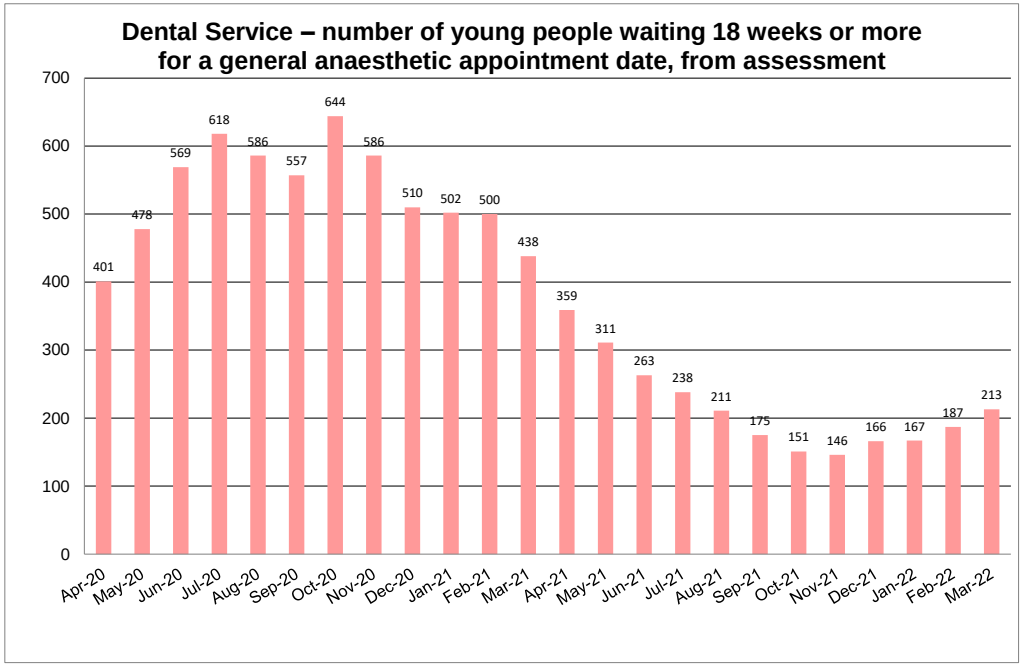
Current performance (including factors affecting this)

- As at 31 March 2022, 213 young people had waited 18 weeks or more for an appointment date, an increase of 26 on the previous month.
- Of the 213 patients waiting, 191 related to our Dorset service (up from 173 as at 28 February 2022), and 22 related to our Somerset service (up from 14 as at 28 February 2022).
- Earlier pandemic protocols had a significant impact on the waiting times and numbers waiting.
- During March 2022 there was also an increase in the number of theatre sessions cancelled by the hospitals due to staff sickness in both counties, which impacted on the waiting lists.
- The first wave of children who tested positive with COVID-19 and who have passed at least 90 days following a positive test are now also being rebooked. This will impact on the waiting list but the effect should start to reduce as the consistency of the GA theatre sessions improves.

Focus of improvement work

- Additional ad hoc lists continue to be sourced wherever possible.
- All children waiting more than 18 weeks for a GA appointment continue to be clinically reviewed prior to their appointment, as dental needs may have changed during the time they have been waiting.
- The number of children per list has been increased to five where possible and further work is being undertaken to review capacity challenges.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 March 2022 increased by 26 compared to 28 February 2022.

Recent Performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number waiting	151	146	166	167	187	213
% > 18 weeks	52.4%	46.5%	48.4%	46.5%	44.3%	45.0%

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.

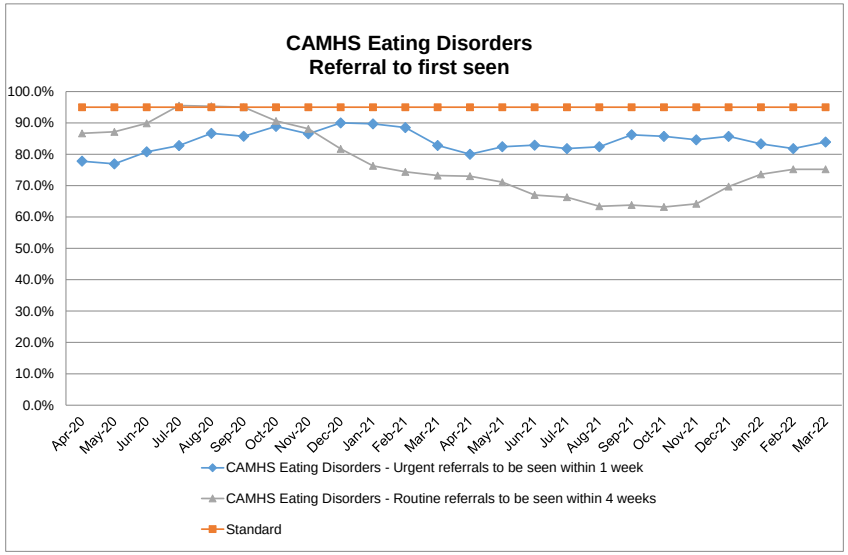
Current performance (including factors affecting this)

- Between 1 April 2021 and 31 March 2022, of 31 urgent referrals, five patients were seen outside of the seven day reporting standard.
- During March 2022, of two urgent referrals, one patient was seen eight days after referral. The delay was due to a shortfall of capacity within the service. As the monthly number of patients referred is low, with no further breaches, compliance with the 95% 12-month standard is predicted to be achieved by April 2023.
- For the period 1 April 2021 to 31 March 2022, of 113 routine referrals, a total of 28 patients were seen outside of the four week reporting standard.
- During March 2022, of 11 routine referrals, three patients were seen outside of the 28 day reporting standard. Two patients were seen 29 days after referral and the other 30 days after referral. As the monthly number of patients referred is low, with no further breaches, the 95% 12-month compliance standard is predicted to be achieved by November 2022.
- 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

- The service is working to recruit to roles that will soon become vacant due to resignations and maternity leave, although finding appropriately qualified candidates is a national issue.
- Referral pathways have been improved. A newly appointed Assistant Psychologist, to triage referrals and offer early advice, should also reduce waiting times.
- The service is still working up the new commissioned pilot Wessex Eating Disorder Association (SWEDA) as part of the pathway, to take on early intervention and low risk work, and to reduce referral numbers.

Line Chart



How do we compare

The latest national performance, reported as at 31 December 2021, was 59.0% for urgent referrals and 66.4% for routine referrals. Our performance was 85.7% and 69.7% respectively.

Performance over the last six months

Performance is based on a rolling 12 months.

Area	Oct	Nov	Dec	Jan	Feb	Mar
Urgent – patients seen within one week	85.7%	84.6%	85.7%	83.3%	81.8%	83.9%
Routine – patients seen within four weeks	63.2%	64.2%	69.7%	73.6%	75.2%	75.2%

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 March 2022, 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 integrated rehabilitation team (IRT).

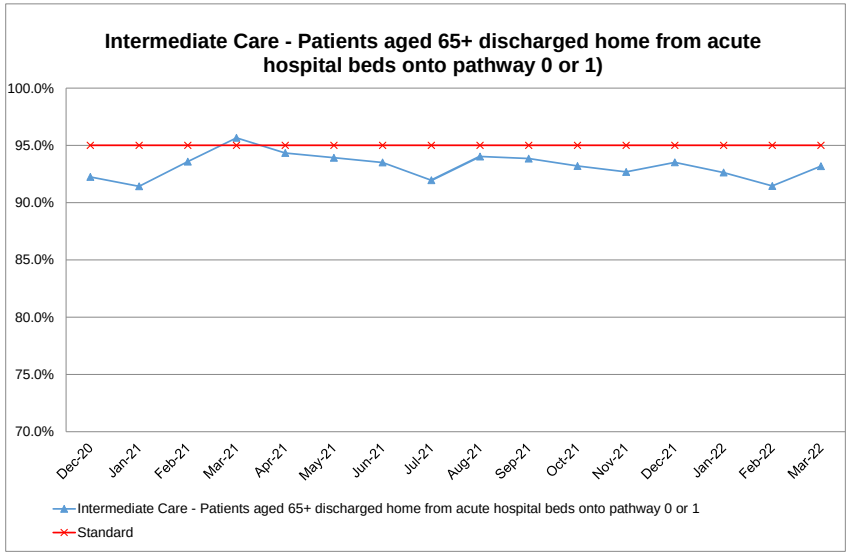
Pathway 1

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

- Capacity in Pathway 1 continues to be challenging. There are strategic workforce actions underway to improve D2A provider capacity, both in the short term and in the long term.
- Local solutions are in progress to mitigate the risks around reduced Pathway 1 provider (homecare) capacity, including:
  1. Permanent recruitment on NHS contracts – to supply to the Pathway 1 homecare sector.
  2. Temporary reassignment of NHS staff to Pathway 1 – this will end in May 2022.
  3. Temporary support from neighbourhood teams (limited to Monday to Friday).
  4. Bank enhancements for evenings and weekends.
  5. Pathway 1-supported bedded pathway.
- Strategic and regional action is being taken to address the difficulties in the domiciliary care market, including:
  1. An hourly pay increase, start up and retention bonus.
  2. Financial support to mitigate homecare business failure.
  3. Regional 'Proud to Care' recruitment campaign and fairs.

Line Chart



How do we compare

The percentage of patients aged 65 or more transferred onto pathway 0 or 1 increased during March 2022 compared to February 2022.

Performance over the last six months

Area	Oct	Nov	Dec	Jan	Feb	Mar
Total Discharges	2,543	2,473	2,605	2,305	2,269	2,495
Pathway 0	2,166	2,104	2,239	1,900	1,868	12,119
Pathway 1	204	188	197	235	207	206
% onto P0 or P1	93.2%	92.7%	93.5%	92.6%	91.4%	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.

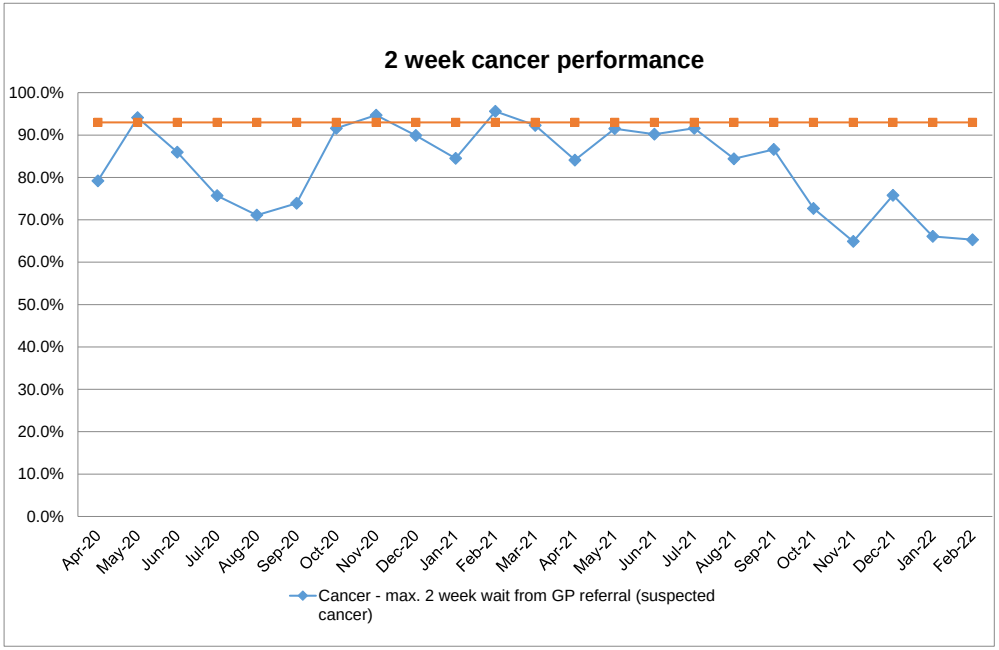
Current performance (including factors affecting this)

- The percentage of patients seen within 14 days of referral by their GP for a suspected cancer was 65.3% in February 2022, below the 93% national standard and below the national average.
- Breast made up 64% of all the breaches of the two-week wait standard in February 2022. Referrals to the service have been exceptionally high, but have reduced slightly to 22% above 2019/20 levels. This, combined with changes to service capacity due to a recent departure, has limited the ability of the service to meet the higher level of demand.
- Colorectal made up a further 24% of two-week wait breaches. A new Faster Diagnosis team is in place and trained to triage referrals, and waiting times are reducing. The referral hub, as described below, is also helping to reduce pathway delays.
- The breast symptomatic (cancer not suspected) 93% two-week wait standard was not achieved in February 2022, with performance of 8.1% and 34 breaches, 32 due to capacity problems described above.

Focus of improvement work

- A review of the breast service capacity and demand has been undertaken, and a recovery plan is being enacted including some support being provided by the Yeovil District hospital service. Full recovery will take a few months due to the need for recruitment to posts, however waits have started to reduce.
- A successful bid was submitted to the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance to establish a primary care referral hub for colorectal, hosted by the Trust. The hub is now operational and is ensuring that Faecal Immunochemical Testing (FIT) and blood tests are undertaken prior to referrals for suspected cancer being then made to secondary care. This will improve the quality of referrals and will also speed up the triage and diagnostic pathway post referral.

Line Chart



How do we compare

National average performance in February 2022, the latest data available, was 80.7%. Our performance was 65.3%. We were ranked 122 out of 131 providers.

Recent Performance

Area	Sept	Oct	Nov	Dec	Jan	Feb
% seen in 2 weeks	86.6%	72.7%	64.9%	75.8%	66.1%	65.3%
Patient choice breaches	57	75	60	77	79	61
Other breaches (including capacity, delayed blood tests)	86	229	372	188	229	287

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.

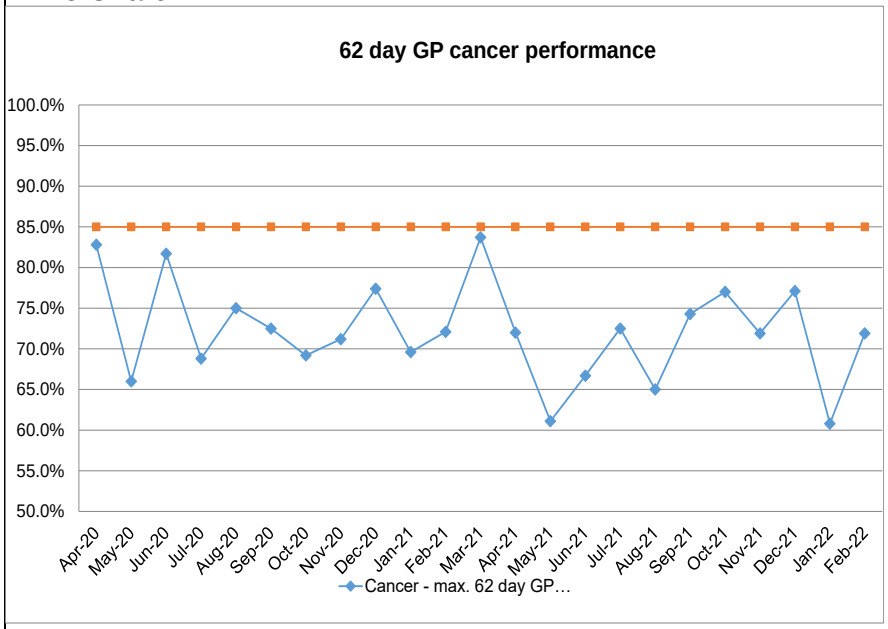
Current performance (including factors affecting this)

- The percentage of cancer patients treated within 62 days of referral by their GP was 72.3% in February 2022, below the national compliance standard but above the national average.
- Colorectal cancer patients made up 24% of the breaches of the 62-day standard in the month, and urology patients a further 22%.
- Ten patients were treated in February 2022 on or after day 104 (the national 'backstop'). Nine were assessed as having unavoidable delays. Five patients had complex diagnostic pathways requiring additional tests or Multi-Disciplinary Team discussions, or transfer between tumour sites. Three patient pathways, although had some internal delays, were further delayed due to the need for additional tests which took longer than ideal at another provider. One patient pathway was delayed because of the patient's lack of fitness. One patient chose to wait longer. One patient pathway had small potentially avoidable delays in their pathway which contributed to an overall longer wait.
- The number of patients waiting over 62 days at the end of March 2022 is slightly worse than the recovery trajectory (84 against a plan of 82).

Focus of improvement work

- A review has been undertaken of the colorectal pathway and a working group is meeting weekly to design and implement pathway interventions. This redesign work has started to increase the number of patients receiving a diagnosis within 28 days. This will reduce future 62-day GP breaches.
- A one-stop outpatient/MRI pathway is being piloted for the prostate cancer pathway, with plans being developed for roll-out.
- A direct GP access referral form for urgent gastroscopies is being piloted, to help speed up the upper GI cancer pathway.
- Artificial Intelligence based reporting continues to be piloted for immediately identifying potential lung abnormalities on chest x-rays. This will speed up the diagnosis of lung cancers.

Line Chart



How do we compare

National average performance for providers was 62.1% in February 2022, the latest data available. Our performance was 72.3%. We ranked 47 out of 142 providers.

Recent performance

62-day GP cancer performance

Area	Sep	Oct	Nov	Dec	Jan	Feb
Compliance	74.3%	77.0%	71.9%	77.1%	60.8%	72.3%

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.

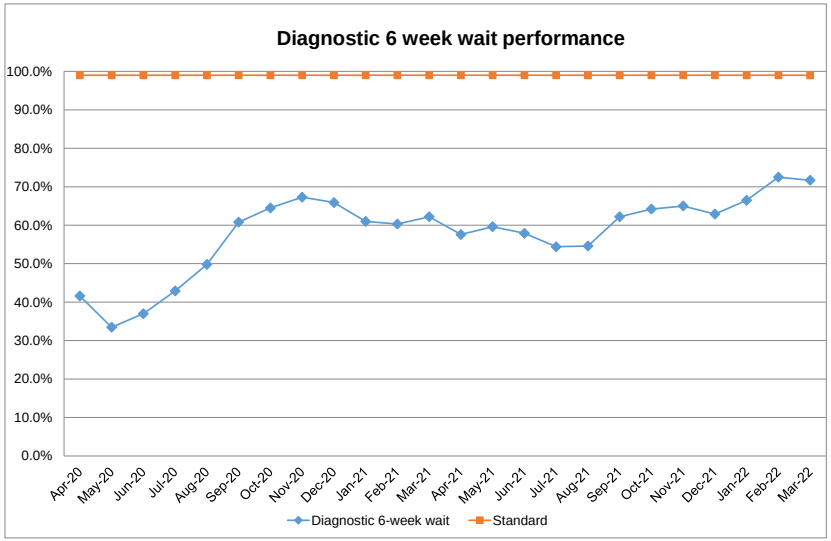
Current performance (including factors affecting this)

- The percentage of patients waiting under six weeks for their diagnostic test decreased slightly, from 72.5% in February 2022 to 71.7% in March 2022.
- This slight deterioration in performance in the month was a direct result of capacity lost due to COVID-related staff sickness.
- The number of patients waiting over six weeks increased from 1,953 in February 2022 to 2,142 in March 2022; the highest numbers of patients were waiting for an echo (increased from 1,408 to 1,559) followed by MRI (reduced from 226 to 165), together making up 80% of the long waiters.
- The total waiting list size increased from 7,113 in February 2022 to 7,574 in March 2022, with the increases mainly in echo and ultrasound.
- The backlog of echo scans is due to a prolonged period of capacity levels being significantly lower than demand during 2021, due to staff departures and long-term sickness within the team.

Focus of improvement work

- The Rutherford Diagnostic Centre opened in September 2021, providing additional static CT and MRI scanners. A further MRI scanner is now operational. The vans previously leased from Rutherford have been retained for use within the county.
- 3.0 WTE echo physiologists were appointed and started in November 2021 following a refreshed recruitment campaign in Spring last year. A further 2.4 WTE were also appointed but withdrew. One person has returned from maternity leave and another from long-term sick leave. A further recruitment round has recently concluded with an internal trainee appointed. A further round of recruitment will commence in the next couple of months, with the aim of appointing two further members of the team. An insourcing provider continues to provide additional capacity and this capacity is due to increase significantly from June 2022. The Rutherford Diagnostic Centre will be providing some physical capacity for the service during 2022/23.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 75.1% in February 2022. Our performance was 72.5%. We were ranked 114 out of 162 trusts for the 15 high volume diagnostic tests. For endoscopy procedures the Trust has recovered more quickly, ranking 55 out of 129 providers for the percentage waiting under six weeks for a colonoscopy, 56 out of 129 for flexi sigmoidoscopy and 64 out of 129 for a gastroscopy.

Recent performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
Actual	64.2%	65.0%	62.9%	66.5%	72.5%	71.7%

Responsive

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

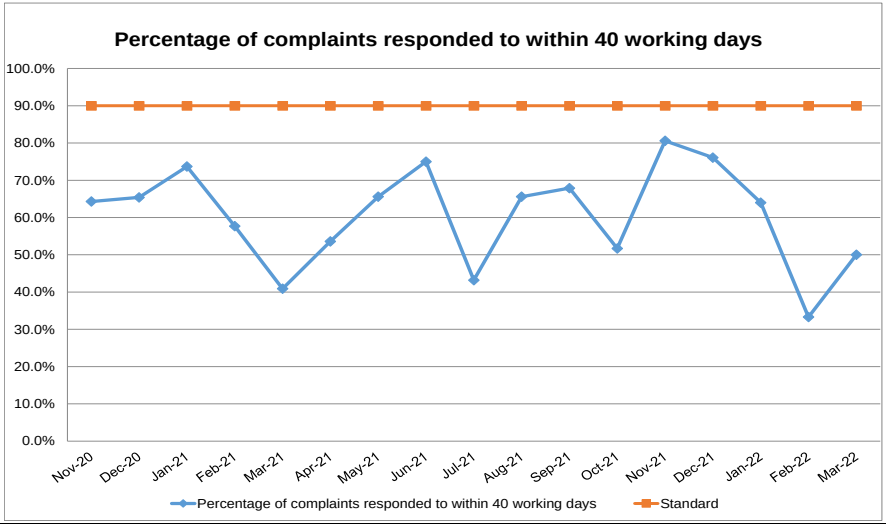
Current performance (including factors affecting this)

- Of 34 complaints responded to during March 2022, a total of 17 (50.0%) were responded to within the 40 working day standard, up from 33.3% (3/9 complaints) in February 2022.
- The 34 complaints closed was a significant increase on nine closed during February 2022.
- Delays occurred due to a combination of reasons including:
  - Ongoing challenges for staff to investigate and respond to complaints with continued effects associated with the pandemic and extreme pressures across all services.
  - Increasingly complex complaints involving multiple teams and directorates.
  - The availability of paper medical notes when multiple teams are involved across directorates.
  - Delays in investigations or holding meetings due to an increase in COVID-related staff sickness.

Focus of improvement work.

- Complaints workshops will recommence as soon as possible, to support the improvement in the quality of complaint responses.
- The appointment of a joint Head of Patient Experience, with a plan for a review of the complaints process with colleagues from Yeovil District Hospital NHS Foundation Trust, as part of integration work.
- There are monthly complaints updates at the Serious Incident Review Group (SIRG), highlighting any response delays and complaint response quality issues.
- The PALS and Complaints information session (presentation) continues to be included in the induction programme for all new staff, including consultants and medical students.
- Complainants who are awaiting late complaint responses are kept updated.
- The Complaints Lead meets regularly with the Directorate Co-ordinators for updates, confirming that investigations are progressing, and addressing any queries.
- Development of the RADAR risk management system continues, including input from the Associate Directors of Patient Care, to ensure we are using the system to its fullest potential.

Line Chart



How do we compare

During March 2022 the percentage of complaints responded to within 40 working days increased compared to February 2022.

Recent Performance

Our performance in recent months is as follows:

Area	Oct	Nov	Dec	Jan	Feb	Mar
% within 40 working days	51.7%	80.6%	76.1%	64.0%	33.3%	50.0%

Complaints open:

Directorate	Within date	Late	Total
Surgery	13	17	30
Integrated	26	8	34
Families	12	0	12
Mental Health	11	0	11
Primary Care	3	2	5
Clinical Support	1	3	4
Centrally Coordinated	0	0	0
Totals:	**66**	**30**	**96**

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.

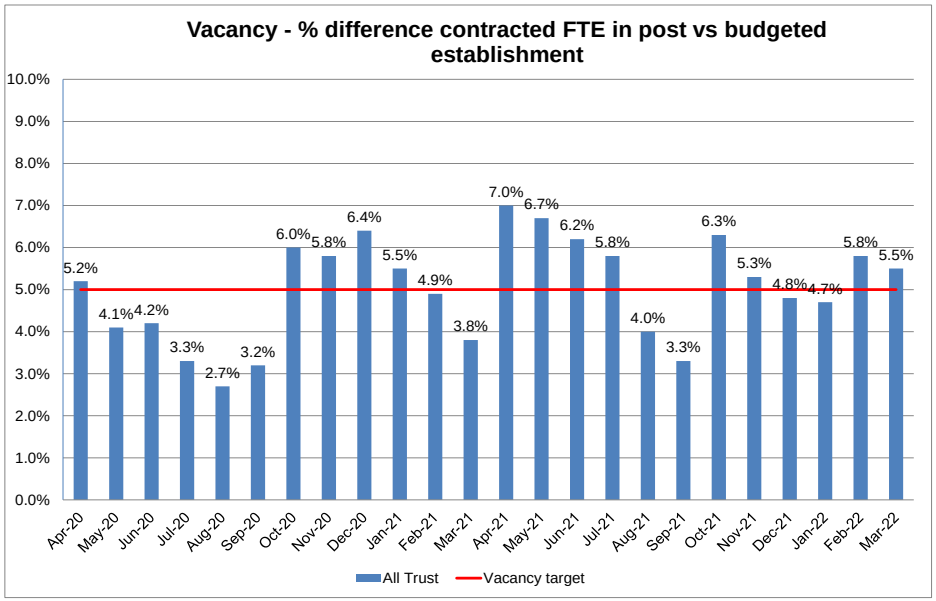
Current performance (including factors affecting this)

- The vacancy rate as at 31 March 2022 decreased to 5.5%, from 5.8% as at 28 February 2022.
- The vacancy rates have been influenced by additional funding made available in respect of the Urgent Care Hub, Intermediate Care capacity, and Children and Young People's services, including the Eating Disorders service.

Focus of improvement work

- Increases in funding are allocated to service budgets prior to recruitment taking place. This difference in timing between the allocation of funding and new team members being appointed into post gives rise to the increase in the reported vacancy rate.
- We continue to undertake a range of proactive measures to recruit colleagues across all service areas.

Run Chart



How do we compare

The reported vacancy rate reduced as at 31 March 2022 compared to 28 February 2022.

Recent performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy rate	6.3%	5.3%	4.8%	4.7%	5.8%	5.5%

Well Led

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

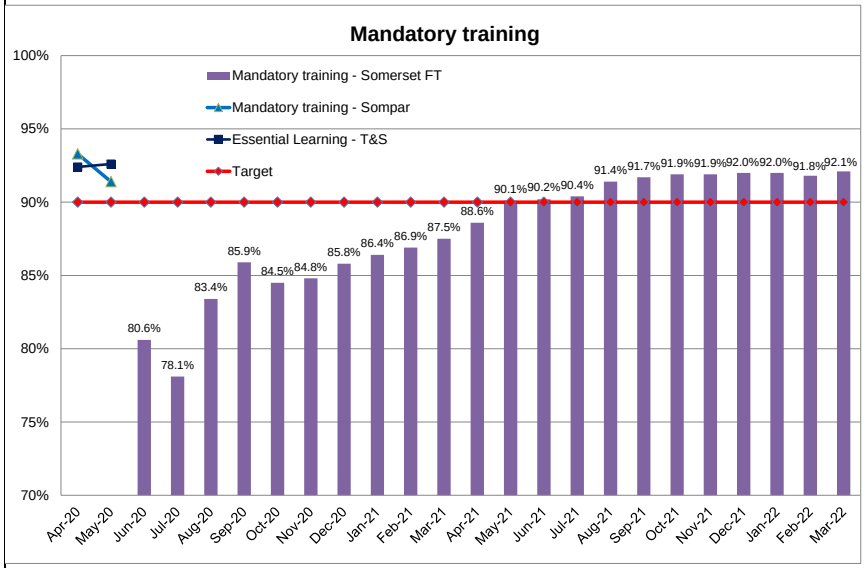
Current performance (including factors affecting this)

- As at 31 March 2022, our overall mandatory training rate was 92.1%, up by 0.3% on the rate as at 28 February 2022.
- Training continues to be affected by the Resuscitation team staffing position. Work with the Yeovil District Hospital Resuscitation team has resulted in a joint appointment to lead the service and an interim medical lead to support and help to reset the team. Modelling for renewal dates continues to be affected by staffing availability, due to short term absence, coupled with low attendance rates on booked training.
- To be compliant, all ten core training subjects must have compliance rates above 90%. Currently, face to face delivery courses for Life Support are problematic, with a static position for other areas such as Preventing & Managing Violence and Aggression Modules 3 and 4, and a slight improvement in Safeguarding level 3. Accommodation restrictions and capacity continue to affect our ability to expand training.

Focus of improvement work

- We continue to assess the recovery of compliance rates where the renewal periods were extended. Staffing pressures continue to affect attendance at planned training, impacting on compliance, and creating issues for accurately establishing the remodelling – failure to attend rates remain over 45% for most face to face courses.
- Life support training continues to be offered across this Trust and Yeovil District Hospital, to offer maximum opportunities for flexible attendance.
- Maintaining re-modelling audits to ascertain a point at which compliance re-stabilises and we can recommend a return to original renewal requirements for life support and safeguarding.
- Reports continue to enable managers to identify and follow up with colleagues where a significant number of courses need to be completed. Directorates receive tailored reports via their People Business Partners to help identify areas of concern.

Run Chart



How do we compare

The compliance rate as at 31 March 2022 was 0.3% higher than the rate as at 28 February 2022.

Recent Performance

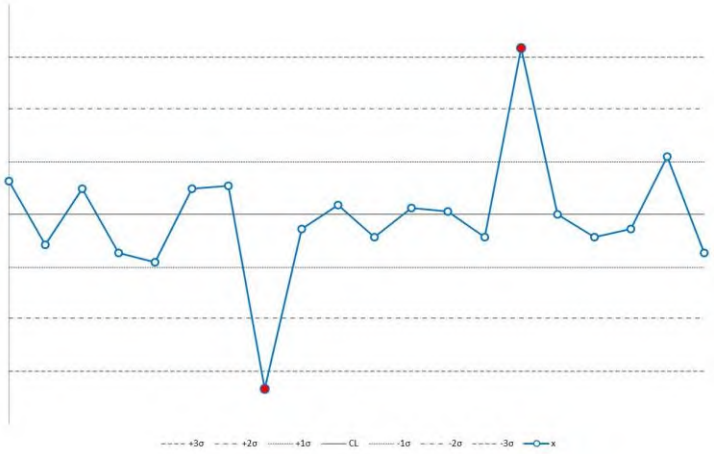
The overall month-end compliance rates for mandatory training in recent months are set out below:

Area	Oct	Nov	Dec	Jan	Feb	Mar
Compliance %	91.9%	91.9%	92.0%	92.0%	91.8%	92.1%

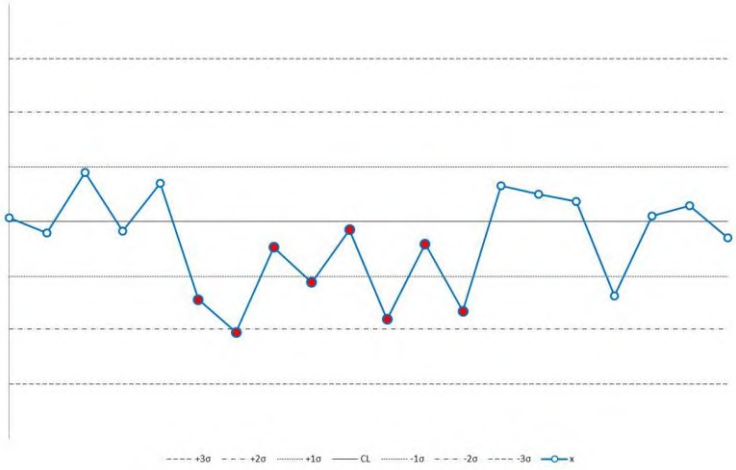
Appendix 1 - Procedure for Interpreting Run Charts

Special Cause Variation Rules

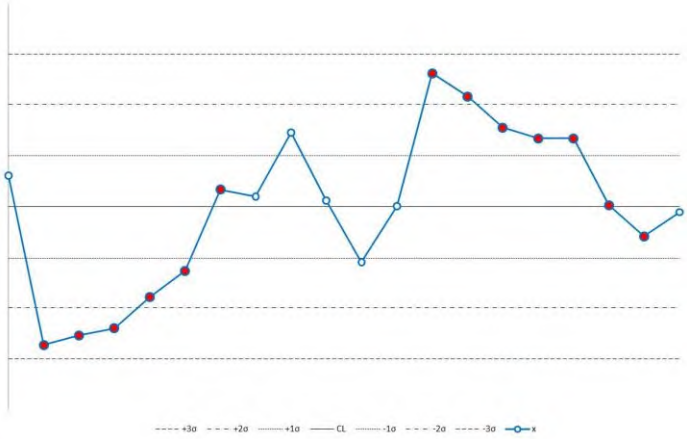
1. A single point outside the control limits



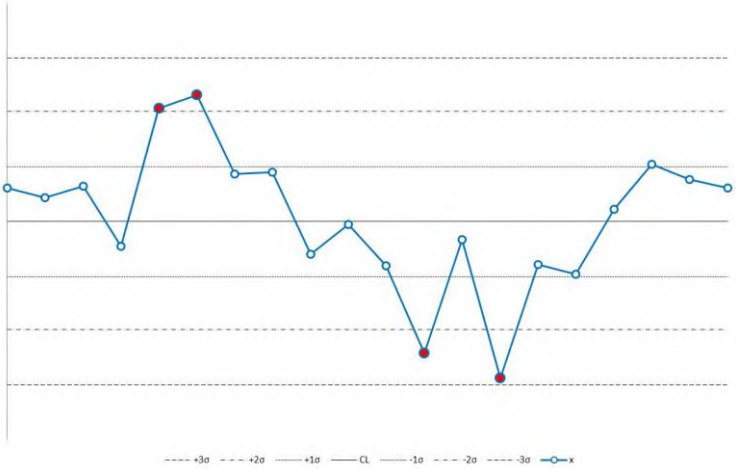
2. A run of eight or more points in a row above (or below) the centreline



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

CARE QUALITY COMMISSION RATINGS FOR OUR PREDECESSOR ORGANISATIONS

Our current Care Quality Commission ratings are as follows:

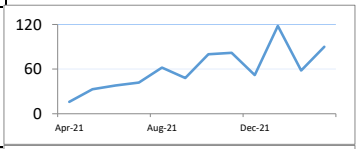
	Somerset Partnership NHS Foundation Trust	Taunton and Somerset NHS Foundation Trust
Overall rating for the Trust	**Good**	**Good**

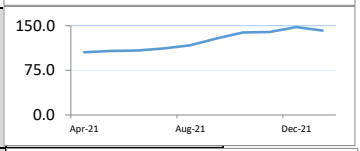
Are services safe?	**Requires improvement**	**Requires improvement**
Are services effective?	**Good**	**Good**
Are services caring?	**Good**	**Outstanding**
Are services responsive?	**Good**	**Good**
Are services well led?	**Good**	**Good**

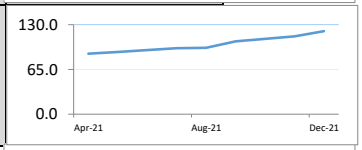
SOMERSET NHS FOUNDATION TRUST

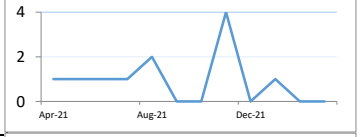
QUALITY MEASURES - 2021/22

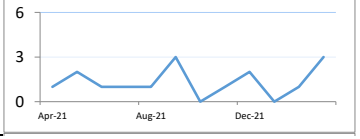
Area	Ref	Measure		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Admissions	1	Number of medical outliers in acute wards		Reporting suspended during the pandemic											
	2	Admissions of under 16 year olds to adult mental health wards		0	0	0	0	0	0	0	0	0	0	0	0
	3	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		16	33	38	42	62	48	80	82	52	118	58	90
Mortality (acute services)	6	Hospital Standardised Mortality Ratio (HSMR)		105.4	107.5	108.1	111.7	117.0	128.7	138.62	139.49	147.65	141.78	February 2022 to be reported after March 2022	
	7	Summary Hospital-level Mortality Indicator (SHMI)		87.9	90.4	93.0	95.7	96.3	105.69	109.29	113.13	120.59	January 2022 to be reported after March 2022		
Incident reporting	8	No of Serious Incidents Requiring Investigation (SIRIs)/Never Events - acute services		1	1	1	1	2	0	0	4	0	1	0	0
	9	Number of recorded Serious Incidents Requiring Investigation - community and mental health services		1	2	1	1	1	3	0	1	2	0	1	3





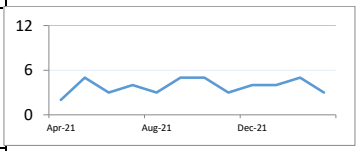
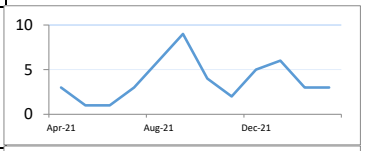
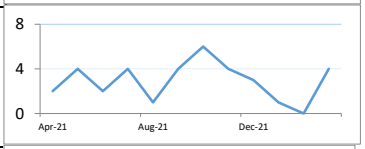
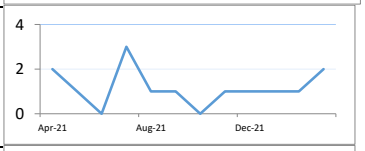
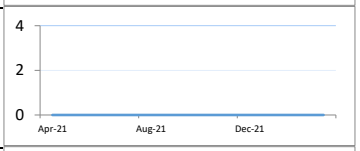
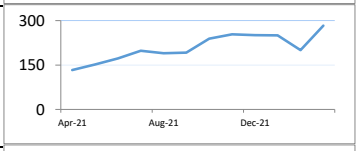
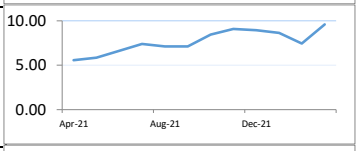
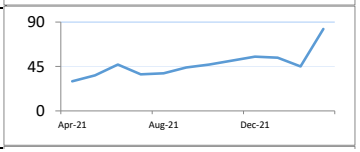






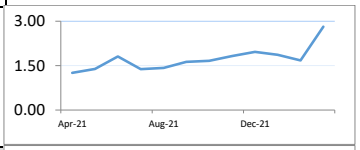
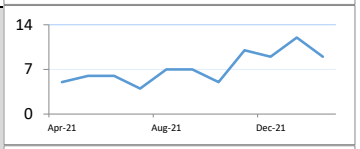
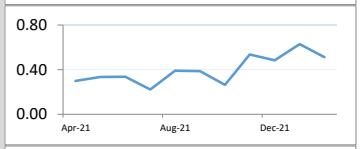
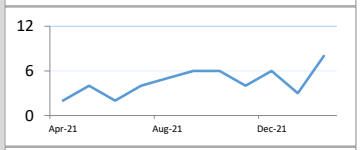
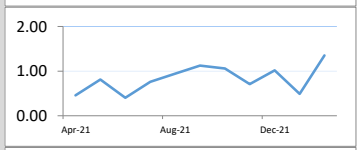
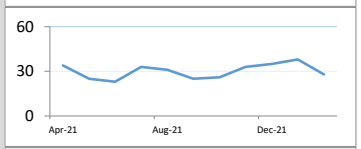
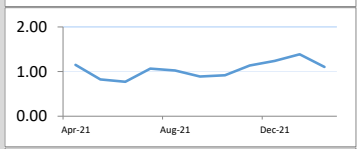
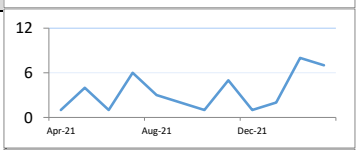
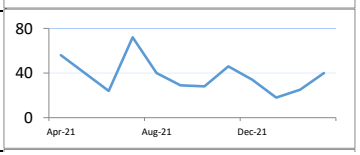
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2021/22

Area	Ref	Measure	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
Infection Control	10	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)	2	5	3	4	3	5	5	3	4	4	5	3	
Infection Control (acute services)	11	MRSA bacteraemias (post)	1	0	0	0	0	1	0	0	1	1	0	0	
	12	E. coli bacteraemia	3	1	1	3	6	9	4	2	5	6	3	3	
	13	Methicillin-sensitive staphylococcus aureus	2	4	2	4	1	4	6	4	3	1	0	4	
Maternity	14	No. of still births	2	1	0	3	1	1	0	1	1	1	1	2	
	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	133	152	172	198	190	192	239	254	251	250	200	283	
	17	Rate of falls per 1,000 occupied bed days - all services	5.57	5.86	6.62	7.40	7.11	7.11	8.46	9.08	8.95	8.64	7.45	9.60	
	18	Number of falls resulting in harm - all services	30	36	47	37	38	44	47	51	55	54	45	83	

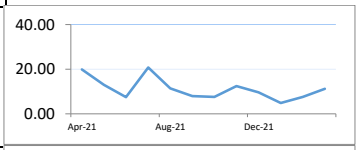
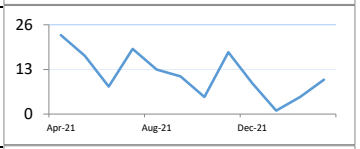
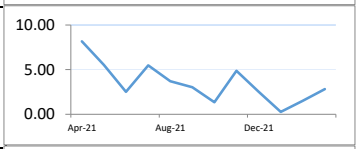
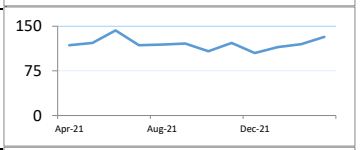
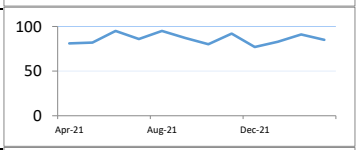
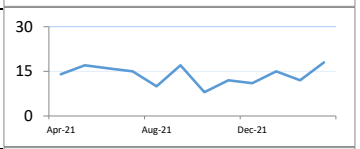
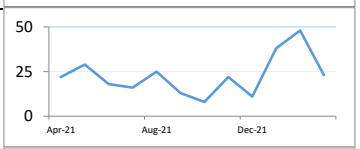
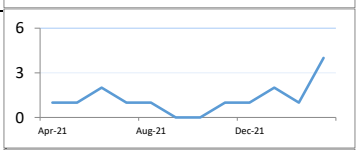
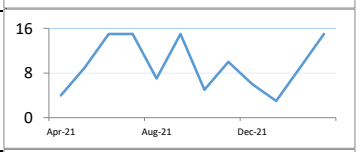
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2021/22

Area	Ref	Measure	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
Falls	19	Rate of falls resulting in harm per 1,000 occupied bed days - all services	1.26	1.39	1.81	1.38	1.42	1.63	1.66	1.82	1.96	1.87	1.68	2.81	
Pressure ulcer damage	20	Acute wards - number of incidents	5	6	6	4	7	7	5	10	9	12	9	Being validated	
	21	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	0.30	0.33	0.34	0.22	0.39	0.39	0.26	0.54	0.48	0.63	0.51		
	22	Community hospitals - number of incidents	2	4	2	4	5	6	6	4	6	3	8		
	23	Rate of pressure ulcer damage per 1,000 community hospital occupied bed days	0.46	0.81	0.40	0.76	0.94	1.13	1.06	0.71	1.02	0.49	1.35		
	24	District nursing - number of incidents	34	25	23	33	31	25	26	33	35	38	28		
	25	Rate of pressure ulcer damage per 1,000 district nursing contacts	1.15	0.83	0.77	1.07	1.03	0.89	0.92	1.13	1.24	1.39	1.10		
Cardiac Arrests	26	No. ward-based cardiac arrests - acute wards	1	4	1	6	3	2	1	5	1	2	8	7	
Restraints (mental health wards)	27	Total number of incidents	56	40	24	72	40	29	28	46	34	18	25	40	

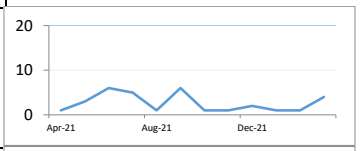
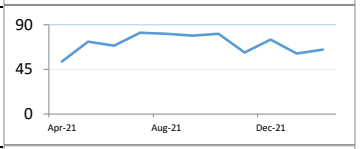
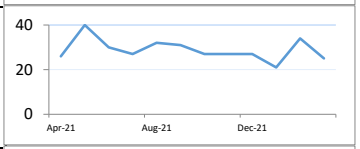
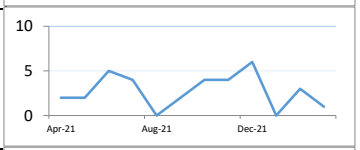
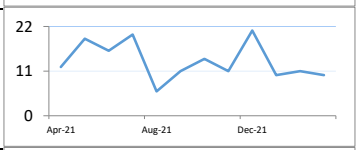
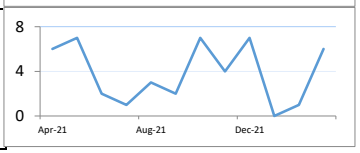
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2021/22

