Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	YDH Guardian Of Safe Working for Postgraduate Doctors Quarterly 4 Report
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	John McFarlane, Guardian for Yeovil
PRESENTED BY:	Daniel Meron, Chief Medical Officer
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report covers the period January to March 2023. The report shows that there is robust evidence that the working hours for trainee doctors at YDH remain safe. The following findings are drawn to the attention of the Board: • Exception report numbers returned to average in this quarter with an issue in relation to orthopaedics now resolved. • Five immediate Safety Concerns due to junior doctors feeling unsupported with orthogeriatrician middle grade on leave.
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: N/A					

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

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

NHS
Somerset
NHS Foundation Trust

YDH Guardian of Safe Working Hours

Kindness, Respect, Teamwork
Everyone, Every day

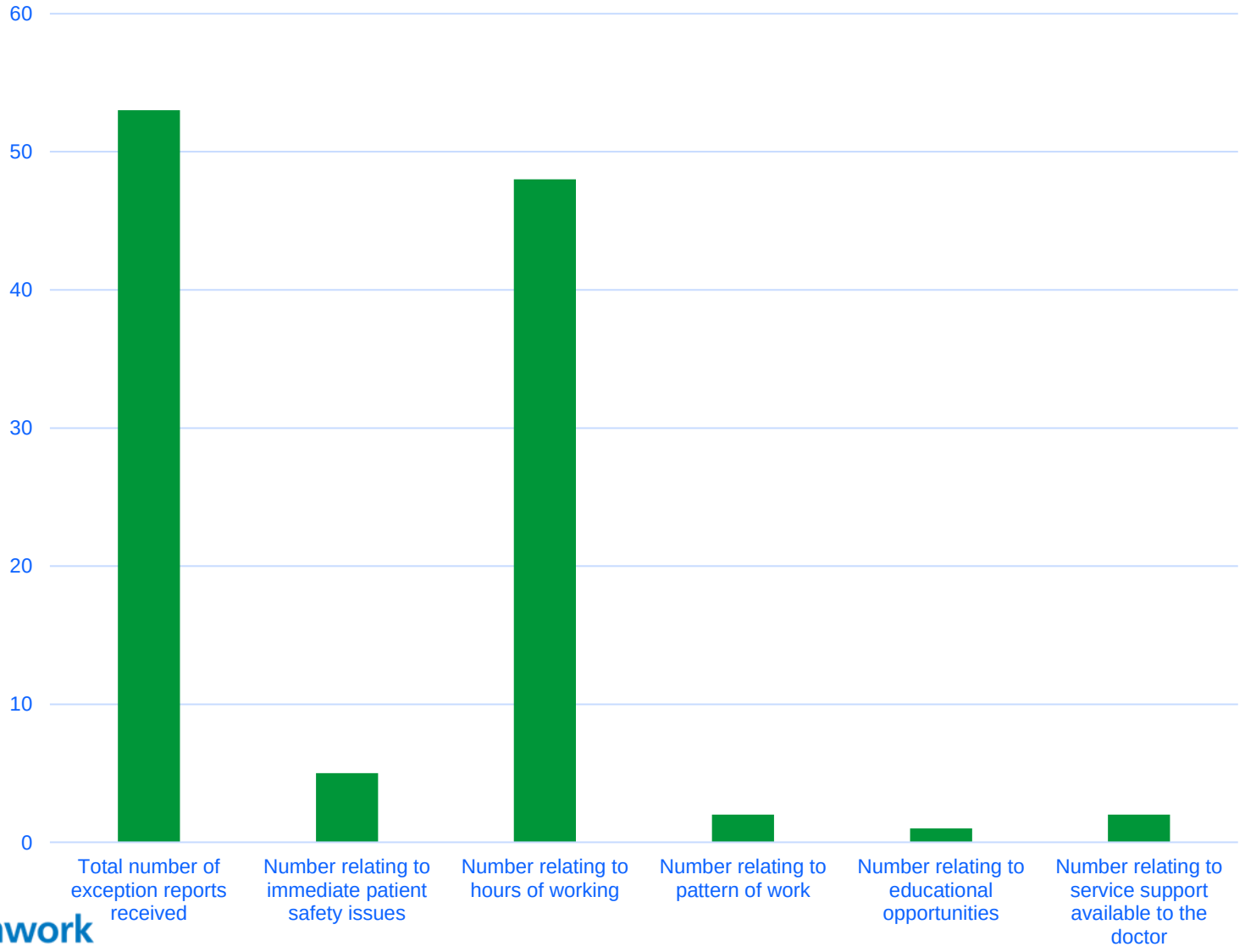
Quarterly Report

John McFarlane

- Allocate was introduced to Yeovil District Hospital NHS Foundation Trust in 2016.

- From 06th December 2016 up until the current reporting date we have received a total of:
  - 1241 Exception Reports (Allocate Total Count)
  - This represents an average of ~ 50 Reports per Quarter
  - Of the reports raised
    - 1096 have related to Hours (95%)
    - 35 have related to Educational Issues
    - 18 have related to Service Provision Issues

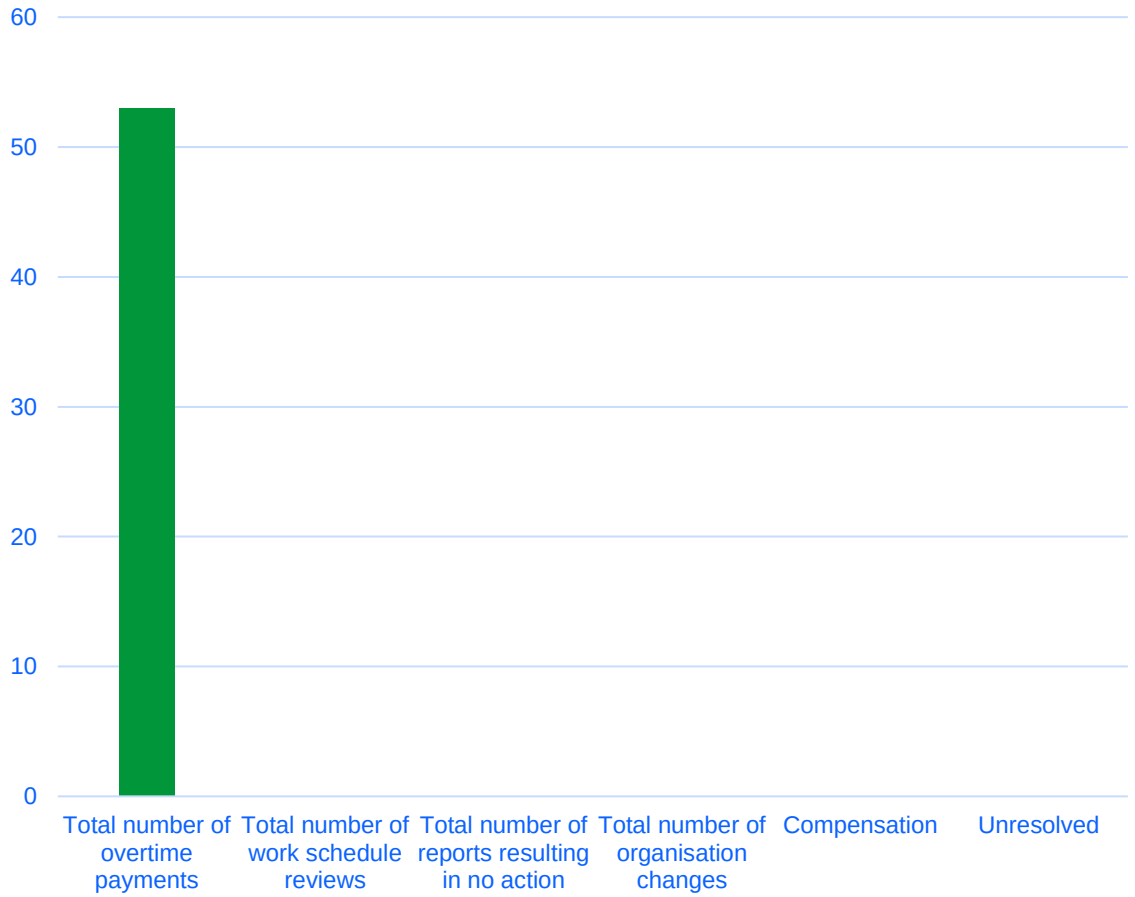
53 exception reports



Somerset NHS Foundation Trust

Kindness, Respect, Teamwork
Everyone, Every day

All resulting in overtime payments



Somerset NHS Foundation Trust

Kindness, Respect, Teamwork
Everyone, Every day

Exception reports for the quarter by rota

- Gen surgery: 7
- Gen medicine: 25
- Paediatrics: 2
- Gastroenterology: 4
- Orthopaedics: 15