Area	Ref	Measure	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
Restraints (mental health wards)	28	Restraints per 1,000 occupied bed days	19.89	13.02	7.52	20.76	11.40	8.00	7.59	12.46	9.62	4.86	7.55	11.26	
	29	Number of prone restraints	23	17	8	19	13	11	5	18	9	1	5	10	
	30	Prone restraints per 1,000 occupied bed days	8.17	5.53	2.51	5.48	3.70	3.03	1.36	4.88	2.55	0.27	1.51	2.82	
Medication incidents - community and mental health wards	31	Total number of medication incidents	118	122	143	118	119	121	108	122	105	115	120	132	
	32	Medication incidents - drug errors	81	82	95	86	95	87	80	92	77	83	91	85	
	33	Medication incidents - incorrect storage	14	17	16	15	10	17	8	12	11	15	12	18	
Ligatures and ligature points - mental health wards	34	Ligatures: Total number of incidents	22	29	18	16	25	13	8	22	11	38	48	23	
	35	Number of ligature point incidents	1	1	2	1	1	0	0	1	1	2	1	4	
Aggression - d mental health rds	36	Violence and Aggression: Number of incidents patient on patient (inpatients only)	4	9	15	15	7	15	5	10	6	3	9	15	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2021/22

Area	Ref	Measure	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
Violence and community and wa	37	Violence and Aggression: Incidents resulting in harm - patient on patient (inpatient only)	1	3	6	5	1	6	1	1	2	1	1	4	
Violence and Aggression - community and mental health services	38	Violence and Aggression: Number of incidents patient on staff	53	73	69	82	81	79	81	62	75	61	65	65	
	39	Violence and Aggression: Incidents resulting in harm - patient on staff	26	40	30	27	32	31	27	27	27	21	34	25	
Unexpected deaths	40	Unexpected Deaths: Total number of incidents to be investigated - community and mental health services	2	2	5	4	0	2	4	4	6	0	3	1	
Seclusion - mental health wards	41	Number of Type 1 -Traditional Seclusion	12	19	16	20	6	11	14	11	21	10	11	10	
	42	Number of Type 2 -Short term Segregation	6	7	2	1	3	2	7	4	7	0	1	6	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2021/22

No.	Description		Links to corporate objectives	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Thresholds
1		Accident and Emergency department (ED)	4, 6, 9	81.5%	77.1%	71.0%	66.6%	59.9%	58.4%	53.9%	56.0%	57.2%	59.4%	56.9%	49.4%	
2	Accident and Emergency / Minor Injury Unit 4-hour performance	Minor Injury Units	4, 6, 9	99.1%	98.9%	98.4%	98.3%	99.0%	98.1%	98.8%	98.4%	99.3%	99.4%	98.9%	98.1%	>=95%= Green >=85% - <95% =Amber <85% =Red
3		Trust-wide	4, 6, 9	90.8%	88.5%	86.4%	84.3%	81.5%	80.6%	78.1%	78.9%	79.5%	80.5%	79.7%	76.8%	
4	Cancer - maximum 2-week wait from GP referral (suspected cancer)		3, 4, 9	84.1%	91.5%	90.2%	91.6%	84.4%	86.6%	72.7%	64.9%	75.8%	66.1%	65.3%	Data awaited	>=93%= Green <93% =Red
5	Cancer - 28 days Faster Diagnosis All Cancers		3, 4, 9	67.1%	71.6%	71.5%	70.0%	71.2%	71.8%	76.5%	75.1%	76.3%	70.3%	81.0%	Data awaited	>=75%= Green <75% =Red
6	Cancer - maximum 31 day wait from diagnosis to first treatment		3, 4, 9	94.1%	92.3%	95.9%	96.3%	96.8%	93.5%	98.2%	94.2%	96.2%	89.6%	98.4%	Data awaited	>=96%= Green <96% =Red
7	Cancer - maximum 62 day wait from urgent GP referral		3, 4, 9	72.0%	61.1%	66.7%	72.5%	65.3%	74.3%	77.0%	71.9%	77.1%	60.8%	72.3%	Data awaited	>=85%= Green <85% =Red
8	Cancer: 62-day wait from referral to treatment for urgent GP referrals – number of patients treated on or after day 104		3, 4, 9	6	10	8	7	7	10	9	5	7	12	10	Data awaited	0= Green >0 = Red
9	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week (rolling 12 months)		3, 4, 9	80.0%	82.4%	82.9%	81.8%	82.4%	86.2%	85.7%	84.6%	85.7%	83.3%	81.8%	83.9%	>=95%= Green >=85% - <95% =Amber <85% =Red
10	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks (rolling 12 months)		3, 4, 9	73.6%	71.1%	67.0%	66.3%	63.4%	63.8%	63.2%	64.2%	69.7%	73.6%	75.2%	75.2%	>=95%= Green >=85% - <95% =Amber <85% =Red
11		All mental health services	4, 6, 9	93.0%	87.4%	92.3%	94.5%	91.7%	93.1%	93.4%	93.3%	93.7%	90.6%	92.1%	93.4%	>=90%= Green >=80% - <90% =Amber <80% =Red
12		Adult mental health services	4, 6, 9	91.5%	88.0%	89.8%	93.6%	90.2%	90.0%	93.1%	93.8%	91.1%	87.4%	91.7%	90.3%	>=90%= Green >=80% - <90% =Amber <80% =Red
13	Mental health referrals offered first appointments within 6 weeks	Older Persons mental health services	4, 6, 9	87.3%	84.3%	93.3%	94.8%	92.9%	96.4%	92.5%	91.1%	94.7%	90.4%	90.4%	96.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
14		Learning disabilities service	4, 6, 9	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
15		Children and young people's mental health services	4, 6, 9	98.5%	98.6%	100.0%	97.7%	96.7%	97.3%	100.0%	97.0%	100.0%	98.5%	96.9%	96.8%	>=90%= Green >=80% - <90% =Amber <80% =Red
16	Diagnostic 6-week wait - acute services		4, 9	57.6%	59.6%	57.9%	54.2%	54.6%	62.2%	64.2%	65.0%	62.9%	66.5%	72.5%	71.7%	>=99%= Green >=98% - <99% =Amber <98% =Red
17	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		4, 6, 9	59.0%	63.3%	64.0%	63.9%	63.3%	63.0%	61.9%	61.9%	61.0%	60.3%	59.3%	59.0%	>=92%= Green <92% =Red
18	52 week RTT breaches		4, 6, 9	2,699	2,323	1,959	1,795	1,691	1,669	1,800	1,772	1,742	1,693	1,736	1,741	0= Green Lower than or equal to H2 plan = Amber Higher than H2 plan = Red
19	78 week RTT breaches		4, 6, 9	559	636	616	691	746	738	654	522	467	410	418	359	N/A
20	104 week RTT breaches		4, 6, 9	30	32	37	51	45	65	105	101	127	131	145	86	0= Green Lower than or equal to H2 plan = Amber Higher than H2 plan = Red
21	Referral to Treatment (RTT) incomplete pathway waiting list size		4, 6, 9	27,662	28,940	30,463	30,912	31,856	31,715	32,302	31,936	31,425	32,013	32,729	33,196	Lower than H2 plan = Green Higher than H2 plan = Red
22	Waiting times: number of people waiting over 18 weeks from referral to first appointment - community services including dental		4, 6, 9	2,057	2,186	2,235	2,465	2,505	2,658	3,123	3,284	3,699	3,749	3,839	3,847	< 82 patients (2017/18 outturn) = Green >=82 - <86 = Amber >86 = Red
23	Community dental services - Child GA waiters waiting 18 weeks or more		4, 6, 9	359	311	263	238	211	175	151	146	166	167	187	213	0 = Green >=0 - =<50 =Amber >50 =Red
24	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	82.8%	83.3%	88.9%	80.0%	50.0%	53.8%	71.4%	65.2%	65.2%	66.7%	78.6%	Data awaited	>=60%= Green <60% =Red
25	Improving Access to Psychological Therapies (IAPT) RTT : percentage of people waiting under 6 weeks		4, 6, 9	90.2%	89.7%	94.5%	90.8%	91.1%	91.2%	89.7%	86.7%	82.6%	75.9%	73.6%	62.3%	>=75%= Green <75% =Red
26	Improving Access to Psychological Therapies (IAPT) RTT: percentage of people waiting under 18 weeks		4, 6, 9	100.0%	98.5%	100.0%	100.0%	100.0%	100.0%	98.5%	99.7%	97.1%	98.7%	98.9%	97.9%	>=95%= Green <95% =Red
27	Improving Access to Psychological Therapies (IAPT) Recovery Rates		4, 7, 9	68.3%	60.2%	67.7%	61.3%	68.1%	59.6%	66.9%	60.5%	61.3%	64.0%	58.4%	55.8%	>=50%= Green <50% =Red
28	Percentage of patients on Care Programme Approach (CPA) Level 2 followed up within 7 days of discharge - all mental health services		4, 9	97.6%	100.0%	98.2%	97.9%	98.1%	100.0%	95.8%	97.7%	98.0%	100.0%	97.6%	100.0%	>=95% = Green <95% = Red
29	Inappropriate Out of Area Placements for non-specialist mental health inpatient care (monthly number of patient days)		4, 5, 9	0	0	11	31	3	0	41	59	5	28	17	7	0= Green >0 = Red
30	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1		4, 5, 9	94.3%	93.9%	93.5%	91.9%	94.0%	93.8%	93.2%	92.7%	93.5%	92.6%	91.4%	93.2%	>=95%= Green >=85% - <95% =Amber >85% =Red
31	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services		4, 9	100.0%	100.0%	94.0%	91.0%	100.0%	96.0%	96.0%	100.0%	95.0%	90.0%	90.0%	93.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
32	Percentage of emergency patients screened for sepsis - acute services		4, 9	91.0%			80.0%			81.2%			Reported quarterly			>=90%= Green >=49% - <90% =Amber <49% =Red
33	Percentage of patients receiving antibiotics within one hour of red flag diagnosis of sepsis - acute services		4, 9	72.7%			75.0%			92.9%						>=90%= Green >=49% - <90% =Amber <49% =Red
34	Percentage of patients with a NEWS of 5 or more acted upon appropriately - acute services		4, 9	New reporting			50.5%	62.4%	45.3%	59.2%	45.7%	50.3%	48.1%	61.1%	47.8%	TBC

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2021/22

No.	Description	Links to corporate objectives	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Thresholds
35	District nursing - cumulative increase / (reduction) in external referrals from 1 April 2021 to 31 March 2022 compared to same months of 2019/20	9	4.3%	2.6%	5.4%	3.9%	3.9%	1.7%	-0.6%	0.3%	1.1%	0.3%	-0.2%	0.3%	TBC
36	Percentage of complaints responded to within 40 working days - Trust-wide	9	53.6%	65.6%	75.0%	43.2%	65.6%	67.9%	51.7%	80.6%	76.1%	64.0%	33.3%	50.0%	>=90%= Green >=75% - <90% =Amber >75% =Red
37	Mandatory training: percentage completed	1, 8, 9	88.6%	90.1%	90.2%	90.4%	91.4%	91.7%	91.9%	91.9%	92.0%	92.0%	91.8%	92.1%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
38	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)	8, 9	7.0%	6.7%	6.2%	5.8%	4.0%	3.3%	6.3%	5.3%	4.8%	4.7%	5.8%	5.5%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
39	Sickness absence levels - rolling 12 month average (Trust-wide)	8, 9	4.5%	4.5%	4.5%	4.5%	4.6%	4.7%	4.7%	4.9%	5.0%	5.1%	Data awaited		<=4.6%= Green >4.6% to <=5.1% =Amber >5.1% =Red
40	Sickness absence levels - monthly average (Trust-wide)	8, 9	4.3%	4.4%	4.4%	4.9%	4.9%	5.5%	6.0%	5.8%	6.1%	6.4%			<=4.6%= Green >4.6% to <=5.1% =Amber >5.1% =Red
41	Reduce the number of working days lost due to stress and anxiety (Trust-wide)	8, 9	348	368	354	401	401	393	331	388	439	383			Monitored using Special Cause Variation Rules. Report by exception.
42	Retention / turnover rates (Trust-wide)	8, 9	10.1%	10.2%	10.3%	10.7%	10.4%	10.4%	10.4%	10.1%	9.6%	11.4%			<=12%= Green 12% to <15% =Amber >15% =Red
43	Career conversations (12 months) - formerly 'Performance review (12-month)'	8, 9	51.4%	48.0%	58.5%	43.6%	46.0%	45.0%	44.0%	50.4%	51.1%	51.1%	48.5%	Data awaited	Trajectory to be agreed

Appendix 5a – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in March 2022, 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.

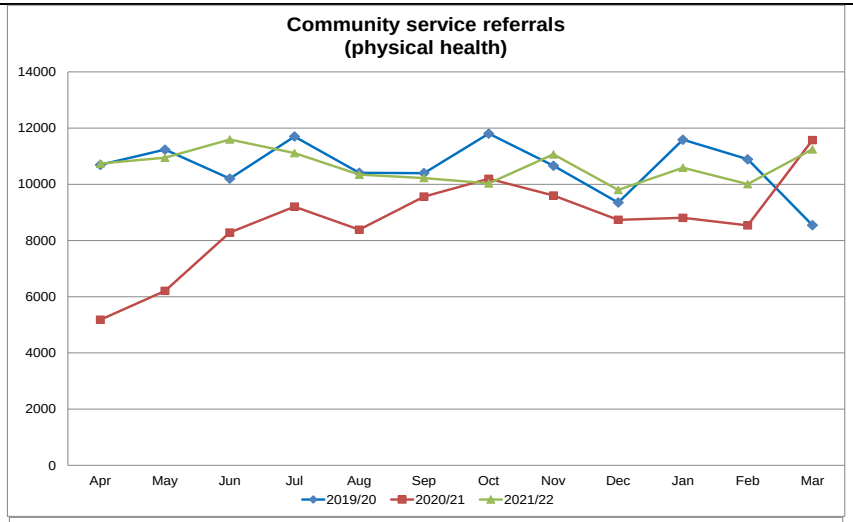
RTT specialty	Over 18 week waiters	Over 52 week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	316	95	529	40.3%
Urology	601	114	1596	62.3%
Trauma & Orthopaedics	1794	427	4755	40.6%
Ear, Nose & Throat (ENT)	1032	101	2594	60.2%
Ophthalmology	1824	167	3866	52.8%
Oral Surgery	835	86	2255	63.0%
Plastic Surgery	1	0	7	85.7%
Cardiothoracic Surgery	1	0	25	96.0%
General Medicine	2	0	6	66.7%
Gastroenterology	884	9	1884	53.1%
Cardiology	887	41	2343	62.1%
Dermatology	25	0	201	87.6%
Thoracic Medicine	253	1	950	73.4%
Neurology	302	2	837	63.9%
Rheumatology	351	29	634	44.6%
Geriatric Medicine	17	1	253	93.3%
Gynaecology	761	84	1972	61.4%
Other – Medical Services	600	30	1562	61.6%
Other - Paediatric Services	313	25	824	62.0%
Other - Surgical Services	2542	526	5371	52.7%
Other – Other Services	255	3	732	65.2%
Total	**13596**	**1741**	**33196**	**59.0%**

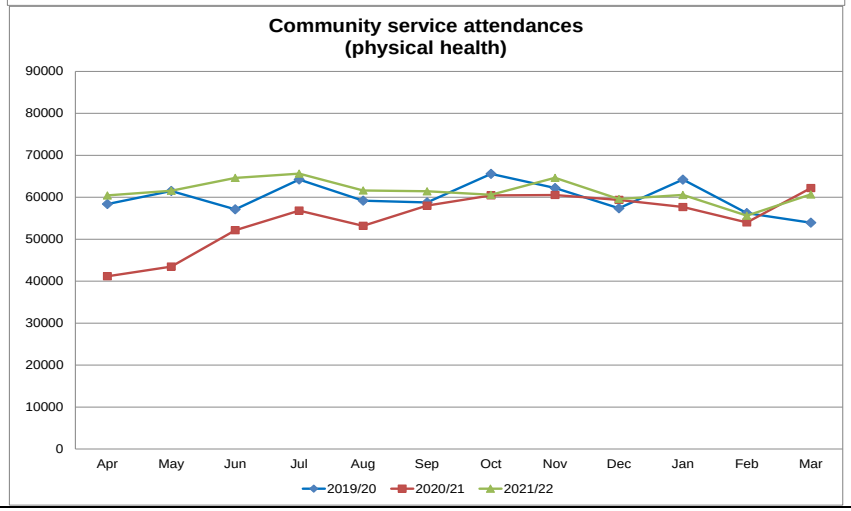
Table 2 – Performance against the 62-day GP cancer standard in February 2022.

Tumour site	No of breaches	Trust performance
Breast	3.0	76.5%
Colorectal	6.0	46.5%
Gynaecology	3.0	70.0%
Haematology	0.0	100%
Head & Neck	1.0	75.0%
Lung	2.0	81.0%
Other	0.0	100%
Skin	0.0	100%
Upper GI	4.0	50.0%
Urology	5.5	77.6%
Total	**24.5**	**72.3%**

Operational context

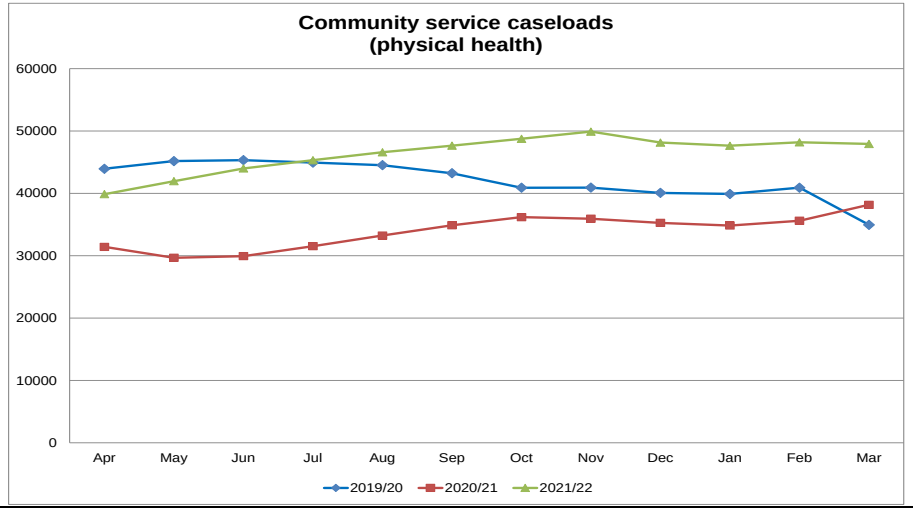
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





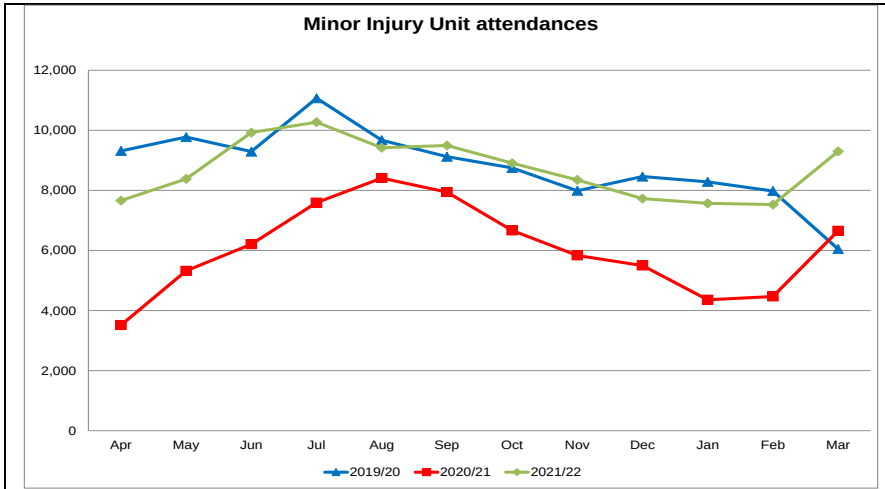
Summary:

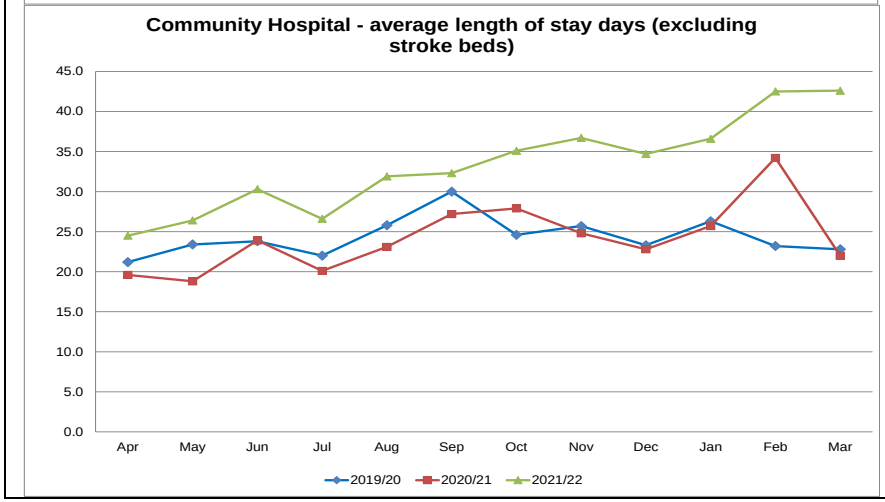
- Direct referrals to our community physical health services for the period 1 April 2021 to 31 March 2022 increased by 22.5% compared to the same months of 2020/21 and were 0.2% higher than the same months of 2019/20.
- Attendances during the same period increased by 11.8% when compared to the same months of 2020/21 and were 2.5% above levels seen during the same months in 2019/20.
- Community service caseload levels as at 31 March 2022 increased by 25.6% compared to 31 March 2021, and were 37.1% above 31 March 2020 levels.
- Increases are expected as COVID restrictions continue to ease.



Operational context

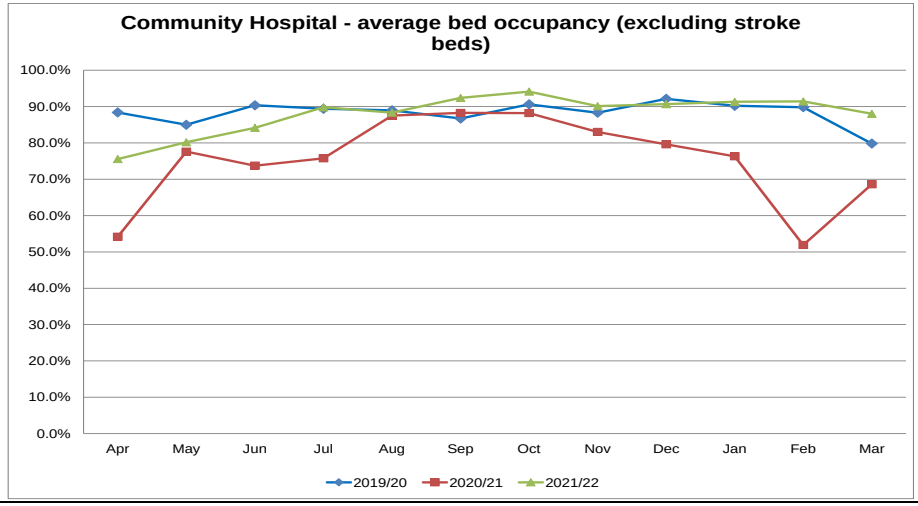
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





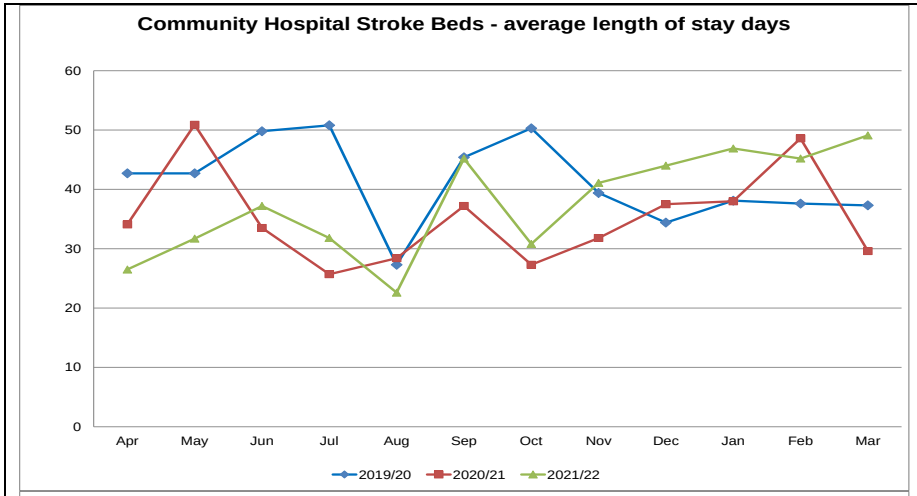
Summary:

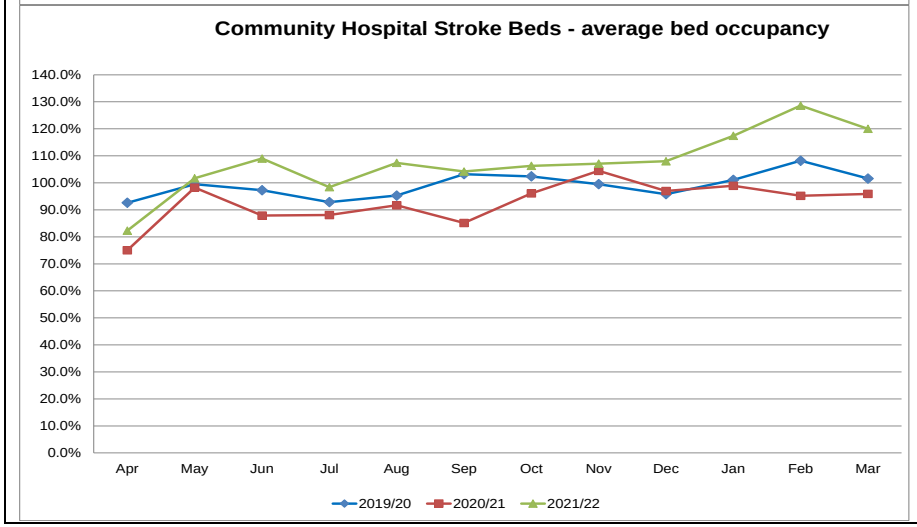
- Between 1 April 2021 and 31 March 2022, the number of Minor Injury Unit attendances was 44.2% higher than the same months of 2020/21 but 1.2% lower than the corresponding period in 2019/20. During March 2022, 98.1% of patients were discharged, admitted or transferred within four hours of attendance, against the national standard of 95%.
- The average length of stay for non-stroke patients in our community hospitals in March 2022 was 42.6 days, the highest over the whole reporting period. Eight patients with stays longer than 100 days were discharged in March 2022.
- The community hospital bed occupancy rate for non-stroke patients in March 2022 decreased below 90% for the first time since August 2021.



Operational context

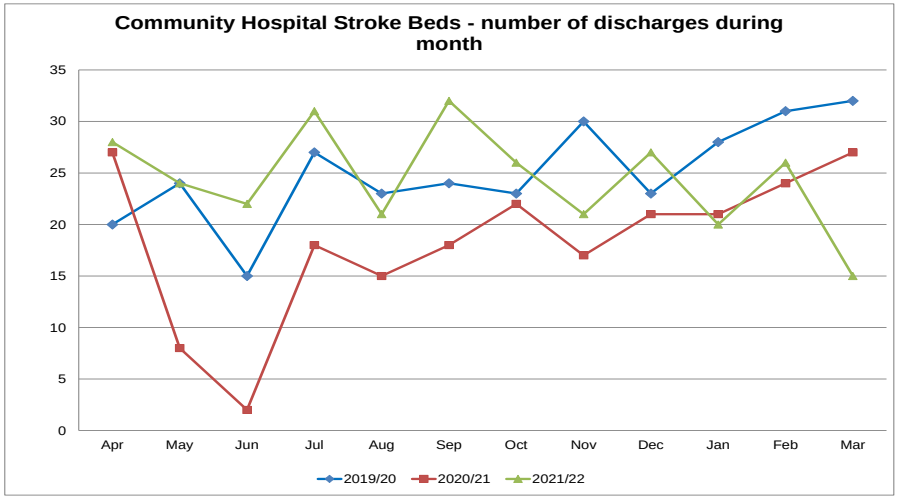
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





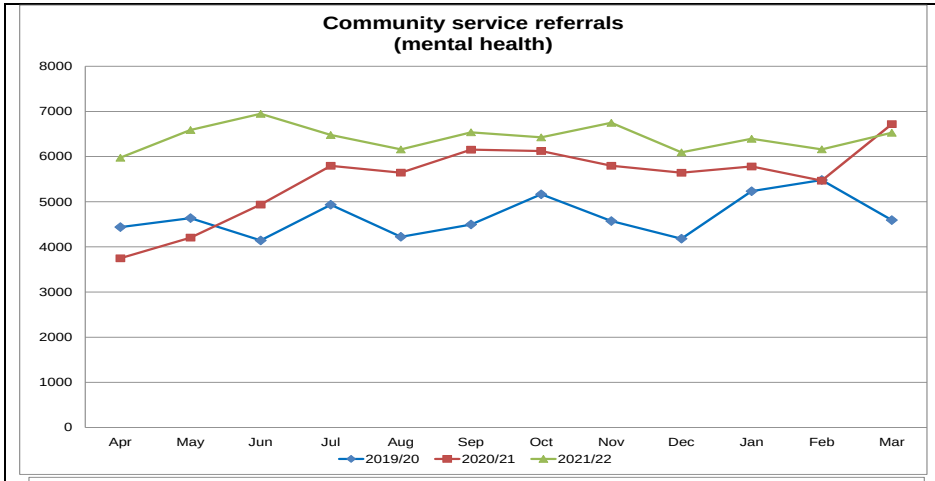
Summary:

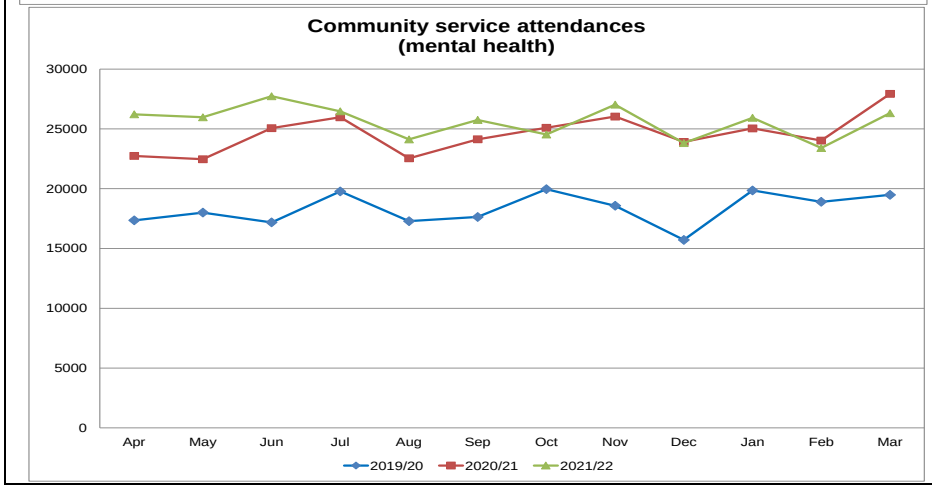
- The average length of stay for stroke patients in our community hospitals during March 2022 was 49.1 days, an increase compared to February 2022.
- Stroke bed occupancy for March 2022 decreased compared to February 2022 but was still 120.0% (i.e. above the number of commissioned stroke beds).
- During 2022 there were 15 discharges of stroke patients, down from 26 in February 2022.



Operational context

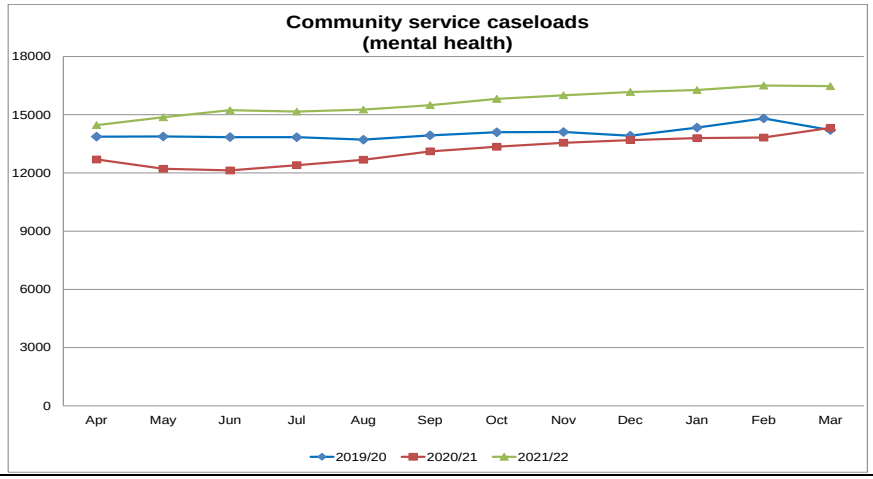
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





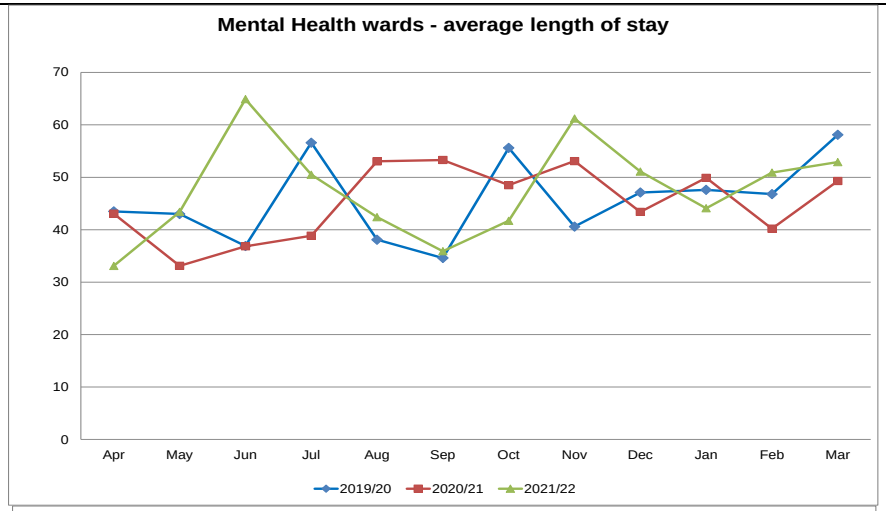
Summary:

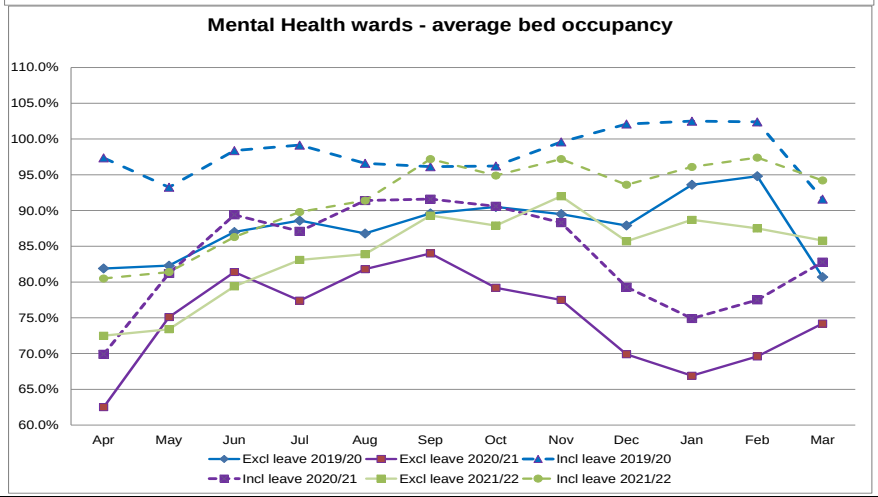
- For the period 1 April 2021 to 31 March 2022, referrals to our community mental health services were 16.7% higher than the same months of 2020/21 and were 37.3% higher than in 2019/20. Increases have occurred across a range of mental health services for adults, and children & young people.
- Attendances for the same period increased by 4.2% when compared to same months of 2020/21 and were 39.8% higher than same months of 2019/20.
- Community mental health service caseloads as at 31 March 2022 increased by 15.0% when compared to 31 March 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

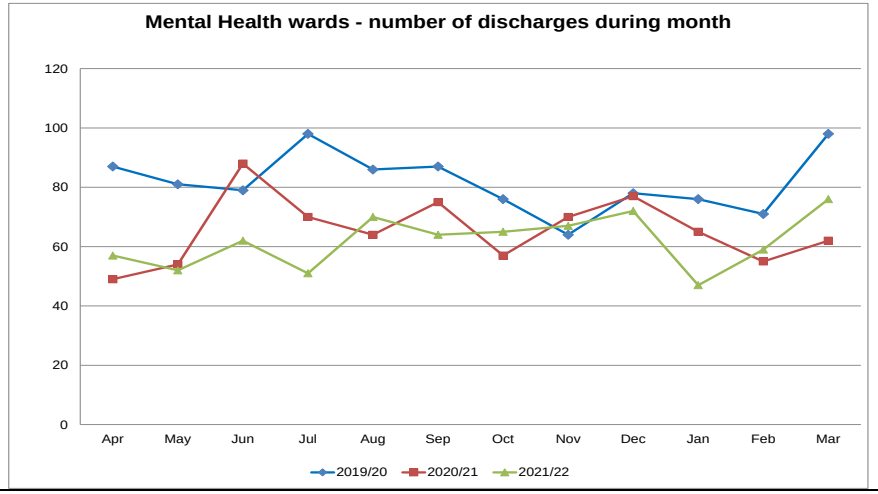
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





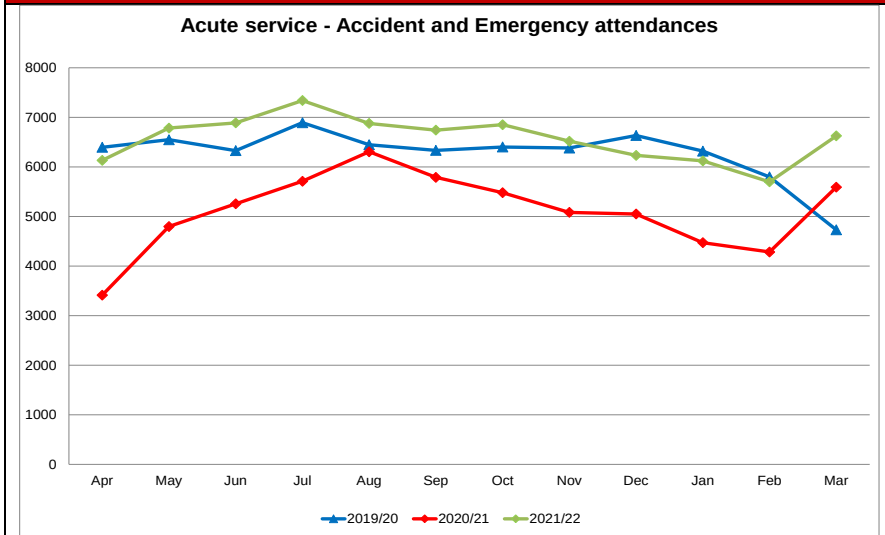
Summary:

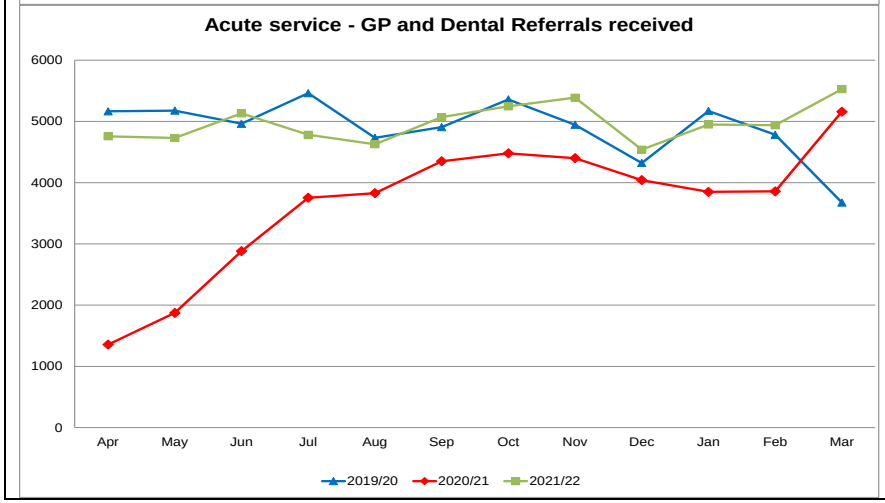
- The average length of stay in our mental health wards during March 2022 was 52.9 days, an increase compared to February 2022. Of 76 patients discharged during March 2022 a total of seven had lengths of stay totalling 100 days or more. One patient had a length of stay of 502 days.
- The mental health bed occupancy rate during March 2022, on the basis of both including and excluding leave decreased compared to February 2022.
- During 2022, a total of 76 patients were discharged, an increase compared to February 2022.



Operational context

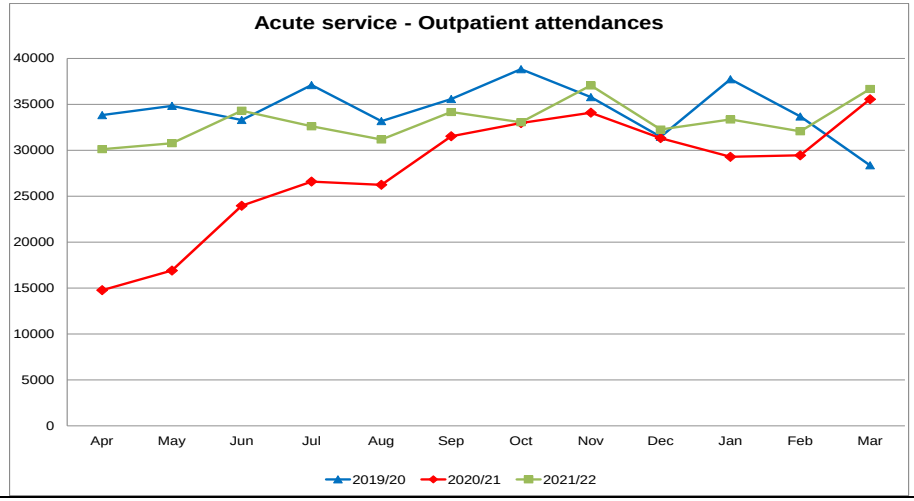
Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





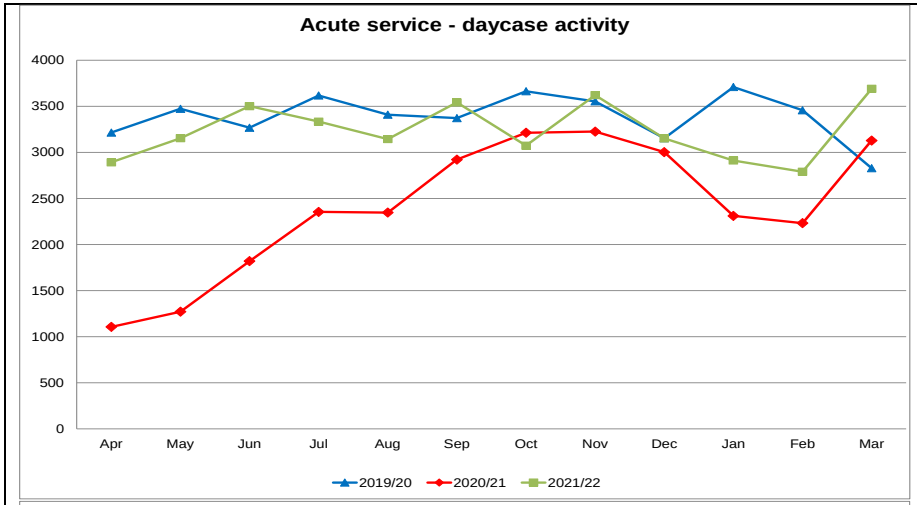
Summary:

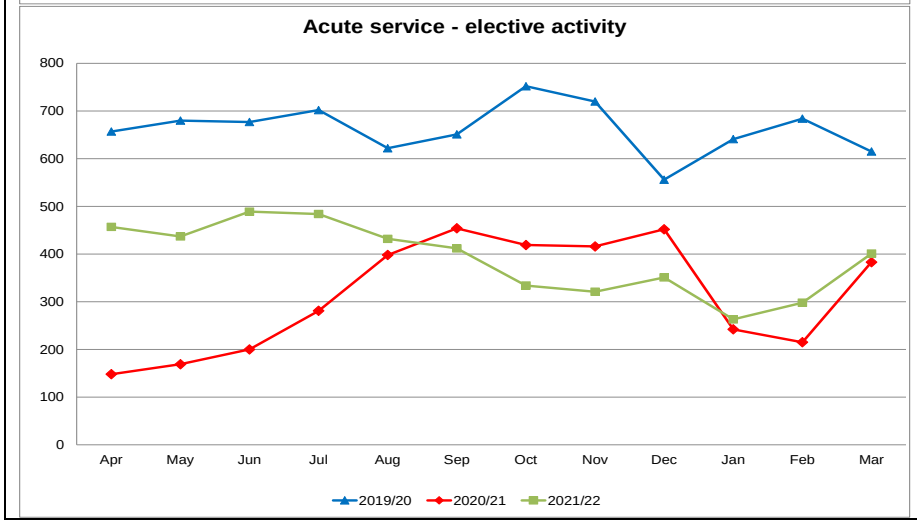
- Between 1 April 2021 and 31 March 2022, attendances to Accident and Emergency were 28.7% higher than the same months of 2020/21, and 4.8% higher than the same months of 2019/20. During March 2022, 49.4% of patients were discharged, admitted or transferred within four hours of attendance, against the national standard of 95%.
- GP and Dental referrals for the period 1 April 2021 to 31 March 2022 increased by 36.2% compared to the same months of 2020/21 and were 1.8% higher than 2019/20 levels.
- Outpatient attendances for the same period increased by 19.5% compared to the corresponding months of 2020/21 but were 3.9% lower than the same months of 2019/20.
- Increases are expected as COVID restrictions ease.



Operational context

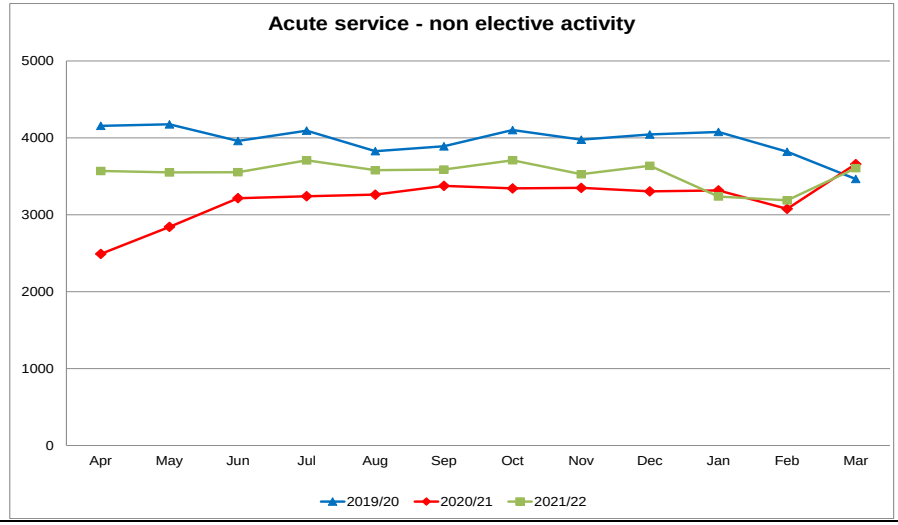
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior year.





Summary:

- The number of day cases undertaken by our acute services for the period 1 April 2021 to 31 March 2022 increased by 34.1% compared to the same months of 2020/21 but was 4.7% below 2019/20 levels.
- Elective admissions for the same period increased by 23.9% compared to the same months of 2020/21, although numbers from September to December 2021 were significantly below the same months of 2020 due to operational pressures experienced within Musgrove Park Hospital.
- Non elective admissions also increased, by 10.3% when compared to the same months of 2020/21, but again were below 2019/20 levels. Increases are expected as COVID restrictions and operational pressures continue to ease.



Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Yeovil District Hospital Finance Report – Month 12
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Corporate Accountant Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	3 May 2022

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)

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 12 - March 2022

Executive summary

For 2021/22 the YDH Group submitted a H1 (April '21 - September '21) plan, which includes central funding as part of the system contractual position. Other COVID monies outside of the system envelope are also available as a retrospective top-up payment. The planning process for H2 (October '21 - March '22) was completed with a breakeven plan submitted on 25 November 2021.

Year to date the Group reported a £0.254m surplus against a breakeven plan. The position is predominantly driven by the impact of ERF with additional unexpected funds being received in March, with pressures from additional escalation bed capacity offset by additional private patient income and other one off benefits compared with run rate. COVID costs have been increasing in the last few months in comparison to run rate and the core group plan but these are offset by the one-off benefits.

A total of £4.4m YTD of ERF monies have been earnt to offset the associated costs, in an effort for YDH to achieve this recovery trajectory. Plans continued to be in place throughout H2 with additional plans due to be implemented, however increasing pressure from COVID and staffing meant YDH did not achieve the activity in line with plan.

Activity levels have shown a general upward trend month on month. YTD activity is 4.3% lower than base 2019/20 levels, however associated indicative income is 0.5% lower, reflecting the increase in acuity the hospital is seeing. Elective recovery activity is included within the reported activity, however due to continued hospital pressures, associated additional income from the Elective Recovery Fund has not been achieved in line with plan.

Performance on a financial trajectory basis	1.	In Month	The Group reports an in month deficit of £0.037m against a planned deficit of £0.293m, and is therefore £0.256m favourable to plan in month.
		YTD	The Group surplus year to date is £0.254m compared with a planned breakeven position, and is therefore £0.254m favourable to plan. This is as per additional ERF monies received in month 12.
Cash	2.	The total cash balance at the 31 March was £28.5m.	
Capital	3.	In Month	In month gross capital expenditure was £6.451m (£6.881m with Managed Equipment Service (MES) additions). The gross capital plan in month was £0.624m (£0.707m including MES).
		YTD	Gross capital expenditure YTD was £10.587m (£14.123m including MES additions) versus planned £6.5m (£10.124m including MES).
CIP performance	4.	YTD	£3.841m has been delivered, £0.151m ahead of planned internal efficiencies; of which 33% of the efficiencies have been achieved recurrently.

Group I&E - Summary

March 2022			£'000'	YTD			Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)	
26,702	20,003	6,699	Income	238,436	227,867	10,568	227,867
(20,181)	(13,319)	(6,862)	Pay	(155,532)	(149,120)	(6,412)	(149,120)
(6,535)	(6,187)	(348)	Non Pay	(75,391)	(70,613)	(4,778)	(70,613)
(14)	**497**	**(511)**	**EBITDA**	**7,512**	**8,135**	**(622)**	**8,135**
(23)	(790)	768	Below EBITDA	(7,258)	(8,135)	877	(8,135)
(37)	**(293)**	**256**	**Adj to Financial Improvement Trajectory (FIT) Basis**	**254**	**(0)**	**254**	**(0)**
3	(1)	4	Donated Assets and other adjustments excluded from FIT	(465)	(247)	(218)	(296)
(34)	**(294)**	**260**	**I&E surplus/(deficit)**	**(210)**	**(247)**	**36**	**(247)**

Key headlines:

Income - recognises income accounted in M12 and offseting expenditure in line with the national guidance - £4.591m for central employer pension contributions and £0.845m for consumables from DHSC bodies for COVID response. Other year to date key favourable variances include overperformance of private patients income (£0.190m fav), drugs and HEE income (offset by costs). The year to date position also includes recalculation of ERF generated due to performance as per the system agreement, additional £2.079m reimbursement of COVID-19 costs incurred outside of the system funding envelope, and £1.458m of pay award impact.

Pay - year to date adverse variances relate to higher agency and bank premium costs from escalation capacity/activity, COVID related expenditure and SHS locum costs reduced by underspends within administrative staffing and £2.3m of estimated H2 ERF costs not spent (equal to income unachievement). Remaining adverse variance includes notional employer pension contributions recognised in month 12 and 6 months of pay award costs offset with additional income recognised in the position. COVID-19 costs of £0.455m in month (£4.568m YTD) have been incurred.

Non Pay - year to date adverse variances seen in drugs (mostly supported by income but some escalation impact), maintenance, catering, IT costs, professional fees and merger costs. Also includes COVID-19 adverse impact of £2.052m YTD due to testing costs and £0.845m of consumables for COVID response recognised in month 12, both are offset by income.

Group I&E - Detail

March 2022			£'000'	YTD			Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)	
22,136	17,692	4,444	NHS Clinical Income	206,428	201,774	4,654	201,774
222	209	13	Non NHS Clinical Income	2,559	2,514	45	2,514
4,000	1,939	2,061	Other Income	26,336	22,605	3,732	22,605
343	163	181	Top Up income	3,112	975	2,137	975
26,702	**20,003**	**6,699**	**Total Income**	**238,436**	**227,867**	**10,568**	**227,867**
(4,384)	(4,539)	155	Medical Pay	(45,911)	(46,474)	563	(46,474)
(6,705)	(4,822)	(1,883)	Nursing Pay	(58,752)	(53,760)	(4,992)	(53,760)
(9,093)	(3,958)	(5,135)	Other Pay	(50,869)	(48,886)	(1,983)	(48,886)
(20,181)	**(13,319)**	**(6,862)**	**Total Pay**	**(155,532)**	**(149,120)**	**(6,412)**	**(149,120)**
(1,655)	(1,913)	258	Drugs	(23,952)	(22,645)	(1,308)	(22,645)
(1,806)	(825)	(980)	Consumables Non Pay	(9,100)	(8,566)	(534)	(8,566)
(3,074)	(3,448)	374	Other Non Pay	(42,339)	(39,402)	(2,936)	(39,402)
(6,535)	**(6,187)**	**(348)**	**Total Non Pay**	**(75,391)**	**(70,613)**	**(4,778)**	**(70,613)**
(14)	**497**	**(511)**	**EBITDA**	**7,512**	**8,135**	**(622)**	**8,135**
(23)	(790)	768	Below EBITDA	(7,258)	(8,135)	877	(8,135)
(37)	**(293)**	**256**	**Adj to Financial Improvement Trajectory (FIT) Basis**	**254**	**(0)**	**254**	**(0)**
71	(26)	97	Donated Assets	(397)	(296)	(101)	(296)
(68)	25	(93)	Other adjustments excluded from FIT	(68)	49	(117)	49
(34)	**(294)**	**260**	**I&E surplus/(deficit)**	**(210)**	**(247)**	**36**	**(247)**

COVID-19 financial summary

FUNDED

Q4 Expenditure for Comparison			COVID19 Related Expenditure £'000	2021/22 YTD									
Jan-21	Feb-21	Mar-21		Annual Plan	Plan YTD	Actual Qtr 1	Actual Qtr 2	Actual Qtr 3	Actual M10	Actual M11	Actual M12	Actual YTD	Variance YTD fav/(adv)
129	118	142	Medical Staff	977	977	279	323	293	82	98	117	1,193	(217)
278	162	121	Nursing	1,853	1,853	436	558	557	264	223	247	2,286	(433)
103	87	86	Other Pay	855	855	248	214	292	99	84	93	1,029	(174)
509	**367**	**348**	**Total Pay**	**3,685**	**3,685**	**964**	**1,095**	**1,143**	**445**	**405**	**457**	**4,509**	**(824)**
4	5	4	Drugs	55	55	1	0	0	0	0	0	1	54
9	3	7	Consumables	67	67	7	2	2	5	0	0	17	50
60	58	60	Other Non Pay	443	443	57	54	47	13	9	50	230	212
74	**66**	**71**	**Total Non Pay**	**565**	**565**	**65**	**56**	**50**	**19**	**9**	**50**	**248**	**317**
23	23	23	**Income**	42	42	54	65	68	23	23	23	254	(212)
605	**456**	**442**	**Total**	**4,292**	**4,292**	**1,083**	**1,217**	**1,260**	**486**	**436**	**530**	**5,011**	**(719)**

Q4 Expenditure for Comparison			COVID19 Expenditure to be Reimbursed £'000	21/22 YTD						
Jan-21	Feb-21	Mar-21		Actual Qtr 1	Actual Qtr 2	Actual Qtr 3	Actual M10	Actual M11	Actual M12	Actual YTD
22	22	19	**Nursing**	19	17	25	(10)	0	(1)	51
0	0	0	**Other Pay**	2	3	3	1	1	(1)	9
162	59	150	**Consumables**	462	510	692	722	297	343	3,027
0	0	14	**Other Non Pay**	18	8	0	0	0	0	26
184	**81**	**183**	**Total**	**501**	**538**	**720**	**714**	**298**	**341**	**3,112**

Key headlines:

Costs 'outside of envelope' will be reimbursed retrospectively to the Trust after a quarterly validation process. i.e. income relating to Qtr 1 costs were received in August.

This includes pathology test costs, running costs of the SIREN trial, and hotel quarantine costs for overseas staff on arrival to the UK.

M10 outside envelope consumables represents retrospective rapid testing.

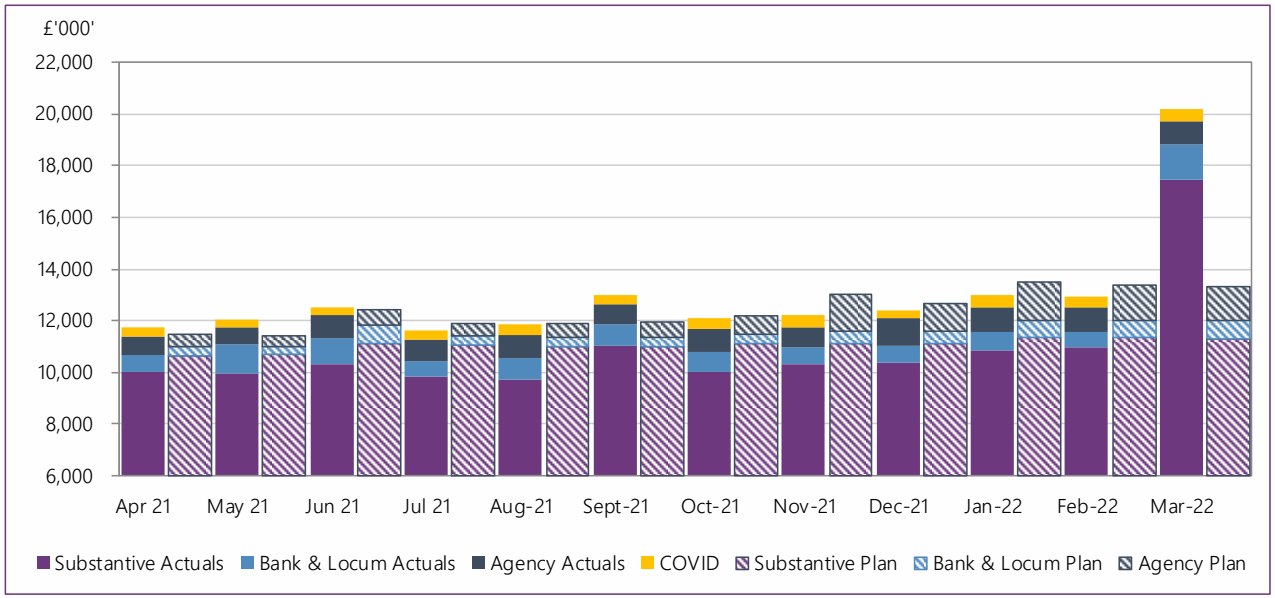
Group pay expenditure

March 2022

vs Plan in month	£6.862m adverse
vs Plan YTD	£6.412m adverse

Mar-22 figures includes £4.591m of notional employer pension contributions

Agency plan includes ERF staffing expenditure in H2 plan - also see agency slide

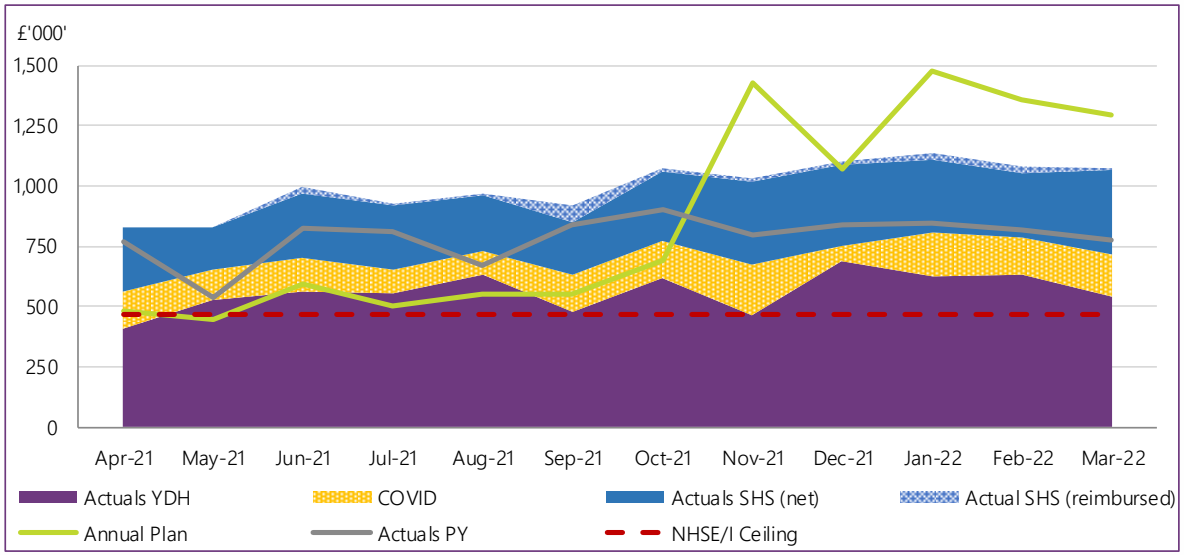


March 2022			£'000'	YTD			Comments	Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)		
4,384	4,539	155	Medical	45,911	46,474	563	See medical analysis on following slides.	46,474
6,705	4,822	(1,883)	Nursing	58,752	53,760	(4,992)	See nursing analysis on following slides.	53,760
1,431	1,134	(297)	Sci, Theraputic & Technical	14,466	15,910	1,443	Includes ERF plan (£2.317m fav) and timing of developments (£0.134m fav). Higher costs in SHS (£0.869m adv) and ODPs (£0.502m adv, within Theatres).	15,910
596	561	(35)	Ancillary	6,383	6,437	54	Favourable within pharmacy and timing of developments.	6,437
7,065	2,263	(4,802)	Estates, Admin & Clerical	30,020	26,539	(3,480)	Incl £4.591m of notional employer pension contributions in M12. YTD fav across various areas - SHS (new practices), HR admin, quality and clinical governance, IT, and snr managers.	26,539
20,181	**13,319**	**(6,862)**	**Total Pay**	**155,532**	**149,120**	**(6,412)**		**149,120**

Group agency expenditure

March 2022

Group plan YTD	£10.446m
Actuals vs Plan YTD	£1.51m adv
NHSE/I ceiling YTD	£5.639m
Actuals vs ceiling YTD	£6.317m over
Actuals vs prior year YTD	£2.534m over

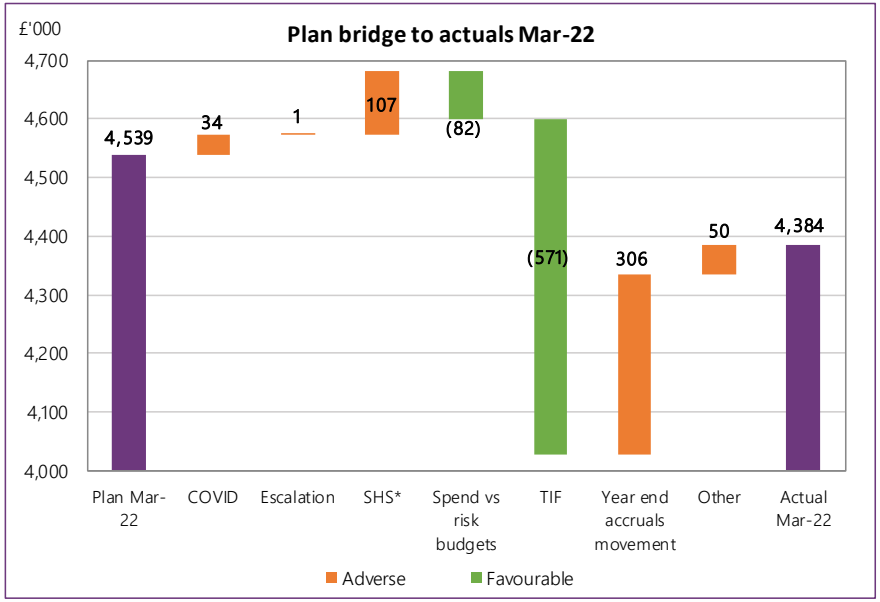


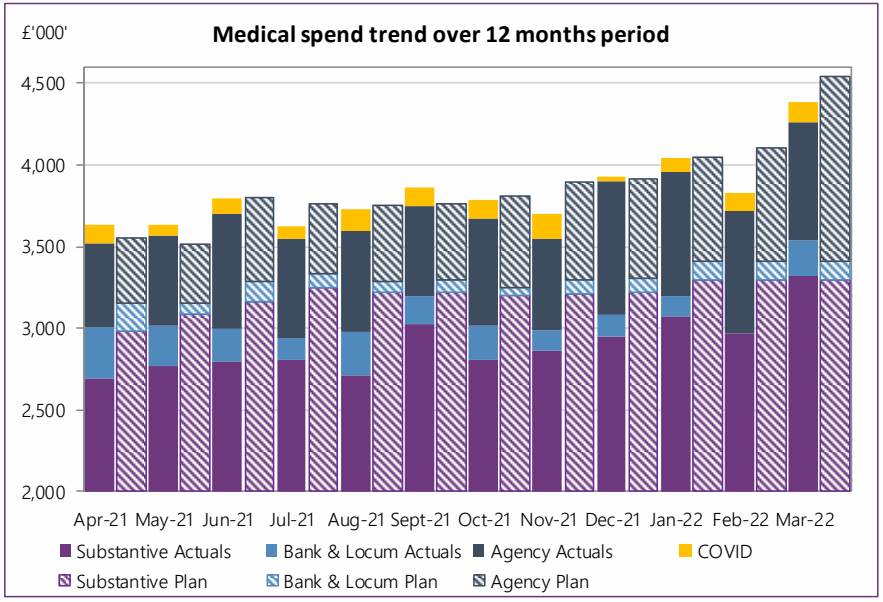
	Variance to Plan fav/(adv)	
£'m	In month	YTD
Nursing	(0.075)	(1.543)
Medical	0.341	(1.712)
Other Pay	(0.046)	1.745
Total	**0.221**	**(1.510)**

Substantive funded posts being supported with agency staff until positions filled

March 2022			£'000'	YTD			Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)	
486	954	468	Medical	5,679	4,836	(844)	4,836
116	90	(26)	Nursing	1,407	454	(953)	454
75	74	(0)	Other Pay	532	3,119	2,586	3,119
677	***1,119***	***442***	***YDH total***	***7,618***	***8,408***	***790***	***8,408***
37	0	(37)	Other Pay	822	3	(819)	3
37	***0***	***(37)***	***SSL total***	***822***	***3***	***(819)***	***3***
301	174	(127)	Medical	2,902	2,034	(868)	2,034
48	0	(48)	Nursing	590	0	(590)	0
8	0	(8)	Other Pay	22	0	(22)	0
358	***174***	***(184)***	***SHS total***	***3,515***	***2,034***	***(1,481)***	***2,034***
1,073	**1,293**	**221**	**Group Total**	**11,955**	**10,446**	**(1,510)**	**10,446**

Group medical spend





Plan bridge to Actuals YTD	£'000'
Plan	**46,474**
COVID	217
Escalation	201
SHS*	(40)
Spend vs risk budgets	(573)
TIF	(635)
Year end accruals movement	306
Pay award	365
Other	(404)
Actual Mar-22	**45,911**
Variance to Plan	**563**

Key headlines:

Note that month 12 includes year end provisions for annual leave due to employees and outstanding professional/study leave.

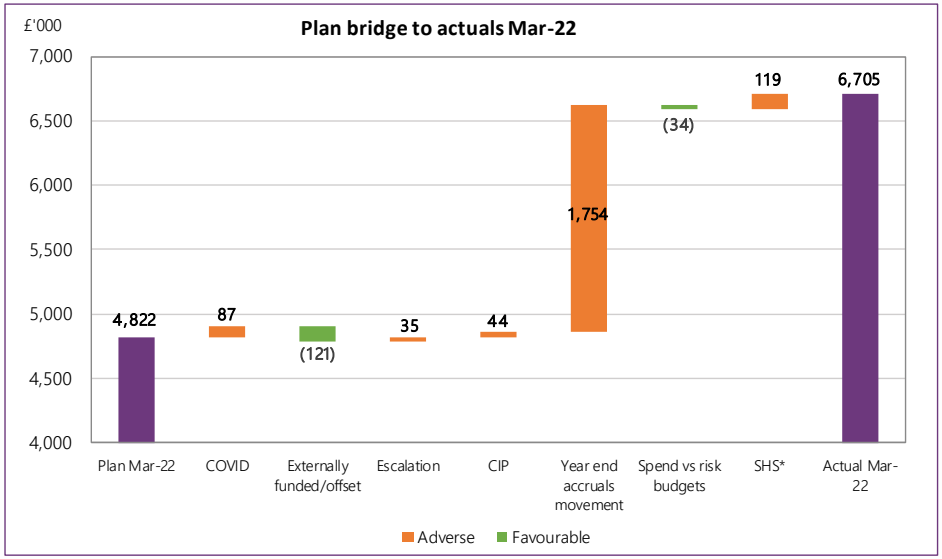
Risk budgets have not been fully allocated YTD due to vacancies not being filled and premium costs of agency not exceeding plan but offset by escalation expenditure.

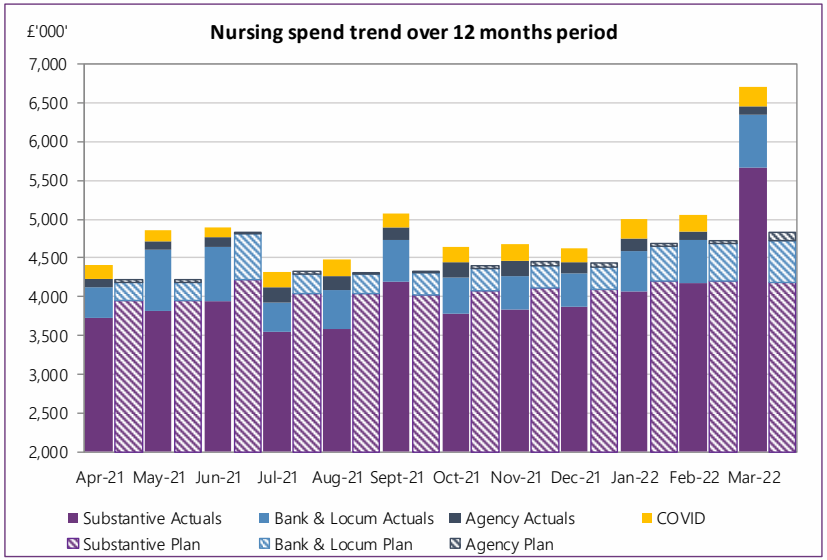
COVID adverse to plan in month due to cover of isolating staff and also long COVID sickness leave.

£0.463m of additional medical staff shifts has been incurred YTD to manage the escalation being seen on the wards. During H2 winter funding has been received from the CCG, the YTD variance above the winter funds is offset by the risk budget underspend.

SHS includes GP vacancy locum cover, COVID clinic time and costs incurred due to increased demand, and timing of SFT practices integration. * This variance includes SHS forecast risk within revised Group plan for H2 but not included in SHS plan.

Group nursing spend





Plan bridge to Actuals YTD	£'000'
Plan	**53,760**
COVID	433
Externally funded/offset	232
Escalation	660
CIP	230
Year end accruals movement	1,754
Spend vs risk budgets	277
SHS*	710
Pay award	695
Actuals	58,752
Variance to Plan	**(4,992)**

Key headlines:

Budget based on risk allocations from budget setting 20/21. COVID expected costs layered on top including; ward reconfigurations, swabbing clinics and increased staff sickness and isolation cover. Elective recovery funding (ERF) related expenditure based on revised system forecast included in the plan too (adjusted retrospectively in Jun 21).

COVID related spend remained high in month due to cover of isolating staff and additional requirements, particularly high in ED

Externally funded/offset relates to variance for externally funded posts (mass vaccination clinic, SIREN testing and maternity transformation) all offset by income or related underspends in other subjective categories. M11&12 21/22 include variances for TIF expenditure included in the H2 plan, offset by income.

Escalation - costs have remained high this month but funding has been allocated in the H2 budgets, resulting in a £35k adverse variance mainly attributable to Jasmine and CDUP.

CIP – the plan has been achieved YTD but in other subjective categories.

Year end accruals movement - Note that month 12 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.

Spend vs risk - there continues to be high levels of bank incentive payments and agency premium to enable us to staff the wards, escalation areas and theatres. Specialing costs have increased in month.

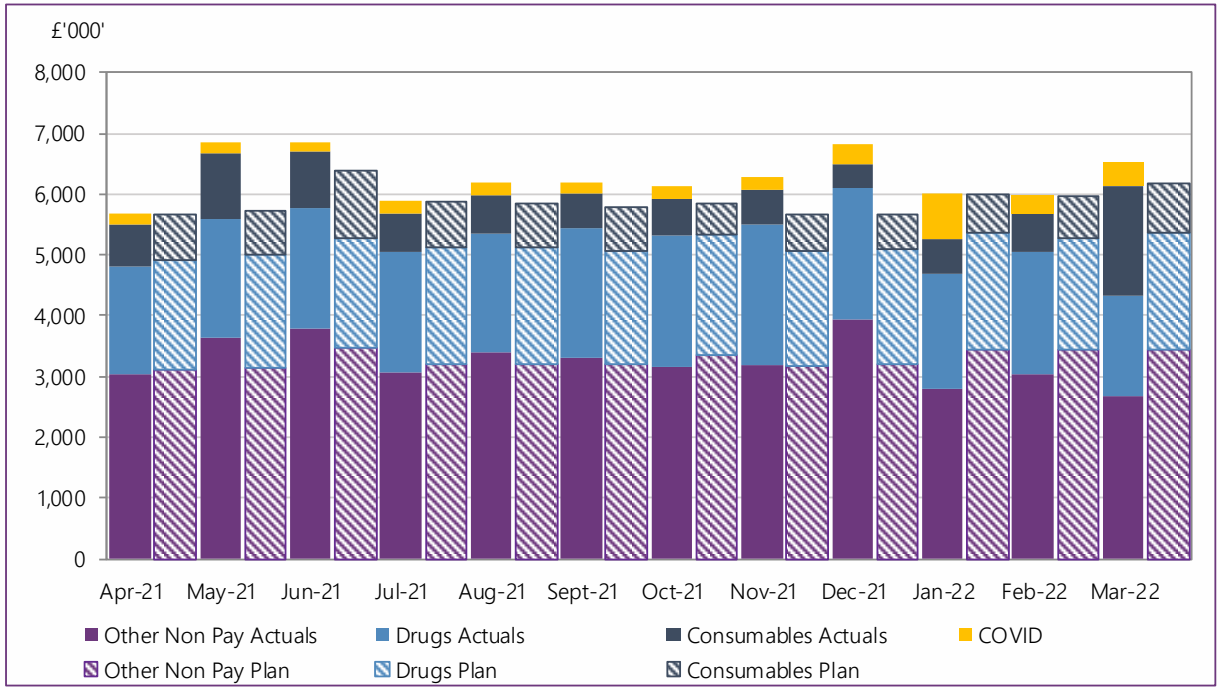
SHS includes nurse practitioner vacancy locum cover, COVID clinic time and costs incurred due to increased demand, and timing of SFT practices integration. *Also includes SHS forecast risk within revised Group plan for H2.

Pay award – budget allocated for pay award in H2 plan from October onwards. YTD variance is mostly offset by additional income.

Group non pay expenditure

March 2022	
vs Plan in month	£0.348m adverse
vs Plan YTD	£4.778m adverse

	Variance to Plan fav/(adv)	
£'m	In month	YTD
Consumables	(0.980)	(0.534)
Drugs	0.258	(1.308)
Other Non Pay	0.374	(2.936)
Total	**(0.348)**	**(4.778)**



Key headlines:

Consumables - Favourable variance within bulk store and theatres with activity lower than planned in H2 due to high non-elective demand. Month 12 recognises £0.845m of consumables donated from DHSC bodies for COVID response, also reflected in operating income.

Drugs - high cost and pass-through drugs spend above plan YTD matched by income (£1.158m). Remaining YTD adverse reflecting increased activity and escalation areas impact on in-tariff funded drugs.

Other non pay - includes £2.052m variance from virus testing expenditure funded by additional income outside the funding envelope. Other adverse variances in year to date were seen in property maintenance (£0.389m), IT software (£0.189m, mainly new ledger implementation), professional fees, merger costs of £0.872m (including exit packages) and catering (£0.163m). Underspends within staff travel, office expenses, training and patient appliances.

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					March 2022	INCOME £'000'				
2021/22 Annual Plan	2019/20 YTD Outturn (Comparator)	YTD Actual	YTD Variance	% variance against plan		2021/22 Annual Plan	2019/20 YTD Outturn (Comparator)	YTD Actual	YTD Variance	% variance against plan
					Split by Commissioner					
No final activity plans agreed with NHSI/E or commissioners	1,264,927	1,207,254	(57,673)	(4.6%)	Somerset (Including NCA activity)	*No final activity plans agreed with NHSI/E or commissioners*	104,509	103,514	(995)	(1.0%)
	57,670	53,973	(3,698)	(6.4%)	Dorset		18,357	17,435	(922)	(5.0%)
	18,685	22,077	3,392	18.2%	NHS England (Including Military) Activity		4,813	5,066	252	5.2%
					NHS England (Including Military) Drugs		6,394	7,372	978	15.3%
	1,341,282	**1,283,304**	**(57,979)**	**(4.3%)**	**Total All Activity**		**134,073**	**133,387**	**(686)**	**(0.5%)**

** Note: the table is reflective of a PbR position and does not consider Commissioner activity challenges, however these changes would not be financially material. Insource has been excluded. This has been costed at 21/22 Final tariff*

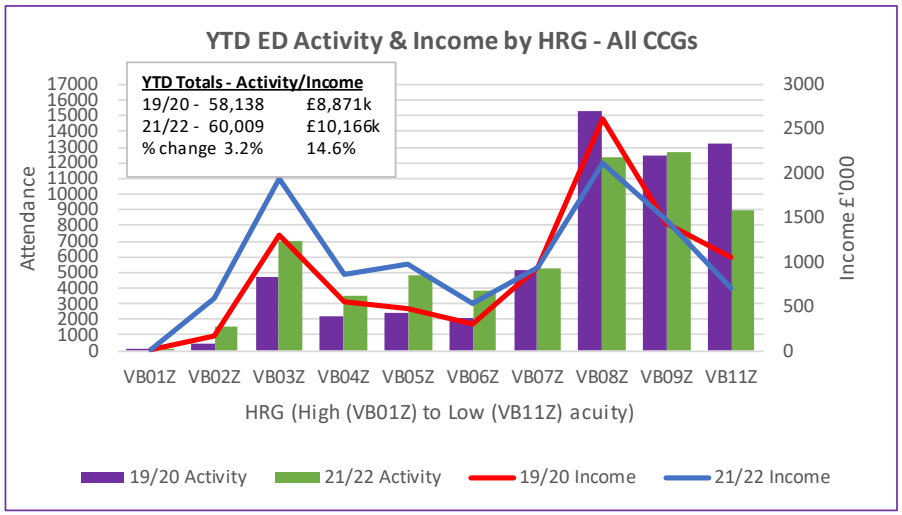
Key headlines:

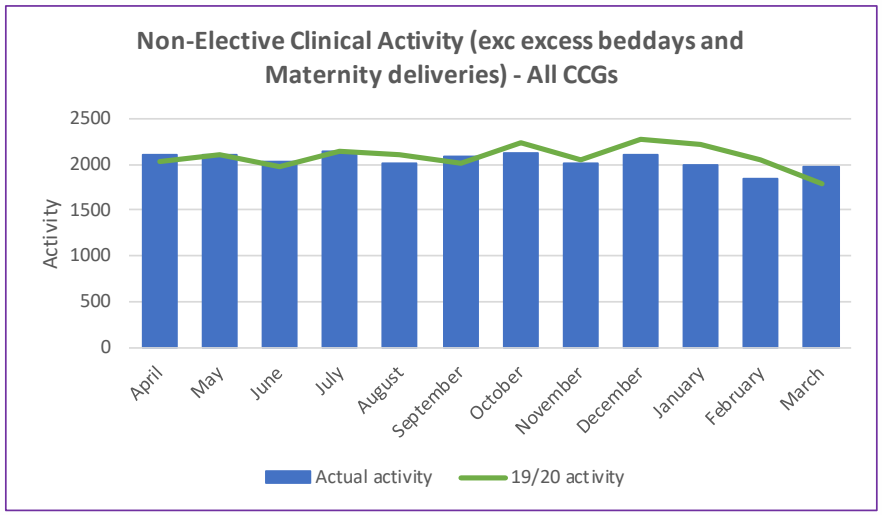
In the absence of any agreed activity plans, 2019/20 outturn has been used to provide a comparator. YTD activity is showing a 4.3% lower activity trajectory, with income 0.5% lower than 2019/20, demonstrating an increase in acuity. AE demonstrates a clear shift in acuity between years, with a 3.2% increase in activity and a 14.6% increase in associated income (see activity slides).

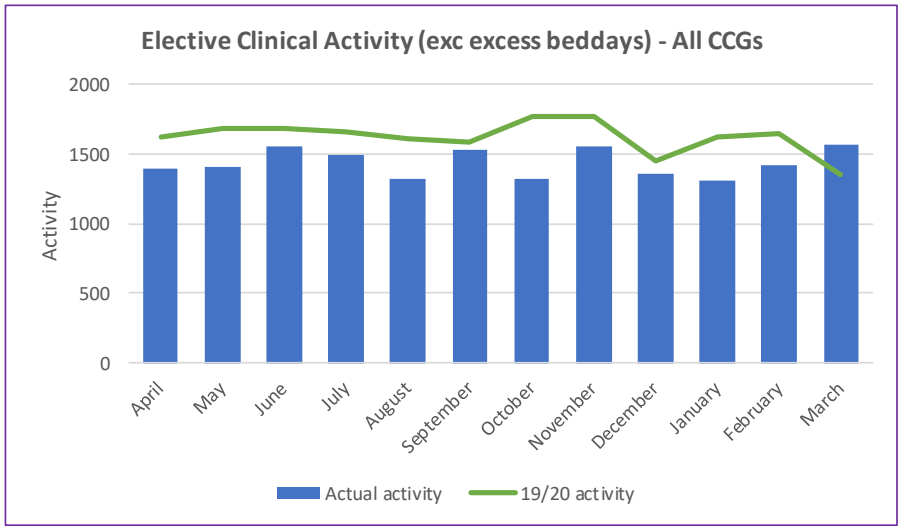
Drugs income is 14.5% over 19/20 levels across all commissioners.

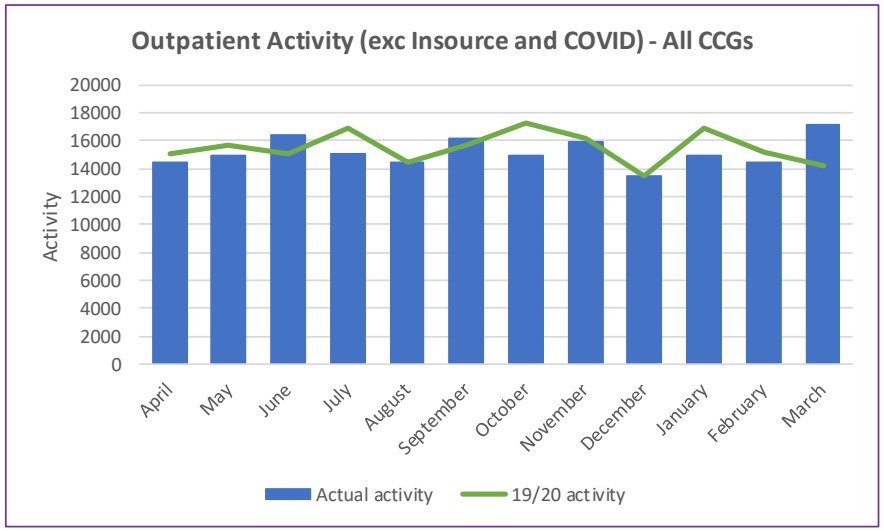
Block contracts have been mandated with main commissioners for the period Apr'21 to Mar'22 (H1 and H2 Plans), in line with ongoing Emergency Financial Regimes. NHSI/E interim plan values for Somerset CCG, Dorset CCG and NHS England are based on the block contract amounts.

Group activity summary

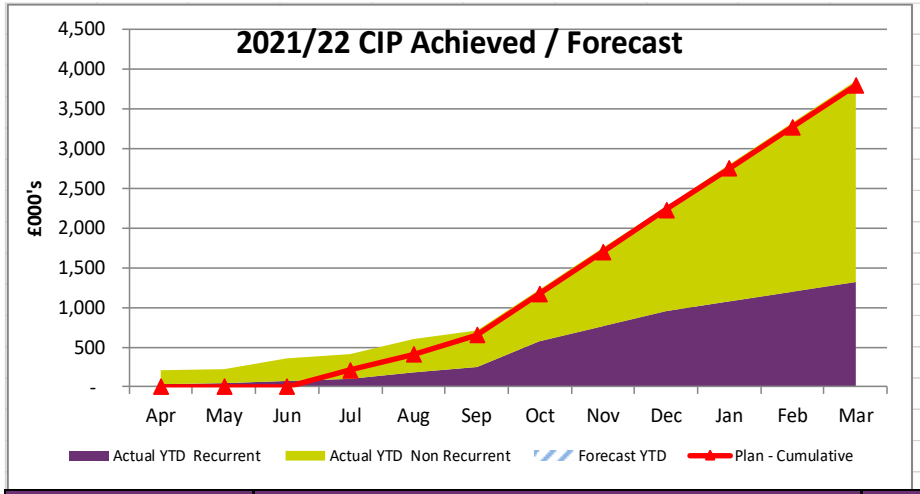




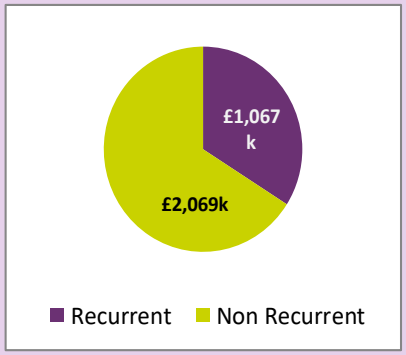




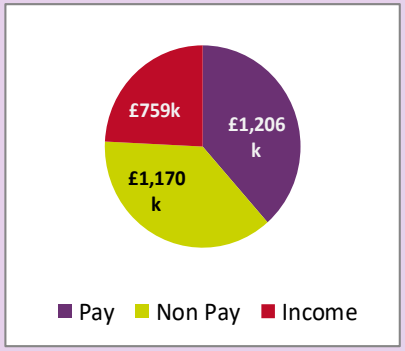
Trust CIP summary



Recurrent v Non Recurrent Savings (YTD)



Savings type (YTD)



Category	In Month					Year To Date					Year End		
	Actual Recurrent	Actual Non Recurrent	Total Achieved	Plan	Variance	Actual Recurrent	Actual Non Recurrent	Total Achieved	Plan	Variance	Delivered to year end	Full Year Plan	Remaining to deliver
Corporate	75	315	390	139	251	563	843	1,406	957	449	1,406	957	449
Elective Care	4	1	5	117	-112	247	239	486	808	-322	486	808	-322
Urgent Care - Integrated Care & Paediatrics	-	-	-	23	-23	-	46	46	117	-71	46	117	-71
Urgent Care	1	42	43	121	-78	72	626	698	593	105	698	593	105
Trustwide	-	-	-	37	-37	-	60	60	221	-161	60	221	-161
SHS	-	-	-	-	0	-	-	-	-	0	-	-	0
SSL	39	43	82	84	-2	185	255	440	440	-0	440	440	-0
Total	**119**	**401**	**520**	**521**	**-1**	**1,067**	**2,069**	**3,136**	**3,136**	**-0**	**3,136**	**3,136**	**-0**

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	YDH Financial Resilience and Commercial Committee Terms of Reference
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	3 May 2022

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 Terms of Reference have been reviewed in the light of meetings being held in common with the Financial Committee. The Terms of Reference reflect the current Committee and the Terms of Reference will be further reviewed to reflect the remit of the Committee post merger.
Recommendation	The Board is asked to approve the revised Terms of Reference for 2022.

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)

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]

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 (THE 'TRUST')
FINANCIAL RESILIENCE AND COMMERCIAL COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee to be known as the Financial Resilience and Commercial Committee ('the Committee').

1.2 The Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference shall be as set out below and will be subject to amendments approved by the Board of Directors ('the Board').

2. Authority

2.1 The Committee is authorised to seek information it requires from any employee of the Trust. All colleagues are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of advisors with such expertise that it considers necessary.

2.2 The Committee is authorised by the Board to make decisions within its terms of reference, including matters specifically referred to it by the Board.

3. Membership

3.1 The Committee shall comprise:

- Three Non-Executive Directors one of whom will act as Chairman and one of which will act as Vice-Chairman
- Chief Finance Officer
- Chief Operating Officer (Hospital Services)
- Chief Operating Officer (Neighbourhoods, Mental Health and Families)
- Director of Strategy and Digital Development
- Chief Officer – Partnerships and Collaboration
- Deputy Chief Finance Officer

In attendance:

- Chief Information Officer (quarterly)
- Director of Redevelopment (bi-monthly)
- Director of Commercial Development (quarterly)
- A Governor member of the Strategy and Planning Group
- Managing Director – SHS (quarterly)
- Managing Director – SSL (quarterly)
- Other executive directors or other colleagues invited as required

4. Quorum

4.1 The quorum necessary for the transaction of business shall be three members of whom two must be Non-Executive Directors and one the Chief Finance Officer or Deputy.