Reasons for ER over last quarter by specialty & grade

ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate patient safety issues	General medicine	Senior house officer	2	0	3	0
	Respiratory Medicine	FY1	1	0	1	0
	Trauma & Orthopaedic Surgery	Foundation house officer 2	0	3	3	0
	Trauma & Orthopaedic Surgery	ST1 *	0	2	2	0
Total			3	5	9	0
No. relating to hours/pattern	Diabetes & endocrinology	FY1	0	1	1	0
	Gastroenterology	FY1	0	4	4	0
	General medicine	FY1	2	11	13	0
	General medicine	FY1 *	0	2	2	0
	General medicine	FY2 *	0	2	2	0
	General medicine	Senior house officer	2	1	4	0
	General medicine	ST4	0	2	2	0
	General surgery	FY1	0	1	1	0
	General surgery	FY1 *	0	2	2	0
	Paediatrics	FY2	0	2	2	0
	Respiratory Medicine	FY1	4	3	7	0
	Trauma & Orthopaedic Surgery	CT1	0	2	2	0
	Trauma & Orthopaedic Surgery	Foundation house officer 2	0	3	3	0
	Trauma & Orthopaedic Surgery	FY2	4	9	13	0
	Trauma & Orthopaedic Surgery	FY2 *	0	1	1	0
	Trauma & Orthopaedic Surgery	ST1 *	0	4	4	0
Total			12	50	63	0
No. relating to educational opportunities	Trauma & Orthopaedic Surgery	ST1 *	0	1	1	0
Total			0	1	1	0
No. relating to service support available	Trauma & Orthopaedic Surgery	FY2 *	0	1	1	0
	Trauma & Orthopaedic Surgery	ST1 *	0	1	1	0
Total			0	2	2	0

- Deanery Gap
- Resp ST
- Gastro GP Gap
- Gastro ST gap
- Stroke ST
- Palliative care FY1

In the past three months there have been 5 Exception Reports raised by the originator as being of “Immediate Safety Concern” (ISC)

On investigation these were found to be as follows:

All in orthopaedics

due to junior doctors feeling unsafe in their practice increased volume of work during a week when the middle grade orthogeriatrician was on leave

- We were below minimum staffing on this day which was a rota gap that was known 5-6 weeks ago. With no orthogeriatrician on annual leave, I had to take care of 18 patients alone. Due to excessive workload, I was unable to allocate enough time to reviewing each patient and I feel that I was forced to compromise on the quality of care due to the sheer volume of patients.
- I was fasting for Ramadan and had to stay an additional hour and half to ensure all urgent jobs were done.
- I have worked through my breaks every day for the last week and still ended up staying late by more than an hour late every single day. This rota gap has been known about for weeks and has not been addressed.

- In future plan to staff ward with 3 junior doctors not 2 when orthogeriatrican on leave

- 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

NHS Somerset NHS Foundation Trust

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)

- Exception report numbers returned to average in this quarter
- ISCs (5) due to junior doctors feeling unsupported with orthogeriatrician middle grade on leave
- 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.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	SFT Guardian Of Safe Working for Postgraduate Doctors Quarterly 4 Report
SPONSORING EXEC:	Daniel Meron, Chief Medical Officer
REPORT BY:	Janet Fallon, Guardian of Safe Working Lee-Ann Toogood, Medical Workforce Manager
PRESENTED BY:	Daniel Meron, Chief Medical Officer
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report covers 7 January 2023 to 19 April 2023. • Exception reporting patterns, rota gaps and locum spending remain consistent, highlight the Medical Directorate and Emergency Medicine as the areas of greatest need for increased staffing going forward • We have seen no Immediate Safety Concerns regarding weekend working this quarter – this is reassuring given the change in allocation of the HOOH Co-ordinator last year We continue to see problems with rota management across the Trust - these processes require ongoing improvement.
Recommendation	The Board is asked to discuss the report and: • Recognise ongoing pressures on staffing and working patterns in busy directorates • Consider measures to increase the substantive workforce with the aim of mitigating these pressures • Support improvements in rota management and administration across the Trust

Links to Joint Strategic Objectives (Please select any which are impacted on / relevant to this paper)
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Is this paper clear for release under the Freedom of Information Act 2000?			✓ Yes	☐ No

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SOMERSET NHS FOUNDATION TRUST

QUARTERLY REPORT ON SAFE WORKING HOURS:
DOCTORS AND DENTISTS IN TRAINING – May 2023

1. INTRODUCTION

1.1. This report covers the period 7 January 2023 to 19 April 2023 and comprises quantitative and qualitative data on working patterns for postgraduate doctors in training across the Trust.

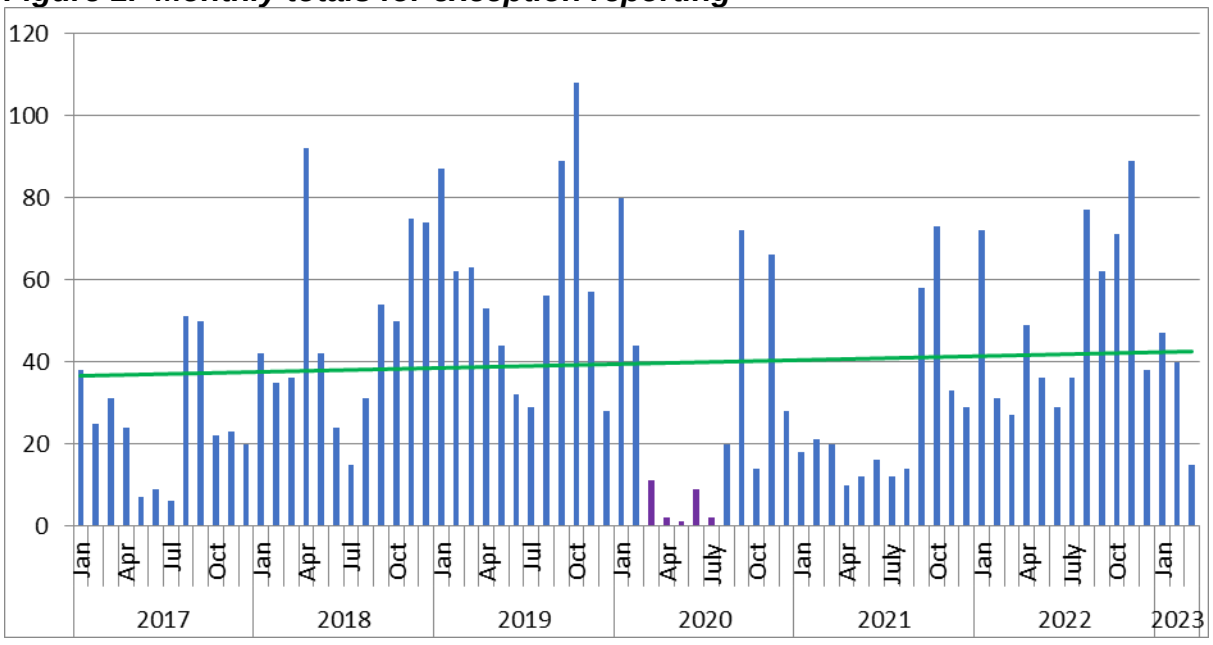
2. EXCEPTION REPORT DATA:

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

Exception reporting since the introduction of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

2.1. As of 06/01/23 - Total of 2810 exception reports since implementation of 2016 TCS (December 2016). The overall cost of exception report overtime is £47,735.05. The monthly breakdown of exception reporting is shown in Figure 1.