5. Frequency of Meetings

5.1 The Committee will meet a minimum of ten times a year.

5.2 Further meetings can be called at the request of the Committee Chair.

6. Responsibilities

6.1 The Committee will provide assurance to the Board that in the relation to the Trust and Subsidiary companies:

- Financial performance is delivered in accordance with the agreed strategy, plans and trajectories;
- The Trust's cost improvement programme is delivered in accordance with agreed plans;
- The Trust's capital investments, including IT, are in line with its strategic objectives and that benefits set out in the business cases for investment are realised;
- It will provide overview and scrutiny in any area of financial planning and financial performance as well as Risk Management of Board Assurance Framework and Trust Level Risks relevant to the committee's remit, and those referred to it by the Board.

Financial Planning and Financial Performance Management

- Examine the key principles and assumptions for the Trust's business planning and budget setting processes.
- Receive assurance that the Trust's financial, activity, capacity and workforce plans are fully aligned.
- Recommend to the Board approval of the Trust's annual operational plan, capital investment plan and revenue budgets.
- Monitor the Trust's performance against its annual financial plan and budgets.
- Receive and monitor reports on financial performance including forecasts, cost improvement programmes and use of resources, noting any trends, exceptions and variances against plans on a Trust-wide and directorate basis and reviewing in detail any major performance variations.
- Maintain an overview of the activity models to ensure consistency and to provide assurance on critical assumptions.

- Monitor workforce and agency spend, linking with the Audit Committee and Quality and Governance Committee as required.

- Consider the adequacy of forecasting models used in relation to financial performance.

- Review income line and service line reporting to support investment and disinvestment decision making in relation to profitable and unprofitable services.

- Consider changes to the Trust reporting requirements under new regulatory arrangements.

- Seek assurance on mitigations for financial risks from contracting and planning with commissioners.

Capital Management

- Review and monitor the strategic five-year capital programme and the annual capital budgets and recommend actions or mitigations to the Trust Board.

- Consider proposals for investment in the estate and technology to ensure alignment with Trust strategy.

- Review and approve capital business cases in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

- Review those capital business cases above the Committee's authority limits as set out within the Trust's Standing Financial Instructions and Scheme of Delegation and make recommendation to the Board for approval.

Treasury Management

- Review the cash position of the Trust.

- To approve and review the Trust's treasury management and working capital policy.

Financial Sustainability

- Oversee the development of a medium to longer term financial sustainability plan.

- Receive updates of the Long Term Financial Model.

Investment Appraisal

- Review and approve revenue business cases in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

- Review those revenue business cases above the Committee's authority limits as set out within the Trust's Standing Financial Instructions and Scheme of Delegation and make recommendation to the Board for approval.

- Review the benefits realisation of business cases and post implementation reviews to ensure that the standard of business case preparation is consistently high.

Commercial Development

- To review major procurements and tenders that require Board approval.

- Review tender opportunities for new business for the Trust and receive an update on horizon scanning of opportunities.

- Monitor performance of commercial activities as necessary. In doing so the committee will seek assurance that such activities deliver improved patient care and/or experience and that the Trust's principal purpose is not jeopardised by over-development of commercial activity.

- Keep under review key strategic, commercial contracts and seek assurance that appropriate due diligence is undertaken on any new contracts and/or renewals.

Risk

- Reviewing and scrutinising the Board Assurance Framework and Finance Risk Register, to ensure that financial risks are appropriately assessed, monitored, prioritised, and that effective controls and plans are in place to mitigate the risks identified, referring to the executive management team or escalating to the Board any identified unresolved risks arising that require executive action or that pose significant threats to the operation, resources or reputation of the Trust.

- Recommend changes to the Board Assurance Framework relating to emerging risks and existing entries within its remit for the executive to consider.

7. Reporting

7.1 Formal minutes of Committee meetings will be recorded.

7.2 The Committee shall report to the Board on its proceedings after each meeting to provide assurance and to escalate issues as appropriate.

7.3 The Committee will undertake an annual self-assessment and review of the Terms of Reference, which will be presented to Board for information and approval.

8. Monitoring and Effectiveness

8.1 The Committee shall have access to sufficient resources to carry out its duties.

8.2 It shall be provided with appropriate and timely training, both in the form of an induction programme for new members and an on-going basis for all members.

8.3 As described above, it will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

8.4 The Board shall also evaluate the effectiveness of the Finance Committee through its internal audit programme and its Annual Governance Statement.

9. Administrative Support

9.1 Meetings will be supported by the Chief Finance Officer's Executive Assistant, whose duties in this respect will include:

- Agreement of agendas.
- Collation and distribution of papers.
- Minute taking.
- Keeping a record of matters arising and issues to be carried forward within an action log.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Somerset NHS Foundation Trust Finance Report – Month 12
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Head of Financial Management Deputy Director of Finance
PRESENTED BY:	Chief Finance Officer
DATE:	3 May 2022

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:.					

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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)

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

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

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

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT TO 31 MARCH 2022

1. SUMMARY

1.1 In month, the Trust recorded surplus of £1.625m which means cumulatively the Trust has achieved a surplus for the year of £1.869m. The favourable variation to plan is due to the SFT share (£1.688m) of an additional £1.931m Elective Recovery Funding (ERF) income received by the Somerset system in March and late receipt of testing costs reimbursement from NHSE of £0.181m. Excluding these adjustments, the Trust would have reported a breakeven position which is consistent with the plan for H2 and previous forecasts.

1.2 In month £17.7m in relation to additional employer superannuation contributions were incurred for which there is corresponding income from NHSE. This adjustment, which is made in March, is for the additional 6.3% contribution which is not included within Trust funding and is paid directly by NHSE to the Pensions Agency. This cost is fully funded by NHSE but is recorded in local accounts on receipt of information at year end.

1.3 Fixed asset impairments of £12.597m were recorded in month. Impairments are calculated following the receipt of the valuation report from Trust valuers. Impairments to expenditure are not included in the assessment of financial performance on a control total basis.

1.4 The Trust continues to experience significant ongoing operational pressures across many of its community, mental health and acute services. There is continuing high demand in our emergency department, a high prevalence of Covid and ongoing challenges with patient flow in many services. Colleagues and teams continue to be under sustained pressure.

1.5 The full capital envelope has been utilised in the year for the Somerset system, through a huge effort by all the teams involved. SFT has delivered its share of the Capital Envelope and supported Yeovil slippage through an increased spend of a further £1m over the plan.

1.6 In total, the Trust has delivered CIP of £9.9m which was consistent with the plan and forecast.

1.7 Cash balances at the 31 March were £58.7m.

1.8 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 March 2022:

Table 1: Income and Expenditure Summary

Statement of Comprehensive Income	Annual Plan £000	Current Month 12			Year to date		
		Plan £000	Actual £000	Fav./ (Adv.) Variance £000	Plan £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
NHS clinical income	535,536	44,801	51,828	7,027	535,536	588,872	53,336
Non-NHS clinical income	2,916	222	123	(99)	2,916	2,561	(354)
Non-clinical income	45,116	3,896	6,226	2,330	45,116	57,892	12,776
Total operating income (excl STF)	**583,568**	**48,919**	**58,177**	**9,258**	**583,568**	**649,325**	**65,758**
Employee expenses	(408,855)	(35,690)	(37,333)	(1,643)	(408,855)	(430,338)	(21,483)
Drugs	(38,270)	(2,990)	(4,560)	(1,571)	(38,270)	(47,348)	(9,078)
Clinical Supplies	(29,009)	(2,110)	(3,028)	(918)	(29,009)	(31,119)	(2,110)
Non-clinical supplies	(77,878)	(5,863)	(7,726)	(1,863)	(77,878)	(104,743)	(26,865)
PFI expenses	(3,415)	(241)	(294)	(53)	(3,415)	(3,367)	48
Total operating expenses	**(557,427)**	**(46,893)**	**(52,941)**	**(6,048)**	**(557,426)**	**(616,914)**	**(59,487)**
EBITDA	**26,141**	**2,026**	**5,236**	**3,210**	**26,142**	**32,412**	**6,270**
Other income	471	61	53	(8)	471	832	361
Depreciation charges	(17,996)	(1,371)	(3,133)	(1,762)	(17,996)	(22,387)	(4,391)
PDC dividend expense	(6,167)	(476)	(550)	(75)	(6,167)	(6,989)	(822)
Other financing costs	(1,799)	(157)	(164)	(7)	(1,799)	(1,956)	(157)
Overall Surplus/(Deficit) after PSF	**650**	**84**	**1,442**	**1,359**	**650**	**1,911**	**1,261**
Adjustments to control total	**(649)**	**(84)**	**182**	**266**	**(650)**	**(42)**	**607**
Control Total	**0**	**0**	**1,625**	**1,625**	**0**	**1,869**	**1,869**

2.2 Additional Clinical income of £0.8m has been received to reimburse the mass vaccination expenditure in month with total expenditure for the year of £9.0m. The mass vaccination programme continues to contribute to the pay and non-pay variances but these continue to be fully offset by income received through reimbursements from NHSE. Covid outside envelope income of £1.186m was received in month (£7.033m YTD).

2.3 An additional £1.688m of (ERF) was received in month as part of the overall system allocation of £1.931m received in month. There is no associated expenditure with this additional income and it is therefore driving the overall surplus position at year end.

3. COST IMPROVEMENT PROGRAMME

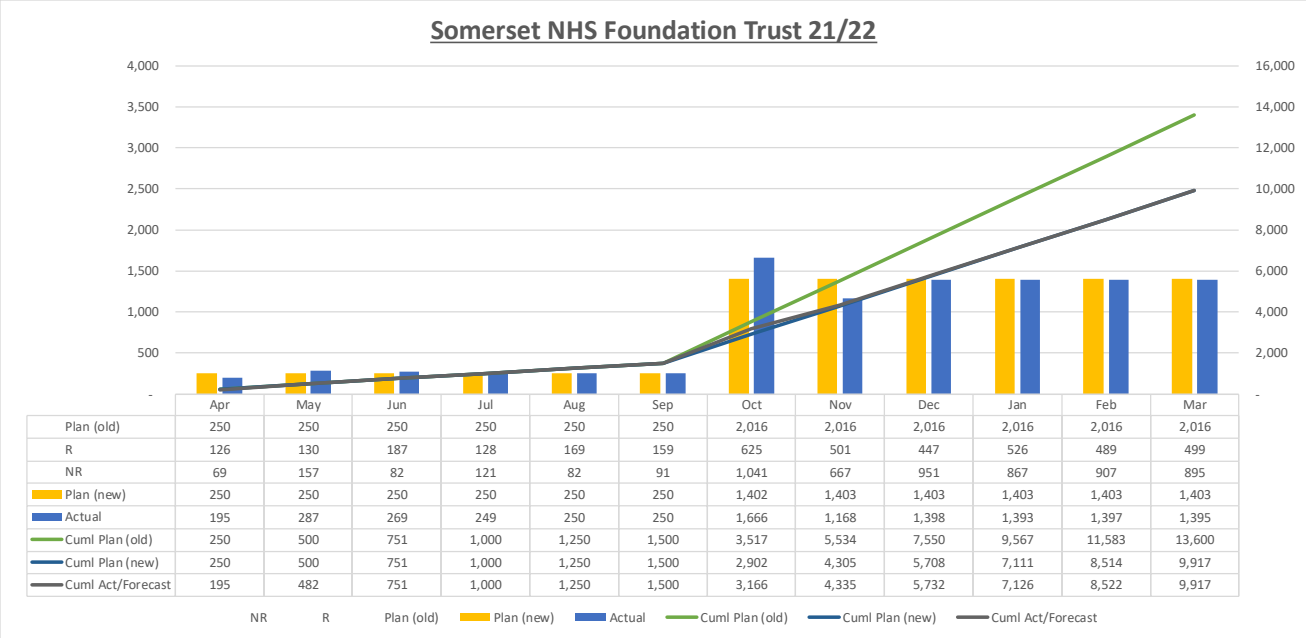
3.1 The H2 plan required CIP delivery of £8.4m with an overall requirement of £9.9m for the year. It is good to report that the trust has achieved its plan and delivered the £9.9m required. In March, recurrent savings of £0.499m were delivered total delivered savings of £1.395m (99% of plan) in month.

3.2 Directorates are continuing to work on their 2022/23 plans. The final CIP requirement will be known when we have completed the final plans for 2022/23 which are due for submission on 28 April.

3.3 The challenge will be a significant step up for services who remain under severe operational pressure. The finance team will continue to support clinical teams and service managers to identify schemes with a focus on securing recurrent savings wherever possible

3.4 Further analysis is provided in Chart 1 below: -

Chart 1: CIP Summary



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan (old)	250	250	250	250	250	250	2,016	2,016	2,016	2,016	2,016	2,016
R	126	130	187	128	169	159	625	501	447	526	489	499
NR	69	157	82	121	82	91	1,041	667	951	867	907	895
Plan (new)	250	250	250	250	250	250	1,402	1,403	1,403	1,403	1,403	1,403
Actual	195	287	269	249	250	250	1,666	1,168	1,398	1,393	1,397	1,395
Cuml Plan (old)	250	500	751	1,000	1,250	1,500	3,517	5,534	7,550	9,567	11,583	13,600
Cuml Plan (new)	250	500	751	1,000	1,250	1,500	2,902	4,305	5,708	7,111	8,514	9,917
Cuml Act/Forecast	195	482	751	1,000	1,250	1,500	3,166	4,335	5,732	7,126	8,522	9,917

4. CASH FLOW & BALANCE SHEET

4.1 The Trust ended the year with cash balances of £58.7m. The cash flow statement is shown in table 2 below:

Table 2: Cash flow statement

Monthly cash flow and forecast	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000
	Actual											
Opening Cash Balance	75,392	63,536	62,178	58,387	49,324	45,261	38,064	31,470	55,767	46,135	44,370	55,972
Surplus/(Deficit) from operations	2,330	246	(8)	1,029	618	626	651	711	293	868	538	(10,541)
Non-cash flows in operating surplus/(deficit)	530	1,617	1,430	(885)	1,627	1,573	1,689	1,896	1,804	2,267	1,792	15,714
Operating cash flows before movements in working capital	2,860	1,863	1,422	144	2,245	2,199	2,340	2,607	2,097	3,135	2,330	5,173
Increase/(decrease) in working capital	(4,168)	(3,579)	(1,098)	(6,463)	(2,749)	(2,475)	(5,257)	16,095	(6,786)	(1,565)	12,718	(9,634)
Net cash inflow/(outflow) from operating activities	(1,308)	(1,716)	324	(6,319)	(504)	(276)	(2,917)	18,702	(4,689)	1,570	15,048	(4,461)
Capital expenditure	(10,281)	(2,815)	(3,444)	(2,804)	(3,282)	(3,927)	(3,383)	(3,013)	(4,155)	(3,052)	(3,215)	(10,966)
Net cash inflow/(outflow) before financing	(11,589)	(4,531)	(3,120)	(9,123)	(3,786)	(4,203)	(6,299)	15,689	(8,844)	(1,482)	11,833	(15,427)
Net cash inflow/(outflow) from financing activities	(267)	3,173	(670)	60	(278)	(2,994)	(295)	8,609	(789)	(282)	(232)	18,185
Net increase/(decrease) in cash and cash equivalents	(11,856)	(1,358)	(3,790)	(9,063)	(4,064)	(7,197)	(6,594)	24,298	(9,633)	(1,764)	11,601	2,758
Closing cash balance	63,536	62,178	58,387	49,324	45,261	38,064	31,470	55,767	46,135	44,370	55,972	58,729

4.2 The Balance Sheet (Statement of Financial Position) information is shown in Table 3 below:

Table 3: Statement of financial position as at 31 March 2022

Statement of Financial Position	Opening Balance 1st April 2021	Current Month Actual	Movement in Year	Balance at end of Previous Period	Current Month Actual	Movement
	£000	£000	£000	£000	£000	£'000
Non Current Assets						
Intangible Assets	19,334	19,800	467	19,530	19,800	270
Property, Plant and Equipment, Other	265,717	302,678	36,962	287,408	302,678	15,270
On SoFP PFI Assets	22,254	21,747	(507)	20,674	21,747	1,073
Investments in Joint Ventures	(7)	797	804	762	797	36
Other investments/financial assets		161	161	239	161	(79)
Trade & other Receivables >1Yr	1,505	2,669	1,164	1,462	2,669	1,207
Non Current Assets	**308,803**	**347,853**	**39,051**	**330,076**	**347,853**	**17,777**
Current Assets						
Inventories	4,784	5,723	939	5,739	5,723	(16)
Trade and other receivables: NHS receivables	10,561	11,218	657	9,007	11,218	2,210
Trade and other receivables: non-NHS receivables	9,439	9,813	374	10,021	9,813	(208)
Non Current Assets Held for Sale	0	15	15	14	15	1
Cash	75,392	58,729	(16,662)	55,972	58,729	2,757
Total Current Assets	**100,176**	**85,498**	**(14,678)**	**80,753**	**85,498**	**4,745**
Current Liabilities						
Trade and other payables: non-capital	(67,354)	(61,641)	5,712	(69,275)	(61,641)	7,634
Trade and other payables: capital	(13,466)	(21,842)	(8,376)	(8,488)	(21,842)	(13,354)
Deferred Income	(14,214)	(6,893)	7,321	(10,487)	(6,893)	3,594
Other Liabilities - Other	(268)	(259)	9	(259)	(259)	0
Borrowings	(3,685)	(3,846)	(161)	(3,840)	(3,846)	(7)
Provisions <1yr	(239)	(850)	(610)	(608)	(850)	(242)
Current Liabilities	**(99,226)**	**(95,331)**	**3,894**	**(92,957)**	**(95,331)**	**(2,374)**
Net Current Assets	**949**	**(9,833)**	**(10,784)**	**(12,204)**	**(9,833)**	**2,371**
Long Term Liabilities						
Capital Creditors >1yr	(367)	0	367	0	0	0
Loans >1yr	(26,044)	(22,737)	3,308	(12,082)	(22,737)	(10,655)
Provisions >1yr	(2,141)	(3,282)	(1,142)	(2,046)	(3,282)	(1,236)
Deferred Income >1yr	(2,458)	(2,200)	259	(2,221)	(2,200)	22
Total Long Term Liabilities	**(31,010)**	**(28,219)**	**2,791**	**(16,350)**	**(28,219)**	**(11,869)**
Net Assets Employed	**278,742**	**309,801**	**31,058**	**301,522**	**309,801**	**8,278**
Tax Payers Equity						
Public Dividend Capital	176,712	212,588	35,876	190,443	212,588	22,145
Revaluation Reserve	69,219	77,595	8,376	69,219	77,595	8,376
Other Reserrves	0	(2,325)	(2,325)	(2,246)	(2,325)	(79)
I&E Reserve	32,811	21,943	(10,868)	44,107	21,943	(22,164)
Total Tax Payers Equity	**278,742**	**309,801**	**31,058**	**301,522**	**309,801**	**8,278**

5. CAPITAL

5.1 The Capital budget increased in March from £63.37m to £63.77m, this change has arisen from a reduction in the Managed Equipment Programme by £0.32m and Donated Assets by £0.27m along with an increased level of spend to support the Combined Somerset System of £1.0m.

5.2 Other minor changes to funding include slightly revised PDC drawdowns for both the Acute Assessment Hub of £0.010m and the New Hospital Programme of £0.028m. The outturn this year represents an extensive programme of spend despite significant pressures caused by supply and logistical constraints alongside the demands of the hospital environment.

5.3 A summary by scheme is set out in the table below:-

Table 4: 2021/22 Capital Programme

Sources of Funding	Plan £000
Depreciation	22,373
Use of Cash resources	7,576
Grants and donations	1,436
PDC	35,456
Capital Loan funding - received and paid	(848)
Finance Leases	(832)
Capital Repayment	(1,920)
PFI MES Funded IFRIC 12	533
Total sources of funding	**63,774**

Acute Programme	Plan £000	Revised Plan £000	YTD Plan £000	YTD Actual £000	Variance v plan £000	FOT
Site Risks / Plant & Equipment	450	450	450	388	(62)	388
Site and Service Development	4,578	4,338	4,578	5,764	1,426	5,764
Total Acute	**5,028**	**4,788**	**5,028**	**6,152**	**1,364**	**6,152**
Community/Mental Health Programme						
Site Risks / Plant & Equipment	600	600	600	452	(148)	452
Site and Service Development	6,818	6,798	6,818	5,567	(1,231)	5,567
Total Community/Mental Health	**7,418**	**7,398**	**7,418**	**6,019**	**(1,379)**	**6,019**
Trustwide						
Site Risks / Plant & Equipment	8,305	9,279	8,305	11,826	2,547	11,826
Site and Service Development	4,116	3,883	4,116	2,352	(1,531)	2,352
Trustwide	**12,421**	**13,162**	**12,421**	**14,178**	**1,016**	**14,178**
Total Internal Capital Envelope	**24,867**	**25,348**	**24,867**	**26,349**	**1,001**	**26,349**
Additional Capital Schemes						
STP 3 - Surgical Centre	17,305	17,096	17,305	17,096	-	17,096
STP Wave 4 - AAH	7,108	7,098	7,108	7,098	-	7,098
NHP	9,000	1,928	9,000	1,928	-	1,928
Diagnostic Imaging/Community Investigate	0	4,246	0	4,246	-	4,246
Cardiac Monitoring	0	91	0	91	-	91
TiF Theatre Efficiency and Max Fax, Plastics Dental	0	1,690	0	1,690	-	1,690
TiF Digital Transformation	0	2,600	0	2,600	-	2,600
Shared Care Record	0	51	0	51	-	51
Cyber Security	0	250	0	250	-	250
Digital Maternity	0	336	0	336	-	336
Wessex House	0	70	0	70	-	70
Learning Academy Expansion DONATED	1,000	1,000	0	1,000	-	1,000
PFI MES Funded IFRIC 12	860	533	1,000	533	-	533
DONATED	705	437	705	437	-	437
Total Additional Schemes	**35,978**	**37,426**	**35,118**	**37,426**	**0**	**37,426**
TOTAL TRUST PROGRAMME	**60,845**	**62,774**	**59,985**	**63,774**	**1,001**	**63,774**

6. OUTTURN

6.1 The Trust has delivered an overall surplus of £1.869m for the year against the planned breakeven position;

6.2 If we discount the late receipt of additional ERF and reimbursed testing income, the Trust has achieved the plan as forecast together with the planned level of efficiency and has maintained a healthy cash balance;

6.3 The draft accounts will be submitted on 26 April and then subject to an extensive period of external audit with final accounts due to be presented to the Audit Committee and Board on 8 June;

7. RECOMMENDATION

7.1 The Board is requested to note the financial performance for the month ending 31 March 2022.

CHIEF FINANCE OFFICER

EXECUTIVE SUMMARY AT 31 MARCH 2022

FINANCIAL PERFORMANCE IN MONTH

	£m Budget	£m Actual	£m Var
Income	48.92	58.20	9.28
Expenditure	-46.89	-52.96	-6.07
EBITDA	**2.03**	**5.24**	**3.21**
Finance Costs	-1.94	-3.80	-1.86
Surplus before exceptional items	**0.09**	**1.44**	**1.35**
Control total adjustments	-0.08	0.18	**0.27**
Adjusted financial performance	**0.00**	**1.62**	**1.62**

Note: Budget reflects the H1 plan submitted in May

NHS IMPROVEMENT SINGLE OVERSIGHT FRAMEWORK

CAPITAL SERVICE COVER

LIQUIDITY

UNDERLYING PERFORMANCE

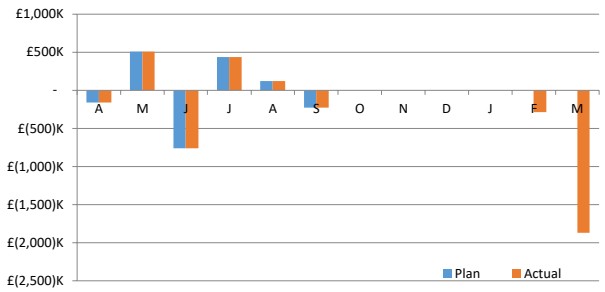
I&E MARGIN VARIANCE FROM PLAN

AGENCY SPEND

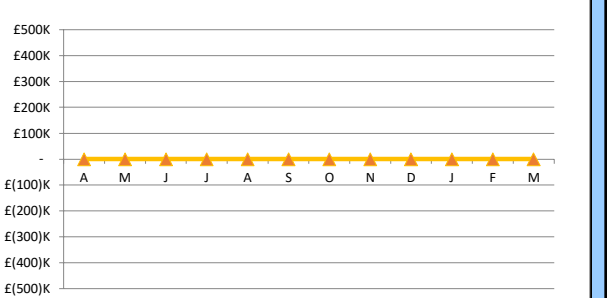
This is currently not reported due to the revised NHSE/I financial framework

CONTINUITY OF SERVICE RATING

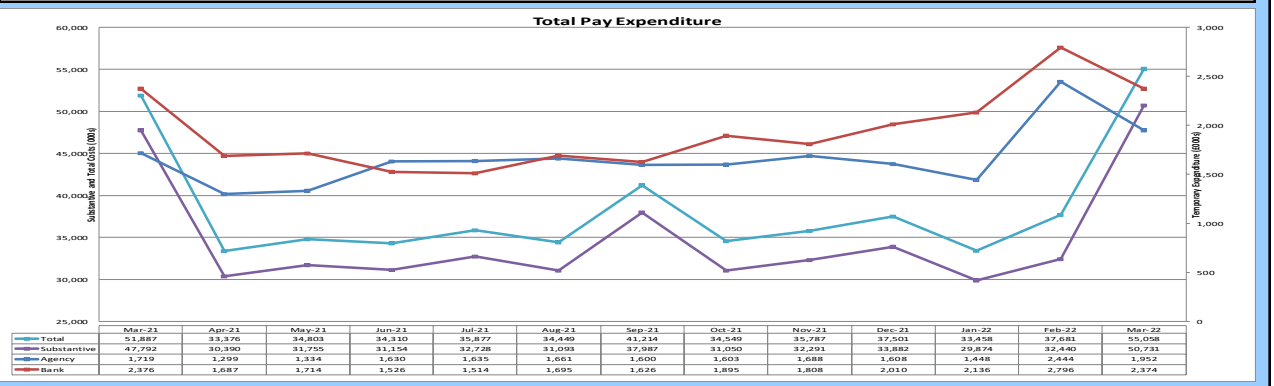
MONTHLY FINANCIAL PERFORMANCE



YEAR TO DATE VARIANCE FROM PLAN

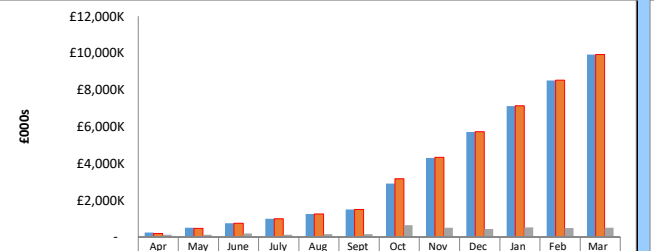


TOTAL PAY EXPENDITURE



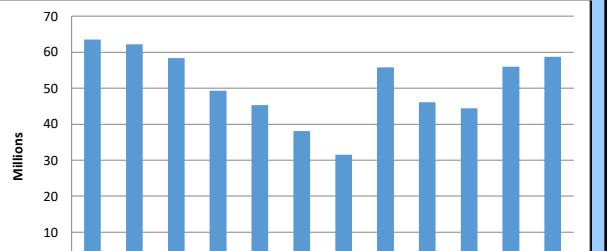
	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Total	51,887	33,376	34,803	34,310	35,877	34,449	41,214	34,549	35,787	37,501	33,458	37,681	55,058
Substantive	47,792	30,390	31,755	31,154	32,728	31,093	37,987	31,050	32,291	33,882	29,874	32,440	50,731
Agency	1,719	1,299	1,334	1,630	1,635	1,661	1,600	1,603	1,688	1,608	1,448	2,444	1,952
Bank	2,376	1,687	1,714	1,526	1,514	1,695	1,626	1,895	1,808	2,010	2,136	2,796	2,374

CIP DELIVERY



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Plan (Cuml)	250	500	750	1,000	1,250	1,500	2,902	4,304	5,707	7,110	8,513	9,917
Actual (Cuml)	195	482	751	1,000	1,250	1,500	3,166	4,335	5,732	7,126	8,522	9,917
Recurrent (in month)	126	130	187	128	169	159	657	501	447	526	489	499

CASH BALANCE



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual	63.5	62.2	58.4	49.3	45.3	38.1	31.5	55.8	46.1	44.4	56	58.7

COMMENTARY

- The Trust has a cumulative breakeven plan for H2 (Oct-March).

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	SFT Finance Committee Terms of Reference
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	3 May 2022

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 Terms of Reference have been reviewed in the light of meetings being held in common with the Financial Resilience and Commercial Committee. The Terms of Reference reflect the current Committee and the Terms of Reference will be further reviewed to reflect the remit of the Committee post merger.
Recommendation	The Board is asked to approve the revised Terms of Reference for 2022.

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)

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]

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 (THE 'TRUST')
FINANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee to be known as the Finance Committee ('the Committee').

1.2 The Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference shall be as set out below and will be subject to amendments approved by the Trust Board ('the Board').

2. Authority

2.1 The Committee is authorised to seek information it requires from any employee of the Trust. All colleagues are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of advisors with such expertise that it considers necessary.

2.2 The Committee is authorised by the Board to make decisions within its terms of reference, including matters specifically referred to it by the Board.

3. Membership

3.1 The Committee shall comprise:

- Three Non-Executive Directors one of whom will act as Chairman and one of which will act as Vice-Chairman
- Chief Finance Officer
- Chief Operating Officer (Hospital Services)
- Chief Operating Officer (Neighbourhoods, Mental Health and Families)
- Director of Strategy and Digital Development
- Chief Officer – Partnerships and Collaboration
- Deputy Director of Finance

In attendance:

- Chief Information Officer (quarterly)
- Director of Redevelopment (bi-monthly)
- Director of Commercial Development (quarterly)
- A Governor member of the Strategy and Planning Group
- Other executive directors or other colleagues invited as required

4. Quorum

4.1 The quorum necessary for the transaction of business shall be three members of whom two must be Non-Executive Directors and one the Chief Finance Officer or Deputy Director of Finance.

5. Frequency of Meetings

5.1 The Committee will meet a minimum of ten times a year.

5.2 Further meetings can be called at the request of the Committee Chair.

6. Responsibilities

6.1 The Committee will provide assurance to the Board that:

- Financial performance is delivered in accordance with the agreed strategy, plans and trajectories;
- The Trust's cost improvement programme is delivered in accordance with agreed plans;
- The Trust's capital investments, including IT, are in line with its strategic objectives and that benefits set out in the business cases for investment are realised;
- It will provide overview and scrutiny in any area of financial planning and financial performance as well as Risk Management of Board Assurance Framework and Trust Level Risks relevant to the committee's remit, and those referred to it by the Trust Board.

Financial Planning and Financial Performance Management

- Examine the key principles and assumptions for the Trust's business planning and budget setting processes.
- Receive assurance that the Trust's financial, activity, capacity and workforce plans are fully aligned.
- Recommend to the Board approval of the Trust's annual operational plan, capital investment plan and revenue budgets.
- Monitor the Trust's performance against its annual financial plan and budgets.
- Receive and monitor reports on financial performance including forecasts, cost improvement programmes and use of resources, noting any trends, exceptions and variances against plans on a Trust-wide and directorate basis and reviewing in detail any major performance variations.
- Maintain an overview of the activity models to ensure consistency and to provide assurance on critical assumptions.

- Monitor workforce and agency spend, linking with the Audit Committee and Quality and Governance Committee as required.

- Consider the adequacy of forecasting models used in relation to financial performance.

- Review income line and service line reporting to support investment and disinvestment decision making in relation to profitable and unprofitable services.

- Consider changes to the Trust reporting requirements under new regulatory arrangements.

- Seek assurance on mitigations for financial risks from contracting and planning with commissioners.

Capital Management

- Review and monitor the strategic five-year capital programme and the annual capital budgets and recommend actions or mitigations to the Trust Board.

- Consider proposals for investment in the estate and technology to ensure alignment with Trust strategy.

- Review and approve capital business cases in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

- Review those capital business cases above the Committee's authority limits as set out within the Trust's Standing Financial Instructions and Scheme of Delegation and make recommendation to the Board for approval.

Treasury Management

- Review the cash position of the Trust.

- To approve and review the Trust's treasury management and working capital policy.

Financial Sustainability

- Oversee the development of a medium to longer term financial sustainability plan.

- Receive updates of the Long Term Financial Model.

Investment Appraisal

- Review and approve revenue business cases in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

- Review those revenue business cases above the Committee's authority limits as set out within the Trust's Standing Financial Instructions and Scheme of Delegation and make recommendation to the Board for approval.

- Review the benefits realisation of business cases and post implementation reviews to ensure that the standard of business case preparation is consistently high.

Commercial Development

- To review major procurements and tenders that require Board approval.

- Review tender opportunities for new business for the Trust and receive an update on horizon scanning of opportunities.

- Monitor performance of commercial activities as necessary. In doing so the committee will seek assurance that such activities deliver improved patient care and/or experience and that the Trust's principal purpose is not jeopardised by over-development of commercial activity.

- Keep under review key strategic, commercial contracts and seek assurance that appropriate due diligence is undertaken on any new contracts and/or renewals.

Risk

- Reviewing and scrutinising the Board Assurance Framework and Finance Risk Register, to ensure that financial risks are appropriately assessed, monitored, prioritised, and that effective controls and plans are in place to mitigate the risks identified, referring to the executive management team or escalating to the Board any identified unresolved risks arising that require executive action or that pose significant threats to the operation, resources or reputation of the Trust.

- Recommend changes to the Board Assurance Framework relating to emerging risks and existing entries within its remit for the executive to consider.

7. Reporting

7.1 Formal minutes of Committee meetings will be recorded.

7.2 The Committee shall report to the Board on its proceedings after each meeting to provide assurance and to escalate issues as appropriate.

7.3 The Committee will undertake an annual self-assessment and review of the Terms of Reference, which will be presented to Board for information and approval.

8. Monitoring and Effectiveness

8.1 The Committee shall have access to sufficient resources to carry out its duties.

8.2 It shall be provided with appropriate and timely training, both in the form of an induction programme for new members and an on-going basis for all members.

8.3 As described above, it will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

8.4 The Board shall also evaluate the effectiveness of the Finance Committee through its internal audit programme and its Annual Governance Statement.

9. Administrative Support

9.1 Meetings will be supported by the Chief Finance Officer's Executive Assistant, whose duties in this respect will include:

- Agreement of agendas.
- Collation and distribution of papers.
- Minute taking.
- Keeping a record of matters arising and issues to be carried forward within an action log.

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Yeovil District Hospital NHS Foundation Trust approval of 2022/23 revenue budget
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	3 May 2022

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 purpose of this report is to present to the Board the 2022/23 annual revenue budget and details of the cost improvement requirements and forecast cashflow.
Recommendation	The Board is requested to approve the 2022/23 annual revenue budget.

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)

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]
Annual 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

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

2022/23 BUDGET

1. INTRODUCTION

1.1. The Trust submitted the final version of its financial, workforce and activity plan to NHSE/I on 28 April 2022. The submission included: -

i) The financial plan – detailed profiled plans for I&E, capital, cash and efficiencies

ii) Workforce plans – setting out demand, supply, efficiency and skill mix information

iii) Activity plans - which set out trajectories for key performance areas

iv) Plan narrative – a system level commentary on the current context and challenges and the key changes in the plan for 2022/23

1.2. In addition, the Somerset system submitted a system wide plan which is a consolidation of Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust and Somerset CCG plans for 2022/23.

1.3. This paper is a summary of the final plan and proposes the annual revenue budget for agreement.

2. SUMMARY

2.1 The financial plan has been constructed with reference to the national planning guidance and local priorities. The national guidance set out a requirement for systems to work collaboratively and focus on the following set of priorities for 2022/23:

1) Investing in the workforce and strengthening a compassionate and inclusive culture

2) Delivering the NHS COVID-19 vaccination programme

3) Tackling the elective backlog

4) Improving the responsiveness of urgent and emergency care and community care

5) Improving timely access to primary care

6) Improving mental health services and services for people with a learning disability and/or autistic people

7) Developing approach to population health management, prevent ill-health and address health inequalities

8) Exploiting the potential of digital technologies

9) Moving back to and beyond pre-pandemic levels of productivity

10) Establishing ICBs and enabling collaborative system working

2.2 Key financial planning assumptions for 2022/23 have been assessed, quantified and reviewed through the Trust internal business planning process and in collaboration with system partners. Business units and departments supported by the finance team have been working on their financial plans to confirm the exiting run rate from 2021/22 into 2022/23 and the additional financial requirements resulting from the priorities set out above for the coming year.

2.3 During the planning process there have been discussions nationally about the disparity between the assumptions in the planning guidance and allocations for inflation and COVID costs which are now higher than those national assumptions. This has resulted in these costs being separately identified within the system and organisational plan. It is expected that there will be further scrutiny and discussion regarding these costs once the system plan has been reviewed by regional NHSE/I.

2.4 The result of this is a planned deficit of £2.858m for the YDH Group which forms part of the overall system plan deficit of £20.330m. If we assume there will be a resolution for the inflation and COVID costs then the overall system plan is balanced.

2.5 The remainder of this paper sets out how the financial plan translates into the revenue budget for 2022/23, for the group and subsidiaries, and requests Board approval.

3. INCOME AND EXPENDITURE

Group

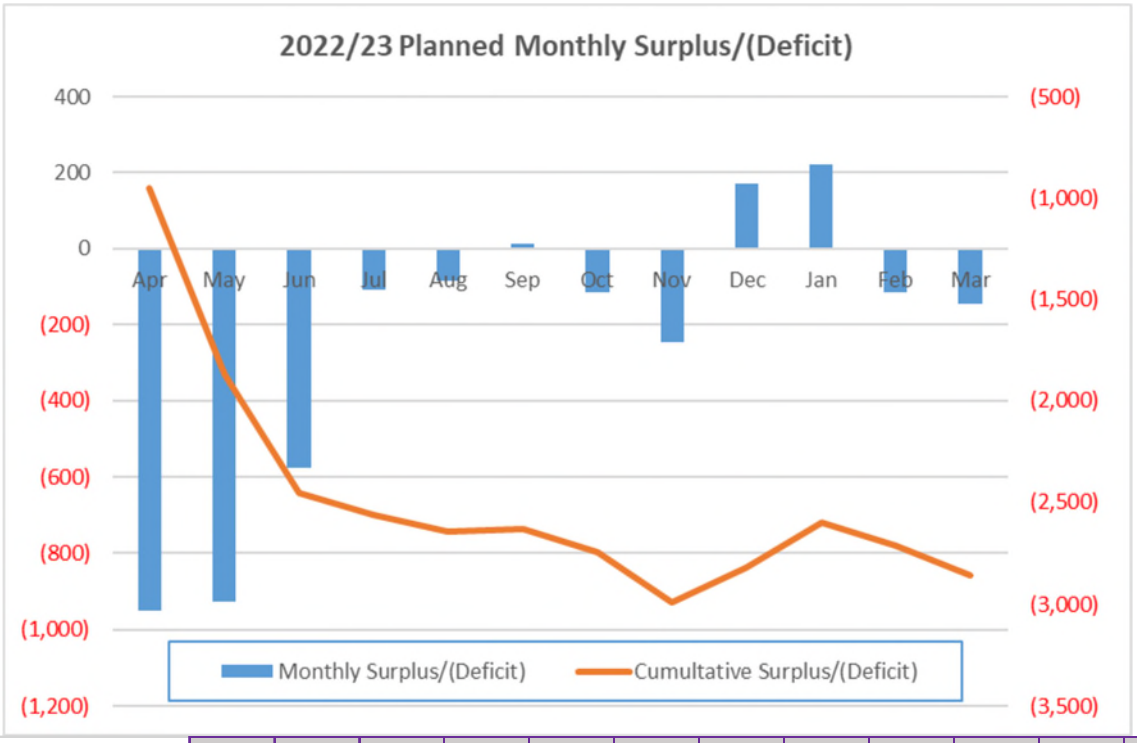
3.1 The summary level group income and expenditure budget at is shown below:

2022/23 Annual Plan	£'000
NHS Clinical Income	208,206
Non NHS Clinical Income	5,536
Other Income	21,416
Total Income	**235,158**
Medical Pay	(46,983)
Nursing Pay	(57,823)
Other Pay	(50,923)
Total Pay	**(155,729)**
Drugs	(21,293)
Consumables Non Pay	(15,700)
Other Non Pay	(32,454)
Total Non Pay	**(69,447)**
EBITDA	**9,982**
Below EBITDA	(12,840)
Adj to Financial Improvement Trajectory (FIT) Basis	**(2,858)**
Donated Assets	1,959
I&E surplus/(deficit)	**(899)**

3.2 Overall group, including subsidiaries, level expenditure budgets are set out in the table below. These are net of the expected CIP plans included in section 4.

Consolidated Group Position £'000	NHS Clinical Income	Non NHS Clinical Income	Other Income	Pay Expenditure	Non Pay Expenditure	Below EBITDA	Total
Elective Care	0	(2,277)	(514)	44,532	14,871	0	56,613
Urgent Care	0	0	(8,944)	56,678	21,580	0	69,314
Clinical Income	(186,065)	0	0	0	74	0	(185,990)
Corporate	0	(460)	(13,968)	19,250	13,557	0	18,379
Central	338	(112)	35,409	5,815	(7,547)	12,290	46,193
Simply Serve Ltd	0	0	(32,927)	10,059	20,878	339	(1,651)
Symphony Healthcare Services	(22,480)	(2,688)	(472)	19,394	6,035	210	0
Total	**(208,206)**	**(5,536)**	**(21,415)**	**155,729**	**69,447**	**12,840**	**2,858**

3.3 The monthly phased group budget is shown beneath:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Surplus/(Deficit)	(949)	(926)	(577)	(107)	(85)	12	(114)	(245)	171	222	(115)	(144)
Cumultative Surplus/(Deficit)	(949)	(1,875)	(2,452)	(2,559)	(2,644)	(2,632)	(2,746)	(2,992)	(2,820)	(2,598)	(2,714)	(2,858)

Simply Serve Limited (SSL)

3.4 SSL is expected to continue to maintain it's profit levels (contribution to the group position) at £1.651m per historical financial performance.

3.5 For clarity, the SSL plan includes an uplift on the intercompany contract, between YDH and SSL. This is 2.8% as per planning guidance, ensuring that income and expenditure are aligned appropriately.

3.6 Delivery of the SSL plan is subject to delivery of £0.6m CIP across the subsidiary.

3.7 The summary level income and expenditure budget for SSL:

2022/23 Annual Plan	£'000
Other Income	32,927
Total Income	**32,927**
Other Pay	(10,059)
Total Pay	**(10,059)**
Drugs	(4,698)
Consumables Non Pay	(4,816)
Other Non Pay	(11,364)
Total Non Pay	**(20,878)**
EBITDA	**1,990**
Below EBITDA	(339)
Adj to Financial Improvement Trajectory (FIT) Basis	**1,651**
Donated Assets	0
I&E surplus/(deficit)	**1,651**

Symphony Healthcare Services Ltd (SHS)

3.8 2022/23 reflects a change in funding sources for SHS. Moving from Trust cash support to contractual income from the CCG. Following discussions with the CCG and the system, an additional £2m funding will flow directly from Somerset CCG to SHS.

3.9 As a consequence of the above SHS will be submitting, as part of the group plan, an organisational breakeven plan. The summary level income and expenditure budget for SHS is:

2022/23 Annual Plan	£'000
NHS Clinical Income	22,480
Non NHS Clinical Income	2,688
Other Income	471
Total Income	**25,639**
Medical Pay	(7,762)
Nursing Pay	(5,029)
Other Pay	(6,602)
Total Pay	**(19,393)**
Drugs	(1,778)
Consumables Non Pay	(328)
Other Non Pay	(3,930)
Total Non Pay	**(6,036)**
EBITDA	**210**
Below EBITDA	(210)
Adj to Financial Improvement Trajectory (FIT) Basis	**0**
Donated Assets	0
I&E surplus/(deficit)	**0**

3.10 The detailed plan includes a CIP requirement of £0.546m, This will be a challenging target for the subsidiary given the demands in Primary Care and current GP vacancies.

3.11 In addition, through the planning process an additional £0.3m cost pressure has emerged due to national contract increase being lower than expected. SHS will proactively look to manage their costs in line with the national Carr-Hill formulae; however should this not be possible the CCG have ring fenced a proportion of the system contingency to manage any agreed pressures in year resulting from this issue.

4. CIP

4.1 The scale of system efficiency to be delivered is significantly greater than in the previous two years, primarily due to the expectation that the country will exit the global pandemic funding regime. There is a general expectation explicit in the planning guidance that the NHS will return to pre-pandemic levels of efficiency and productivity. This is supplemented by the local funding pressures the system needs to resolve.

4.2 The above is resulting in a Trust savings programme of £4.562m for 2022/23. This has been allocated to both the subsidiaries and the YDH business units. This is broadly based on the historical allocation methodology used pre-pandemic, excluding areas that are not influenceable or where costs are pass through.

4.3 The programme represents an extremely challenging target for the group to deliver as teams and departments begin to exit the pandemic, whilst also looking at merged system functions across the Somerset system.

4.4 The breakdown is set out below:

Cost Improvement Programme	Budgets in scope £'000	Allocated CIP target £'000
Elective Care	48,242	1,038
Urgent Care	55,780	1,200
Clinical Income	0	0
Corporate	19,865	427
Central	6,973	150
Simply Serve Ltd	0	600
Symphony Healthcare Services	0	546
Total	**130,860**	**3,962**
Plus:		
Medicines	3,693	200
Private Patients	0	100
International Recruitment	0	300
Total	**134,553**	**4,562**

4.5 At present, approximately 64% of the target has schemes fully developed, in progress or being scoped. This does currently leave £1.629m unidentified.