Figure 1. Monthly totals for exception reporting



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2.2. **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	52 *(112)*	36	16	Hours 42 Educational 4 Service Support 5 Pattern 1
Anaesthetics	0 *(0)*	0	0	
DCT Trainees	0 *(0)*	0	0	
ENT	0 *(0)*	0	0	
General Surgery	26 *(16)*	7	19	Hours 20 Pattern 6
O&G	0 *(1)*	0	0	
Oncology/ Haematology	0 *(13)*	0	0	
Paediatrics	6 *(6)*	0	6	Hours 6
Psychiatry	10 *(11)*	1	9	Hours 7 Service Support 2 Pattern 1
Trauma & Ortho	16 *(7)*	5	11	Hours 14 Service Support 2
Urology	1 *(6)*	0	1	Hours 1
Vascular	0 *(2)*	0	0	
Total	**111 *(174)***	**49**	**62**	

Table 2: Exception reports per trainee grade

Grade of trainee	**No. exceptions raised**
F1	64 *(97)*
F2	31 *(26)*
CT1-2 / ST1-2	11 *(44)*
ST3+	5 *(7)*
Total	**111 *(174)***

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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	**1.1**	0	0
	CT1/2	0	**0.4**	0	
	F1/F2	1	0	0	
Emergency Medicine	ST3+	8	**0.8**	0	0
	CT1/2	14	**1.8**	0	
	F2	2	**1.9**	0	
	F1	1	0	0	
Medicine (including Neurology & Haem / Onc)	ST3+	16	**1.0**	2	112
	CT1/2	15	**0.2**	32	
	F2	15	0	16	
	F1	19	**1**	72	
Obs & Gynae	ST3+	8	**0**	1	1
	ST1/2	10	**0**	0	
Ophthalmology	ST1-3	5	0	0	0
Paediatrics	ST	18	**2.6**	1	1
	F2	1	**0**	0	
Psychiatry	ST4+	7	2.2	9	11
	CT1-3	16	**1.2**	0	
	F2	2	0	0	
	F1	3	0	2	
T&O	ST3+	7	0	0	7
	CT1/2	1	0	0	
	F2	8	0	7	
Surgery	ST3+	7	0	0	23
	CT1/2	11	**1.4**	0	
	F2	1	0	0	
	F1	11	0	23	

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Qualitative summary of exception reports

2.3. Overall numbers of exception reports (ERs) are down this quarter, however we continue to the majority coming from the Medical Directorate. There have been increases in ER numbers from General Surgery and Trauma & Orthopaedics. This reflects the pressure of work across the Trust.

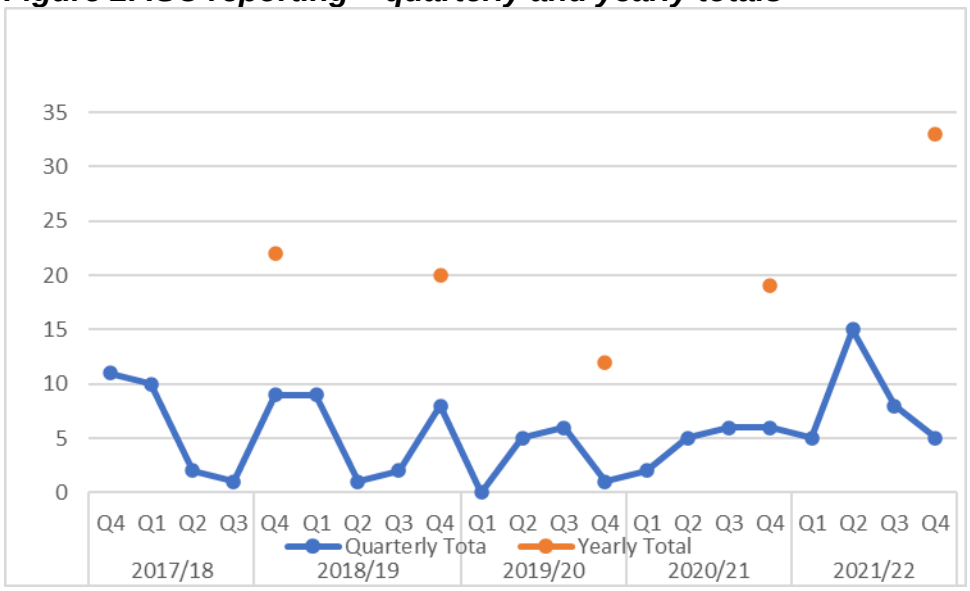
2.4. On review of all ERs from Trauma & Orthopaedics and Surgery, five of these relate to the pressure of work at weekends. This remains under close monitoring following the re-allocation of the Hospital Out Of Hours (HOOH) Co-ordinator to the Medical weekend team in December 2022.

Immediate safety concerns (ISCs)

2.5. Five ISCs have been raised during this quarter. Two of these came from the Medical Directorate and related to safe staffing levels in the Cardiology Department. A further two originated from the Psychiatry Team, relating to staffing and senior support on the wards. One ISC was raised in Paediatrics relating to a very busy shift with high workload and acutely unwell patients.

2.6. We have not seen any ISCs relating to weekend working in Medicine, Surgery or Trauma & Orthopaedics this quarter.

Figure 2. ISC reporting – quarterly and yearly totals



Fines

2.7. No fines were issued during this quarter.

Work schedule reviews

2.8. Four level 1 work schedule reviews were completed this quarter. These took place in the Cardiology Department regarding minimum staffing levels, the Psychiatry Department regarding minimum staffing levels and senior support, and the Trauma & Orthopaedics Department regarding the morning trauma

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meeting, which was impacting on the length of night shifts for the F2 doctors. All concerns were raised to relevant clinical leads and the DME.

Bank and agency data

Specialty	Shifts Requested	Worked as Bank/ Internal Cover	Worked as Agency	Hours Requested	Worked as Bank/ Internal Cover	Hours worked as Agency
Accident & Emergency	515	261	254	5124.5	2482	2642.5
AMU/GIM	1588	224	1364	12914.58	1844.25	11070.33
Anaesthetics	36	36	0	235	235	0
ENT	4	4	0	30	30	0
Gastroenterology	51	51	0	399.5	399.5	0
General Surgery	24	24	0	274.25	274.25	0
Maxillo-Facial	32	11	21	372	112	260
Obstetrics & Gynaecology	450	10	440	3905.5	116	3789.5
Ophthalmology	16	16		84.5	84.5	0
Peadiatrics	45	18	27	463	119	344
Respiratory	34	9	25	236	36	200
Trauma & Orthopaedics	25	25	0	214.5	214.5	0
Community Services	223	0	223	1786	0	1786
Grand Total	3043	689	2354	26039.33	5947	20092.33

Request Grade	Shifts Requested	Worked as Bank/ Internal Cover	Worked as Agency	Hours Requested	Worked as Bank/ Internal Cover	Hours Worked as Agency
F1	108	24	84	873.5	190.5	683
F2	103	103	0	775.5	775.5	0
ST1/2	1975	355	1620	16678.33	3275.5	13402.83
ST3+	603	207	396	5069.5	1705.5	3364
Grand Total	2789	689	2100	23396.83	5947	17449.83

3. ISSUES ARISING

Workforce development

3.1. Over recent years we have seen a consistent increase in the workload across all areas of the Trust, but particularly in the Medical Directorate, with a significant increase in the medical bed base and dependence on locum staff to manage this.

3.2. The Emergency Department currently relies heavily on Associate Specialist and locum staff to support safe rota design, which is reflected in high bank & agency spending.

3.3. Day-to-day staffing levels have been significantly impacted by the Terms & Conditions of Employment for doctors in training, and will be further impacted by increasing uptake of less-than-full-time working.

3.4. The Board has previously supported measures to improve staffing levels, including expansion of the Clinical Fellow programme in Medicine. It is likely

that further recruitment of substantive medical staff will be necessary going forward, in addition to planned expansions in training programme posts.

Postgraduate Doctor Forum (PDF)

3.5. The last PDF was held on Monday 20th February 2023. Issues raised including the upcoming strike action and concerns regarding management of the Medical Registrar rota. For the past two years, we have had significantly fewer medical registrars available at the end of the academic year compared with the beginning, largely due to sickness or maternity leave. This results in conversations regarding rota re-writing and can cause stress and upset to the trainees, particularly if there is a concern that their annual leave plans may be affected. This has been raised with the Associate Medical Director for Medicine and the rota writing team.