Progress			Total
Fully Developed £'000	Plans in progress £'000	Opportunity £'000	£'000
350	602	1,981	2,933

4.6 Of the currently identified schemes, £1.933m (66%) are recurrent and £1.000m non-recurrent. Business Units will continue to be supported to increase the value of identified schemes and improve the percentage of schemes that will deliver recurrent benefits. Of the identified schemes, 12% have a green risk rating, the split is shown below:

GREEN	AMBER	RED	Total
£'000	£'000	£'000	£'000
350	1,487	1,096	2,933

5. CASH

5.1 The summary cash flow statement is set out below. This details the main cash inflows and outflow with the predicted year end cash balances.

5.2 This outlines that across the group cash from operating activities will be sufficient to meet the operating costs for the next 12 months.

5.3 There is no planned borrowing in 2022/23.

Statement of Cash flows	Group Plan 2022/23 £'000
Cash flows from operating activities	
Operating surplus	2,632
Non-cash income and expense:	
Depreciation and amortisation	9,309
Income recognised in respect of capital donations	(2,530)
(Increase)/decrease in receivables	0
(Increase)/decrease in inventories	(242)
Increase/(decrease) in payables and other liabilities	8,000
Increase/(decrease) in provisions	0
Corporation tax (paid)	(100)
Net cash from operations	**17,069**
Cash flows from investing activities	
Interest received	15
Payments to acquire intangible assets	(2,000)
Payments to acquire tangible fixed assets	(32,324)
Receipt of cash donations to purchase capital assets	250
Net cash used in investing activities	**(34,059)**
Cash flows from financing activities	
Public Dividend Capital received	14,995
Interest paid on loans including Department of Health loans	(24)
Loans repaid - including finance lease and PFI capital	(5,400)
Interest element of finance lease including intercompany	(565)
Interest on PFI and other service concessions	(84)
PDC capital (paid)/refunded	(2,407)
Net cash used in financing activities	**6,515**
Decrease in cash and cash equivalents	**(10,475)**
Cash and cash equivalents at 1 April 2022	**28,453**
Cash and cash equivalents at 31 March 2023	**17,978**

6. STATEMENT OF FINANCIAL POSITION

6.1 The statement of financial position based on the current revenue plans set out above and planned capital expenditure programme:

Statement of Financial Position	Group Plan 2022/23 £'000
Non current assets	
Intangible assets	8,503
Property, plant and equipment	175,126
Investments in associates and joint ventures	14
Trade and other receivables	708
Total non current assets	**184,351**
Current assets	
Inventories	2,971
Trade and other receivables	14,007
Cash and cash equivalents	17,978
Total current assets	**34,956**
Current liabilities	
Trade and other payables	(44,718)
Borrowings	(3,877)
Provisions	(3,650)
Total current liabilities	**(52,245)**
Total assets less current liabilities	**167,062**
Non current liabilities	
Borrowings	(64,197)
Provisions	(1,972)
Total non current liabilities	**(66,169)**
Total assets employed	**100,893**
Financed by	
Public dividend capital	158,295
Revaluation reserve	13,326
Income and expenditure reserve	(70,728)
Total taxpayers' & others' equity	**100,893**

7. RECOMMENDATION

7.1 The Board are asked to note and approve the Group's 2022/23 annual revenue budget as set out above.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Somerset NHS Foundation Trust approval of 2022/23 revenue budget
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Director of Finance
PRESENTED BY:	Chief Finance Officer
DATE:	3 May 2022

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 purpose of this report is to present to the Board the 2022/23 annual revenue budget and details of the cost improvement requirements and forecast cashflow.
Recommendation	The Board is requested to approve the 2022/23 annual revenue budget.

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
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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)

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]
Annual 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

2022/23 BUDGET

1. INTRODUCTION

1.1. The Trust submitted the final version of its financial, workforce and activity plan to NHSE/I on 28 April 2022. The submission included:

i) The financial plan – detailed profiled plans for I&E, capital, cash and efficiencies

ii) Workforce plans – setting out demand, supply, efficiency and skill mix information

iii) Activity plans - which set out trajectories for key performance areas

iv) Plan narrative – a system level commentary on the current context and challenges and the key changes in the plan for 2022/23

1.2. In addition, the Somerset system submitted a system wide plan which is a consolidation of the SFT, Yeovil District Hospital and CCG plans for 2022/23.

1.3. This paper is a summary of the final plan and proposes the annual revenue budget for agreement.

2. SUMMARY

2.1 The financial plan has been constructed with reference to the national planning guidance and local priorities. The national guidance set out a requirement for systems to work collaboratively and focus on the following set of priorities for 2022/23:

1) Investing in the workforce & strengthening a compassionate & inclusive culture

2) Delivering the NHS COVID-19 vaccination programme

3) Tackling the elective backlog

4) Improving the responsiveness of urgent & emergency care & community care

5) Improving timely access to primary care

6) Improving mental health services & services for people with a learning disability &/or autistic people

7) Developing approach to population health management, prevent ill-health, & address health inequalities

8) Exploiting the potential of digital technologies

9) Moving back to & beyond pre-pandemic levels of productivity

10) Establishing ICBs & enabling collaborative system working

2.2 Key financial planning assumptions for 2022/23 have been assessed, quantified and reviewed through the Trust internal business planning process and in collaboration with system partners. Directorates supported by the finance team have been working on their financial plans to confirm the exiting run rate from 2021/22 into 2022/23 and the additional financial requirements resulting from the priorities set out above for the coming year.

2.3 During the planning process there have been discussions nationally about the disparity between the assumptions in the planning guidance and allocations for inflation and COVID costs which are now higher than those national assumptions. This has resulted in these costs being separately identified within the system and organisational plan. It is expected that there will be further scrutiny and discussion regarding these costs once the system plan has been reviewed by regional NHSE/I.

2.4 The result of this is a planned deficit of £8.176m for SFT which forms part of the overall system plan deficit of £20.330m. If we assume there will be a resolution for the inflation and COVID costs then the overall system plan is balanced.

2.5 The remainder of this paper sets out how the financial plan translates into the revenue budget for 2022/23 and request Board approval.

3. INCOME AND EXPENDITURE

3.1 The summary level income and expenditure budget at Trust and Directorate level is shown below:

Statement of comprehensive income	Budget £'000
Operating income from patient care activities	591,454
Other operating income	38,593
Employee expenses	(436,760)
Operating expenses excluding employee expenses	(191,727)
OPERATING SURPLUS / (DEFICIT)	1,560
Finance Costs	(9,544)
Surplus/(Deficit) 2022/23	**(7,984)**
Adjustments to Financial Performance	(192)
Adjusted Financial Performance Surplus/Deficit	**(8,176)**

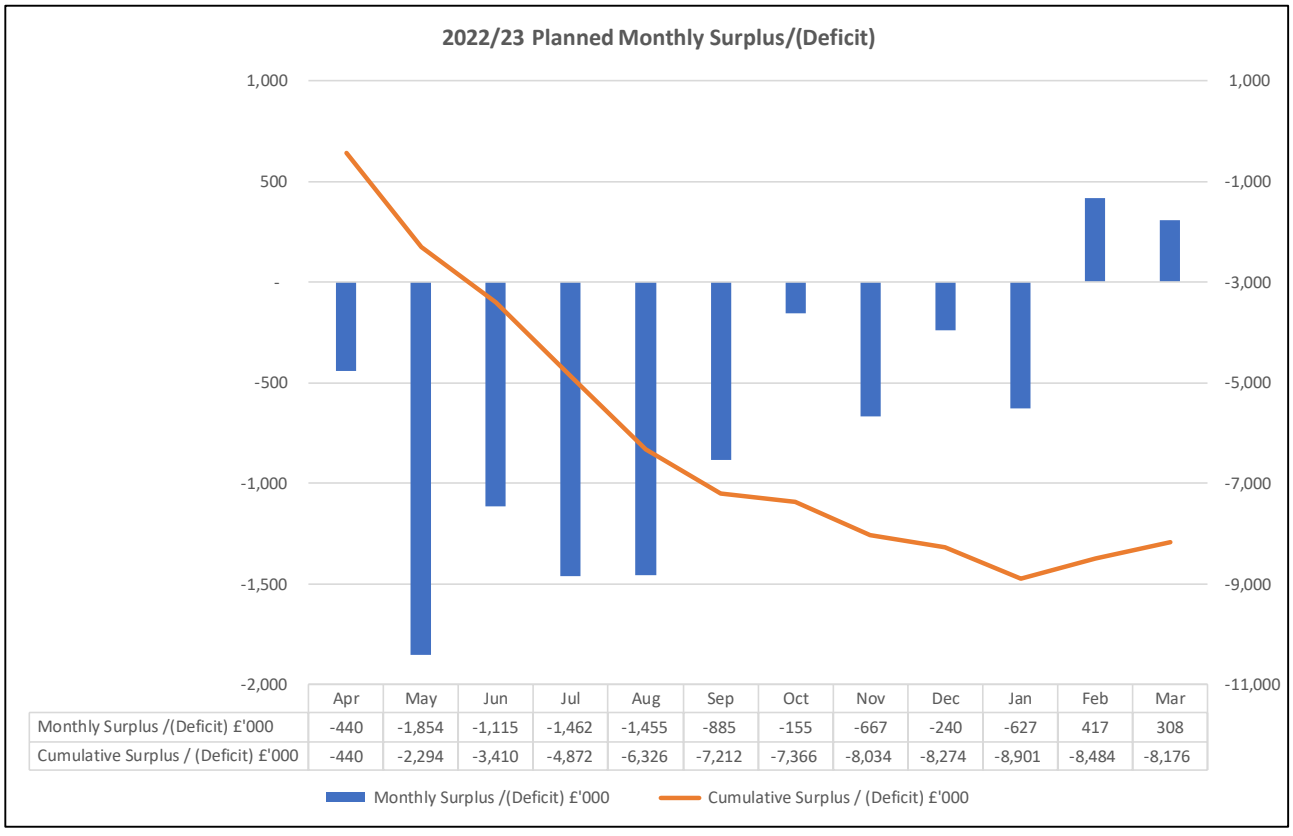
3.2 Directorate level expenditure budgets are set out in the table below. These are net of the CIP target shown in section 4.

DIRECTORATE	CLINICAL SUPPLIES £'000	DRUGS £'000	EMPLOYEE BENEFITS £'000	FINANCING COSTS £'000	NON CLINICAL SUPPLIES £'000	NON NHS CLINICAL INCOME £'000	OTHER INCOME £'000	2022/23 TOTAL BUDGET £'000
CLINICAL SUPPORT & SPECIALIST	5,140	20,912	46,913	5,058	17,215	(4)	(3,861)	91,372
CORPORATE SUPPORT SERVICES	2,224	72	60,598	34,688	44,258	(3,162)	(26,969)	111,710
FAMILIES CARE DIRECTORATE	2,430	2,083	45,318	0	2,092	0	(662)	51,262
INTEGRATED AND URGENT CARE	8,130	7,095	86,202	(0)	4,446	0	(571)	105,302
MENTAL HEALTH AND LD	89	627	59,033	0	9,585	0	(55)	69,278
OPERATIONAL MANAGEMENT	198	18	4,840	0	2,977	0	(32)	8,000
PRIMARY CARE & NEIGHBOURHOODS	1,420	71	36,556	0	3,615	0	(1,203)	40,460
RESERVES	540	517	13,186	0	888	0	(1,062)	14,068
SURGICAL CARE	13,655	9,118	84,115	0	2,303	0	(1,012)	108,178
TOTAL	**33,826**	**40,512**	**436,760**	**39,746**	**87,379**	**(3,166)**	**(35,427)**	**599,630**
NHS Clinical Income								**(591,454)**
2022/23 Annual Plan Deficit								**8,176**

3.3 The breakdown of corporate which includes the corporate support service departments and other central budgets such as CNST, capital charges and depreciation is shown in the table below:

CORPORATE	CLINICAL SUPPLIES £'000	DRUGS £'000	EMPLOYEE BENEFITS £'000	FINANCING COSTS £'000	NON CLINICAL SUPPLIES £'000	NON NHS CLINICAL INCOME £'000	OTHER INCOME £'000	2022/23 TOTAL BUDGET £'000
CENTRAL BUDGETS	0	0	2,465	0	3,692	0	(7,238)	(1,081)
CENTRAL INCOME	38	0	662	0	169	0	(2,445)	(1,576)
DIR OF CORPORATE GOVERNANCE	3	0	5,390	0	15,845	0	(0)	21,238
DIR OF STRATEGIC DEVELOPMENT	539	33	13,618	0	5,575	(2,318)	(6,224)	11,224
DIRECTOR OF FINANCE	(156)	0	4,322	749	1,612	0	(54)	6,472
DIRECTOR OF MEDICINE	0	0	1,194	0	38	0	(503)	729
DIRECTOR OF NURSING	0	0	3,650	0	189	0	(245)	3,594
DIRECTOR OF PEOPLE	6	39	7,724	0	2,543	0	(1,192)	9,120
ESTATES AND FACILITIES	1,795	0	14,249	0	14,218	0	(1,918)	28,343
CAPITAL CHARGES & DEPRECIATION	0	0	7,324	33,939	378	(844)	(7,151)	33,645
TOTAL	**2,224**	**72**	**60,598**	**34,688**	**44,258**	**(3,162)**	**(26,969)**	**111,710**

3.4 The monthly phased Trust budget is shown in the chart below:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Surplus /(Deficit) £'000	-440	-1,854	-1,115	-1,462	-1,455	-885	-155	-667	-240	-627	417	308
Cumulative Surplus / (Deficit) £'000	-440	-2,294	-3,410	-4,872	-6,326	-7,212	-7,366	-8,034	-8,274	-8,901	-8,484	-8,176

4. CIP

4.1 The scale of system efficiency to be delivered is significantly greater than in the previous two years. There is a general expectation explicit in the planning guidance that the NHS will return to pre-pandemic levels of efficiency and productivity. This is supplemented by the local funding pressures the system needs to resolve.

4.2 This is resulting in a Trust savings programme of £14.181m for 2022/23. This has been allocated to Directorates based on the allocation methodology used pre-pandemic which is to essentially exclude areas that are not influenceable or where costs are pass through.

4.3 The breakdown by directorate and corporate area is set out below:

Directorate	2022/23 CIP Target £'000
Central	582
Clinical Support & Specialist Services	2,022
Director of Corporate Governance	160
Director of Finance	183
Director of Nursing	101
Director of People	242
Director of Strategic Development	513
Estates	787
Families Directorate	1,307
Integrated & Urgent Care	2,088
Mental Health & LD	1,157
Operational Management	411
Primary Care & Neighbourhoods	1,540
Surgery	3,089
Trust Total	**14,181**

4.4 As at the current date, just over 56% of the target has schemes either fully developed, in progress or being scoped:

Progress			Total
Fully developed £'000	Opportunity £'000	Plans in progress £'000	£'000
2,734	3,607	1,641	**7,982**

4.5 Of the currently identified schemes, £3.183m (40%) are recurrent and £4.799m non-recurrent. Directorates will continue to be supported to increase the value of identified schemes and improve the percentage of schemes that will deliver recurrent benefits. Of the identified schemes, 80% have a green risk rating, the split is shown below:

GREEN	AMBER	RED	Total
£'000	£'000	£'000	£'000
6,429	240	1,313	**7,982**

5. CASH

5.1 The summary cash flow statement is set out below. This details the main cash inflows and outflows with the predicted year end cash balance.

5.2 Cash from operating activities will be sufficient to meet the operating costs for the next 12 months.

5.3 There is no planned borrowing.

Statement of cash flows	Plan Year Ending 31/03/2023 £'000
Cash flows from operating activities	
Operating surplus/(deficit)	958
Non-cash income and expense	
Depreciation and amortisation	27,646
Income recognised in respect of capital donations (cash & non-cash)	(1,200)
Amortisation of PFI credit	(259)
Increase/(decrease) in trade and other payables	(890)
Increase/(decrease) in provisions	(69)
Net cash generated from/(used in) operations	**26,186**
Cash flows from investing activities	
Interest received	189
Purchase of property, plant and equipment and investment property	(64,651)
Proceeds from sales of PPE & investment property	200
Receipt of cash donations to purchase capital assets	2,262
Net cash generated from/(used in) investing activities	**(62,000)**
Cash flows from financing activities	
Public dividend capital received	40,316
Loans from Department of Health and Social Care - repaid	(848)
Capital element of lease payments	(3,529)
Capital element of PFI, LIFT and other service concession payments	(2,009)
Interest element of lease payments	(332)
Interest element of PFI, LIFT & other service concession obligations	(1,277)
PDC dividend (paid)/refunded	(7,461)
Net cash generated from/(used in) financing activities	**24,860**
Increase/(decrease) in cash and cash equivalents	**(10,955)**
Cash and cash equivalents at start of period	58,729
Cash and cash equivalents at end of period	47,774

6. STATEMENT OF FINANCIAL POSITION

6.1 The statement of financial position based on the current revenue plans set out above and planned capital expenditure programme.

Statement of Financial Position	Plan Year Ending 31/03/2023 £'000
Non-current assets	
Intangible assets	15,495
On-SoFP IFRIC 12 assets	20,409
Other property, plant and equipment	351,652
Right of use assets - leased assets for lessee (excl PFI/LIFT)	24,127
Investments in associates and joint ventures	1,001
Receivables: due from non-NHS/DHSC Group bodies	1,462
Total non-current assets	**414,146**
Current assets	
Inventories	5,739
Receivables: due from NHS and DHSC group bodies	9,732
Receivables: due from non-NHS/DHSC Group bodies	11,254
Cash and cash equivalents: GBS/NLF	47,774
Cash and cash equivalents: commercial/in hand/other	490
Total current assets	**74,989**
Current liabilities	
Trade and other payables: capital	(13,532)
Trade and other payables: non-capital	(67,833)
Borrowings	(6,360)
Provisions	(821)
Other liabilities: deferred income incl contract liabilities	(10,487)
Other liabilities: other	(259)
Total current liabilities	**(99,292)**
Total assets less current liabilities	**389,843**
Non-current liabilities	
Borrowings	(41,083)
Provisions	(1,947)
Other liabilities: other	(1,941)
Total non-current liabilities	**(44,971)**
Total net assets employed	**344,872**
Financed by	
Public dividend capital	252,507
Revaluation reserve	69,405
Other reserves	(2,246)
Income and expenditure reserve	25,206
Total taxpayers' and others' equity	**344,872**

7. RECOMMENDATION

7.1 The Board are asked to note and approve the Trust's 2022/23 annual revenue budget as set out above.

CHIEF FINANCIAL OFFICER

Yeovil District Hospital NHS Foundation Trust/	
REPORT TO:	Trust Board
REPORT TITLE:	Learning from Deaths (Quarter 4)
SPONSORING EXEC:	Chief Medical Officer
REPORT BY:	Learning from Deaths Manager
PRESENTED BY:	Chief Medial Officer
DATE:	3 May 2022

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 Trust has implemented the required recommendations in implementing the National Guidance on Learning from Deaths. The Mortality Report includes summary tables for the Trust, which should be presented to the Board on a quarterly basis. This is a requirement of the National Quality Board Guidance on Learning from Deaths March 2017 and the NHS Improvement Implementing the Learning from Deaths framework, key requirements for Trust Boards July 2017.
Recommendation	The Quarter 4 report reflects the ongoing progress with the Medical Examiner identifying cases requiring further investigation through Mortality Reviews or Clinical Investigations. In addition the difficulties that are experienced when demand exceeds capacity to complete formal Mortality Reviews.

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 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]
Quarterly 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

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

LEARNING FROM DEATHS FRAMEWORK

Mortality Report/Learning from Deaths

Quarter 4 2021/2022

1. INTRODUCTION

1.1 In December 2016 the CQC report Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England, identified that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. In March 2017 the National Quality Board published national guidance on learning from deaths to initiate a standardised approach to learning which includes a number of recommendations to be included into Trust's governance frameworks.

1.2 These recommendations included having a Director responsible for the learning from deaths agenda, a Non-Executive Director to take oversight of progress and implementing a systematic approach to identifying the deaths requiring review, with a robust methodology for case record reviews. Ongoing developments included specific guidance for NHS Trusts in working with families, published in July 2018 and the introduction of Medical Examiners who commenced their role in the Trust on 1st July 2020. The intention is to make sure that all deaths not investigated through the coronial process are subject to a degree of independent scrutiny, with increased transparency for the bereaved and an opportunity for them to raise concerns.

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

1.4 The report highlighted several challenges for Trusts in the future. These include:

- Monitoring and evolving the role of the Medical Examiner, providing continuous safety improvement, and responding to complaints and concerns.
- Developing systems to allow learning from deaths that have occurred outside of a hospital, with effective information sharing across NHS providers.
- Improving support for staff as agreed across national bodies, including NHS Improvement and the Healthcare Safety Investigation Branch to enable them to carry out robust reviews and investigations of deaths and serious incidents.

1.5 The Quarterly Learning from Deaths report confirms the Trust's position in relation to these challenges as well as documenting our progress with the evolving systems used to identify and learn from a patient's death. All in hospital deaths can provide information about the individual patient's care

and management and this report details the learning that can be identified from many investigative sources.

1.6 The way we review a patient's death can take many forms with learning identified through several processes including but not exclusively those detailed below;

- External analysis of Mortality outcomes data through the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI)
- Scrutiny through the Medical Examiner service.
- Formal Structured Judgement Mortality Reviews.
- Coronial activity.
- Serious Incident Reviews.
- Complaints and Bereavement concerns.
- Learning Disability Reviews (LeDeR)
- Perinatal Mortality Reviews.
- Child Death Review processes.
- Review of COVID-19 related deaths.

1.7 Those cases reviewed through the above processes during Quarter 4 have allowed both local and Trustwide learning to be identified and shared. Within this report we firstly highlight any specific learning and actions followed by more detail about each investigative process and identification of general themes as well as defining the number of reviews undertaken through each process.

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

Learning from Mortality Reviews and investigative processes undertaken within the quarter:

1.9 Of the deaths reviewed using the Structured Judgement Tool so far in the quarter:

- There were some issues with the quality of documentation with clerking details incomplete without reason.
- Structured Judgement Reviews continue to show low avoidability scores.

Issues positive and negative:

- Evidence of good practice is being identified and recorded.
- Medical Examiner capacity has increased leading to appropriately identified cases for full Mortality Review

- Trust wide increases in activity have delayed completion of the full mortality reviews, but local reviews have been possible and learning continues to be identified.

Lessons Learned:

- Clear Treatment Escalation plans including end of life decisions need to be in place before patient transfer to a lower level of care or other unit. This will minimise inappropriate readmissions and transfers back into the acute unit.

- When patients are under multiple Multidisciplinary teams and pathways there is a potential for delays in treatment where priorities conflict.

- The fact that a patient is a cancer patient, albeit a curative one, can negatively impact on their care and management including the timeliness of potential ICU escalation.

- Insufficient information and clear Treatment Escalation Plans can lead to questions from the ICU team in terms of accepting patients escalated to them.

- Early and active intervention from the Mental Health Team needs to be requested and actioned to prevent patient deterioration before assessments can be completed.

- Formal Capacity assessments need to be completed in a timely manner and documented effectively.

Actions Taken:

- Continued progress to develop Trakcare and ensure effective migration to electronic patient records.

- Ongoing education regarding the need for Treatment Escalation Plans that reflect changing circumstances as patients move from one setting to another.

- Work within Oncology to ensure that patients admitted to general wards during ongoing treatments such as chemotherapy have a clear documented plan enabling the acute physicians to make appropriate decisions about continued management and escalation.

- Ongoing work to ensure that escalation plans are updated and clearly documented to facilitate appropriate decision making when patients deteriorate and may be unable to convey their wishes.

1.10 The following sections of this report describe the investigative processes which have been used to identify the above learning. Where there has been activity within the reporting quarter this is included along with details of any more general themes identified.

External analysis of Mortality outcomes data through the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI)

<u>The Trust Position - Mortality Rates. In hospital deaths per month</u>

Summary Hospital-Level Mortality Indicator (SHMI)

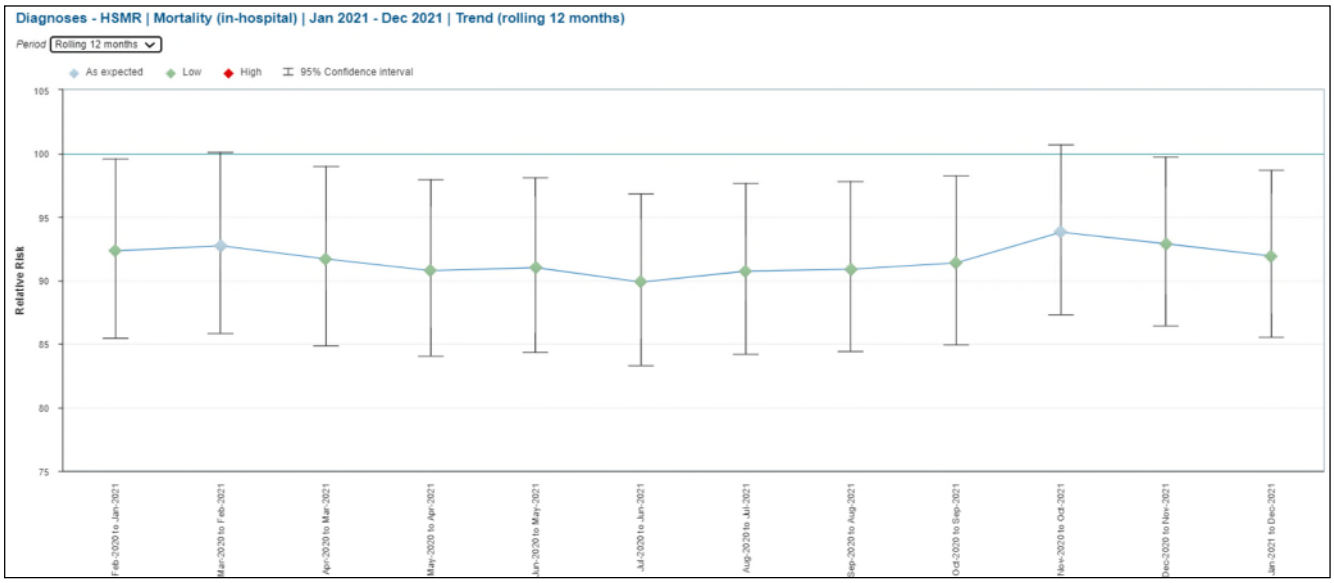
1.11 The number of deaths in hospital is captured through the Summary Hospital-Level Mortality Indicator (SHMI). This reports mortality at Trust level using a standard and transparent methodology, which is published quarterly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Our latest reported SHMI covering 12 months November 2020 to October 2021 is 96.86 and although this figure has increased slightly it remains within the expected range with no diagnostic groups showing as an outlier.

Hospital Standardised Mortality Ratio (HSMR)

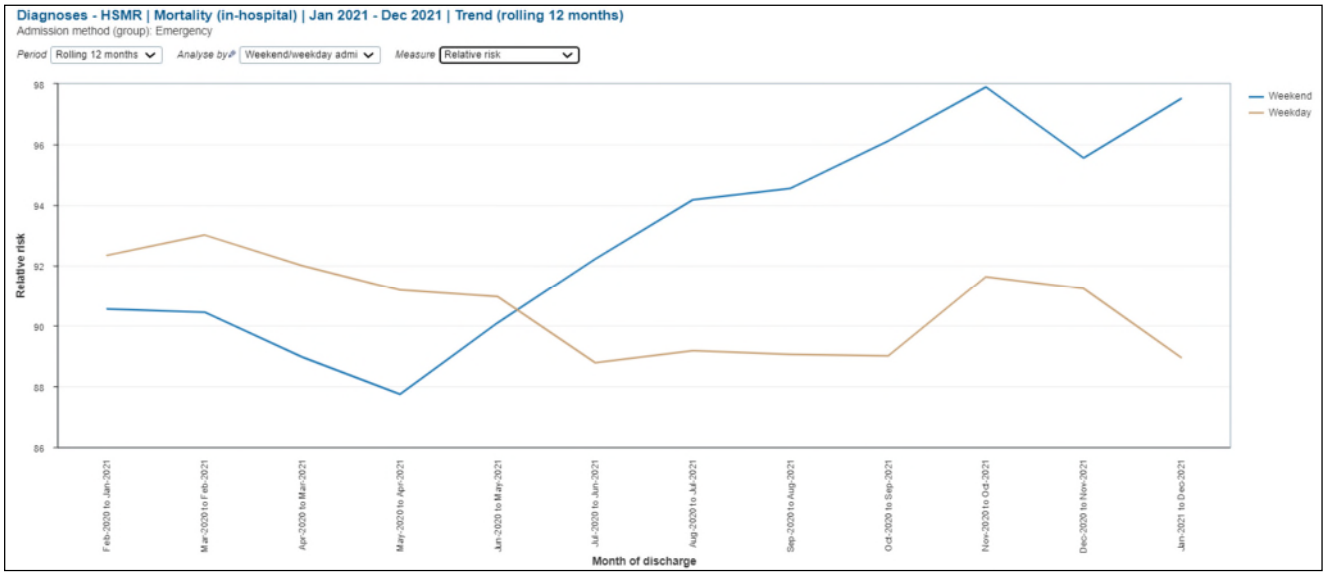
1.12 The Trust uses Dr Foster to support analytical review of outcomes data. There have been changes to the way that Dr Foster receives the national HES (Hospital Episode Statistics) data and this now comes directly from NHS Digital, improving filters and enhancing methodology to improve the accuracy of comorbidity and palliative code indicators and the predictive ability of the risk model.

1.13 Dr Foster outcomes data includes reporting of the Hospital Standardised Mortality Ratio (HSMR), which reviews a set number of indicators to inform understanding of quality and improvements in clinical care. The Trust HSMR for the latest reporting period January 2021 to December 2021 is 91.9 which is lower than expected.

1.14 A rolling data set shows a slight decrease in our HSMR since October 2021 as shown below.



1.15 The Trust's weekday HSMR is currently 88.9, significantly lower than expected with the weekend figure at 97.5 as expected. This weekend rate which had been showing a sharp increase since April 2021 is being monitored in case of a further peak.



Dr Foster HealthCare Intelligence Mortality Data

1.16 The Dr Foster analysis provides external assurance, providing a monthly analytical review of outcomes data in respect of Mortality within the Trust. The latest Dr Foster report with a data set from January 2021 to December 2021 highlights the Trust's position with both HSMR and SMR remaining statistically significantly low. Monitoring of our data reassures us that the reported figures are a true reflection of the current position.

1.17 The Dr Foster data also shows that we have maintained our high level of reporting of significant comorbidities. This positively affects our HSMR as this is calculated by comparing the number of expected deaths with the actual number of deaths. Patients with more comorbidities are by definition in a higher risk group for anticipated death.

1.18 The COVID pandemic has resulted in a change in patient activity which has reduced the denominator data and the variation in the number of observed deaths in some diagnoses groups. This trend is monitored within the monthly data report. Currently if all Covid-19 activity is removed from the HSMR the figure reduces to 90.0, statistically lower than expected.

Mortality Alerts

1.19 There were 2 new CUSUM alerts and one Mortality Alert reported by Dr Foster in Quarter 4. CUSUM is short for cumulative sum and an alert occurs when the number of deaths, readmissions or activity within the Trust in a cohort of patients with the same coded condition, (taking account of their comorbidities) is higher than anticipated. The alerts were in relation to –

- Other perinatal conditions
- Short Gestation, low birth weight and fetal growth retardation.
- Cataract – This Mortality Alert was identified as a coding error which has been rectified.

1.20 CUSUM Mortality alerts are reviewed firstly by identifying the number of patients in the cohort to ascertain if monitoring or review is appropriate. Where there are small numbers the data may be subject to change. If a review is commissioned, the accuracy of the codes allocated to their case is interrogated. If this does not show any issues an assessment of care and management from the patient records is completed. This allows us to ascertain why the alert has occurred and to identify any actions that should be taken to address any issues with the management of this group of patients. This process may result in the coding for the patient spell being amended if their main documented condition or cause of death has changed since their admission. Reviews are carried out through the Mortality Review Group or by the clinical teams involved, with the outcome fed back through the Clinical Outcomes Committee.

1.21 The two previous alerts reported in Quarter 3, Occlusion or stenosis of precerebral arteries (1 death recorded compared to an expected zero figure) and diagnostic endoscopic procedures on lower GI tract – (6 observed compared to an anticipated 1.9) continue to be monitored.

1.22 In respect of the alerts for Congestive Heart Failure and Senility and Organic Mental Disorders from Quarter 1 we continue to monitor and the numbers have not increased. The alerts reported in Quarter 2 for Diabetes Mellitus with complications and 'other joint' have also been monitored with no further increase or additional alert indicating that further action is required.

The Medical Examiner service

1.23 The introduction of the Medical Examiner Role in 2020 has helped to formalise our Mortality Review Processes. The current challenges and development include:

- Plans for all patients who die in the hospital to have an initial notes review by the Medical Examiner. This was not previously possible due to the number of available sessions and the retirement of one of our Medical Examiners. Additional Medical Examiner sessions have been recruited and these changes are beginning to be reflected in the number of case reviews undertaken.

- The majority of deaths should be scrutinised and assessed to identify any issues for referral. A discussion also occurs with the doctor responsible for completing the Medical Certificate of Cause of Death (MCCD). This prompts learning for the individual doctor and can serve to reduce the possibility of the documented cause of death being rejected by the Registrar's Office.

- There will also be a conversation between the Medical Examiner Officer or Medical Examiner and the patient's Next of Kin to explore any care concerns that they may have. This allows the team to identify any potential issues and to address these at an early stage.

- Where a cause of death has not been identified or this fits within the coronial rules an initial Coroner's referral is made to determine if further investigation will be required.

- Developments to date include active collaboration with Somerset Foundation Trust to provide a seamless cross-country process and the appointment of a dedicated lead with the responsibility for the rollout of these systems to include community deaths.

1.24 Of those cases referred to the Coroner by the Bereavement team for agreement about the cause of death within Quarter 4, the majority resulted in a form 100A being issued. This means the Coroner was informed of the death but the doctor has been given permission by the Coroner to issue the Medical Certificate and the Registrar is advised that the Coroner has been made aware of the death but no further investigation is necessary. Those cases resulting in a formal Coroner's inquest are discussed under Coronial activity below.

Formal Structured Judgement Mortality Reviews.

Learning from Deaths

The Three Stage Process

1.25 In addition to the above overview reporting mechanisms it is important to provide a formal system to review the care and management of any patient who dies within the Trust. The Trust's Learning from Deaths Manager holds responsibility for ensuring robust systems are used to identify and share learning from any death within the hospital.

1.26 The Structured Judgement Review Tool (SJR) from the Royal College of Physicians has been adapted to facilitate its use throughout the hospital. Formal mortality reviews are undertaken with data analysis used to inform improvements in care and provide reports to the Board.

1.27 The Mortality Review Group and the Learning from Deaths Manager oversee reviews of the management and care of all patients who have died within the hospital. A three-stage process is used with those patients requiring a formal review identified through the formal Medical Examiner interventions at the time of completing the death certification.

- Mortality review 1 - An initial assessment completed by the Medical Examiner enables early identification of any case where a potential problem exists. For example, where the cause of death does not follow from the admission diagnosis or where a potential omission in care or poor management is identified. Any such case is referred to the Specialty Team or the Mortality Review group who are responsible for undertaking a detailed mortality review to identify any concerns and to ensure learning for improvement. This system ensures that all patient deaths are subject to an initial review of their management and care, with a small number going forward for a full formal Mortality or Clinical review.

- Mortality Review 2 - Cases identified for this type of review will undergo a full review via speciality Morbidity and Mortality meetings with presentation of any significant findings at local Clinical Governance Sessions. Outcomes from these meetings, in particular any learning and actions taken will be recorded through the Learning from Deaths Manager within the Structured Judgement Review tool. The SJR tool summarises each review with an avoidability score. This is used to determine whether the information identified during the review, shows any evidence that the patient's death could have been avoided if different actions had been taken or the circumstances had been different. Any investigation undertaken outside of this process, for instance Serious Untoward Incident Investigations where death has occurred will now include an avoidability score as part of the investigation

summary. This ensures all patient in hospital deaths can be categorised depending on the level of avoidability in each individual case regardless of the investigative process.

There are some groups of patient who will automatically be subject to a Mortality Review 2, regardless of any findings identified by the Medical Examiner. These are where the number of deaths in the specialty is small, where the patient had a Learning Disability and where there is evidence of a hospital acquired COVID-19 infection which has been cited as the cause or contributed to the death.

- Mortality Review 3 - The third stage of the process involves the referral of any patient whose Mortality review has identified a degree of avoidability greater than 50% to the Mortality Review Group for verification and action. The Medical Examiner may also refer cases direct for this level of review. These cases may also include those where an incident investigation has been undertaken which does not cover the patient's death or where a case has been referred for a formal coroner's inquest.

1.28 The current investigation processes continue where an incident has been reported, the Coroner is involved, or where other potential issues have been identified through the complaints or bereavement process. The Medical Examiners, Medical Examiner's Officer and Learning from Deaths Manager liaise closely to avoid duplication and ensure that all deaths in hospital are reviewed at an appropriate level with outcomes, both positive and negative, recorded and shared. The Mortality Review Group continues to allocate formal review to clinicians with the expectation that they will perform the formal review and discuss with colleagues, ensuring a robust process.

1.29 The Trust's Learning from Deaths Manager has responsibility for collating learning from all inpatient deaths whichever review method is used. Outcomes are reported through the Incident Investigation and Learning Group, Local Governance Meetings, the Mortality Review Group and the Clinical Outcomes Committee as well as being summarised within this quarterly report.

Quarter 4 Review Outcomes

1.30 Quarter 4 saw 181 of our inpatient deaths (77%) scrutinised by the Medical Examiner. These would be classified as a Mortality Review at level 1 as described above. Of these cases 45 were recorded as having been referred to the Coroner for agreement about the cause of death, 23 were referred for a full review using the Structured Judgement Tool. 18 of these to be completed through the Mortality Review Group and 5 by the clinical teams

1.31 The reduced number of inpatient deaths scrutinised by the Medical Examiner in Quarter 3 (33%) has been addressed with additional reviews at Mortality Review 1 level completed on a random selection of case notes, alongside additional speciality reviews, bringing the percentage of reviews up to 77%. Of the additional reviews one case was referred to the Mortality Review Group for a full Structured Judgement review.

1.32 Although Quarter 4 has seen an increase in Medical Examiner reviews, clinical activity within the Trust has meant that it has not

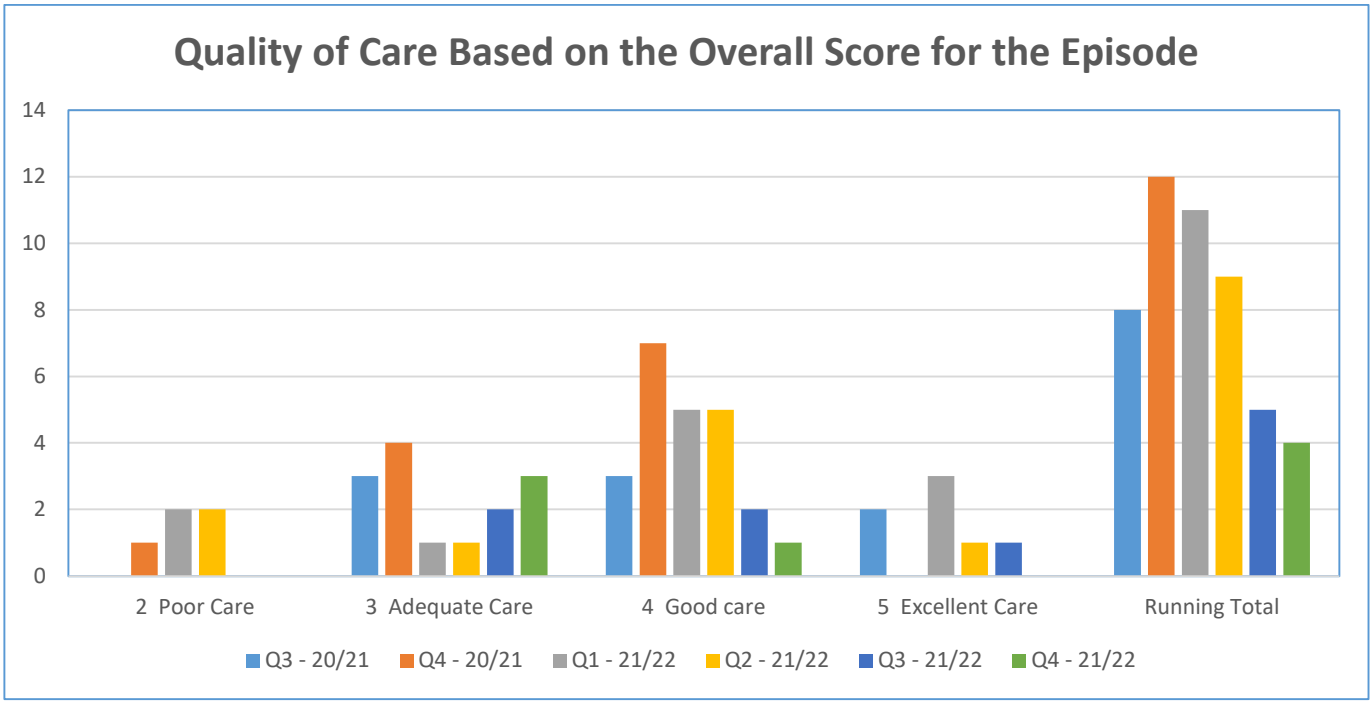
been possible to complete the second stage review for those cases referred to the Mortality Review Group within an acceptable timeframe.

1.33 For those reviews undertaken using the Structured Judgement Tool so far in Quarter 4 (and the updated cases from the previous quarter), all scored a 5 or 6 and were not judged to be avoidable.

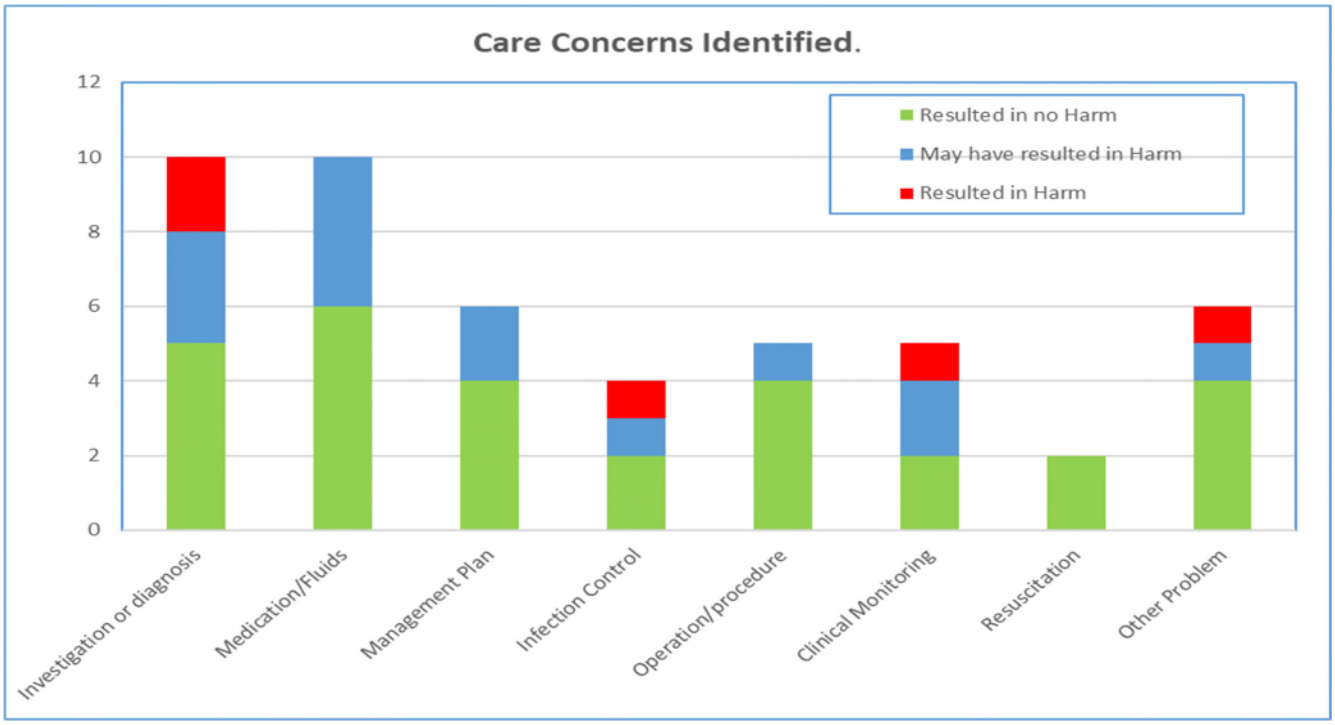
1.34 This data is summarised in the following charts:

Quarter 4 2021/22 -

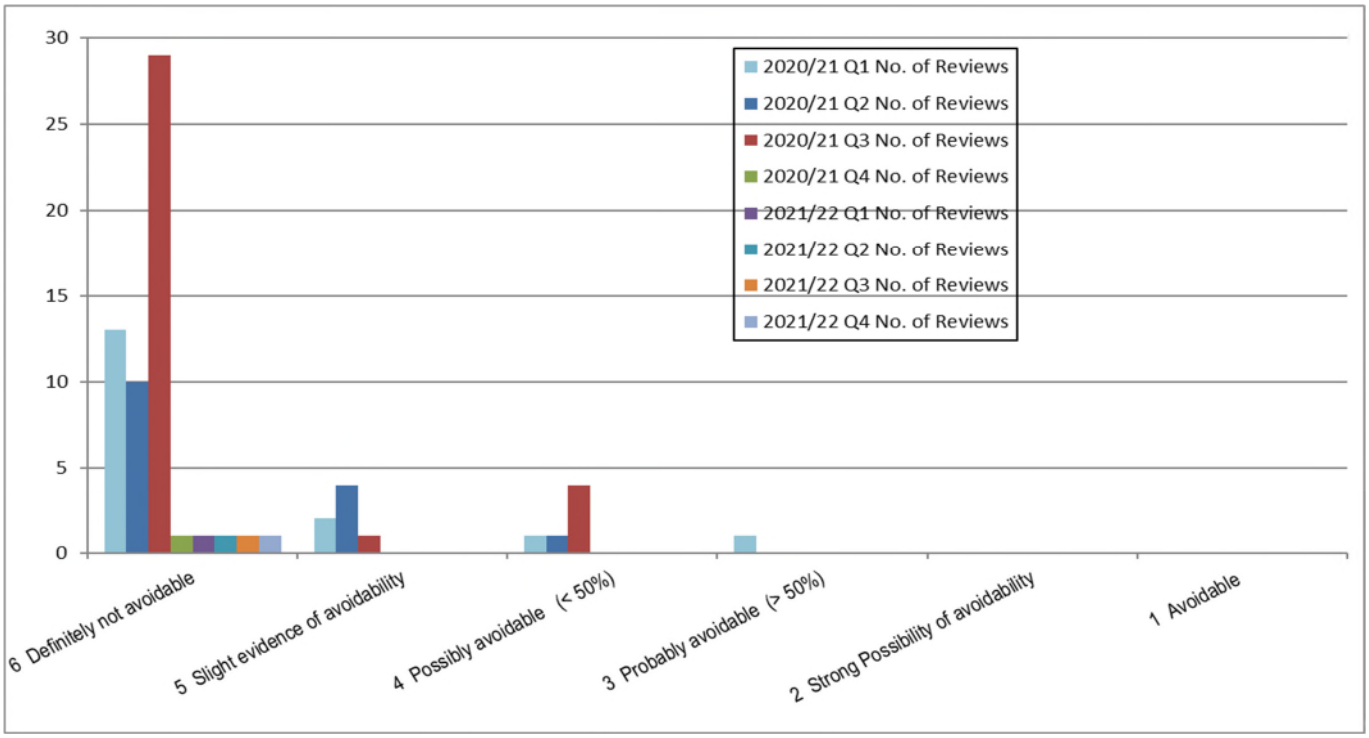
Findings from case reviews completed using the Structured Judgement Tool



Care Concerns rolling year to date



Level of avoidability of death in each case reviewed - Rolling data 2020-2022



Structured Judgement Tool Avoidability Score

1 – Definitely avoidable
2 - Strong possibility of avoidability
3 – Probably avoidable greater than 50%
4 - Possibly avoidable less than 50%
5 - Slight evidence of avoidability
6 - Definitely not avoidable

Coronial Activity

1.35 There are also cases where the Coroner has requested investigative statements from staff in relation to the death of an inpatient or where the patient had a recent admission or procedure that could be relevant to their death. 4 new instructions were received relating to deaths in quarter 4.

1.36 A patient died following transfer to Kings College Hospital following out of hospital overdose and liver failure and one following a fall at a care home sustaining an intracranial bleed. One patient was admitted following a choking episode resulting in Aspiration Pneumonia, and one as a result of malnutrition and a fall at home on background of alcohol abuse.

1.37 Formal statements have been requested for all cases with no omission or care problems identified to date that would be considered to have contributed to the patients' deaths.

1.38 The Regulation 28 Prevention of Future Deaths regulation notice following from the inquest reported in the previous quarter has been addressed. Actions including increasing access to and linking of pre-hospital clinical information to the Trust's electronic patient records and changes to the education and local induction of new staff to the Emergency Department are in place. A formal response has been provided to HM Coroner who will expect these changes in process to be embedded and monitored to ensure they remain efficient.

1.39 The Trust is also waiting for two long-standing cases to go to inquest in the near future. (Deaths reported in 2013 and 2017)

Serious Incident Reviews, Complaints and Bereavement concerns.

1.40 There was one incident in Quarter 4 where a Serious Incident Investigation was commissioned relating to a patient's death and two cases under review. Additional details will not be available until these investigations are complete.

1.41 One case resulted from a Patient Advice and Liaison enquiry with concerns relating to care and a lack of interventions in a deteriorating patient. The review confirmed that intervention would have been inappropriate and would not have prevented the patient's death.

Learning Disability Deaths

1.42 No patients with a Learning Disability died in the quarter. All deaths where a patient has been confirmed as having a Learning Disability are reported in line with national requirements and reviewed as part of the Trust's formal process with a subsequent referral externally for a full LeDeR review. Following the changes to the current process these cases will be subject to a full Mortality Review (MR2) using the Structured Judgement Tool.

Perinatal and Child Death reviews

Neonatal and Maternal Deaths

1.43 CNST requires that cases and actions reviewed using the Perinatal Mortality Review Tool (PMRT) are reported to Trust Board quarterly. The PMRT facilitates a comprehensive, robust and standardised review of all perinatal deaths from 22+0 gestations (excluding terminations) to 28 days

after birth; as well as babies who die after 28 days following neonatal care. Review is undertaken by a multidisciplinary panel of clinicians which has to include a panel member who is external to the unit.

1.44 The web-based tool presents a series of questions about care from pre-conception to bereavement and follow-up care. The factual information is entered in advance of a multidisciplinary panel of internal and external peers (allowing for a 'Fresh eyes' perspective) review of cases. The tool is used to identify required learning with action plans generated, implemented and monitored.

1.45 Reviews undertaken and the findings are detailed in the Trust's Quarterly Maternity Quality Report.

Review of COVID-19 related deaths.

1.46 The Trust is required to maintain processes to investigate and learn from cases where COVID-19 has been identified as hospital acquired and listed as the cause of death or a contributory factor.

1.47 The South West Regional Healthcare Setting Outbreak Framework from NHS England and NHS Improvement guidance states that where there is any evidence that the COVID-19 infection may have been hospital-acquired and a death has resulted, there is scope for learning. If the infection was acquired due to issues in healthcare provision, such as non-compliance with IPC processes this is potentially a Serious Incident.

1.48 The Mortality processes and Medical Examiner Role link closely with the Post Infection Review (PIR) process which, in agreement with the CCG and following the Outbreak Framework, requires a serious incident review for all cases where a lapse in care has been identified.

1.49 The Trust has developed processes to identify any care and service delivery problems within the group of patients where a COVID-19 infection has contributed to or caused their death. Where a patient has COVID-19 identified as a cause of death documented on their death certificate a review is undertaken to determine if there were any lapses in care. Those cases where a lapse is identified a serious incident review is commissioned. No omissions have been identified from reports completed in the quarter.

1.50 This information concludes the Quarterly Mortality and Learning from Deaths report for Quarter 4.

Appendix 1

This table is a summary of the number of deaths in month against the number reviewed using the investigative processes available. Please note there is a delay in accurate reporting of in-quarter reviews due to the time frames of external surveillance data from Dr Foster and the mortality review process . This table will be updated quarterly.

	2020/21								2021/22															
	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total	April	May	June	Q1 Total	Jul	Aug	Sep	Q2 Total	Oct	Nov	Dec	Q3 Total	Jan	Feb	Mar	Q4 Total
Total deaths in the Trust (including ED deaths)	52	81	96	**229**	104	76	57	**237**	61	68	59	**188**	68	71	62	**201**	87	71	82	**240**	87	83	64	**234**
Number subject to a Level 1 Mortality Review	49	62	58	**169**	85	49	37	**171**	49	47	33	**129**	49	47	25	**121**	38	35	39	**112**	64	63	54	**181**
Number referred for a Level 2/3 Mortality Review	7	14	17	**38**	10	16	8	**34**	8	3	4	**15**	6	4	3	**13**	5	3	10	**18**	9	7	5	**23**
Number of completed Level 2/3 Reviews	7	14	17	**38**	10	16	18	**34**	8	3	4	**15**	5	3	1	**9**	4	0	5	**9**	3	2	0	**5**
Number investigated as a Serious Incident	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	0	1	0	**1**
Learning Disability deaths	0	0	1	**1**	0	1	1	**2**	1	0	0	**1**	0	1	0	**1**	0	0	0	**0**	1	0	0	**1**
Bereavement concerns	0	0	0	**0**	0	0	0	**0**	0	1	1	**2**	0	0	1	**1**	0	1	2	**3**	0	1	0	**1**
Coroner's Inquest investigations	3	1	2	**6**	0	1	1	**2**	0	1	1	**2**	2	2	1	**5**	4	1	4	**9**	1	2	3	**6**
Number thought more likely than not to be due to problems with care	0	0	0	**0**	0	0	1	**1**	0	0	**1**	**0**	0	0	0	**0**	1	0	0	**1**	0	0	0	**0**

It should be noted that scrutiny of all patient deaths by the Medical Examiner and the resultant change in process means that comparative data is not yet available for all types of investigative review. Where available retrospective data has been added to the above chart.

In Q4 181 cases were reviewed by the Medical Examiner as a first level Mortality Review and 23 deaths were referred for a full case review in the quarter

- 5 were subject to a level 2 Mortality Review using the SJR tool, with the remainder awaitng completion of the review.
- 1 case was referred for a LeDeR review following initial local review.
- 0 cases are being investigated under the serious incident review process.
- 1 case was reviewed where bereavement concerns were raised and 6 will be reviewed as part of the coronial process.

Somerset NHS Foundation Trust/	
REPORT TO:	Trust Board
REPORT TITLE:	Learning from Deaths (Quarter 4)
SPONSORING EXEC:	Chief Medical Officer
REPORT BY:	Head of Patient Safety and Learning Deputy Chief Medical Officer (Trust medical lead for LfD) Quality and Safety Analyst
PRESENTED BY:	Dr Matthew Hayman, Deputy Chief Medical Officer (Trust medical lead for LfD)
DATE:	3 May 2022

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 learning from deaths framework published by NHS Improvement places a number of requirements on NHS trusts, including to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meetings. This report demonstrates the processes in place for how Somerset FT learn from deaths and how this learning is shared and improvements made
Recommendation	The Board is asked to discuss the report.

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

LEARNING FROM DEATHS FRAMEWORK

1. MORTALITY PROCESS UPDATE

1.1 Medical examiner's office had 438 deaths reported to them between January and March 2022. Of these 39 were Community Hospital Deaths. 97% of the 438 deaths were scrutinized by the medical examiner team. The Medical Examiner ensures the appropriate direction of deaths to the coroner and during this period 67 deaths were referred. Medical practitioners will have a duty to report deaths to a coroner for which they are unable to ascertain the cause of death, the cause of death is unnatural, or the death occurred in custody or state detention, e.g. under a section of the mental health act.

1.2 On 31 March 2022 Mr Tony Williams retired as Chief Coroner for Somerset, the new Acting Senior Coroner for Somerset is Samantha Marsh. We are assisted by 3 Deputy Coroner's and their Officers. As an organisation we have inquests being heard as far apart as Kent and Devon, with a number being held in Dorset. Currently there is some delay in hearing Inquests. The delay is mainly attributable to the impact of covid, in Somerset there has not been the capability to hear inquests remotely. We anticipate in person inquests to resume by the beginning of summer,

1.3 Clinical colleagues remained under unprecedented pressure throughout the reporting period at times affecting timeliness of mortality review completion. Senior review is underway to see how we can support colleagues with mortality reviews in a more timely manner. We acknowledge that a few families have had cause to raise complaints due to delays. We are working closely with these families to support them.

1.4 Maternity services now provide a report shared with the Trust Board each quarter that includes details of any perinatal death, what has been reviewed and the subsequent action plans. The report should evidence that the Perinatal Mortality Review Tool (PMRT) has been used to review eligible perinatal deaths and that the required standards have been met. The maternity governance team have now implemented (as of Dec 2021) a monthly PMRT meeting which will be held on the 1st Thursday of every month. This structure will enable regular review of cases with a multidisciplinary team (MDT) and an external representative. All finalised reports and subsequent action plans are shared with the parents according to their wishes. During the quarter reported there were six perinatal deaths in the reporting period which were eligible to be notified to MBRRACE-UK; all six were notified within seven days.

2 LEARNING, IMPROVEMENT, AND CHANGE

2.1 Learning from the PMRT has included the alignment of guidance for neonatal abstinence in both maternity and SNCU. Also, to ensure

that the guidance requires 2 confirmatory ultrasound scans for intra uterine deaths so that there is consistency.

2.2 Medical examiner's office had 473 deaths reported to them between October – December 2021. Of these 40 were Community Hospital Deaths 40. From 96.5% of the 473 deaths were scrutinized by the medical examiner team. The Medical Examiner ensures the appropriate direction of deaths to the coroner and during this period 80 deaths were referred. Medical practitioners will have a duty to report deaths to a coroner for which they are unable to ascertain the cause of death, the cause of death is unnatural, or the death occurred in custody or state detention, e.g. under a section of the mental health act.

2.3 Haematology and oncology are regularly reviewing deaths of patients in their care. The haematology team recently undertook a review of a patient who was receiving joint care between SFT and YDH. It was recognised that improved communication across the joint pathway may have resulted in an earlier investigation, and this may in turn have prevented an admission to hospital where they acquired an infection and died. The family has been supported throughout the review and have responded positively to the learning identified.

2.4 Following the recent death of a patient on ITU who had not received the covid 19 vaccine due to a severe needle phobia, a system wide learning event will take place. This will promote better understanding of how individuals with complex needs require further assistance with their healthcare; the multiagency learning review will take place and involve other stakeholders from social care. This is a good example of the wider learning from deaths agenda where stakeholders and the family will be involved in a discussion which we hope will help shape future care.

2.5 In 2020 there were 3 cases where patients who had been in contact with our service had been involved in homicides. Further review in conjunction with NHS England has shown that there may be further learning to be identified from one of the cases. As such we are working closely with an external provider to determine any additional learning and consequently any additional improvements. The outcome to this will be known later in the year.

2.6 Although not a contributory factor to the patient's death there was an acknowledgement that the management of a patient receiving outpatient mental health services was not meeting their individual needs. Where there are additional needs which cannot be met via attend anywhere or by a telephone call then the individual should be offered a face-to-face appointment where reasonable. Following discussion at MH SIRG this will now be shared with colleagues as part of the Governance Matters newsletter produced by the MH directorate.

2.7 Since 2014, all In-patient deaths following hip fracture have been reviewed by a multi-disciplinary team consisting of orthopaedic surgeon, ortho-geriatrician and anaesthetist. In the first year, we demonstrated that this process detected 3 times as many care errors as preceding orthopaedic M&M process. Although 150 sounds like a lot of deaths, Musgrove

has had both absolute and casemix-adjusted rates below national average for almost all of that time, and last year was a national statistical outlier for low mortality. The top 3 avoidable care errors that probably/possibly contributed to death were (in order) management of peri-operative hypotension, management of pre-existing co-morbidity and failure to escalate. Peri-operative hypotension accounted for nearly half of the total. These findings have driven changes in clinical practice and provided data to support business cases for investment in the hip fracture service, especially orthogeriatrics.

2.8 Following on from the above review of hip fractures further work was undertaken by the anaesthetics and ITU department. Using Quality Improvement methodology, they came up with the following management plan to apply to all patients:

1. The minimum target blood pressure is the same for all patients (100mmHg) and is a continuum of the target blood pressure in the operating theatre.

2. If target blood pressure falls below this, patients are to receive 2 boluses of intravenous fluid.

3. If the blood pressure does not recover, an infusion of metaraminol is to be started (this is the drug that increases blood pressure).

4. If the metaraminol cannot be safely weaned off after 1 hour, the patient is referred automatically to critical care for discussion around suitability of escalation of care (which is appropriate for the majority of patients).

2.9 This affected approximately 45 patients per year (roughly 10% of all patients who are admitted with a fractured neck of femur) and these have been admitted to critical care without any adverse impact on the safe delivery of critical care to other patients. The nurses in the post-operative recovery have also fed back that they feel empowered to manage their patients better. Further improvement work is ongoing on the trauma wards around management of hypotension. This project is being led by a consultant anaesthetist.

3 MORTALITY REVIEWS

		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Community hospital	**Deaths**	14	8	20	21	17	12	15	15	13	15	24	20
	ME Reviews	0	0	0	0	11	8	9	13	11	12	19	N/A
	Reviews	5	2	15	11	5	1	4	5	5	4	5	0
	Stage 2	0	0	1	0	1	0	2	0	0	0	0	0
Contact with MH services in the last 6 months	**Deaths***	5	7	3	4	7	5	5	0	1	4	5	4
	ME Reviews	0	0	0	0	0	1	0	0	0	1	0	0
	Reviews	5	7	3	4	7	5	0	0	1	4	5	4
	Stage 2	5	4	4	2	3	5	0	0	1	3	3	3
Learning disabilities	**Deaths****	1	0	3	0	0	0	3	3	1	1	0	0
	LeDeR	1	0	3	0	0	0	3	3	1	1	0	0
	Stage 2**	1	0	3	0	0	0	3	3	1	1	0	0
Acute inpatients	**Deaths**	110	73	80	89	96	103	89	105	94	185	101	133
	ME Reviews	110	73	80	89	96	103	89	105	94	185	101	133
	Reviews	8	14	13	12	12	9	5	5	3	2	2	2

*MH death that meets criteria of being seen by MH services within 6 months prior to death
**All LD deaths who have been referred to the LFD team

4 STANDARDISED MORTALITY REPORT MARCH 2022

Standardised mortality report - March 2022

Data source

4.1 This report refers to two measure of standaradised mortality: summary hospital-level mortality index (SHMI) and hospital standardised mortality ratio (HSMR). For information regarding these indicators please refer to the quick guide in Appendix A.

Date run:	Latest SHMI available:	Lastet HSMR available:
8th March 2022	October 2021*	October 2021*

4.2 The source of the data is Healthcare Evaluation Data (www.hed.nhs.uk) which uses hospital episode statistics (HES) to calculate the indicators. Patients who have signed up to the national opt out programme are not included in the HES data. SHMI HES is used rather that the NHS digital dataset as the SHMI using HES data is more up-to-date.

***HSMR data is published to October 2021 and SHMI is published to November 2021, however for Somerset FT data beyond September is incomplete, we are waiting for further update from coding. Therefore, this analysis has been restricted to data upto October 2021.**

4.3 Covid 19 has affected activity and mortality rates in a significant way which is not fully represented in the SHMI and HSMR models. SHMI exclude all spells with a suspected or confirmed diagnosis of covid in any position, as well as any patient with mention of covid on the death certificate. HSMR does not include spells where primary diagnosis on admitting episode is confirmed or suspected covid, but may include spells with a confirmed or suspect covid diagnosis in other positions.

Overall position

	Period	RR	LCL	UCL	Banding
SHMI	Nov 20 – Oct 21	99.27	94.64	104.06	**As expected**
HSMR	Nov 20 – Oct 21	117.12	110.26	124.30	**Above expected**

Position for admission on weekdays

	Period	RR	LCL	UCL	Banding
SHMI	Nov 20 – Oct 21	98.28	93.05	103.73	**As expected**
HSMR	Nov 20 – Oct 21	114.81	107.06	122.98	**Above expected**

Position for admissions at weekends

	Period	RR	LCL	UCL	Banding
SHMI	Nov 20 – Oct 21	102.62	92.85	113.13	**As expected**
HSMR	Nov 20 – Oct 21	124.62	110.25	140.35	**Above expected**

Higher than expected HSMR position

4.4 The overall HSMR value for the 12 month period November 2020 to October 2021 remains significantly higher than expected. It includes significantly high value for the individual months of January 2021, September 2021 and October 2021.

4.5 Nationally (all Trusts) the HSMR position is within the expected range at 100.39 (95% CI: 99.89 – 100.90). Somerset FT has the 10th highest HSMR of all acute Trusts for the 12 month period and is one of 40 acute Trusts to have a significantly higher than expected HSMR for the period.

4.6 Somerset FT HSMR activity has the third lowest rate of palliative care coding of acute Trusts. Without adjustment for Palliative care, HSMR is within the expected range. (101.04 , 95% CI 95.12 to 107.24).

Position by treatment site

4.7 *Sites with 60 or less SHMI spells are not included*

Treatment site	SHMI (November 20 – October 21)	HSMR (November 20 – October 21)
RH5A8 - MUSGROVE PARK HOSPITAL	As expected 98.3 (95% CI: 93.7 - 103.0) Excess deaths: -30.6	**Above expected** 114.6 (95% CI: 107.5 - 122.0) Excess deaths: 124.6
RH5K6 - BRIDGWATER COMMUNITY HOSPITAL	As expected 88.0 (95% CI: 46.8 - 150.5) Excess deaths: -1.8	As expected 82.6 (95% CI: 26.6 - 192.8) Excess deaths: -1.1
RH536 - RYDON	As expected 0.0 (95% CI: 0.0 - 372.5) Excess deaths: -1.0	As expected 0.0 (95% CI: 0.0 - 7952.2) Excess deaths: -0.1
RH572 - ROWAN	As expected 0.0 (95% CI: 0.0 - 406.3) Excess deaths: -0.9	As expected 0.0 (95% CI: 0.0 - 10904.2) Excess deaths: 0.0
RH5G5 - FROME COMMUNITY HOSPITAL	**Above expected** 163.6 (95% CI: 108.7 - 236.5) Excess deaths: 10.9	**Above expected** 183.5 (95% CI: 112.0 - 283.3) Excess deaths: 9.1
RH5F8 - WEST MENDIP COMMUNITY HOSPITAL	As expected 75.2 (95% CI: 34.3 - 142.8) Excess deaths: -3.0	As expected 143.6 (95% CI: 71.6 - 256.9) Excess deaths: 3.3
RH5G2 - WINCANTON COMMUNITY HOSPITAL	As expected 117.9 (95% CI: 69.8 - 186.3) Excess deaths: 2.7	As expected 115.8 (95% CI: 61.6 - 198.0) Excess deaths: 1.8
RH5G1 - SOUTH PETHERTON HOSPITAL	**Below expected** 56.2 (95% CI: 29.9 - 96.1) Excess deaths: -10.1	As expected 77.7 (95% CI: 40.1 - 135.7) Excess deaths: -3.5
RH5Q3 - NUFFIELD NHS CONTRACT	As expected 0.0 (95% CI: 0.0 - 2121.7) Excess deaths: -0.2	As expected 0.0 (95% CI: 0.0 - 14580.3) Excess deaths: 0.0
RH5F5 - MINEHEAD COMMUNITY HOSPITAL	**Above expected** 164.0 (95% CI: 101.5 - 250.7) Excess deaths: 8.2	**Above expected** 310.5 (95% CI: 165.1 - 530.9) Excess deaths: 8.8

Treatment site	SHMI (November 20 – October 21)	HSMR (November 20 – October 21)
RH5F4 - BURNHAM ON SEA WAR MEMORIAL HOSPITAL	As expected 161.8 (95% CI: 88.4 - 271.4) Excess deaths: 5.3	As expected 187.0 (95% CI: 80.5 - 368.4) Excess deaths: 3.7
RH563 - PYRLAND	As expected 118.3 (95% CI: 31.8 - 302.8) Excess deaths: 0.6	As expected 263.4 (95% CI: 70.9 - 674.4) Excess deaths: 2.5
RH5F9 - CREWKERNE HOSPITAL	As expected 145.8 (95% CI: 66.5 - 276.9) Excess deaths: 2.8	As expected 140.6 (95% CI: 67.3 - 258.5) Excess deaths: 2.9
RH5F6 - WILLITON HOSPITAL	As expected 152.6 (95% CI: 88.8 - 244.3) Excess deaths: 5.9	**Above expected** 284.2 (95% CI: 146.7 - 496.5) Excess deaths: 7.8

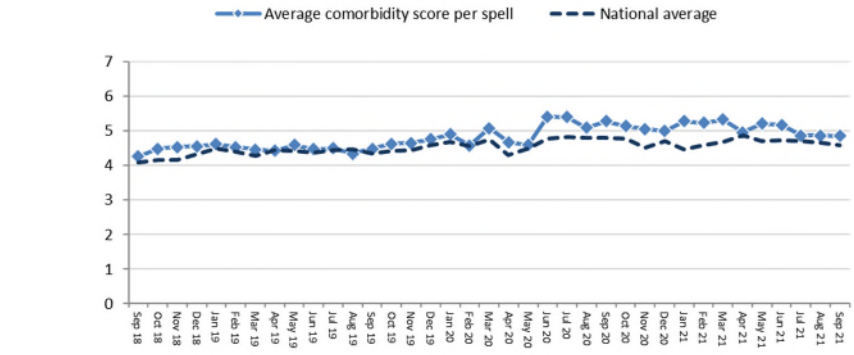
4.8 **Position by CCS diagnosis group** *Includes groups where latest SHMI or HSMR are not as expected*
A table showing CCS outliers over time is available as appendix B

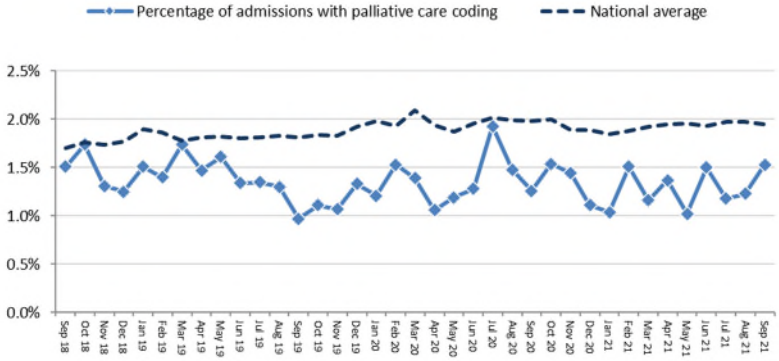
CCS Diagnosis group	SHMI (November 20 – October 21)	HSMR (November 20 – October 21)
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	As expected 95.5 (95% CI: 81.5 - 111.2) Excess deaths: -7.8	**Above expected** 125.7 (95% CI: 105.9 - 148.1) Excess deaths: 29.0
106 - Cardiac dysrhythmias	As expected 70.6 (95% CI: 32.2 - 134.0) Excess deaths: -3.8	**Below expected** 16.0 (95% CI: 0.2 - 89.1) Excess deaths: -5.2
149 - Biliary tract disease	**Below expected** 46.9 (95% CI: 18.8 - 96.7) Excess deaths: -7.9	**Below expected** 24.7 (95% CI: 2.8 - 89.2) Excess deaths: -6.1
2 - Septicemia (except in labor)	As expected 96.6 (95% CI: 81.3 - 113.9) Excess deaths: -4.9	**Above expected** 125.5 (95% CI: 104.3 - 149.7) Excess deaths: 25.0
68 - Senility and organic mental disorders	As expected 122.4 (95% CI: 95.4 - 154.7) Excess deaths: 12.8	**Above expected** 160.4 (95% CI: 117.4 - 214.0) Excess deaths: 17.3
226 - Fracture of neck of femur (hip)	**Below expected** 64.3 (95% CI: 42.7 - 93.0) Excess deaths: -15.5	As expected 85.9 (95% CI: 55.6 - 126.9) Excess deaths: -4.1
114 - Peripheral and visceral atherosclerosis	**Below expected** 66.0 (95% CI: 42.7 - 97.4) Excess deaths: -12.9	As expected 87.9 (95% CI: 52.1 - 138.9) Excess deaths: -2.5
241 - Poisoning by psychotropic agents	**Above expected** 330.5 (95% CI: 106.5 - 771.3) Excess deaths: 3.5	Not included
219 - Short gestation; low birth weight; and fetal growth retardation	**Below expected** 23.9 (95% CI: 2.7 - 86.1) Excess deaths: -6.4	Not included

CCS Diagnosis group	SHMI (November 20 – October 21)	HSMR (November 20 – October 21)
128 - Asthma	**Above expected** 498.0 (95% CI: 100.1 - 1455.1) Excess deaths: 2.4	Not included
24 - Cancer of breast	**Above expected** 174.7 (95% CI: 103.5 - 276.1) Excess deaths: 7.7	**Above expected** 206.7 (95% CI: 109.9 - 353.4) Excess deaths: 6.7
133 - Other lower respiratory disease	As expected 185.1 (95% CI: 95.5 - 323.3) Excess deaths: 5.5	**Above expected** 218.3 (95% CI: 104.5 - 401.4) Excess deaths: 5.4
199 - Chronic ulcer of skin	**Above expected** 203.6 (95% CI: 111.2 - 341.7) Excess deaths: 7.1	As expected 174.8 (95% CI: 83.7 - 321.5) Excess deaths: 4.3
158 - Chronic renal failure	**Above expected** 384.1 (95% CI: 140.3 - 836.1) Excess deaths: 4.4	As expected 156.4 (95% CI: 31.4 - 457.0) Excess deaths: 1.1

4.9 Clinical coding – Comorbidities & palliative care

	Trust position (October 20 – September 21)	Percentile	England average
Average comorbidity score per spell (SHMI)	5.07	57th (71 of 124)	7.01
Percentage of discharges with palliative care coding (SHMI)	1.3%	2nd (3 of 124)	2.80%





Effect of palliative care adjustment

4.10 The standard indicator for SHMI does not include an adjustment for palliative care coding in its models whereas the standard indicator for HSMR does. In addition to the standard indicators, HED published additional indicators with or without the adjustment for palliative care.

4.11 In both cases, where palliative care adjustment is included, the indicators shows higher than expected deaths, whereas when no adjustment for palliative care is made the ratio of observered to expected deaths is within the expected range.

	Without palliative care adjustment	With palliative care adjustment
SHMI *Nov 20 – Oct 21*	99.3* *(95% CI: 94.6 – 104.1)* As expected	118.4 *(95% CI: 112.9 – 124.2)* **Above expected**
HSMR *Nov 20 – Oct 21*	101.0 *(95% CI: 95.1 – 107.2)* As expected	117.1* *(95% CI: 110.3 – 124.3)* **Above expected**

**Standard indicator*

Effect of palliative care adjustment

4.12 The standard indicator for SHMI does not include an adjustment for palliative care coding in its models whereas the standard indicator for HSMR does. In addition to the standard indicators, HED published additional indicators with or without the adjustment for palliative care.

4.13 In both cases, where palliative care adjustment is included, the indicators shows higher than expected deaths, whereas when no adjustment for palliative care is made the ratio of observered to expected deaths is within the expected range.

4.14 Somerset FT HSMR activity has the fourth lowest rate of palliative care coding of acute Trusts. Palliative care is recognised if any episode within the spell includes treatment specialty code 315 (Palliative Medicine Service) or the diagnosis code Z515 (Encounter for palliative care). At SFT we have a devolved palliative care process where teams are enabled to deliver palliative care rather than refer to the specialist palliative care service and therefore there is a lower number of 315 and Z515 codes.

4.15 The national standard for coding requires the addition of the palliative care code only when a specialist palliative care team have been involved in the patient's episode of care. Palliative care services across Trusts vary. Some Trusts include specialist palliative care or provisions for hospice services, This is then reflected in the HSMR outcomes.

5 INTERNAL AUDIT REPORT

5.1 The trust's internal auditor has reviewed the Trust's Learning from Deaths process – below is a summary conclusion of the internal auditor's report:

‘Through our discussions with the Head of Patient Safety & Learning, Medical Examiners (MEs) and supporting evidence provided, we sighted and evidenced a good working relationship and regular Learning from Deaths feedback meetings between the Trust and the MEs. The Trust has made good progress in implementing actions from the CQC inspection.

5.2 We concluded that whilst the Trust has a current policy and primarily utilises the Royal College of Physicians (RCP) Structured Judgement Review template, practices in relation to the completion of the SJR template could be improved. For example, having complete action plans for the implementation of learning points and recording engagement with family/carers. Therefore, we have assigned substantial assurance over the design and moderate assurance over the operational effectiveness for the systems in place. However, please note the limitations of scope above – further testing may have uncovered further issues which would have impacted on our opinion.

5.3 The auditors determined a sound system of internal control designed to achieve system objectives, which gave them substantial assurance. Although there was only moderate assurance around the effectiveness of the tool. Since their visit there has been a response to this which is underway and is led by the learning from deaths lead and the trusts mortality lead.

6 PLANS FOR THE FUTURE

6.1 Planning for the roll out of the Medical Examiner service across the whole of Somerset is underway and being led by Helen Gilliland, Implementation Lead – Somerset Medical Examiner Service. SFT and YDH are linking closely as this develops.

6.2 Already directorates are reviewing the backlog of mortality reviews caused by covid and the additional service pressures. The LFD team are working closely with the directorates to support this, and we anticipate a steady increase in reviews being undertaken. In conjunction with the directorates the LFD team will support shared learning and improvement across the trust.

6.3 The patient safety incident review framework launch is due in June 2022. NHSE/I anticipate that trusts will take time to implement this over the following 12 months. The Learning from Deaths process is integral to the PSRIF safety agenda within the organisation.

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Guardian Of Safe Working Hours Quarterly Report – January 2022 to March 2022
SPONSORING EXEC:	Chief Medical Officer
REPORT BY:	Guardian of Safe Working
PRESENTED BY:	John McFarlane, Guardian of Safe Working /Chief Medical Officer
DATE:	3 May 2022

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

Executive Summary and Reason for presentation to Committee/Board	This report covers 1 January 2022 to 31 March 2022. Exception reporting data continues to highlight the pressures faced by doctors particularly in general surgery and general medicine. Seven immediate safety concerns have been raised, six of which related to senior cover in general surgery. Ongoing staff absences due to Covid-19 remains a concern in view of the unpredictability and the impact on junior doctors.
Recommendation	The Board is asked to discuss the report.

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

- ☐ Obj 1 Improve health and wellbeing of population
- ☒ Obj 2 Provide the best care and support to children and adults
- ☐ Obj 3 Strengthen care and support in local communities
- ☐ Obj 4 Reduce inequalities
- ☐ Obj 5 Respond well to complex needs
- ☒ 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)

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]
Reported to the Board on a quarterly basis.

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

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

YDH

Guardian of Safe Working Hours

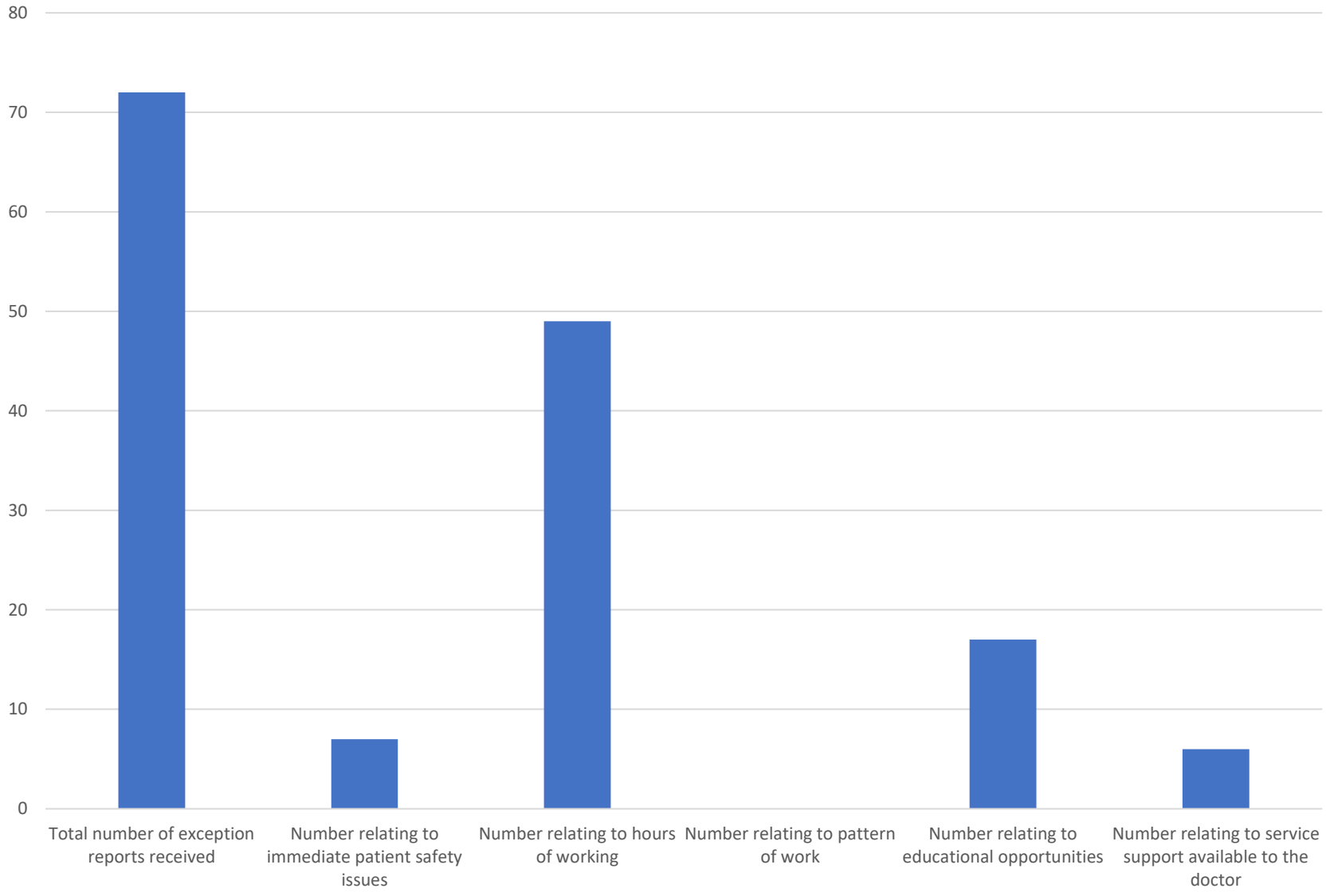
Quarterly Report
Jan to March 2022

Exception Reports at YDH – Historical Perspective

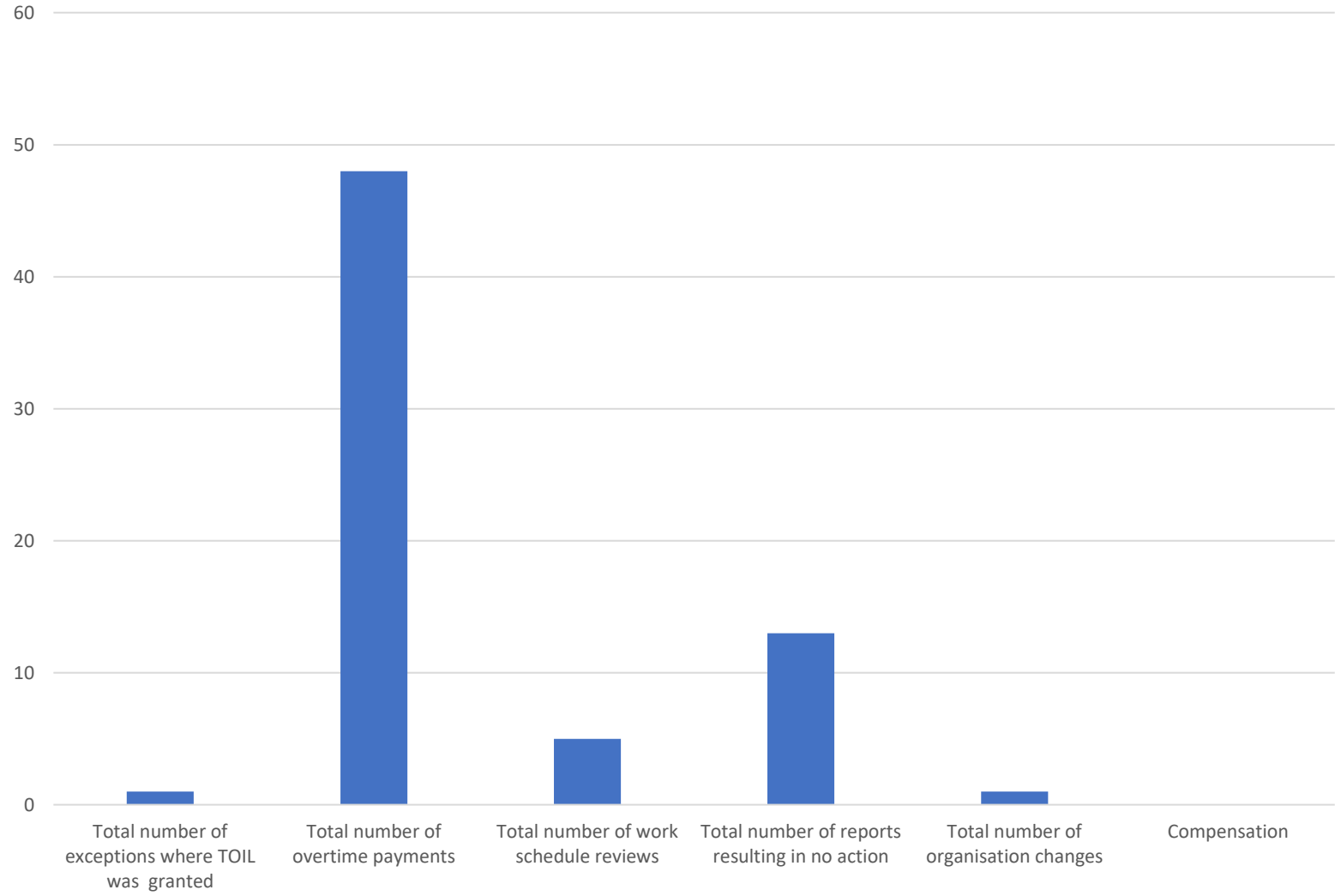
- Allocate was introduced to Yeovil District Hospital NHS Foundation Trust in 2016.

- From 06 December 2016 up until the current reporting date we have received a total of:
  - 1093 Exception Reports (Allocate Total Count)
  - This represents an average of ~ 50 Reports per Quarter
  - Of the reports raised
    - 1043 have related to Hours (95%)
    - 35 have related to Educational Issues
    - 18 have related to Service Provision Issues

72 exception reports



Mainly overtime payments, rota reviews and teaching sessions



Exception reports for the quarter by rota

- Gen surgery: 54
- Gen medicine: 18

Immediate Safety Concerns

In the past three months there have been 7 Exception Reports that was raised by the originator as being of "Immediate Safety Concern" (ISC)

On investigation these were found to be as follows:

- 6 related to no senior cover in general surgery
- 1 related to overtime, and not of ISC

Actions / Resolutions for surgical staffing issues

- Locum SAS grade started 7 march– Monday –Friday, to cover IP Daily surgical ward round
- SAS grade returned from long term sickness 16 march and was assigned to attend AEC
- F1/F2 Extra Twilight shift : locum started 13 march for 3 months
- locum surgical registrar covering ad hoc sessions as required
- approval for an extra Locum F1 to start asap

Rota Gaps

- 1 vacancy General Medicine COE –F1 Las post

Trainee Doctors – at YDH

- Number of doctors in training (total) at YDH is 78
- Number of doctors in training at YDH on the 2016 T&CS is 78 (100%)

Guardian of Safe Working Fines

- There have been no fines imposed at YDH in this Reporting Period

- *The secondary limits that attract a fine are*
  - *a doctor working more than an average of 48 hours per week in any 3 month period*
  - *a doctor working more than an absolute maximum of 72 hours in any given week*
  - *a doctor getting less than getting 8 hours rest between shifts*
  - *a doctor missing more than 25% of rest breaks in any 4 week period.*

- *(Historically there have been no fines imposed at YDH since the start of Exception Reporting)*

Summary

Summary (1)

- There is robust evidence that the working hours for trainee doctors at YDH remain safe, as they relate to the 2016 T&Cs and the hours limits set out by those T&Cs.

- However there are a number of areas which continue to be the cause of significant concerns this quarter, particularly general surgery

Summary (2)

- Hopefully the increased staffing in general surgery will see a drop in the number of exception reports

- We have on going issues with staff absences due to coronavirus that everyone is working hard to accommodate for including managers and doctors, however the unpredictability of staff absences makes management tricky with an increased burden of work on the junior doctors which we hope will settle as the pandemic subsides

NHS Somerset NHS Foundation Trust

NHS Yeovil District Hospital NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Guardian Of Safe Working for Junior Doctors Quarterly Report – April 2022
SPONSORING EXEC:	Chief Medical Officer
REPORT BY:	Guardian of Safe Working Medical Workforce Manager
PRESENTED BY:	Janet Fallon, Guardian of Safe Working
DATE:	3 May 2022

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

Executive Summary and Reason for presentation to Committee/Board	This report covers 9 January 2022 to 12 April 2022. Exception reporting data continues to highlight the pressures faced by doctors working in acute areas of the Trust, including medicine, surgery and trauma & orthopaedics. Immediate safety concerns have been raised relating to safe staffing levels in the context of high numbers of outlying patients and high levels of staff sickness. Exception reporting data is reviewed in the Medical Staffing Working Group to inform decisions on recruitment and allocation of postgraduate doctors in training. Rota management is increasingly complex and requires appropriate administrative and IT support to provide compliant rostering systems and safe staffing levels.
Recommendation	The Board is asked to discuss the report and agree: ▪ Its ongoing support of safe working practices within the Trust ▪ To support departments with administration and management of rotas. ▪ Ongoing engagement of senior management team with the Medical Staffing Working Group.

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☐ Obj 1 Improve health and wellbeing of population
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Reported to the Board on a quarterly basis.