Rota management

3.6. We continue to see problems with rota management across directorates, often resulting in rotas being issued with insufficient notice (minimum 6 weeks prior to the start of placement) and problems managing rota gaps as outlined above.

3.7. Additional concerns regarding rota management have been raised in the end-of-placement survey circulated to trainees by the Postgraduate Academy team in April 2023.

3.8. This survey had **29 responses** from a variety of trainees as listed below:

Grade: CT 1/2/3 - **3**; F2 - **12**; F1 - **14**

Specialty: Emergency Medicine = **3**; General Practice = **2**; ICU/Critical care = **2**; Medicine = **9**; Surgery = **6**; T&O = **3**; Psychiatry = **2**; Paediatrics = **1**; Palliative care = **1**

3.9. Trainees in ED and the Care of the Elderly departments (4 out of 29) reported that their rotas were not circulated in a timely fashion. Six trainees from ED, Medicine, Surgery and ICU reported that their rota design could be improved.

3.10. Trainees from Medicine (2) and ED (1) felt that their rota did not provide adequate rest between shifts, and three trainees from Medicine, ICU and Surgery reported insufficient flexibility to take annual / study leave.

3.11. 10 out of 29 respondents reported their rota caused physical or mental exhaustion. 17 out of 29 reported exceptions to their working practices. Of these, 19 reported working over their contracted hours; nine reported missed educational opportunities; six reported missing rest breaks and three reported a lack of support on shifts. Five trainees reported that they had not completed exception reports in these instances, with one highlighting a “fear of being seen as less competent than peers” as the reason. The remaining four did not submit a report as these were isolated incidents and they felt well supported by their teams.

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3.12. Compared with previous survey results, we are seeing greater engagement with the exception reporting process and far fewer reports of being actively or passively discouraged to report by colleagues.

4. SUMMARY

4.1. Exception reporting patterns, rota gaps and locum spending remain consistent, highlight the Medical Directorate and Emergency Medicine as the areas of greatest need for increased staffing going forward.

4.2. We have seen no Immediate Safety Concerns regarding weekend working this quarter – this is reassuring given the change in allocation of the HOOH Co-ordinator last year.

4.3. We continue to see problems with rota management across the Trust - these processes require ongoing improvement.

5. RECOMMENDATIONS

5.1. The Board is asked to discuss the report and:

- Recognise ongoing pressures on staffing and working patterns in busy directorates .
- Consider measures to increase the substantive workforce with the aim of mitigating these pressures.
- Support improvements in rota management and administration across the Trust.

Janet Fallon, Guardian of Safe Working

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Six Monthly Wellbeing Guardian report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Graham Hughes
PRESENTED BY:	Graham Hughes
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report provides information on the work taking place around Colleague Wellbeing and more specifically around the nine principles set out for Wellbeing Guardians.
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
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Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report is presented to the board on a six monthly 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

WELLBEING GUARDIAN UPDATE

1. INTRODUCTION

1.1. This report outlines the health and wellbeing work undertaken since the last submission. It highlights areas of current work, future work streams, key challenges and any support needed from the Board. It is set in the context of several key strategies that underpin our endeavours.

2. NATIONAL PERSPECTIVE

2.1. The primary driver is the NHS People Plan (2021/22) [1]ambition: more people, working differently, in a compassionate and inclusive culture. Actions to deliver this are organised around four pillars:

- Looking after our people – with quality health & wellbeing support for everyone
- Belonging in the NHS – with particular focus on tackling discrimination that some staff face
- New ways of working and delivering care – making effective use of the full range of our people's skills and experience
- Growing for our future – how we recruit and keep our people, and welcome back colleagues who want to return.

2.2. This report will focus on the Looking After Our People element. Accompanying the NHS People Plan is the development of the NHS People Promise [2] which outlines seven workstreams with supporting commitments.

2.3. Our priorities have also been driven out by NHSE operational planning guidance[3] and the NHS Staff and Learners' Mental Wellbeing Review (2019) [4] which helped shape the wellbeing guardian role and nine principles that can be found in Appendix 1.

[1] NHS England » NHS People Plan
[2] NHS England » Our NHS People Promise
[3] NHS England » 2022/23 priorities and operational planning guidance
[4] Mental Wellbeing Report | Health Education England (hee.nhs.uk)

2.4. All of this sets the context around why there is a need for our continued focus on Wellbeing and more importantly the need for us to embed this within our organisation.

3. LOCAL PERSPECTIVE

3.1. At a local level, these documents and recommendations have helped to shape our Trusts People Strategy (2023-2028).

3.2. The strategic objective of the People Strategy is to support our colleagues to deliver the best care and support through a compassionate, inclusive, and learning culture. The strategic aim encompasses the new values: People First – Kindness, Respect, Teamwork – everyone, every day.

3.3. In addition, each Trust is encouraged to complete the NHSE Health & Wellbeing Framework diagnostic tool to establish a baseline, covering seven key areas.

3.4. Appendix 2 details the results from the self-assessment, the tool and results are used to support the Wellbeing agenda for the Trust. Whilst all areas will need more work over the coming years, the focus in 2023 will be those areas highlighted as the least developed in the baseline survey.

4. NHS SURVEY AND PEOPLE PULSE

4.1. The NHS staff survey results for our organisation shows positive results compared to the national comparator group average for:

- my organisation takes positive action on health and wellbeing.
- colleagues experiencing work-related Musculo-skeletal injuries.

4.2. The national People Pulse survey will provide evidence of progress throughout the year. See Appendix 3 and 4 for more detail on both survey results.

5. INTERNAL AUDIT FOR HEALTH AND WELLBEING

5.1. Internal audits were carried out across both legacy organisations last year. Recommendations have been incorporated into an action plan which covers four key priority areas:

- **strengthening the governance structure for health & wellbeing including, reviewing reporting arrangements** - From a governance perspective, the restructuring of the culture strategy group and sub-groups has enabled the wellbeing action group to form. In the future it

will widen its representation to include operational colleagues, including wellbeing champions.

- **gaining adequate feedback on wellbeing initiatives & services** – Colleague Support Service uses survey methods on all initiatives, including on completion of 1:1 appointments. All training programmes have qualitative and quantitative feedback from participants.

- **better utilising the available data** – a dashboard is in development to get information in one place.

- **enhancing the role of the wellbeing guardian** – regular meetings in place with our guardian.

6. WORK TO DATE

6.1. Health and Wellbeing covers a variety of services and initiatives that are provided within the Trust and below are some of the key areas covered.

- Work with the inclusion team, using the data available, has helped the wellbeing teams understand the experiences of diverse staff groups around wellbeing provision. A specific example is the Colleague Support service engaging with the colleague networks to offer additional options to get involved, as it was identified that Black, Asian, and ethnic minority colleagues were less likely to access the service offerings. Current evidence shows referrals for multicultural colleagues have gone up 76% since 2021. This indicates progress in overcoming barriers to accessing support.

- The Colleague Support service continues to grow with colleague referrals increasing month on month. In March 23, 49 new referrals came into the service with 41 needing more than just the initial contact. The number of colleagues reaching out to the service from the YDH site is increasing. Historically the service has not been used by medical colleagues and working with the senior doctor wellbeing team the service is now seeing medical colleagues using the service when needed.

  In addition to the new referrals made in March 2023 the service had:

  243 appointments a 50:50 mix of new and follow ups.

  Seven Compassion Circles were held

  11 reflective conversations and

  11 post incident support sessions.

- The wellbeing team has also supported colleagues with other matters such as financial wellbeing information and support in the workplace for menopause. Colleagues report that they have gained a great deal from sessions including feedback - “that it is being acknowledged as a problem for staff and taken seriously” “Confidence to have supportive menopause related conversations” “understanding myself to help inform others and be an advocate for actions and support required in the workplace. Ask the questions of others.”

- Use of direct contact with the wellbeing team from managers and colleagues, allows us to tailor provision to the individual and signpost to resources and support, for example, stop smoking services, hardship funds, menopause information, individual stress risk assessments.