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

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

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QUARTERLY REPORT ON SAFE WORKING HOURS:
DOCTORS AND DENTISTS IN TRAINING – April 2022

1. EXECUTIVE SUMMARY

1.1 This report covers 9 January 2022 to 12 April 2022.

1.2 Exception reporting data continues to highlight the pressures faced by doctors working in acute areas of the Trust including medicine, surgery and trauma & orthopaedics.

1.3 Immediate safety concerns have been raised relating to safe staffing levels in the context of high numbers of outlying patients and high levels of staff sickness.

1.4 Exception reporting data is reviewed in the Medical Staffing Working Group to inform decisions on recruitment and allocation of postgraduate doctors in training.

1.5 Rota management is increasingly complex and requires appropriate administrative and IT support to provide compliant rostering systems and safe staffing levels.

2. INTRODUCTION

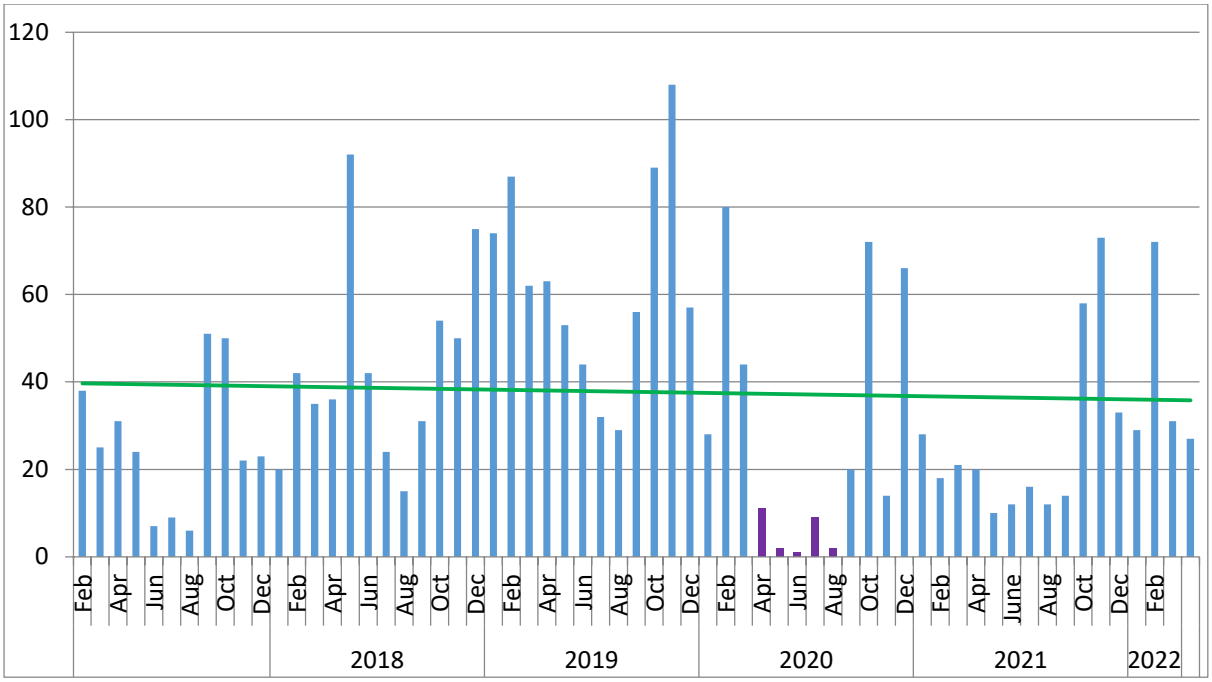
2.1. The data presented below is to allow the Board to assess the current risks to the provision of safe patient care posed by rota gaps and vacancies, and patterns of exception reporting by postgraduate doctors in training. This is followed by a qualitative summary of issues arising and actions take to address these.

3. EXCEPTION REPORT DATA:

Number of doctors/dentists in training on 2016 TCS (total):	263
Job plan allocation for Guardian of Safe Working:	1.5 PAs
Job plan allocation for Educational Supervisors per trainee:	0.125 PAs

3.1. **Exception reporting since the introduction of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016**
As of 11/4/22 - Total of 2333 exception reports since implementation of 2016 TCS (December 2016). The overall cost of exception report overtime is £38,713.08. The monthly breakdown of exception reporting is shown in *Figure 1*.

Figure 1. Total number of exception reports in the Trust by month



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

Table 1: Exception reports per specialty

Specialty	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**	**Type**
Acute & General Medicine	43 (54)	17	26	Educational 3 Hours 33 Pattern 3 Service support 4
Anaesthetics	0 (0)	0	0	
DCT Trainees	0 (0)	0	0	
ENT	2 (0)	2	0	Hours 2
General Surgery	40 (0)	2	38	Hours 36 Pattern 2 Service support 2
Neurology	7 (0)	0	7	Educational 7
O&G	0 (0)	0	0	
Oncology/ Haematology	8 (0)	6	2	Hours 8
Paediatrics	2 (0)	0	2	Natural breaks 1 Hours 1
Psychiatry	7 (3)	5	2	Hours 7
Trauma & Ortho	6 (0)	0	6	Educational 3 Hours 1 Pattern 1 Service support 1
Urology	7 (0)	0	7	Hours 7
Total	**122 (57)**	**35**	**91**	

Table 2: Exception reports per trainee grade

Grade of trainee	**No. exceptions raised**
F1	85 (38)
F2	14 (19)
CT1-2 / ST1-2	18 (0)
ST3+	5 (0)
Total	**122 (57)**

Table 3: Exception reports relating to number of trainees and rota gaps per specialty

Specialty	Grade	No. of trainees	Rota gaps (average WTE)	Exception reports per grade	Exception reports per specialty
Anaesthetics/ ICU	ST3+	9	**0.3**	0	0
	CT1/2	12	**1**	0	
	F1/F2	3	0	0	
Emergency Medicine	ST3+	8	**0.8**	0	0
	CT1/2	14	**0.6**	0	
	F2	2	0	0	
	F1	1	0	0	
Medicine (including Neurology & Haem / Onc)	ST3+	16	**0.6**	0	58
	CT1/2	15	**0.4**	15	
	F2	15	0	5	
	F1	19	0	38	
Obs & Gynae	ST3+	8	**1**	0	0
	ST1/2	10	**0.4**	0	
Ophthalmology	ST1-3	5	0	0	0
Paediatrics	ST	18	**0.2**	2	2
	F2	1	**0**	0	

Psychiatry	ST4+	7	0	5	7
	CT1-3	16	**1**	2	
	F2	2	0	0	
	F1	3	0	0	
T&O	ST3+	7	0	0	6
	CT1/2	1	0	0	
	F2	8	0	6	
Surgery	ST3+	7	0	0	40
	CT1/2	11	**0.4**	0	
	F2	1	0	1	
	F1	11	0	39	

Qualitative summary of exception reports

3.3. A very high level of exception reporting continues to be seen across the medical directorate, reflecting the pressure of work relating the high levels of outlying patients and staff sickness due to COVID. The vast majority of exception reports relate to additional hours worked, which is paid as overtime.

3.4. We have seen a rise in exception reporting from surgery when compared with the same quarter in 2021, however surgical activity at that stage was drastically reduced due to the ongoing COVID-19 winter wave in 2021.

3.5. Exception reports raised in neurology relate to changes in educational opportunities due to a recent restructuring of that department. This is being addressed by the Postgraduate Medical Education team.

Immediate safety concerns (ISCs)

3.6. Five ISCs have been raised this quarter. One of these related to work within the medical directorate, describing a very busy day on the Acute Medical Unit with a lack of staff due to sickness. This was exacerbated by the acuity of the patients admitted and the pressures on senior members of staff, who were less well able to support the doctor in question due to staff sickness.

3.7. Further ISCs have been submitted by doctors working in trauma and orthopaedics, largely relating to staffing levels in the context of

inpatient numbers, including orthogeriatric patients and orthopaedic outliers (e.g. those on COVID wards). Over the winter, the T&O F2 doctors were asked to assist with medical outliers on their base wards for a brief period of time, however, the workload became unmanageable. This was addressed by consultants in the T&O and Care of the Older Person teams and is no longer an ongoing issue, although high number of outlying patients remains a problem across directorates.

3.8. Two ISCs in general surgery were reported following a short notice rota gap on a set of night shifts. A locum doctor was found to support the night team, but unfortunately was new to the Trust, without relevant access to clinical systems. This has been raised with the Medical Workforce Team and rota co-ordinators in surgery.

Fines

3.9. No fines were issued during this quarter.

Work schedule reviews

3.10. Work schedule reviews have taken place in Acute Medicine, relating to the pressure of work and safe staffing levels on the Acute Medical Unit. This has been escalated to the AMU rota co-ordinator. Further work schedule reviews have taken place in general surgery with regards to safe staffing and service support.

3.11. A wider scale work schedule review is ongoing in psychiatry, as doctors have reported that the amount of hours worked during on-call shifts is regularly in excess of hours paid. This is under review with the Medical Workforce Team.

3.12. **Bank and agency data**

Speciality	Shifts Requested	Worked as Bank/ Internal Cover	Worked as Agency	Hours Requested	Worked as Bank/ Internal Cover	Hours worked as Agency
Accident & Emergency	505	185	320	5179.75	1859.25	3320.5
AMU	366	97	269	3351.35	932.75	2418.6
Anaesthetics	3	3	0	37	37	0
ENT	9	9	0	67.25	67.25	0
Gastroenterology	21	21	0	239	239	0
General Surgery	25	23	2	278	231	47
Maxillo-Facial	10	10	0	91	91	0
Obstetrics & Gynaecology	7	5	2	68	21	47
Ophthalmology	10	10	0	106	106	0
Paediatrics	109	15	94	1061	171	890
Respiratory	3	3	0	21.5	21.5	0
Trauma & Orthopaedics	38	35	3	357	329.75	27.25
Community Services	230	0	230	1879.3	0	1879.3
Grand Total	1336	416	920	12736.2	4106.5	8629.65

Request Grade	Shifts Requested	Worked as Bank/ Internal Cover	Worked as Agency	Hours Requested	Worked as Bank/ Internal Cover	Hours Worked as Agency
F1	78	78	0	676.9	676.9	0
F2	86	86	0	731	731	0
ST1/2	246	205	262	4315.35	1890.5	2424.85
ST3+	223	185	338	4771.05	1886.75	2884.3
Grand Total	633	554	600	10494.3	5185.15	5309.15

4. ISSUES ARISING

4.1. **Staffing levels**
In light of the current pressures on our inpatient teams relating to overall inpatient numbers, number of outliers and higher than usual staff sickness levels, exception reporting data highlights increased risk to safe staffing levels, largely across medicine but also in general surgery and T&O. This is on a background of general fatigue and lower morale across clinical teams due to the ongoing COVID-19 pandemic and social care crisis.

4.2. Staffing levels are closely monitored by the Medical Workforce Team and Postgraduate Medical Education. Areas of greatest need are identified and flagged to the Medical Staffing Working Group. This allows for the GoSW and senior management team to remain informed of potential concerns regarding safe staffing and working patterns. Additional clinical staff are sought by individual departments and the Medical Workforce Team via the Temporary Staffing Department. This process is reflected in the high number of bank and agency hours requested in acute specialties, such as A&E and acute medicine.

4.3. Introduction of the Clinical Fellow programme in the medical directorate in August 2021 helped to mitigate this risk of increased inpatient numbers. Full recruitment to this programme in 2022 with be vital to safe staffing levels within medicine. Alternative solutions, such as locum posts, support from allied healthcare professionals (AHPs) or restructuring of teams may be required if this programme is under-recruitment.

4.4. Exception reporting data is provided to the Postgraduate Medical Education Team to contribute to decisions on future allocation doctors in training, in particular the upcoming expansion of the Foundation Programme. The data also highlights the teams and departments that would benefit from

additional support from AHPs such as Physician Associates and Clinical Nurse Specialists.

Postgraduate Doctor Forum

4.5. The name of our forum has changed to “Postgraduate Doctor Forum” following recent guidance from Health Education England. The meeting is supported by the Medical Administration Team, Postgraduate Medical Education Team, Chief Registrar, Doctors’ Mess Presidents, Trust BMA representatives and LNC chair, and includes standing agenda items on the Doctors’ Mess, Exception Reporting Data and Fatigue & Facilities Funding.

4.6. Most recently the forum has been held virtually due to social distancing guidelines in the context of high numbers of COVID-19 cases amongst staff. In general, virtual meetings are less well attended than face-to-face, so we hope to return to in person meetings when possible.

Quality Improvement Project on Exception Reporting

4.7. An ongoing quality improvement project is being led by a group of Foundation Doctors (Dr Kwame Buadooh, Dr Celeste Yau and Dr Cherry Choudhary), with a focus on improving engagement with the exception reporting process. The team have performed a survey of trainees and implemented a number of change ideas, including posters, a teaching session for Foundation doctors and a video for postgraduate doctors and supervisors. A follow-up survey is planned for later this year. Specific sessions for educational and clinical supervisors are being added to local training sessions starting in April 2022.

Rota management

4.8. The management of doctor rotas has become increasingly complicated over recent years. This is due partly to the changes in working patterns introduced with the 2016 contract, but also due to higher levels of less-than-full-time working and high levels of staff sickness. Rota co-ordinators across a number of directorates are finding this increasingly difficult to manage, particularly those who are primarily clinicians without allocated time or remuneration for the role. Problems with rota management have a direct impact on safe patient care, and so appropriate support for rota administration is vital. IT solutions such as electronic rostering programmes may help to mitigate the associated risks and may provide crucial support the clinical and administrative teams managing our doctor rotas.

5. SUMMARY

5.1. Exception reporting data continues to highlight the pressures faced by doctors working in acute areas of the Trust including medicine, surgery and trauma & orthopaedics.

5.2. Immediate safety concerns have been raised relating to safe staffing levels in the context of high numbers of outlying patients and high levels of staff sickness.

5.3. Exception reporting data is reviewed in the Medical Staffing Working Group to inform decisions on recruitment and allocation of postgraduate doctors in training.

5.4. Rota management is increasingly complex and requires appropriate administrative and IT support to provide compliant rostering systems and safe staffing levels.

6. RECOMMENDATIONS

6.1. The Board is asked to discuss the report and agree:

- Its ongoing support of safe working practices within the Trust
- To support departments with administration and management of rotas.
- Ongoing engagement of senior management team with the Medical Staffing Working Group.

Janet Fallon, Guardian of Safe Working

Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Going Concern Assessment – Yeovil District Hospital
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Corporate Accountant
PRESENTED BY:	Chief Finance Officer
DATE:	3 May 2022

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 going concern assumption is a fundamental principle in the preparation of the year end accounts, under which the Group is ordinarily viewed as continuing in the business of healthcare provision for the foreseeable future. The term 'going concern' refers to the basis of measurement of an organisation's assets and liabilities and hence how they are included in the accounts. An organisation operating under the going concern principle will record these assets and liabilities as being able to be realised in the normal course of business. An organisation that does not prepare accounts under the going concern principle may have to record assets at a much lower break-up value and reclassify liabilities to being short term. The primary focus for assessing going concern status is whether the organisation will have the ability to pay debts as they fall due. This is dependent on the cash reserves and sources of funds available to support operations. The Group must include within the Annual Report a disclosure detailing the judgement it has taken regarding going concern and this in turn will be subject to audit examination.
Recommendation	The Board is requested to approve that it is suitable for the 2021/22 accounts to be prepared under the going concern basis.

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

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]
. Annual 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

YEOVIL DISTRICT HOPSITAL NHS FOUNDATION TRUST

GOING CONCERN ASSESSMENT

1. INTRODUCTION:

1.1 International Accounting Standards (IAS1) require the directors to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 2.14,

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

1.2 Whilst it is unlikely that an NHS body will be determined not to be a going concern, this interpretation does not exempt the management of NHS bodies from undertaking a going concern review.

1.3 The Trust's external auditors will seek evidence to support their evaluation of management's going concern assessment and any disclosures in the financial statements. They need to conclude whether there is material uncertainty relating to the entity's ability to continue as a going concern. Where the auditor concludes that they are satisfied that the accounts should be prepared on a going concern basis but there are material uncertainties relating to the entity's ability to continue as such then they will report this using an emphasis of matter paragraph in their audit report.

2. GOING CONCERN ASSESSMENT

2.1 In a letter of 1 April 2021, NHS England and Improvement set out the application of the going concern principle to the NHS, as follows:

'Local auditors conduct their work with reference to auditing standards which apply to all types of entity. Auditors are required to evaluate management's adoption of the going concern basis and management's assessment of any material uncertainties over that basis that may require disclosure.

The Public Audit Forum issues guidance to auditors on how auditing standards should be applied in the public sector. Its publication 'Practice Note 10' was revised in late 2020. This updated guidance to auditors, approved by the Financial Reporting Council, explains that where the applicable financial reporting framework provides that the anticipated continued provision of services is a sufficient basis for going concern, then this should determine the extent of the auditor's procedures on going concern. This is the case in the NHS, with the DHSC Group Accounting Manual (GAM) and NHS foundation group annual reporting manual (FT ARM) both based on the HM Treasury Financial Reporting Manual (FReM) where this definition applies.

This means that, for the 2021/22 year end onwards, while management in NHS bodies will still need to document their basis for adopting the going concern basis, this assessment should solely be based on the anticipated future provision of services in the public sector.'

2.2 The guidance is clear that, where this is the case, there will not be any material uncertainties over going concern requiring disclosure.

2.3 The application of Practice Note 10 to the NHS means that, whilst the Board will still need to document the rationale for adopting the going concern basis, the assessment should solely be based on the anticipated future provision of services in the public sector.

2.4 As the Board has every expectation that the services provided by the Group will continue to be provided in the public sector, it is appropriate to adopt the going concern basis in preparing the accounts for 2021/22. Consideration is given below to whether there are uncertainties regarding future issues which should be disclosed to enable a true and fair view.

3. CURRENT YEAR PERFORMANCE

3.1 Due to the ongoing global pandemic, NHS funding for the year 2021/22 has again primarily been linked to the level of income required to cover the necessary costs of providing services including the costs of the response to the pandemic. The Group was required to achieve breakeven control total under this arrangement, which it has achieved.

3.2 As a consequence the 2021/22 group annual accounts will report a small surplus position (before the consolidation of Charitable Funds).

4. 2022/23 OUTLOOK

4.1 At present the draft group budget for 2022/23 is currently showing a control total deficit of £3.1m, however it is expected that the group, system and partner organisations will submit a breakeven final plan.

4.2 The group continues to develop detailed financial plans with its system partners for the financial year to the end of March 2023, the final budget plan for 2022/23 is due for submission on 28 April 2022. Based on current assumptions, it is not expected that the group will require additional cash support. Any additional cash support will be met from current cash reserves outlined in the cashflow summary below.

4.3 There are currently on-going discussions around merging the Group with Somerset NHS Foundation Group from 1 April 2023.

4.4 This therefore requires consideration when assessing the going concern of the Group. However, it is expected that there will continue to be a provision of services in the future.

4.5 The Boards of Directors of both organisations have agreed a Strategic Outline Case that was submitted to NHE England/Improvement (NHSE/I). A full business case will be completed during the 2022/23 financial year for submission to NHSE/I to seek final approval for the merger.

4.6 It is anticipated that the services provided by the group will continue to be provided in the public sector by the merged group in the future.

Forecast cashflow:

At the 1 April 2022

Current cash balance:	£28.4m
Less capital PDC commitments from 21/22	(£4.8m)
Less other commitments from 21/22	(£3.6m)
22/23 Income and expenditure planned deficit	(£3.7m)
23/24 Q1 Income and expenditure forecast deficit	(£0.9m)
Final Cash Balance 30 June 2023	£15.4m

4.7 The cash balance at the end of each month is expected to be at least £1.0m whilst not dropping below the minimum threshold of £1.0m set out by NHSE/I at any point during the month.

4.8 The Group expects to meet all of its financial obligations without requiring additional cash from Department of Health and Social Care in 2022/23. If this changes, any future cash requirements are expected to be funded through additional PDC drawdowns.

5. CONCLUSION

5.1 The Board of Directors is asked to consider which of the following scenarios is most appropriate for the Group:

1. The group is clearly a going concern and it is appropriate for the accounts to be prepared on the going concern basis.

2. The group is clearly a going concern but there are some uncertainties regarding future issues which should be disclosed in the accounts to ensure the true and fair view. These are not material because they do not place in doubt the application of the going concern concept.

5.2 It is recommended that scenario 2 is adopted, in recognition of the uncertainty in relation to future income, and the merger proposal merits disclosure. The Audit Committee has considered the paper and recommends approval of statement 2 to the Board of Directors.

5.3 The following disclosure would be made in the accounts:

Proposed going concern disclosure to be included within the 2021/22 annual accounts.

Going concern

In preparation of the year end accounts the Board of Directors is required to undertake an assessment as to whether the Group will continue as a going concern.

The group prepares its accounts under the financial reporting framework set out for the NHS, which is based on the HM Treasury Financial Reporting Manual (FReM). The FReM provides that the anticipated continued provision of services in the public sector is a sufficient basis for preparing the accounts on a going concern basis.

As the Board of Directors has every expectation that the services provided by the Group will continue to be provided in the public sector, it is appropriate to adopt the going concern basis in preparing the accounts for 2021/22. The Board of Directors has considered whether there are uncertainties regarding future issues which should be disclosed to enable a true and fair view.

There are currently on-going discussions around merging the Group with Somerset Foundation NHS Trust from 1 April 2023. However, this does not change the Board of Directors expectation that the services provided by the Group will continue to be a provided in the public sector in the future.

Therefore, these accounts have been prepared under a going concern basis as set out in IAS 1.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Going Concern Assessment – Somerset NHS FT
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Head of Financial Services
PRESENTED BY:	Chief Finance Officer
DATE:	3 May 2022

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 going concern assumption is a fundamental principle in the preparation of the year end accounts, under which the Group is ordinarily viewed as continuing in the business of healthcare provision for the foreseeable future. The term 'going concern' refers to the basis of measurement of an organisation's assets and liabilities and hence how they are included in the accounts. An organisation operating under the going concern principle will record these assets and liabilities as being able to be realised in the normal course of business. An organisation that does not prepare accounts under the going concern principle may have to record assets at a much lower break-up value and reclassify liabilities to being short term. The primary focus for assessing going concern status is whether the organisation will have the ability to pay debts as they fall due. This is dependent on the cash reserves and sources of funds available to support operations. The Trust must include within the Annual Report a disclosure detailing the judgement it has taken regarding going concern and this in turn will be subject to audit examination.
Recommendation	The Board is requested to approve that it is suitable for the 2021/22 accounts to be prepared under the going concern basis.

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

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

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

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

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

GOING CONCERN ASSESSMENT

1. INTRODUCTION

1.1 International Accounting Standards (IAS1) require the directors to assess, as part of the accounts preparation process, the Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 2.14:

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

1.2 Whilst it is unlikely that an NHS body will be determined not to be a going concern, this interpretation does not exempt the management of NHS bodies from undertaking a going concern review.

1.3 The Trust's external auditors will seek evidence to support their evaluation of management's going concern assessment and any disclosures in the financial statements. They need to conclude whether there is material uncertainty relating to the entity's ability to continue as a going concern. Where the auditor concludes that they are satisfied that the accounts should be prepared on a going concern basis but there are material uncertainties relating to the entity's ability to continue as such then they will report this using an emphasis of matter paragraph in their audit report.

2. GOING CONCERN ASSESSMENT

2.1 IAS 1 states the review should take into account as much information about the future as possible but should look ahead at least 12 months from the end of the reporting period. In practice our auditors like the review to consider at least 12 months from the signing of the accounts, scheduled for 8 June 2022.

2.2 The going concern assessment should include a review of:

Financial Conditions	• inability to meet the planned annual financial targets • the need to use a Working Capital Facility to meet future obligations when they fall due • any necessary Working Capital/loan facilities have not been agreed • existence of significant operating losses, historical and projected • anticipated or actual major loss of commissioner income • major cost improvement programme with high risk of non- achievement • major losses or cash flow problems which have arisen since the balance sheet date
Operating Conditions	• loss of key management without replacement • loss of key staff without replacement and/or industrial relation difficulties • significant failure to achieve Care Quality Commission standards resulting in any restrictions on services provided

	• fundamental changes in the market or technology to which the trust is unable to adapt adequately
Other Conditions	• serious non-compliance with regulatory or statutory requirements • pending legal or regulatory proceedings against the trust that may, if successful, result in claims that are unlikely to be satisfied • changes in legislation or government policy expected to adversely affect the trust • issues which involve a range of possible outcomes so wide that an unfavourable result could affect the appropriateness of the going concern basis • significant concerns about finance or quality raised by regulators

2.3 Directors should request and consider evidence to support their assessment including identifying any potential remedial actions that may need to be addressed, to support their conclusion prior to their approval of financial statements. Evidence to consider may include:

Forecasts & budgets	• budget covering at least up to 12 months from the date of the approval of the financial statements • cash flow forecasts covering at least up to 12 months from the date of the approval of the financial statements and providing monthly balances for the period to the end of the financial year, reflecting agreed commissioning contracts • critical assumptions underlying forecasts and budgets • commissioning intentions, agreement of contract activity • CIP risk rating • capital programme cash flow forecasts and financing sources • an adequate matching of projected cash inflows with projected cash outflows including all liabilities and other commitments
Access to funding	• availability of an agreed financing facility if required • cash resources available to the Trust compared to the Trust's expected cash requirements
Medium & long-term plans	• medium or long-term plans that give an indication in general terms of how the directors expect the Trust's business to fare
Health services & markets	• the economic environment within which the Trust operates & any economic, political or other factors which may cause the health market to change
Contingent liabilities	• potential cash outflows during the review period relating to legal proceedings, environmental costs and service liability
Financial & operational risk management	• key risks identified by the Trust in its Risk Register • counterparty risks that arise from concentration on key suppliers or commissioners who may themselves be facing financial difficulty
Sensitivity analysis & stress testing	• critical assumptions that underlie the budgets and forecasts • the extent to which cash flows vary with changes in assumptions
Systems Controls	• Head of Internal Audit Opinion

2.4 The evidence considered has been contained within the monthly finance reporting to Finance Committee and Board. The Trust 2022/23 Financial Plan was approved by the Finance Committee on 26 May 2022 ahead of the annual accounts being signed. Guidance from NHS England /Improvement has also been considered.

2.5 Having due consideration to the relevant conditions and having performed the assessment utilising the evidence outlined above, the Directors need to evaluate which one of three potential conclusions is appropriate to the specific circumstances of the Trust. The Directors may conclude one of the following:

i) there are no material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern;

ii) there are material uncertainties related to events or conditions that may cast significant doubt about the Trust's ability to continue as a going concern, but the going concern basis remains appropriate;

iii) use of the going concern basis is not appropriate.

2.6 Directors should request and consider evidence to support their assessment including identifying any potential remedial actions that may need to be addressed, to support their conclusion prior to their approval of financial statements. Evidence to consider may include:

2021/22 Going Concern Assessment

Conditions	Criteria	Evidence
Financial	1. meeting the planned annual financial targets 2. any necessary interim financing facilities are agreed 3. existence of significant operating losses, historical and projected 4. anticipated or actual major loss of commissioner income 5. major cost improvement programme with high risk of non-achievement 6. major losses or cash flow problems which have arisen since the balance sheet date	1. Adjusted financial performance achieved during 2021/22 in line with plan. 2. None required. 3. None. 4. Nothing anticipated outside of plan. 5. CIP plans in progress and confident of plan delivery. 6. Not anticipated.
Operating	7. loss of key management without replacement 8. loss of key staff without replacement and/or industrial relation difficulties 9. significant failure to achieve Care Quality Commission standards resulting in any restrictions on services provided	7. None anticipated. 8. Not expected. 9. No concerns.

	10. fundamental changes in the market or technology to which the trust is unable to adapt adequately	10. Not anticipated.
Other	11. serious non-compliance with regulatory or statutory requirements	11. None.
	12. pending legal or regulatory proceedings against the trust that may, if successful, result in claims that are unlikely to be satisfied	12. None.
	13. changes in legislation or government policy expected to adversely affect the trust	13. None expected.
	14. issues which involve a range of possible outcomes so wide that an unfavourable result could affect the appropriateness of the going concern basis	14. None expected.
	15. significant concerns about finance or quality raised by regulators	15. None.

3. CONCLUSION AND RECOMMENDATION

3.1 The Trust continues to develop detailed financial plans for the financial year to the end of March 2023 (Appendix 1: showing significant cash reserves available to support the Trust's continued activities). Based on current assumptions, it is unlikely that the Trust will require additional cash support in the form of interim revenue loan support from the Department of Health and Social Care.

3.2 The Trust is due to merge with Yeovil District Hospital on 1 April 2023 and it is expected that the merged Trust will continue to provide the same level of services in the future.

3.3 For these reasons and based on the assessment above, the Directors consider it appropriate to continue to adopt the going concern basis in preparing the accounts.

3.4 The Audit Committee reviewed the paper and is recommending approval of the application of Going Concern to the Board.

CHIEF FINANCE OFFICER

Appendix 1

Monthly cash flow forecast	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Opening Cash Balance	58,726	51,654	43,872	44,407	39,469	34,416	37,362	34,761	31,452	37,732	34,347	33,960
Surplus/(Deficit) from operations	(531)	(1,387)	(2,022)	(664)	(1,025)	(1,316)	1,095	397	1,053	271	134	1,661
Non-cash flows in operating surplus/(deficit)	2,193	2,192	2,192	2,202	2,202	2,202	2,208	2,207	2,207	2,214	2,214	2,213
Operating cash flows before movements in working capital	**1,662**	**805**	**170**	**1,538**	**1,177**	**886**	**3,303**	**2,604**	**3,260**	**2,485**	**2,348**	**3,874**
Increase/(decrease) in working capital	(749)	(681)	(756)	(681)	(682)	2,950	(681)	(680)	(853)	(682)	(681)	2,958
Net cash inflow/(outflow) from operating activities	**913**	**124**	**(586)**	**857**	**495**	**3,836**	**2,622**	**1,924**	**2,406**	**1,803**	**1,668**	**6,832**
Capital expenditure	(8,027)	(7,738)	(7,929)	(5,627)	(5,382)	(5,673)	(5,056)	(5,074)	(5,167)	(5,020)	(1,915)	(2,043)
Investing activities	316	116	382	116	116	382	116	116	382	116	116	380
Net cash inflow/(outflow) before financing	**(6,798)**	**(7,498)**	**(8,133)**	**(4,654)**	**(4,771)**	**(1,456)**	**(2,318)**	**(3,035)**	**(2,379)**	**(3,101)**	**(132)**	**5,168**
Net cash inflow/(outflow) from financing activities	(274)	(283)	8,668	(284)	(282)	4,402	(284)	(274)	8,659	(284)	(255)	5,351
Net increase/(decrease) in cash and cash equivalents	(7,072)	(7,781)	535	(4,938)	(5,053)	2,946	(2,602)	(3,309)	6,280	(3,385)	(387)	10,519
Closing cash balance	**51,654**	**43,872**	**44,407**	**39,469**	**34,416**	**37,362**	**34,761**	**31,452**	**37,732**	**34,347**	**33,960**	**44,479**

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Boards
REPORT TITLE:	Capital Programme 2022/23
SPONSORING EXEC:	Director of Strategy and Digital Development
REPORT BY:	Ian Boswall, Director of Redevelopment Neil Murray, Strategic Accountant
PRESENTED BY:	Director of Strategy and Digital Development
DATE:	3 May 2022

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 as part of the overall financial plan for Somerset NHS Foundation Trust and Yeovil District Hospital Foundation Trust.
Recommendation	The Boards are asked to discuss the report and review the recommendation from the Joint Finance Committee/ Financial Resilience and Commercial Committee to approve the joint capital programme for the 2022/23 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)

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
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

2022/23 CAPITAL PROGRAMME

1. INTRODUCTION

1.1 NHSE/I have issued capital envelope allocations to Somerset ICS. The allocation has been based on a calculation reflecting the asset base and deprecation levels of both organisations along with some recognition of backlog maintenance requirements and previous surpluses. These are reflected in the draft programme shown in Appendix A. The detail below sets out a planned position which meets the required overall envelope and the risks to delivery.

2. 2022/23 CAPITAL PROGRAMME

Commitments

2.1. A number of commitments have already been made into 2022/23 as a result of business cases previously agreed. These are detailed within the table below and reflect the first call on the system capital envelope:

Scheme Committed	**SFT £'m**	**YDH £'m**
Community Diagnostic Centre Taunton	1.500	
Acute Assessment Hub completion	0.800	
IFRS 16 Lease renewals	0.007	0.031
Yeovil & Dorset Dental Lease Fit Out	1.900	
Mental Health Ward reconfiguration - Rowan	2.415	
Community Mental Health Property refurbishments	0.800	
Wessex House upgrades	0.153	
Community services Taunton	0.150	
Elective Care Delivery (Modular Theatre)		2.379
Car Park Enabling Works		0.100
Backlog Maintenance Schemes - slippage 21/22		0.220
Minor Works Schemes - slippage 21/22		0.222
Breast Unit Provision – Trust contribution		0.250
Salix Trust Commitment		0.130
ICU E-charting		0.207
Total	**7.725**	**3.539**

Appendix A excludes ring-fenced primary care operational capital of £1.000m in 2022/23 with similar levels of £1.004m in 23/24 and £1.007m in 24/25.

Process Undertaken

2.2. Aligned with previous years the draft programme has been undertaken based on

- Prior commitments from previous years

- Previously agreed business cases or strategic plans (including the digital plan)

- Allowance for backlog maintenance, medical equipment and IT refresh programmes

2.3. Due to the constrained nature of the funding envelope and the impact of schemes which had not been completed in the previous financial year the ability to commit capital expenditure in addition to those elements already included with the programme is limited. However, the bringing forward of capital spend into 2021/22 has mitigated this risk to some extent.

2.4. The backlog maintenance and equipment replacement programmes are based on the risk assessed position of the Trusts. A review of the comparative risk positions will be undertaken during the first quarter to ensure that there is an equitable balance of risk between organisations and care settings. The base plan set out ensures there is funding allocated to acute, mental health and community settings.

2.5. The proposed capital programme has been reviewed by the joint Capital Delivery Group and joint Strategic Estates group and provides at the start of the year for an over commitment of £1.500m. This reflects the current impact of supply chain and construction availability and mitigates the impact of potentially underspending at the end of the financial year. Progress against the schemes will be managed during the year to ensure that expenditure remains within the available envelope. The 26th April 2022 Joint Finance Committee in Common reviewed the proposed 2022/23 capital programme and recommend it for approval by both Trust Boards.

2.6. Key additional external funding streams

- STP wave 3 capital (MPH Surgical Scheme). Expenditure of £20.841m represents the figure included within the current scheme funding agreement with the Department of Health and Social Care (DHSC). Based on the current programme of works and the impact of supply chain delays this level of expenditure is unlikely to be achieved in year. Discussions are ongoing with the DHSC to potentially defer and element of this funding into the next financial year.

- New Hospital Programme (NHP) funding of £1.030m reflects agreed funding to maintain the current core project team and progress some of the scheme requirements. Further funding will need to be agreed once the Strategic Outline Case has been approved by the NHP team to enable development of the Outline Business Case.

- Elective Recovery monies (£14.950m with £7.500m in 2022/23) reflect the costs currently identified to deliver facilities on the Yeovil site.

- SALIX capital. YDH has been granted £9.860m and SFT £1.062m. The grants have been given on the basis of expenditure being completed within the financial year with Yeovil making a contribution of £0.130m in addition to the grant.

- Charitable funds have been estimated for SFT and YDHl with the additional inclusion of the Ambulatory Breast Unit scheme funded by £2.000m of monies raised by the Yeovil Breast unit appeal.

3. RISKS

3.1. Inherently within the programme there remain a number of risks and these are broadly split into three categories

- 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.

- 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 the Surgical Centre.

- 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.

4. RECOMMENDATIONS

4.1 The Trust Boards are asked to approve the proposed capital programme for 2022/23.

Appendix A **Somerset ICS Capital Plan Summary**	Somerset FT 2022/23 £'000	Yeovil FT 2022/23 £'000	Combined 2022/23 £'000
Allocated Capital Envelope Funding			**29,383**
Disposals of Property			**200**
Total Envelope Available			**29,583**
SCHEMES FUNDED FROM CAPITAL FUNDING ENVELOPE			
COMBINED BUDGETS			
Programme Management & Feasibility Work	400	100	500
HEAD (PEAG/ Environment)	100		100
Backlog Maintenance	3,400	1,250	4,650
Major Medical & Surgical Equipment	3,427	490	3,917
Information Technology	1,964	276	2,240
Infrastructure Upgrade & Carbon Neutral	0	200	200
EPR/Digital Requirements	4,651		4,651
Risk contingency	222	84	306
Total Combined Budgets	**14,164**	**2,400**	**16,564**
ACUTE			
Acute - Site Risks / Plant & Equipment Replacement			
A4L	25		25
Fire Precautions / Security	100	227	327
Health & Safety incl IPCT	55		55
on- Site residences refurbishment	70		70
Ward Refurbishment/upgrade	100	500	600
Total Site Risks / Plant & Equipment	**350**	**727**	**1,077**
Acute - Site and Service Development			
Minor Schemes	100	183	283
Departmental relocations (Includes Corporate Decant)	100	75	175
Split air con for drug storage		100	100
Ventilation Plant Upgrade - SSD		500	500
IMIP phase 2 onwards	200		200
Total Site and Service Development	**400**	**858**	**1,258**
COMMUNITY/ MENTAL HEALTH			
Site Risks / Plant & Equipment Replacement			
Health and Safety Community	250		250
Patient Environment - PLACE	50		50
Sundry Equipment - MH & C	100		100
Total Site Risks / Plant & Equipment	**400**	**0**	**400**
Site and Service Development			
Wincanton boiler house relocation	300		300
Contingency	220		220
Total Site and Service Development	**520**	**0**	**520**
COMMITMENTS			
CDC Projects not completed	1,500		1,500
AAH internal (PDC deferral not granted)	800		800
IFRS16 Lease Renewals	7	31	38
Slippage - Yeovil & Dorset Dental	1,900		1,900
Mental Health Ward reconfiguration Rowan	2,415		2,415
B/f mental health new property refurbishment	800		800
Wessex House (if PDC not awarded)	153		153
Harrison House	150		150
Elective Care Delivery		2,379	2,379
Car Park Enabling Works		100	100
Backlog Maintenance Schemes - slippage 21/22		220	220
Minor Works Schemes - slippage 21/22		222	222
Breast Unit Provision		250	250
SALIX Trust Commitment		130	130
ICU/E-charting		207	207
			0
Total Commitments	**7,725**	**3,539**	**11,264**
TOTAL TRUST EXPENDITURE FROM CAPITAL ALLOCATION	**23,559**	**7,524**	**31,083**
Balance/(Shortfall) for Site Risks & Site Developments			**(1,500)**
EXTERNALLY FUNDED SCHEMES			
STP 3 - Surgical Centre	20,841		20,841
NHP - MPH	1,030		1,030
Modular Theatre	0	7,500	7,500
Digital Maturity	711		711
Cybersecurity	94		94
Salix	1,062	9,860	10,922
PFI MES Funded IFRIC 12 - SFT	1,903	1,399	3,302
Donated Acute	600	2,280	2,880
Donated Community	110		110
TOTAL ADDITIONAL CAPITAL SCHEME EXPENDITURE	**26,351**	**21,039**	**47,390**
TOTAL PLANNED CAPITAL EXPENDITURE	**49,910**	**28,563**	**78,473**

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	Trust Boards
REPORT TITLE:	Name of the merged organisation
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Director of Corporate Services
PRESENTED BY:	Director of Corporate Services
DATE:	3 May 2022

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 findings of the engagement process on the name for the merged organisation. Overall, the vast majority of respondents preferred Somerset NHS Foundation Trust as the name of our future merged trust. However, the percentage of YDH colleagues who said that they preferred Somerset NHS Foundation Trust as the name of the merged trust is smaller than for other audiences (56% compared with 86% for SFT colleagues, 66% for partners and stakeholders, 84% for patients and 83% for members of the public). The proportion of Somerset FT colleagues, patients and members of the public who prefer Somerset NHS Foundation Trust is similar (86%, 84% and 83%). The themes that emerged from the feedback were that this name is simple, accurate, shorter and to the point, easier to remember, includes our whole county and will save money and other resources on things like signage and templates when we bring our two organisations together. This feedback is strong, and on that basis, we are proposing to the Trust Boards of both organisations that we name our new organisation Somerset NHS Foundation Trust.
Recommendation	The Boards are asked to consider the outcome of the engagement process and to approve the recommendation to name the new organisation Somerset NHS Foundation Trust.

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

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

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)

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]
Not applicable.

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

IDENTIFYING A NAME FOR OUR MERGED TRUST

OUTCOME OF FINAL PHASE OF ENGAGEMENT

1. PURPOSE

1.1. The purpose of the report is to present the findings of the engagement process on the name for the merged organisation to the Board.

2. WORK DONE UP UNTIL FEBRUARY 2022

2.1. In June 2021, the executive teams from both YDH and Somerset FT agreed the process to identify a name for the merged trust, working within the naming conventions and requirements for NHS organisations.

2.2. It was agreed to follow the process below to identify a name for the merged trust:

- Seek suggestions for a new name from colleagues and stakeholders working within the NHS guidance.
- Both executive teams identify a shortlist to seek feedback on
- Seek feedback and preferences on the shortlist from colleagues and a wider group of stakeholders
- Provide information on the engagement process and proposal for a new name to both Council of Governors and Trust Boards for decision
- Communicate outcome to colleague and stakeholders.

2.3. For four weeks from 28 June – 25 July 2021 we asked colleagues from both trusts and some stakeholders for their suggestions for names for the merged trust. We used all communications channels within both trusts to reach colleagues and wrote to stakeholders:

2.4. We received 179 responses with 94 suggested names for the new trust. The names with the most suggestions were:

- Somerset NHS Foundation Trust - 73
- Somerset Healthcare NHS Foundation Trust - 4
- Somerset Combined NHS Trusts (query if it would meet NHS protocols for naming organisations) - 3
- United Somerset NHS Foundation Trust (would not meet NHS protocols for naming organisations) - 3

2.5. At the programme board in the middle of January 2022 the following shortlist was agreed:

- Somerset NHS Foundation Trust
- Somerset Healthcare NHS Foundation Trust
- Somerset County NHS Foundation Trust.

3. FINAL PHASE OF ENGAGEMENT ON THE SHORTLIST

3.1. From 21 February – 20 March 2022, we ran a questionnaire asking colleagues from both trusts, patients, members of the public, and stakeholders and partners which of the three shortlisted names they think would be best for a merged trust that will care for a population of more than half-a-million people living in Somerset and beyond, employ around 12,000 colleagues, and provide acute services from two hospitals, run community hospitals and community-based services, mental health and learning disability services and a proportion of the county's GP practices.

3.2. The questionnaire asked which name respondents thought was the most appropriate for our future merged trust and why. We publicised the survey through both trust's internal communications channels throughout the four-week engagement period, via the trusts' websites and their corporate social media channels. Somerset Clinical Commissioning Group sent the information out via their engagement channels, and we wrote to Somerset MPs, Healthwatch and NHS commissioners and providers from as far north as South Gloucestershire, down to Devon and Dorset inviting feedback.

4. SURVEY RESPONSES

4.1. We received 1,921 responses broken down into:

Members of the public	- 123
Patients	- 103
Partners or stakeholders	- 41
Colleagues from YDH	- 432
Colleagues from SFT	- 1,222

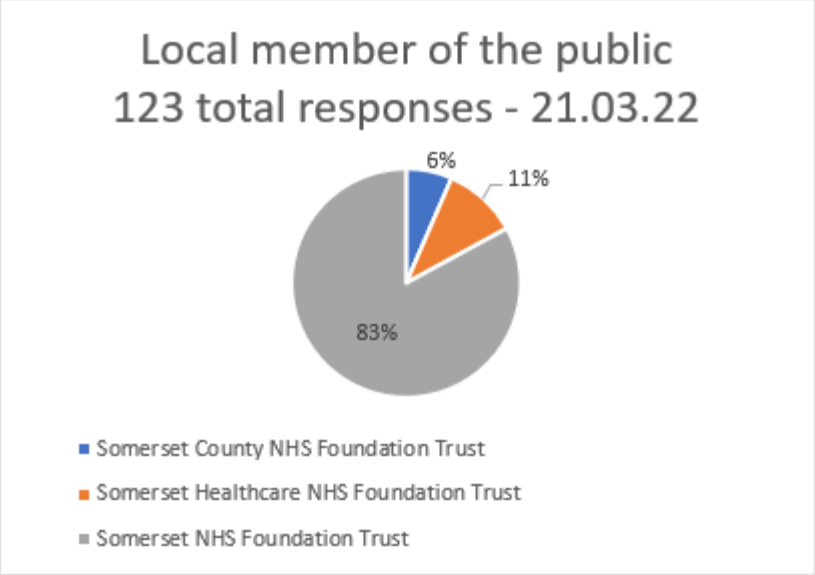
4.2. The number of responses from colleagues at YDH and SFT represent about 14% to 15% of colleagues in both organisations.

Total responses:

- 1,513 (78.5%) respondents preferred Somerset NHS Foundation Trust
- 206 (10.7%) respondents preferred Somerset County NHS Foundation Trust
- 202 (10.5%) respondents preferred Somerset Healthcare NHS Foundation Trust.