- Employee voice is essential, and the ongoing engagement of Wellbeing Champions has been successful. We currently have 224 and in August 2022, we began to recruit colleagues that are based within the YDH acute site with a positive uptake. Our Wellbeing Champions continue to help support a healthy workplace environment. They are a conduit between their team and any wellbeing initiatives. They have been critical in providing that listening ear and signposting to our services such as the Colleague Support Line and engaging with us around what our colleagues maybe concerned with. They feedback in various ways, and we are developing training on themes such as grief, moral injury, anxiety at their request. One example of where the wellbeing champions played a vital role was in the feedback on the cost of living, supporting focus groups on fuel costs with community colleagues and as a result of their feedback the wellbeing team ensured they were all signed up as referrers to all Somerset foodbanks and Dorset where required.

- Each month as part of our wellbeing approach, a specific focus is taken. For example, we offered a faith and belief event as part of the spiritual and cultural wellbeing month, building on previous events to understand if this is something that is important to colleagues.

  In October 2022 the focus was menopause with a range of webinars and training sessions for managers which were well received.

  During April 2023 the focus was on Stress awareness with the launch of the PReP leaflet and links to useful webinars and resources. We have been supporting teams to conduct their own stress risk assessments to establish areas for development and action.

- Wellbeing conversations are one of the three priorities of the people plan. The training course has been piloted with wellbeing champions before the wider rollout. All colleague networks have been involved with the development of a wellbeing plan resource to support the wellbeing conversations initiative. This will ensure it is accessible to all.

- Supporting perimenopause and menopause through collaboration with the women's network to form a working group on menopause has resulted in learning sessions on menopause for managers, menopause cafes in teams, the virtual Menopause Meet up peer support group and a Trust policy is in development.

- The Mindful Employer Charter has just been revalidated for a further two years. It holds the Trust to account in providing access to emotional wellbeing support for colleagues, providing resources, supports employing people with existing mental health conditions, and providing reasonable adjustments. The benefit to the Trust is that we demonstrate to colleagues and others we are an inclusive organisation, we have access to helpful resources, and we support colleagues' mental wellbeing.

- Initial design work on colleague wellbeing spaces is underway and key members of the Health and Wellbeing team are part of this group currently looking at the design stage.

- Cost of living group continues to explore what else can be provided without disadvantaging colleagues through tax implications. All this will contribute to retaining our colleagues. Financial worries can have a huge impact on a person's wellbeing, so it is encouraging to see from data form the Pulse Survey that shows colleagues know where to go to find information and a small percentage had accessed services. We continue to make a small number of referrals to local food banks.

- Supporting colleagues with Musculoskeletal issues remains a focus with absence figures for the Trust showing that MSK issues are within the top 5 reasons colleagues are absent from work and in the 2022 NHS Staff Survey 13% of colleagues within legacy SFT and 14% of colleagues in legacy YDH said they have experienced MSK problems as a result of work activities in the last 12 months. Physio4U rapid access to physiotherapy continues to provide timely access for colleagues at SFT. The benefit of having this in-house service is that we can get colleagues back into the workplace or indeed prevent them from being absent. The service for pregnant colleagues allows us to cater proactively for this protected group of colleagues. We are using the data to spot any trends in injuries in teams and work is now being undertaken to establish similar reporting for the service at YDH.

- Senior Doctor Wellbeing continues with the Senior Doctor wellbeing team identifying key actions from the data collected which is being used to form the focus for 2023. Wellbeing is being discussed at every opportunity, the impact of this results in our doctors feeling that the organisation takes wellbeing seriously. See Appendix 5.

Professional development inductions are routine with all colleagues (and include wellbeing) and wellbeing is incorporated in all doctor appraisals. All new colleagues are sent a welcome pack including booklet. Senior doctor wellbeing leads are using a new framework for their work and linking more closely with their OD Lead counterparts. Mentoring is in place for all new senior doctor colleagues and integration of the teams across Trust is developing.

Challenges

- National funding has been withdrawn from the resilience hubs. Locally, we have safeguarded our Colleague Support Service (CSS) for a further year until March 2024 by careful financing. National lobbying is still taking place for further funding. This does highlight a potential resourcing issue for the CSS that needs to be considered in the next financial year.

- Finding adequate rest spaces in bases, particularly in the main acute sites. Whilst temporary solutions are being sought for out of hours spaces, permanent spaces need to be provided.

- Cost of living pressures on colleagues this includes car parking costs, financial difficulties in waiting for work mileage to be paid, increased referrals to food banks.

- Hot meal provision for colleagues and visitors is another issue. The current provision isn't comprehensive enough but with the recent move of catering back in house at MPH site, for example, this will be improved.

- Enabling wellbeing conversations, respectful resolution and leadership development offers to be taken up in already stretched operational teams.

- Continued pressure on colleagues and the impact on colleague wellbeing, in turn the impact on patient safety and experience.

Future work

- A comprehensive review of Trust current Occupational Health services, Physio4U and EAP provision, to establish value for money and potential new providers in the future or the bringing back in-house of certain services.

- Leading the planning & delivery of the wellbeing virtual conference for the ICS in the autumn/winter.

- Using the wellbeing space design principles for an identified space at MPH

- Using the NHS survey data that shows disabled colleagues feel least supported in their health and wellbeing and working with the lived experience network to gain further insight and appropriate actions.

- Wellbeing conversation training roll-out.

- Integrating a wellbeing perspective into HR processes e.g., policies, job descriptions.

- Continued collaboration with Inclusion, Leadership and OD, HR, Freedom to Speak up and Patient Safety to triangulate colleague information to supporting creating the right conditions for our colleagues to thrive at work.

- Further work with the Senior Doctors is to upskill medical clinical leaders. This will benefit all doctors and in turn the wider workforce across the Trust. Measures are in place such as the regular surveys to assess the impact.

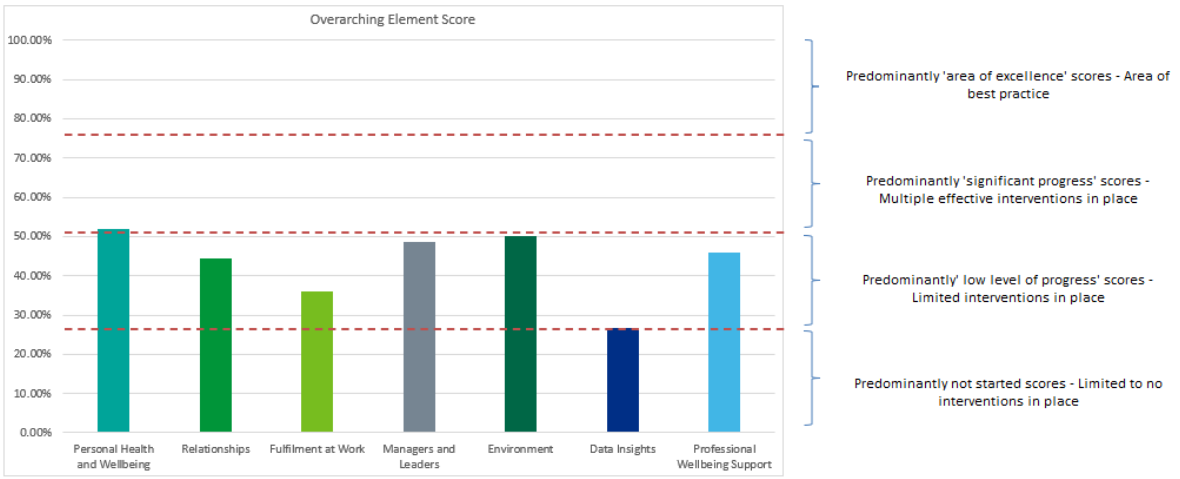
Appendix 1

NHS Wellbeing Guardian Principles

Appendix 2

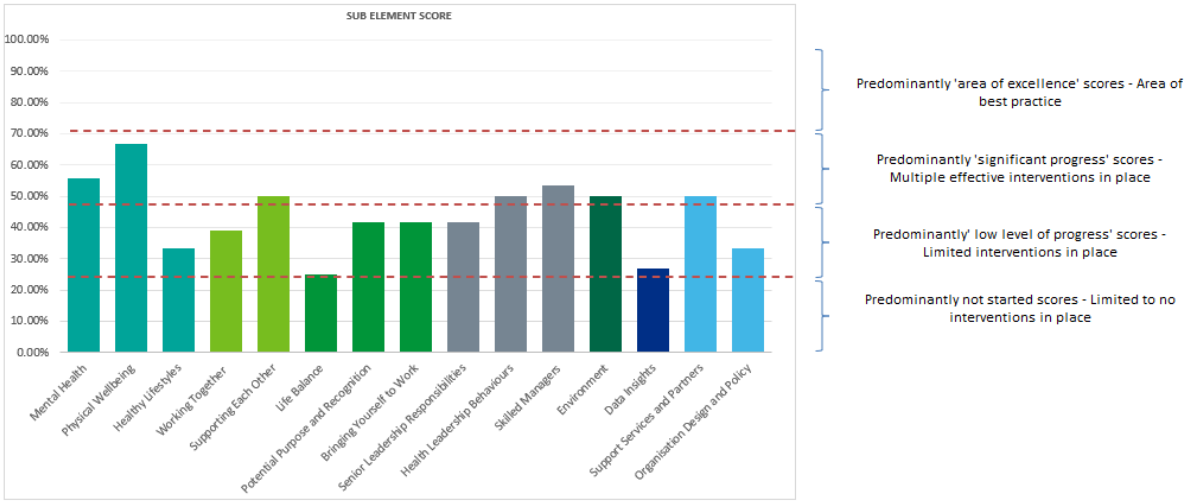
Health & Wellbeing Framework Diagnostic Tool Baseline data.

Graph 1: Overarching Element Score



This shows the priority areas for the coming year within the seven key areas. Relationships, data insights and fulfilment at work.

Graph 2: Sub element score



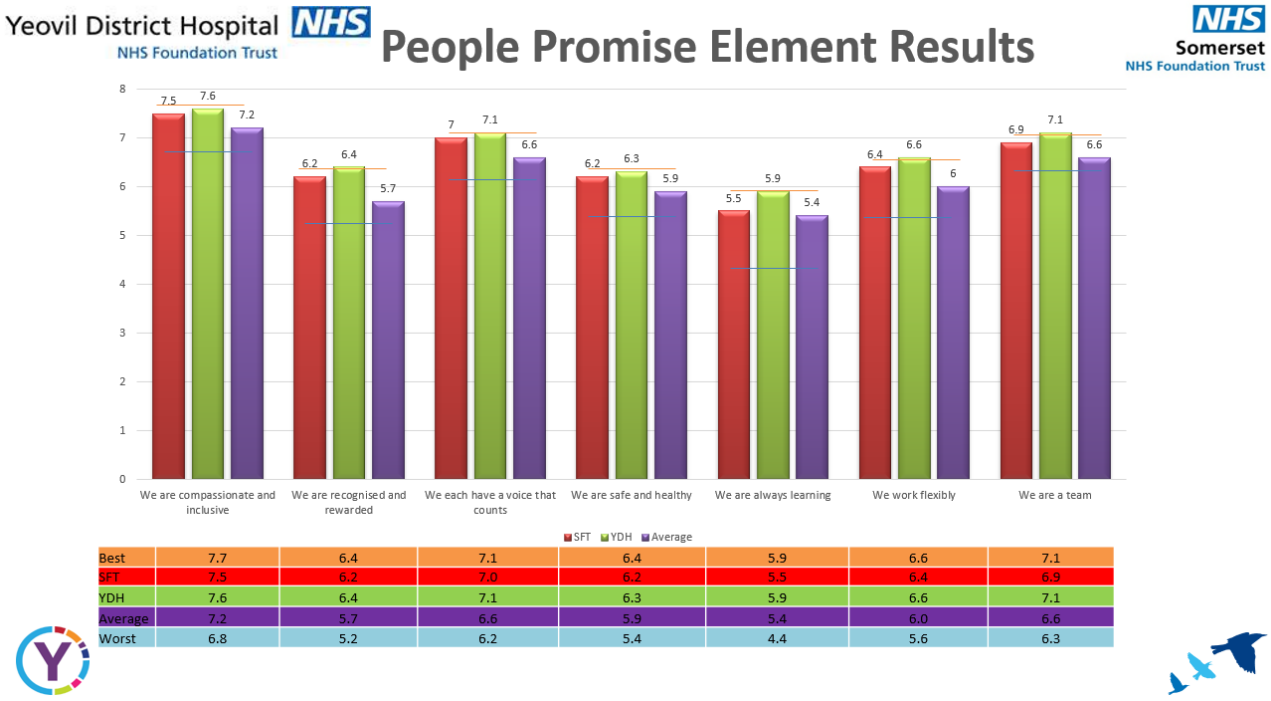
This further breakdown of the data highlights the priorities which include healthy lifestyles, life balance and data insights.

Appendix 3

NHS Survey 2022

The response rate for the 2022 survey was 45% for SFT and 50% for YDH.

Graph 1: Combined results for all elements of the People Promise.



This is a new way of representing the data, however, some questions remain the same as 2021 and so can be compared.

Table 1: We are safe and healthy – subscores.

We are safe and healthy - Subscores

We are safe and healthy	YDH 2021	YDH 2022	SFT 2021	SFT 2022	Peer Average 2022
Health and safety climate	6.0	5.8	5.5	5.5	5.2
Burnout	5.2	5.1	5.1	5.1	4.8
Negative experiences	8.1	7.9	7.8	7.8	7.7

Small changes for YDH and no change in scores for SFT. Drilling down to specific questions that are important indicators for our work, the details are shown in the following tables.

Table 2: My organisation takes positive action on health & wellbeing.

Health & Safety climate	YDH 2021	YDH 2022	SFT 2021	SFT 2022	Peer Average 2022
My organisation takes positive action on health & wellbeing.	73.8%	71.4%	61.7%	62.1%	55.6%

This shows a small decrease for YDH and a slight increase for SFT, both Trusts being well above the comparator average in this category.

Table 3: Experience of MSK problems as a result of work activities

Negative experiences	YDH 2021	YDH 2022	SFT 2021	SFT 2022	Peer Average 2022
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	27.1%	27.6%	27.5%	27.2%	30.6%

This shows slight variations for both trusts but below the comparator group average.

Table 4: During the past 12 months have you felt unwell as a result of work-related stress.

Negative experiences	YDH 2021	YDH 2022	SFT 2021	SFT 2022	Peer Average 2022
During the last 12 months have you felt unwell as a result of work-related stress?	38.5%	38.7%	44.5%	40.9%	45.1%
Senior Doctor results		62%		52%	58% average (not peer)

This shows a slight variation for YDH and a reduction for SFT. Both trusts are below the peer average for this category. Senior doctor data for the same question has been included in this table.

Appendix 4

The People Pulse – January 2023

The People Pulse survey is currently used quarterly by SFT and a wellbeing survey incorporating the eight key questions is used by YDH. A smaller number of respondents completed the survey for both Trusts. SFT had 308 and YDH had 340. From April 2023 the People Pulse survey will be utilised and more regularly.

January 2023 results include:

Table 5: My organisation is proactively supporting my health and wellbeing.

Colleague feedback	YDH Jan 2023	SFT Jan 2023	UK PLC benchmark
My organisation is proactively supporting my health and wellbeing.	69%	62.0%	67.8%

This shows over two-thirds of the sample in YDH and almost this amount for SFT, felt that the organisation actively supports their health & wellbeing.

Table 6: In my team we support each other.

Colleague Feedback	YDH Jan 2023	SFT Jan 2023	UK PLC benchmark
In my team we support each other	82%	81.8%	78.9%

This shows a good level of support within teams at both trusts and above the benchmark.

Table 7: Accessing financial wellbeing support and making use of that support.

Colleague Feedback	SFT Jan 2023
I know where to access financial wellbeing support if I need to	73.9%
Have you made use of the financial wellbeing support available to you?	8.8%

The highest response rate for not using the financial wellbeing support available was – I don't currently need it for SFT.