4.3. **Survey responses broken down by audience**

Responses from members of the public

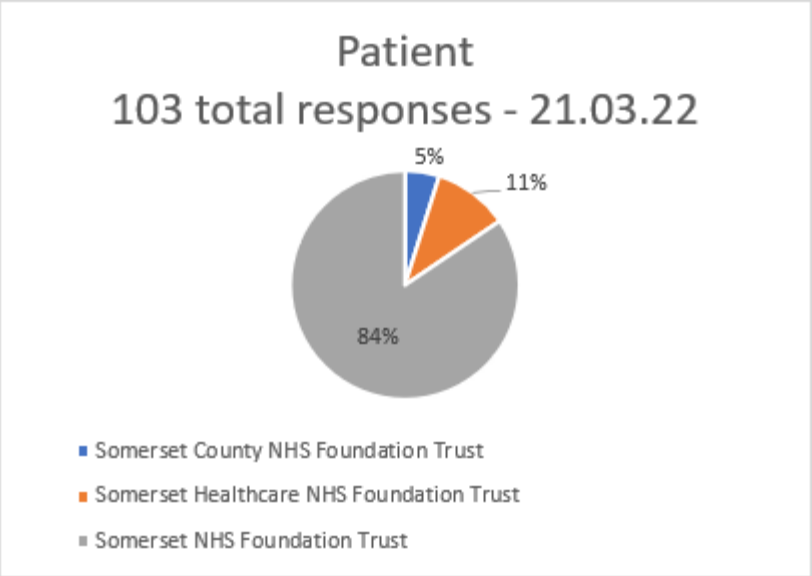


8 preferred Somerset County NHS Foundation Trust
13 preferred Somerset Healthcare NHS Foundation Trust
102 preferred Somerset NHS Foundation Trust

4.4. In the reasons provided for preferring Somerset NHS Foundation Trust the following themes are identified:

- Short and sweet, less of a mouthful, easier to say and remember
- The words “county” and “healthcare” are unnecessary
- Waste of time and cost to change the name.

Responses from patients

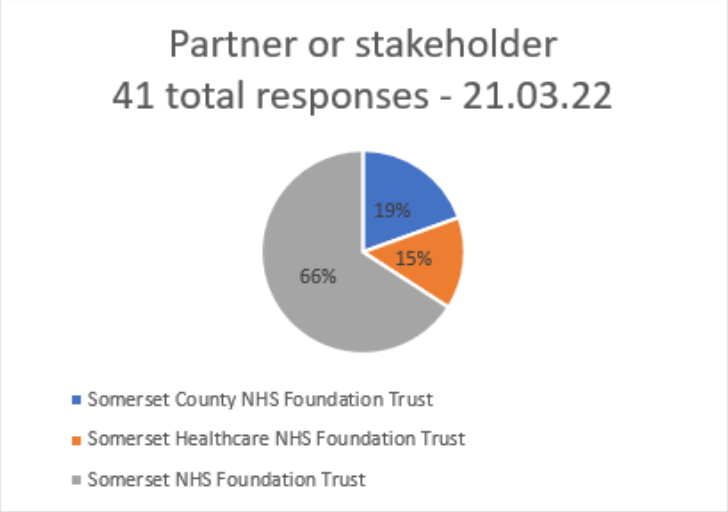


- 5 preferred Somerset County NHS Foundation Trust
- 11 preferred Somerset Healthcare NHS Foundation Trust
- 87 preferred Somerset NHS Foundation Trust

4.5. In the reasons provided for preferring Somerset NHS Foundation Trust the following themes are identified:

- Simple, accurate, shorter and to the point, more memorable
- Money saved on rebranding.

Responses from stakeholders and partners

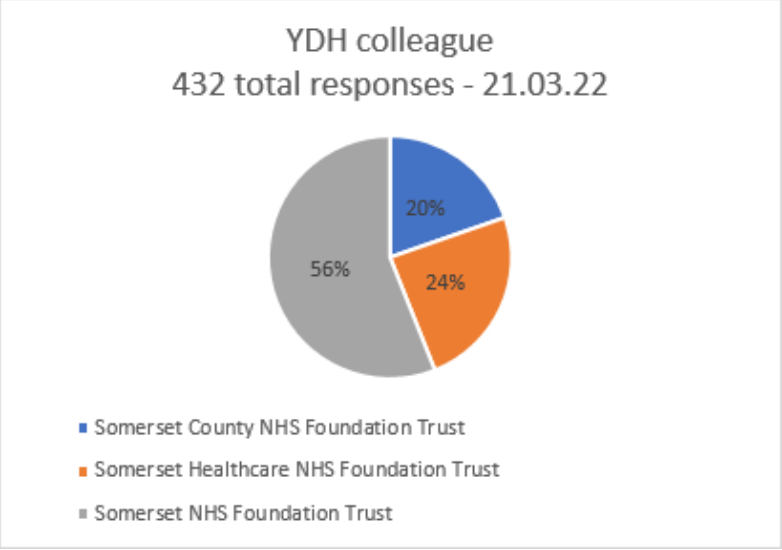


- 8 preferred Somerset County NHS Foundation Trust
- 6 preferred Somerset Healthcare NHS Foundation Trust
- 27 preferred Somerset NHS Foundation Trust

4.6. n the reasons provided for preferring Somerset NHS Foundation Trust the following themes are identified:

- Simple, accurate, shorter and to the point, easier to remember
- Money saved on rebranding.

Responses from colleagues at YDH



- 85 preferred Somerset County NHS Foundation Trust
- 105 preferred Somerset Healthcare NHS Foundation Trust
- 242 preferred Somerset NHS Foundation Trust

4.7. In the reasons provided for preferring Somerset NHS Foundation Trust (56% of YDH colleagues who responded) the following themes are identified:

- Simple, accurate, shorter and to the point, easier to remember ("the public will shorten it even if they other two are chosen")
- Cheapest and less waste of resources - money saved on signage etc.

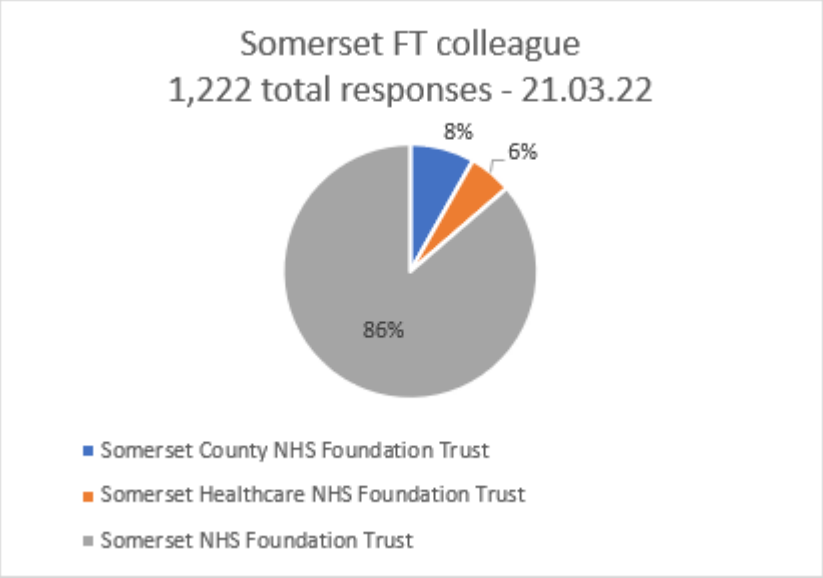
4.8. In the reasons provided for preferring Somerset Healthcare NHS Foundation Trust (24% of YDH colleagues who responded) the following themes are identified:

- Makes it clear that it is healthcare
- Signals a change; new merger, new beginning; important to signal difference from Somerset NHS Foundation Trust

4.9. In the reasons provided for preferring Somerset County NHS Foundation Trust (20% of YDH colleagues who responded) the following themes are identified:

- Covers the whole county
- Makes it different, signals a change

Responses from colleagues at SFT



- 100 preferred Somerset County NHS Foundation Trust
- 67 preferred Somerset Healthcare NHS Foundation Trust
- 1055 preferred Somerset NHS Foundation Trust

4.10. In the reasons provided for preferring Somerset NHS Foundation Trust (86% of colleagues from SFT who responded) the following themes are identified:

- Waste of money and resources to change it, a name change is disruptive
- Simple, succinct, shorter than the other two, easier to remember, encompasses the whole of Somerset, healthcare and county are unnecessary words

4.11. In the reasons provided for preferring Somerset County NHS Foundation Trust (8% of SFT colleagues who responded) the following themes are identified:

- Covers the whole county
- Signals a change, that a merger has taken place

4.12. In the reasons provided for preferring Somerset Healthcare NHS Foundation Trust (6% of colleagues from SFT who responded) the following themes are identified:

- Makes it clear that it is healthcare
- Makes it different, signals a change

5. SUMMARY

5.1. Somerset NHS Foundation Trust is the name that was preferred by the majority of respondents in total and the majority of respondents in each separate audience. However, the percentage of YDH colleagues who said that they preferred Somerset NHS Foundation Trust as the name of the merged trust is smaller than for other audiences (56% compared with 86% for SFT colleagues, 66% for partners and stakeholders, 84% for patients and 83% for members of the public). The proportion of Somerset FT colleagues, patients and members of the public who prefer Somerset NHS Foundation Trust is similar (86%, 84% and 83%). The reasons for preferring Somerset NHS Foundation Trust are very similar for each audience and primarily the simplicity of the name, the fact that it encompasses the whole county and will be less cost effective and disruptive to change.

6. RECOMMENDATION

6.1 The Boards are asked to consider the outcome of the engagement process and to approve the recommendation to name the new organisation Somerset NHS Foundation Trust.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Assurance report from the SFT Audit Committee meeting held on 12 April 2022
SPONSORING EXEC:	Barbara Gregory, Chairman of the Audit Committee
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Barbara Gregory, Chairman of the Audit Committee
DATE:	3 May 2022

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 Audit Committee meetings held on 12 April 2022 and the assurance received by the Committees. The Committee identified a concern in relation to the findings of the Payroll – Banding and Increments and the Sickness Absence reports and agreed to ask the People Committee to review the report at its next meeting.
Recommendation	The Board is asked to note the assurance provided and the area of concern identified by the Audit Committees.

Links to Board Assurance Framework and Corporate/Directorate Risk Register (Please select any which are impacted on / relevant to this paper)	
Yeovil District Hospital NHS FT	
☒ 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 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 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

AUDIT COMMITTEE MEETING HELD ON 12 APFRIL 2022

1. PURPOSE

1.1 The report sets out the items discussed at the meeting held on 12 April 2022, the assurance received by the Committee and any areas of concern identified.

1.2 The SFT and YDH meetings were held as separate meetings and the Committees will move to meetings held in common from July 2022.

2. ASSURANCE RECEIVED

Board Assurance Framework

2.1 The Committee discussed the Board Assurance Framework (BAF) and noted that the highest strategic risks related to objectives 4 (safe, sustainable, effective, high quality, person-centred support in the most appropriate setting) and 9 (to deliver levels of performance that are in line with our operational plans, system ambitions). The reasons for the heightened levels of these risks had previously been discussed at Board and Committee meetings and were well understood.

2.2 The Committee discussed gaps in assurance in relation to workforce planning and noted that workforce planning had been identified as a gap in assurance in a number of the objectives and this mainly related to system wide workforce planning. This will be an area of focus for the ICS following its formal establishment.

2.3 The Committee noted that a review of the strategic objectives and the format of the BAF had been undertaken at the April 2022 Joint Board Development Day and that a report will be presented to the July 2022 meeting.

2.4 The Committee agreed that it could take significant assurance from the BAF process and the actions being taken to mitigate risks.

Internal audit progress report

2.5 The Committee received the 2021/22 internal audit progress report and noted that the two remaining audits on the audit plan will be presented to the July 2022 Committee meeting.

2.6 The Committee received assurance from auditors that Covid-19 restrictions and colleague sickness had not impacted on the completion of the audits, although for some audits the scope of the audit had to be adjusted to take account of the restrictions and colleague sickness.

Data Security and Protection toolkit Audit

2.7 The Committee received the Data Security and Protection Toolkit audit report which had highlighted a moderate risk to the Trust's data

security and protection control environment. The report rated confidence in the DSP Toolkit return as high.

2.8 The Committee noted that the recommendations highlighted in the report will be implemented prior to the submission of the DSP Toolkit. The Committee agreed that the report provided significant assurance.

Communication and Liaison with Service Users, Carers and Families Data Quality audit report

2.9 The Committee received the communication and Liaison with Service Users, Carers and Families audit report which provided moderate assurance for design and moderate assurance for operational effectiveness. The Committee noted that four medium and two low priority recommendations were made and that the implementation of the recommendations will be monitored through the internal audit follow up process. The Committee agreed that the audit report provided good assurance.

Sickness Management audit report

2.10 The Committee received the Sickness Management audit report which provided moderate assurance for design and limited assurance for operational effectiveness. The Committee noted that two high and one medium priority recommendations were made.

2.11 The Committee noted that the audit had been requested by the Trust as it had been recognised that this was an area for improvement. The Committee agreed that the report provided some level of assurance in relation to the design of processes. In addition, the recent roll out of the ESR self service for managers module for recording absence will strengthen oversight of all types of absence.

Internal audit follow up report

2.12 The Committee received the internal audit recommendations follow up report and agreed that the report provided the Committee with significant assurance about the timely implementation of the recommendations.

Internal Audit Annual Report and Annual Statement of Assurance

2.13 The Committee received the Internal audit Annual report and Annual Statement of Compliance and noted the Head of Internal Audit Opinion. The Committee agreed that the “moderate” assurance opinion provided the Committee with significant assurance about the Trust’s governance processes.

Annual Internal Audit Plan for 2022/23

2.14 The Committee received and approved the audit plan for 2022/23

Counter Fraud Progress Report

2.15 The Committee received the counter fraud progress report and particularly noted the self assessment against the Count Fraud Functional Standard Return for 2021/22.

2.16 The Committee particularly discussed compliance with the Code of Conduct standards and agreed that this was a difficult standard to achieve. The Committee noted the changes to the Declaration of Interest system and the actions being taken to increase compliance.

2.17 The Committee further discussed the counter fraud survey response rate and was assured that, although the response rate was low, there was good evidence of counter fraud awareness amongst colleagues.

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

Counter Fraud Recommendation Tracker

2.19 The Committee received the counter fraud recommendations follow up report and the Committee agreed that the report provided significant assurance about the implementation of the recommendations.

Counter Fraud Workplan for 2022/23

2.20 The Committee received and approved the workplan for 2022/23

External audit report

2.21 The Committee received the external audit progress report and noted that the interim audit and the Value of Money risk Assessment work had been completed. The Committee noted that the Value for Money Risk Assessment had not identified any significant risks.

2.22 The Committee received technical updates in relation to: GAM 2021/22 – Updated fair pay disclose requirements; NAO report – NHS backlogs and waiting times in England; On the 2022 Audit Committee agenda; Health and Care Transformation: and How to Get workforce Planning Right.

Benchmarking Report

2.23 The Committee received the Q3 benchmarking report and noted that, overall, the Trust was placed in the middle compared to other trusts. The Trust however benchmarked better than others trusts in relation to the level of recurrent efficiencies.

Value for Money Risk Assessment 2021/22

2.24 The Committee received the Value for Money Risk Assessment report. The Committee noted that the Risk Assessment had not identified any significant risks and it was expected that, on the basis of this assessment, a “clean” external audit opinion will be issued.

2.25 The Committee agreed that the report provided the Committee with significant assurance.

Going Concern Statement

2.26 The Committee received the Going Concern Statement and agreed to recommend approval of the application of Going Concern to the Board.

2021/22 National Cost Collection

2.27 The Committee received the National Cost Collection return and approved the process for the reference cost submission.

Six Monthly Progress report from the Quality and Governance Committee

2.28 The Committee received the six monthly progress report from the Quality and Governance Committee and agreed that the report provided significant assurance about the items discussed at the Quality and Governance Committee meetings.

Losses and Special Payments

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

Single Quotation/Tender Waiver Action report

2.30 The Committee received the single quotation/tender waiver action report and noted the single quotation and tender waiver actions and the reasons for these actions.

Audit Committee Work Plan

2.31 The Committee discussed progress against its work plan and agreed that good progress was being made.

Accounting Policy Changes

2.32 The Committee discussed the Accounting Policy Changes which were proposed as a result of a review of the Somerset FT and Yeovil District Hospital FT polices. The aim of these changes was to ensure consistency in preparation for the year end accounts of both Trusts and the reasons for these changes were noted.

2.33 The Committee approved the changes to the Accounting Policy as set out in the report and the financial impact of these changes on the accounts.

3. AREAS OF CONCERN/FOLLOW UP

Payroll - Banding and Increments

3.1 The Committee received the Payroll – Banding and increments audit report which provided limited assurance for design and moderate assurance for operational effectiveness. The Committee noted that one high, two medium and one low priority recommendations were made and the implementation of the recommendations will be monitored through the internal audit follow up process.

3.2 The Committee expressed its concerns about the lack of controls identified in the report and felt that the timescale for implementing the recommendations was too long. It was agreed to raise these concerns with the Chief of People and Organisational Development and ask the People Committee to consider the audit report. The Committee asked for a detailed update to be provided to its July 2022 meeting.

Sickness Management audit report

3.3 The Committee agreed that although it received some level of assurance about controls, the operational effectiveness of the controls was a concern.

4. RISKS

4.1 The Committee identified risks relating to a number of findings in the Payroll – Banding and Increments and Sickness Absence Management audit reports.

4.2 The Committee agreed to ask the People Committee to review the findings of the Payroll – Bandings and Increments and Sickness Absence Management internal audit reports.

CHAIRMAN OF THE AUDIT COMMITTEE

Yeovil District NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Assurance report from the YDH Audit Committee meeting held on 12 April 2022
SPONSORING EXEC:	Paul Mapson, Chairman of the Audit Committee
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Paul Mapson, Chairman of the Audit Committee
DATE:	3 May 2022

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 Audit Committee meeting held on 12 April 2022 and the assurance received by the Committee. The Committee identified concerns in relation to the estates maintenance audit report and asked for the report to be shared with the Simply Service Ltd Board at its April 2022 meeting. The Committee further asked for a progress report on the implementation of the audit recommendations to be presented to the July 2022 Audit Committee meeting.
Recommendation	The Board is asked to note the assurance provided and the area of concern identified by the Audit Committee.

Links to Board Assurance Framework and Corporate/Directorate Risk Register (Please select any which are impacted on / relevant to this paper)	
Yeovil District Hospital NHS FT	
☒ 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)
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 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

YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST

AUDIT COMMITTEE MEETING HELD ON 12 APFRIL 2022

1. PURPOSE

1.1 The report sets out the items discussed at the meeting held on 12 April 2022, the assurance received by the Committee and any areas of concern identified.

1.2 The SFT and YDH meetings were held as separate meetings and the Committees will move to meetings held in common from July 2022.

2. ASSURANCE RECEIVED

Internal audit progress report

2.1 The Committee received the 2021/22 internal audit progress report and noted that the remaining Data Security and Protection Toolkit audit on the audit plan will be presented to the July 2022 Committee meeting.

2.2 The Committee received the summary Data Quality RTT audit report which provided a moderate opinion for both design and effectiveness. The Committee noted that three medium and one low priority recommendations had been made and that the implementation of the recommendations will be monitored through the internal audit follow up process.

2.3 The Committee agreed that the report provided good assurance.

Internal audit follow up report

2.4 The Committee received the internal audit recommendations follow up report and agreed that the report provided the Committee with significant assurance about the implementation of the recommendations.

Internal Audit Annual Report and Annual Statement of Assurance

2.5 The Committee received the Internal audit Annual report and Annual Statement of Compliance and noted the Head of Internal Audit Opinion. The Committee agreed that the “moderate” assurance opinion provided the Committee with significant assurance about the Trust’s governance processes.

Annual Internal Audit Plan for 2022/23

2.6 The Committee received and approved the audit plan for 2022/23. The Committee identified value for money and workforce strategy as possible audit areas and consideration will be given whether these can be covered as part of scheduled audits.

Counter Fraud Progress Report

2.7 The Committee received the counter fraud progress report and particularly noted the self assessment against the Count Fraud Functional Standard Return for 2021/22.

2.8 The Committee particularly discussed compliance with the Code of Conduct standards and agreed that this was a difficult standard to achieve. The Committee noted the changes to the Declaration of Interest system and the actions being taken to increase compliance.

2.9 The Committee further discussed the counter fraud survey response rate and was assured that, although the response rate was low, there was good evidence of counter fraud awareness amongst colleagues.

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

Counter Fraud Workplan for 2022/23

2.11 The Committee received and approved the workplan for 2022/23.

External audit report

2.12 The Committee received the external audit progress report and noted the good progress made with the interim audit.

2.13 The Committee received technical updates in relation to: GAM 2021/22 – Updated fair pay disclose requirements; NAO report – NHS backlogs and waiting times in England; On the 2022 Audit Committee agenda; Health and Care Transformation: and How to Get workforce Planning Right.

Benchmarking Report

2.14 The Committee received the Q3 benchmarking report and noted that, overall, the Trust was placed in the middle compared to other trusts. The key areas where the Trust benchmarked less well were agency expenditure and capital spend. The Trust was placed in the top quarter in terms of achievement against planned private patient income. The Committee noted that the agency spend included Symphony Health Services locums which may distort hospital related agency spend.

Value for Money Risk Assessment 2021/22

2.15 The Committee received the Value for Money Risk Assessment report. The Committee noted that the Risk Assessment had not identified any significant value for money related risks.

2.16 The Committee agreed that the report provided significant assurance.

Going Concern Statement

2.17 The Committee received the Going Concern Statement and agreed to recommend approval of the application of Going Concern to the Board.

2021/22 National Cost Collection

2.18 The Committee received the National Cost Collection return and approved the process for the reference cost submission.

Single Quotation/Tender Waiver Action report

2.19 The Committee received the single quotation/tender waiver action report and noted the single quotation and tender waiver actions and the reasons for these actions.

2.20 The Committee suggested asking auditors to carry out some sample testing of single quotation/tender waiter actions in 2023/24.

Losses and Special Payments

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

Risk Management

2.22 The Committee discussed the Board Assurance Framework (BAF) and noted that the two highest strategic risks related to the Care for our Population (increasing levels of demand) and the Innovate and Collaborate (failure to agree new models of care and a clear clinical strategy across Somerset) objectives.

2.23 The Committee noted the six top risks on the Corporate Risk Register – one risks scored at 25 and the remainder scored at 20 – and agreed that these risks were in line with the level of operational pressures across the wider system. The Committee agreed that these risks were a concern but the identification and management of these risks provided the Committee with assurance about risk management processes.

2.24 The Committee noted that a review of the strategic objectives and the format of the BAF had been undertaken at the April 2022 Joint Board Development Day and that a report will be presented to the July 2022 meeting.

Accounting Policy Changes

2.25 The Committee discussed the Accounting Policy Changes which were proposed as a result of a review of the Somerset FT and Yeovil District Hospital FT polices. The aim of these changes was to ensure consistency in preparation for the year end accounts of both Trusts and the reasons for these changes were noted.

2.26 The Committee noted the financial impact of a significant increase in pay within three years of retirement and agreed to draw this to the attention of the Chief of People and Organisational Development.

2.27 The Committee approved the changes to the Accounting Policy as set out in the report and the financial impact of these changes on the accounts.

3. AREAS OF CONCERN/FOLLOW UP

Estates Maintenance audit report

3.1 The Committee received the estates maintenance audit report which provided moderate assurance for design and limited assurance for operational effectiveness. The Committee noted that one high and five medium priority recommendations were made and that the implementation of the

recommendations will be monitored through the internal audit follow up process.

3.2 The Committee expressed its concerns about the performance and governance related findings in the report and the Committee asked for the report to be shared with the Simply Service Ltd Board at its April 2022 meeting. The Committee further asked for a progress report to be presented to the July 2022 Audit Committee meeting.

4. RISKS

4.1 The Committee did not identify any new risks.

CHAIRMAN OF THE AUDIT COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Assurance Report from the Quality and Governance Committee meeting held on 23 March 2022
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Jan Hull, Chairman of the Quality and Governance Committee
DATE:	3 May 2022

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 Quality and Governance Committee meeting held on 23 March 2022. The Committee received assurance in relation to: • Care Quality Commission Action Plan - resus trolley check action; • Corporate Risk Register - significant progress made in relation to the district nursing risk • Claims and Litigation - oversight and governance processes; • Elective Recovery update - focus on elective recovery and the improvements already made. The Committee identified the following areas of concern or for follow up: • Corporate Risk Register - new risk in relation to the disaggregation of RiO data for public health nursing records and the need to ensure that colleagues working across children and adult social care were able to access the public health nursing records;

	• pressure on services - continued high levels of delays in discharges and the impact on bed capacity and the elective recovery programme; • Maternity Incentive Scheme (MIS) – compliance with Safety Actions 6 and 8 due to the impact of the high Covid-10 infection levels; • Elective Recovery update - the size of the performance issues and the link to the bed capacity issues; • Emergency Department update - deterioration in meeting the four hour target, challenges admitting patients attending ED as a result of the bed capacity issues; the high volume of patients; the generally long waits for patients to be seen in ED; and the need to queue ambulances outside the ED; • Homicide Action Plan – for discussion at the next planning meeting. The Committee identified three areas to be reported to the Board or to other Committees: • Patient Flow; • Pressures on services, including on ED and the Elective Recovery Programme, and decisions made in relation to infection control measures; • Colleague wellbeing and morale.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Quality and Governance Committee. The Board is asked to note that the May 2022 meetings of the Quality and Governance Committee and Governance and Quality Assurance Committee will be held in common. The Governance Committee and Governance and Quality Assurance Committee has not met since January 2022.

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

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE COMMITTEE MEETING

1. PURPOSE

1.1. The report sets out the items discussed at the formal meeting held on 23 March 2022, along with the assurance received by the Committee and any areas of concern identified. The meeting was conducted by video conference call.

2. ASSURANCE RECEIVED

Care Quality Commission Action Plan

2.1 The Committee received assurance that the resus trolley check action had been implemented.

Corporate Risk Register

2.2 The Committee received the up-to-date Corporate Risk Register and noted that there were currently 19 risks on the risk register, three rated 25, seven rated as 20, five rated 16 and four rated 15. The details of these risks were noted.

2.3 The Committee asked for the district nursing risk to be updated in the next iteration of the Corporate Risk Register to reflect the significant progress made.

Claims and Litigation

2.4 The Committee received an update on claims and litigations and noted the number of claims received, the themes of the claims and the areas with the highest number of claims and value of claims.

2.5 The Committee agreed that the update, and the joined up working with complaints and incident management services and coroners, provided the Committee with significant assurance regarding oversight and governance processes.

Elective Recovery Update

2.6 The Committee received an update on the elective recovery programme. The Committee noted that outpatient recovery was progressing well in terms of levels of outpatients being seen and recovery was at 100% of pre Covid-19 levels. Day case activity was also progressing well and delivery was at 95% of pre Covid-19 levels, but this level of performance was linked to the bed capacity pressures and the availability of the day surgery unit.

2.7 The Committee noted that the key challenge related to inpatient surgical activity where activity levels were low due to the bed capacity issues.

2.8 The Committee further noted the increase in diagnostic capacity, and particularly echo and MRI activity which had positively impacted on the number of longest waiting patients both for SFT and YDH. In addition, SFT was performing well in terms of the longer waiting cancer patients.

2.9 The Committee further received an update on the work carried out over the last 12 months which had enabled the Trust to achieve its current performance levels and the details of the actions were noted.

2.10 The Committee received an overview of the challenges for 2022/23; the expected performance issues; the actions being taken to keep patients safe whilst awaiting treatment; and the colleague wellbeing concerns.

2.11 The Committee agreed that the report provided the Committee with assurance about the focus on elective recovery and the improvements already made.

3. AREAS OF CONCERN OR FOLLOW UP

Corporate Risk Register

3.1 The Committee noted that a new risk had been identified in relation to the disaggregation of RiO data as the County Council had asked for public health nursing records to be moved to an independent version of RiO. The Committee noted the concerns expressed about this change and the need to ensure that colleagues working across children and adult social care were able to access the public health nursing records.

3.2 The Committee noted that a large number of additional risks scoring 15 or above had been identified in the last few months at Directorate level and the majority of these risks were linked to the corporate risks on escalation and staffing. The identification of these risks had reinforced the corporate level risks rated at 20 and 25.

3.3 The Committee noted the concerns about the demand pressures and staffing levels and noted the excellent work by colleagues across both trusts services in ensuring that services can continue to be provided. There was however concern that the levels of risk and safety were fragile. The Committee recognised these concerns and was assured about the levels of scrutiny both at trust and at system level.

Pressure on Services

3.4 The Committee received an update on the pressure on services and noted the continued high discharge delays and the impact on bed capacity and the elective recovery programme. In addition, the Committee noted the high volume of Covid-19 positive patients and the impact on all aspects of bedded care; the high levels of sickness absence and the significant impact on some of the teams; and the disruptions to patient pathways.

3.5 The Committee noted the very high number of Covid-19 positive patients in mental health inpatient services and further noted that risk

assessments were being carried out to be able to maintain capacity in mental health wards.

3.6 The Committee noted that, in view of the considerable pressures, a safety huddle process had been set up to enable the pressures to be managed in line with Trust command and control arrangements. In addition, in consultation with the UK Health Security Agency, the Clinical Commissioning Group and the Care Quality Commission, a decision had been made to relax the infection control and prevention measures, the details of which were noted.

3.7 The Committee supported the decisions taken and was assured that all options had been explored to ensure that all essential services can continued to be provided.

Maternity Incentive Scheme (MIS)

3.8 The Committee received an update on the maternity incentive scheme and noted that it may not be possible to declare compliance with Safety Actions 6 and 8 due to the impact of the high Covid-10 infection levels. The Committee that Safety Action 4 had now been fully implemented and full compliance can be declared. The Committee noted that reports and updates in relation to the most recent Ockenden report would be presented to the Trust Board and the next meeting of the Committee in May 2022.

Elective Recovery Update

3.9 The Committee agreed that it had received levels of assurance in relation to performance and actions being taken, but in view of the size of the performance issues and the link to the bed capacity issues, this remained an area of concern.

Emergency Department Update

3.10 The Committee received an update on the emergency department pressures and noted the deterioration in meeting the four hour target. The Committee received assurance that all patients were triaged within 30 minutes after arriving at the front door.

3.11 The Committee noted the challenges admitting patients attending ED as a result of the bed capacity issues; the high volume of patients; the generally long waits for patients to be seen in ED; and the need to queue ambulances outside the ED. The Committee recognised the impact of these continued pressures on colleague wellbeing and morale.

3.12 The Committee noted the development of a new ED – Early Warning Score tool which was used to measure the escalation status, and the recruitment of a third registered nurse.

3.13 In view of the ongoing pressures on the ED and the impact on patients, the Committee that this remained an area of concern.

Homicide Action Plan

3.14 The Committee received the homicide action plan for information and noted that the action plan will be included on the agenda of the next planning meeting.

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

4.1 The Committee identified the following risks and issues to be reported to the Board and/or Board Committees:

- Patient Flow;
- Pressures on services, including on ED and the Elective Recovery Programme; and decisions made in relation to infection control measures;
- Colleague wellbeing and morale.

5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The objectives covered at the meeting related to:

- **Objective 4, safe, high quality care -** the detailed discussion regarding the current operational position in acute and ED services has provided the Committee with positive and negative assurance. The MIS provided positive assurance for this objective. The report on elective recovery provided positive and negative assurances. Overall, this confirmed the heightened risk scoring for achievement of this objective;
- **Objective 6 – reduce inequalities** – negative assurance from the report in relation to homicides;
- **Objective 1, learning organisation –** positive assurance provided from the Claims and Litigation report and assurance on the process for learning from the Homicide Action Plan**.**

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

Jan Hull
CHAIRMAN OF THE QUALITY AND GOVERNANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Assurance Report from the Mental Health Act Committee meeting held on 8 March 2022
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Alexander Priest, Chairman of the Mental Health Act Committee
DATE:	3 May 2022

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 Mental Health Act Committee meeting held on 8 March 2022 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committees received assurance in relation to: • The Head of Mental Health Act report; • The update from the Clinical Commissioning Group in relation to patient transport and the establishment of a community sentence treatment requirements service; • Update from Swan Advocacy; • Out of Area Placements; • The Mental Health Act Forensic Report; • Out of Area Treatment for Somerset Patients; • Complaints and Issues; • Audit Action Plans; • Risk Register;

	The Committees identified the following area for follow up: • the Mental Capacity Act (MCA), Deprivation of Liberty (DoLs) and Liberty Protection Safeguards (LPS) – the concerns in relation to training uptake in some operational directorates, the delays in publishing a LPS Code of Practice and the implementation of LPS from April 2022; • the pressures on the Approved Mental Health Professional (AMHP) services and the low number of S12 doctors available to undertake assessments out of hours; • the increased use of S62s. The Committee did not identify any risks to be reported to the Board but agreed that: • AMHP/Section 12 capacity; and • LPS implementation delay remained areas of risk or follow up.
Recommendation	The Board is asked to note the assurance and the areas for follow up identified by the Committee.

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

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

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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)
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

ASSURANCE REPORT FROM THE MENTAL HEALTH ACT COMMITTEE

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 8 March 2022, the assurance received by the Committee and any areas of concern identified.

2. ASSURANCE AND UPDATES RECEIVED

Head of Mental Health Act Co-ordination report

2.1. The Committee received the Head of Mental Health Act Co-ordination report and noted:

- that there were 144 people subject to the Mental Health Act as at 1 March 2022;
- the service level agreement to administer the MHA on behalf of Yeovil District Hospital NHS Foundation Trust;
- the number and types of sections between the period 1 March 2021 to March 2022; the significant increase in the number of S3s; and the overall reduction in the number of sections; details of the Managers' Panel and Tribunal hearings;
- the update on the reform of the Mental Health Act (MHA);
- the publication of the Care Quality Commission's "Monitoring the Mental Health Act 20/21 annual report". The report set out concerns regarding children held in unsuitable environments whilst waiting for CAMHS beds. The Committee noted that it had not been possible to quantify this figure within Somerset as this information could not be directly obtained from the electronic patient record.

2.2. The Committee discussed the reporting format for future reports and the Committee asked for the following information to be included in the report: S136 data; benchmarking information; exception reporting (use of force, positive and proactive care; escalation process); ratio of detained/non detained patients and demographic information where available. The Committee discussed whether to include patient experience data but agreed that just data will not be helpful and in view of the narrow remit of the Committee, it was agreed that patient experience, unless related to MHA compliance, should be overseen by the Quality and Governance Committee.

2.3. The Committee discussed the increase in S3s and it was noted that this increase was likely caused by patients not accessing services during the Covid-19 lockdown. It was expected that the number of S3s will stabilise over the next few months.

2.4. The Committee agreed that the report provided significant assurance about the work taking place.

Update from the Clinical Commissioning Group's (CCG) Commissioning Managers

2.5. The Committee noted that the procurement process for the patient transport – which included the conveyance of patients with mental health issues had been concluded and that a recommendation will be presented to the CCG's Governing Body at the end of March 2022.

2.6. The Committee noted that a procurement process for the provision of community sentence treatment requirements for people coming before courts had been concluded. This service related to alcohol, drugs, mental health requirements or a combination of these requirements. This service will be in place from 1 April 2022.

Swan Advocacy Update

2.7. The Committee received an update from Swan Advocacy and noted the increase in support required in a number of the mental health inpatient units. The number of referrals had reduced and this could be due to an increase in the number of Mental Health Act advocates on wards and the shift from an "opting out" approach during Covid-19 to the traditional self referring approach.

2.8. The Committee discussed the escalation process for issues identified by the Independent Mental Health Advocates (IMHA) and agreed that the process was robust. The Committee further noted that the theme in relation to "S132 rights being read" had been raised as a risk on the mental health and learning disabilities directorate risk register.

2.9. The Committee agreed that the report provided significant assurance about the work of the advocates.

Care Quality Commission Compliance Visits

2.10. The Committee noted that no CQC compliance visits had been carried out since the last Committee meeting.

Out of Area Placements

2.11. The Committee received an update on children and adolescent mental health services (CAMHS) out of area placements and noted that no CAMHS patients had been placed out of area. The report provided the Committee with significant assurance and the Committee complimented the CAMHS team on their excellent work in trying to keep CAMHS patients within Somerset.

2.12. The Committee received an update on the breakdown of a placement for a young person in Looked After accommodation and noted the difficulties looking after this patient whilst an alternative placement was being secured. The Committee received assurance that although the young person may not have been in the right environment for a short period, a review had highlighted that good care was provided and that sound decisions were made regarding the patient's care and wellbeing.

Mental Health Act Forensic Report

2.13. The Committee received the MHA forensic report and noted that, from April 2022, requests for admission to secure care for Somerset patients will be supported by the new Specialist Community Forensic Teams and that information on the number of requests will be included in future reports.

Oat of Area Treatment Somerset (OATS) patients

2.14. The Committee received an update on OATS patients and noted that the number of OATS remained very low and that reviews were being undertaken on a regular basis.

2.15. The Committee agreed that the report provided significant assurance about the process for preventing patients with mental health issues having to be placed out of area and the process for monitoring patients who had to be placed out of area. The Committee noted the reasons for the out of area placements.

Complaints and Issues

2.16. The Committee received the report setting out the complaints and issues received and resolved by the Trust in relation to patients under the MHA during the period 1 December to 28 February 2022 and noted that no such complaints had been received during this period. The Committee received an update on the investigations into the unexpected deaths of detained patients and noted that final reports will be circulated to the Committee once completed.

Audit Action Plans

2.17. The Committee received an update on the actions identified in the S17 Leave audit report and the Committee noted that good progress was being made.

2.18. The Committee received an update on the actions identified in the S132 patients right to information audit report and noted the work taking place to improve recording of these rights.

2.19. The Committee received the Consent to Treatment audit report and action plan and noted the findings and actions being taken.

2.20. The Committee agreed that the reports provided significant assurance but asked for updated action plans to be presented at an appropriate future meeting.

Risk Register

2.21. The Committee received the directorate risk register and noted the risks. The Committee discussed the risks relating to Pyrland Ward's bed availability and St Andrews' move to the Summerlands site. The Committee further discussed the Holford Ward risk but noted that the risk rating will be reviewed as it was not felt accurate.

3. AREAS OF CONCERNS/FOLLOW UP

Update on the Mental Capacity Act (MCA), Deprivation of Liberty (DoLs) and Liberty Protection Safeguards (LPS)

3.1. The Committee received an update on the Mental Capacity Act (MCA), Deprivation of Liberty (DoLs) and Liberty Protection Safeguards (LPS) performance and noted the continued improvement in Level 1 MCA training uptake and the decrease in level 2 MCA training uptake. There was a focus on training clinical colleagues but it was agreed that this should be followed up with operational managers. The Committee received assurance about the actions being taken to increase training sessions.

3.2. The Committee further noted the continued steady increase in the number of DoLs applications over the last 12 months particularly in community and acute services.

3.3. The Committee noted that the implementation of the Liberty Protection Safeguards had been delayed but a new date had not yet been confirmed. It was however expected that the consultation on the draft Code of Practice will commence shortly.

Update on AMHPS services

3.4. The Committee received an update on the Approved Mental Health Professional (AMHP) services and noted the pressures on AMHPs services. The Committee noted the difficulties covering overnight shifts; the data collection issues; the breakdown of some of the placements for young people with Learning Difficulties and the resulting difficulties faced by this group of patients.

3.5. The Committee further noted that there continued to be a reliance on a small number of doctors willing to undertake S12 assessments out of hours and the reliance on this small number of doctors could pose difficulties during annual leave/sickness and could result in a delay in the assessment. The Committee noted that the shortage of S12 doctors will be followed up with the Medical Director for Mental Health and Learning Disabilities.

Audit Action Plans

3.6. The Committee further noted the increased use of Section 62s due to delays by second opinion appointed doctors (SOADs). The Committee noted that this delay will be raised at the Care Quality Commission Liaison meeting.

4. RISKS

4.1. The Committee did not identify any new risks but agreed that:

- AMHP/Section 12 capacity; and

- LPS implementation delay

remained areas of risk or follow up.

Alexander Priest
CHAIRMAN OF THE MENTAL HEALTH ACT COMMITTEE

Somerset NHS Foundation Trust/Yeovil District Hospital NHS Foundation Trust	
REPORT TO:	The Trust Board
REPORT TITLE:	Assurance Report from the People and Workforce Committee meetings held in common on 8 March 2022
SPONSORING EXEC:	Director of Corporate Services
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Stephen Harrison and Graham Hughes, Chairmen of the People and Workforce Committees
DATE:	3 May 2022

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 8 March 2022 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 stories from the Engagement Champions; • the work relating to the merger engagement/cultural alignment and the internal audit findings on cultural maturity; • the findings from the staff surveys; • the merger plans - the focus on the integration of the people service and the work on the restructuring of the senior people team; • overseas recruitment; • the focus on an inclusive culture. The Committees identified the following area for follow up:

	• the merger related communications had been identified as a risk; • the requirement for a detailed review of the terms and conditions of bank and agency staff, including understanding the drivers and motivations for signing up for bank work; • the impact of a new digital systems on colleagues. 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 objectives one and eight of the Board Assurance Framework.
Recommendation	The Boards are asked to note the assurance and the areas for follow up identified by the People and Workforce Committees.

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

ASSURANCE REPORT FROM THE PEOPLE AND WORKFORCE COMMITTEES

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held in common on 8 March 2022, 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

Colleague Stories – Engagement Champions

2.1. The Committees received a presentation from a Simply Serve Limited (SSL) and Yeovil District Hospital NHS Foundation Trust (YDH) engagement champion. The Committee received assurance from both engagement champions that there were good levels of engagement between senior management teams and the engagement champions. The Committee noted that the key issues raised by SSL colleagues were the need for clarity about the future of SSL and colleagues' workload.

2.2. The Committees noted the feedback from the YDH engagement champion about his experience as a BAME colleague and the challenges BAME colleagues face adapting to a new work environment and culture. A key challenge was the need for clarity on decisions that will impact BAME colleagues due to the lack of family support.

2.3. The Committees noted that the champions' workload had been raised at the initial engagement champions meeting and will continue to be kept under review.

Cultural/Engagement

2.4. The Committees received an update on work relating to the merger engagement/cultural alignment and agreed that the internal audit report on cultural maturity provided the Committees with significant assurance that both organisations had a very strong culture awareness. The key areas of focus were identified as: digital activity, branding, communications and values.

2.5. The Committees further received the findings from the 2021 staff surveys and agreed that, in spite of the lower responses rates, the findings and benchmarking information provided significant assurance. The Committees noted that feedback from the survey will inform the priorities of the next iteration of the People Strategy.

2.6. The Committees noted that SSL colleagues were not included in the national staff survey but the findings of a local survey provided

significant assurance. The areas to be followed up will be included in the overarching action plan.

Merger Plans

2.7. The Committees noted the people integration workstream charter and received assurance that the integration of the people service to be able to provide sufficient support to the organisations was seen as a priority.

2.8. The Committees received the updated due diligence template for people and organisational development and noted the key risks – vacancy levels, continue pressure on colleagues and bank and agency usage. The Committees received partial assurance about the resources available within the people services to deliver the merger work and recognised that the merger of the people teams will create capacity to focus on the merger.

2.9. The Committees received an update on the development of the People Strategy and noted that feedback on the vision of the Strategy was being sought. The Committees noted the Kings Fund - Tired of Being Exhausted report and the seven key actions which could be considered as part of the work on the development of the People Strategy for the merged organisation.

2.10. The Committee agreed to invite a colleague from the National People Team to a future Committee meeting.

2.11. The Committee further received an update on the work on the restructuring of the senior people team and the Committee agreed that the progress made to date provided the Committee with significant assurance.

Resourcing

2.12. The Committees received an update on overseas recruitment and noted the significant vacancy factor in mental health nursing. The Committees noted that the overseas recruitment campaign for 2022 will focus on the recruitment of 160 registered general nurses and 30 registered mental health nurses for SFT and 1452 nurses and 72 radiographers for YDH as an NHS agency for other trusts. The Committees noted the successful bid for funding to support the recruitment of 12 mental health nurses in the South West and the actions identified in relation to overseas recruitment.

2.13. The Committees further noted that community mental health recruitment was a key risk and that no international framework relating to community mental health competences was available.

2.14. The Committee received significant assurance that international recruitment was progressing well.

2.15. The Committees deferred a report on workforce planning to the next Committee meetings.

Developing an Inclusive Culture

2.16. The Committees received an update on the Our Inclusion Journey: Reflections and Next Steps and the focus on increasing the impact

of engagement to see a real shift in terms of diversity and experiences of inclusion.

2.17. The Committees noted the next steps and agreed that the focus on an inclusive culture provided the Committees with significant assurance.

3. AREAS OF CONCERN OR FOR FOLLOW UP

Merger Plans

3.1. The Committee agreed that merger related communications remained a risk.

3.2. The Committees noted the concerns raised about bank and agency terms and conditions and agreed that a detailed review of the terms and conditions, including understanding the drivers and motivations for signing up for bank work, should be undertaken as part of the merger work.

Digital Strategy

3.3. The Committees received the Digital Transformation Business Case which was part of the Strategic Outline Case for the replacement of digital systems and noted the key highlights of the strategy and the focus on personalised health records.

3.4. The Committees noted the actions being taken and recognised the impact a new digital systems can have on colleagues.

4. ISSUES REQUESTED TO BE FOLLOWED UP BY OTHER COMMITTEES

4.1. No issues had been requested to be followed up by the People and Workforce Committee.

5. ASSURANCE FRAMEWORK

5.1. The Committee received assurance in relation to objectives one and eight (culture and workforce).