This question was not used in YDH but results for a similar question are:

Colleague Feedback	YDH Jan 2023
Have you struggled to feed yourself or your family in the last six months?	Yes = 7% No = 83%
If yes, did you go to an outside source for help?	Yes = 4% No = 95% Not answered = 1%

Senior Doctor Wellbeing results

Do you feel the organisation takes positive action on health and wellbeing? % Yes definitely						
	2018	2019	2020	2021	2022	
TST	25% Cons 28% SAS*	30% Cons 44% SAS*				
Sompar	17% Cons 28% SAS*	44% Cons 29% SAS*				
SFT			43% Cons 40% SAS*	46% (local data)	38% (local data)	34% local data see chart#
YDH					25% (local data)	
My organisation takes positive action on health and wellbeing % agree and strongly agree.						
SFT				69% Cons (151) 61% SAS* (70)	61% Cons (175) 75% SAS* (76)	
YDH				65% Cons (48) 50% SAS* (20)	50% Cons (56) 58% SAS* (22)	

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Six monthly Inclusion update
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Harriet Jones, Head of Inclusion
PRESENTED BY:	Harriet Jones, Head of Inclusion
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report outlines some of the strategic priorities for the inclusion team, as well as an overview of progress in implementing our Inclusion Roadmap.
Recommendation	The Board is asked to note and discuss the inclusion work.

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

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

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

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

☒ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

INCLUSION UPDATE

1. BACKGROUND AND PURPOSE

1.1 This report outlines some of the strategic priorities for the inclusion team, as well as an overview of progress in implementing our Inclusion Roadmap.

1.2 The priorities and progress described below provide a more detailed insight into how we use the data and analysis of colleague data, including the Workplace Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES) reports, to identify systemic actions and improvements.

1.3 The Board received the joint WRES and WDES reports in November 2022. Data is due to be submitted in May 2023, and the full reports will be shared with Board when finalised.

1.4 The Inclusion team are in the process of developing a long-term inclusion work-plan. This is being developed in consultation with multiple teams and with our colleague networks. The intention is that this workplan will outline our priorities for the next 3 to 5 years, with clear success measures and accountabilities. This work plan will replace the need for separate action plans for the WRES and WDES.

2. DATA INSIGHTS, PROGRESS TO DATE, AND FUTURE PLANS

Support for disabled colleagues

2.1. **What we know:** Our WRES reports have highlighted that disabled colleagues in both SFT and YDH have a lower engagement score from the NHS staff survey compared to colleagues with no disability. Further analysis has highlighted that colleagues with a disability are significantly less positive about their wellbeing at work.

2.2. An audit was completed by BDO in March 2023 which focused on the Disability Confident scheme and the support available for colleagues with a disability. This final report will be presented at the April audit committee. The findings from the report identified actions required in 4 key areas –

1. Networks: Greater support needed for our Neurodiversity network and Lived Experience network. Actions include support for the networks to grow, raise awareness, and to reach out across all locations across the trust, particularly at YDH where these networks are new.

2. Recruitment: improvements are required to improve the recruitment process to ensure adjustments are easily available. Additional

information and training is required for hiring managers, and our recruitment team need to have a detailed knowledge of adjustments and the guaranteed interview scheme in order to effectively support and advise hiring managers.

3. Reasonable Adjustments: significant improvements are required to make the reasonable adjustment process simple, easy to access, and supported consistently across our trust. Actions include creating a new policy and process for providing reasonable adjustments, training and upskilling for our HR Advisory service, and additional information and guidance for managers. Specific attention is needed to ensure advice, guidance and adjustments are available to Neurodiverse colleagues.

4. Recording reasonable adjustments: there is currently no process for recording, reporting, or monitoring reasonable adjustments in place across the organisation. This is particularly important for technical and IT adjustments.

2.3. **What we're doing:** A task and finish group has been convened to implement the majority of actions from the audit. The key aims for this task and finish group will be to:

- Work with the QI team to undertake a process mapping exercise – reviewing the support in place for people with a disability from the point a role is advertised, throughout the recruitment process, to induction and onboarding, ensuring adjustments are in place and reviewed, through to development, retention, and progression.

- Inform the development of a new reasonable adjustments policy and process;

- Develop a clear process for the new central fund for reasonable adjustments;

- Ensure actions from the disability audit and the process mapping exercise are implemented, with clear success measures identified.

Violence & Aggression towards colleagues

2.4. **What we know:** As highlighted in multiple WRES reports, we know that our Black, Asian and ethnic minority colleagues are significantly more likely to experience physical violence and harassment or abuse at work from patients or service users. Staff survey analysis has highlighted that LGBQT+ colleagues, disabled colleagues and women are also more likely to experience harassment, bullying, or abuse from patients.

2.5. **What we're doing**: This is a high priority and we are working on appropriate resourcing to support this work. The inclusion team is working with partners to create a strategy around violence and aggression. Our initial draft strategy identifies work in three key areas:

- Administration and governance: this includes the policies and processes in place to support colleagues. For example, having a reporting framework that enables colleagues to speak up, access appropriate support, and for mangers to ensure reports are addressed and responded to.

- Environment: review pilots of the use of body cams or other physical interventions to prevent, record or dissuade violence. We also need to consider our physical environment and whether we're providing safe and secure workplaces for colleagues.

- Behaviours and culture: explore how we build confidence and skills across our organisation in responding to inappropriate behaviours. From an inclusion perspective, this might include specific skills building around responding to racism or homophobic abuse from service users towards colleagues.

2.6. To enable this work, we need to improve the triangulation of data sets such as Radar and Ulysses reporting, Freedom to Speak Up reports, or security information.

Progression and retention of international colleagues

2.7. **What we know**: Our WRES data has consistently shown that the representation of our Black, Asian and ethnic minority colleagues drops sharply between Bands 5 and 6. Further analysis has shown that this is largely due to the growth in international recruitment into nursing and midwifery roles. While there has been some progress in increased representation of BAME colleagues in Band 6 nursing roles, this is not happening at the rate we'd like to see. We also need to undertake further analysis of our retention data for internationally recruited colleagues.

2.8. In medical roles, analysis suggests that internationally trained colleagues are more highly represented in SAS roles, rather than Consultant positions. There are many reasons why this might be the case, which needs further investigation.

2.9. **What we're doing**: This will be a priority area of focus, and we are looking at the possibility of creating some dedicated time for a member of the inclusion team to focus on strategic projects to address this issue. This would involve multiple workstreams bringing together colleagues from across the organisation to consider:

- Review of the onboarding support for internationally educated colleagues – including doctors, nurses, and AHPs. Ensuring we have consistent and meaningful support available.

- Exploring cultural competency training for managers.

- Identifying opportunities for improving retention of internationally trained colleagues.

2.10. We've updated the people metrics on the Trust's balance scorecard to include the percentage of colleagues in senior roles (classified as band 8a and above and consultant roles) by ethnicity, gender and disability, to increase visibility of underrepresentation, and to enable service groups to understand their local data and take data-informed actions.

Support for the Trans and non-binary community

2.11. **What we know**: Unfortunately, the NHS staff survey does not help us understand the experiences of Trans or non-binary colleagues, but feedback through our LGBTQ+ network and concerns raised with the inclusion team have identified several issues and concerns that we are working to address. These include:

- Challenges faced when transitioning in the workplace with processes being unclear, slow or not fully inclusive. This includes practical steps such as updating IT systems, email addresses and name badges.
- Uncertainty and nervousness from colleagues who are caring for Trans or non-binary patients. Colleagues want to get it right for our patients but are unsure or nervous about how to provide inclusive care.

2.12. **What we're doing**: Several projects have begun to start addressing the issues above, including:

- A task & finish group has been set up and is looking at improving IT systems and processes to make transitioning at work easier, quicker, and more supportive.

- Developing a guide for colleagues who are transitioning or coming out as non-binary at work, and information and guidance for their manager.

- A QI Silver project team has been established to review the information and support available to Trans and non-binary patients, and to colleagues providing care to Trans and non-binary communities.

- The Trust has opted in to the Rainbow Badge phase 2 programme. This scheme focuses on LGBTQ+ inclusion within healthcare and acts as an audit process. This includes a review of relevant policies, a colleague and patient experience survey, as well as a survey of services to explore the provision of care for the LGBTQ+ community. Following submission of our survey data and evidence, we will receive a Bronze, Silver or Gold award, as well as an action plan with dedicated support from the LGBT Foundation to review and implement our action plan.

Pay Gap

2.13. **What we know**: In addition to our annual gender pay gap reports, we undertook a detailed analysis of our pay gap data by gender and by race to understand the key drivers of our pay gap. For SFT and YDH combined, our mean gender pay gap was at 20% (female colleagues on average paid less than male colleagues), while our race pay gap was at +10% (Black, Asian and ethnic minority colleagues on average paid more than white colleagues). Further analysis identified several causes and areas for action:

- While our organisation is female-dominated, there is a lower representation of women in higher paid roles, which influences our organisational wide pay gap.

- When looking at role type and pay bands, pay gaps within agenda for change bands are relatively low. However, there are much larger pay gaps within our medical and dental workforce.

- The pay gap in favour of Black, Asian and ethnic minority (BAME) colleagues is due to a larger representation of BAME colleagues in medical and dental. When we looked at these roles separately, we identified a small race pay gap within consultant roles.

- Analysis of the Clinical Excellence Awards identified inequalities in relation to race and gender, with women and BAME colleagues being less likely to apply and awarded lower value awards.

2.14. **What we're doing**: Based on our analysis, we have identified the need to focus particular attention on the Clinical Excellence Award, to understand how we make this national scheme as inclusive as possible at a local level. We also need to do a more detailed analysis to understand why we're seeing larger pay gaps within medical roles and within consultant positions in particular. We will collaborate with the medical leadership team to progress this work.

Inclusive communications

2.15. **What we know**: Following a number of conversations with our network leads and feedback from patients through PALS, we know that we need to develop a more consistent and considered approach to inclusive language within communications and engagement. For example, concerns have been raised around whether our language is too gender-neutral, or not gender-neutral enough.

2.16. **What we're doing**: We are working in collaboration with the Communications team and Patient Engagement team to develop an inclusive language guide. This guide is based on national advice and research. We will adapt and tailor this guide following engagement with colleague networks and patients. Once we have clear and consistent guidance in place, we will then look to develop a process for reviewing existing material across the organisation, in consultation

with a representative readership panel, to support continuous improvement of communications material and to ensure we are applying inclusive language guidance consistently.

2.17. We also know that we are not as good as we could be at sharing our progress and approach to inclusion. We aim to work in collaboration with the Communications team to develop a comms plan for raising awareness of inclusion, progress, and our networks internally, but also externally.

Inclusive recruitment

2.18. **What we know**: There is a significant body of research highlighting challenges with traditional approaches to recruitment – this research shows that common recruitment practice is not inclusive in its design, and does not lead to equitable outcomes. This is reflected in feedback from colleague networks where recruitment has been identified as a key area for improvement to support inclusion.

2.19. **What we're doing**: We've been working closely with the recruitment team to consider alternative options for recruitment, and how we can transition to a skills-based model of recruitment. This has developed into several workstreams:

- The recruitment team are reviewing our Applicant Tracking System which will go out for tender later this year. Our aim is to build a spec for a system that is designed to support inclusive practice and accessibility while also improving the experience for colleagues using the system.

- We are undertaking a diagnostic with a partner company (RoleMapper) to explore how we could improve our job design, job architecture and job descriptions. The aim of this project is to map out a route to consistent and inclusive job descriptions, a fundamental step in moving towards skills based inclusive recruitment. This will also respond to feedback from hiring managers that has demonstrated this is an area for improvement.

- We've been supporting the recruitment team to ensure inclusion is weaved throughout new recruitment training for hiring managers.

3. IMPLEMENTING OUR INCLUSION ROADMAP

3.1 The Inclusion Team published the Inclusion Roadmap in 2022 - this document set out the short-term plan for creating the framework, governance structures and ways of working that will enable us to define and measure impact and create sustainable and systemic change. The Roadmap outlines a change in 'how' we create an inclusive workplace and culture. The Roadmap covers actions under 3 priority areas: governance, networks and a sustainable approach to training. Progress against these three areas is summarised below.

3.2 **Governance:** Create an inclusion governance structure for our merged organisation that supports a systemic approach.

In progress:

- A new Equality Delivery System (EDS) process was launched in 2022, and we submitted a report as a merged organisation in February 2023. The new process requires each Trust to identify three services to be assessed against the EDS requirements. For the first pilot year, we were asked to review two services, and the inclusion team led this in collaboration with the Maternity service and the Colleague Support service. Feedback from the national team has indicated that many trusts have not engaged in the EDS process, despite this being a requirement under CQC guidelines. The long-term aim is to build inclusion data and discussion into Service Group governance mechanisms – this would enable local-level plans and accountability for inclusion, as well as ensuring EDS requirements are built in and easily met.

- The Inclusion Steering Group had been in place for 3 years within SFT, co-chaired by Matthew Bryant and Andy Heron. A review meeting was held by the Inclusion Steering Group in January 2023 to discuss what had worked well, and what could be improved in future, in preparation for a combined and revised group to be in place post-merger. It has been agreed that a group will continue to meet – renamed as the Inclusion Action Group – and the terms of reference and membership is currently under review. The aim for the Inclusion Action Group will be to oversee the implementation of an inclusion work plan. Phil Brice and Isobel Clements have agreed to co-chair this committee. The Inclusion Action Group will report to the Culture Strategy Group, which was reviewed and refreshed ahead of the merger.

- The inclusion team is working closely with Tracy Jones (Associate Director People Services) and Lincoln Andrews (Head of Compliance and Effectiveness) to ensure all reviewed and updated People Policies embed inclusion content where relevant and undertake a meaningful Equality Impact Assessment. As part of this process, we are working together to review and improve the Equality Impact Assessment process to ensure policies across the trust are developed with inclusion in mind from the initial scoping and design stage. The new EIA tool will be rolled out for all new policies and strategies following testing and review with the People Policy Group.

Priorities for the next 6 months:

- We are working with the Management Information team to create a data dashboard that will present colleague and patient data split by diversity demographics. Having easy access to data will significantly improve our ability to support Service Groups, corporate teams, as well as undertaking detailed analysis to identify trends and areas for improvement. We are working closely with colleagues supporting

clinical integration, to ensure this inclusion data forms part of the discussion and planning of team and service integration. This will ensure integrated services can consider equality impacts, and design services to meet the diverse needs of our community.

3.3 **Colleague networks:** Enable our networks to grow and effectively influence strategic and operational decision making**.**

In progress:

- Kate Lindenau (Inclusion Coordinator) has been providing strategic support and advice for colleague networks and has been working with network leads to develop clear terms of reference for each network. A framework has also been developed to bring greater clarity around the role and purpose of networks, and how the inclusion team provides support, advice, and strategic partnership.

- The quarterly reports from our 6 networks are attached in Appendix 1.

Priorities for the next 6 months:

- A priority for 2023/24 is to promote networks across all areas of the trust, to ensure colleagues from all locations are able to access network activities and feel welcomed.

- Create a development programme for network leads to ensure they are valued, supported and developed in their role.

3.4 **Sustainable approach to training:** Provide meaningful and impactful training and development opportunities relating to inclusion.

In progress:

- We have designed and delivered workshops on Allyship – these workshops have been co-created with Anna Baverstock and Deepak Mannari (both Consultants leading on doctor wellbeing). This has been trialled with senior colleagues, and with the Executive Team. The aim will be to build this content in to leadership development across the Trust.

Priorities for the next 6 months:

- Continue to work with the Leadership and OD team to ensure inclusion is woven throughout leadership development programmes.

- Revamp the mandatory equality training module to make this more engaging and trust-specific. All colleagues are required to complete this every three years.

4. LEADERSHIP

4.1 We know that we need to do more to build inclusive leadership skills and capabilities across our organisation. Specifically, we need to support teams to build inclusive practice and principles into their work. This is a key priority for the coming 12 months.

4.2 Progress has been made, and we are starting conversations with our senior leaders. For example:

- The Head of Inclusion has been meeting with members of the Executive team to identify personal inclusion priorities and objectives for the next 12 months. We have been working to ensure these objectives are systemic.

- We are looking to roll this approach out to other senior leaders across the organisation, and some senior teams have already been asked to identify inclusion actions and objectives.

- We have collaborated with the OD and Leadership team to deliver inclusive leadership and allyship content to over 400 people at several senior leadership away days.

- We aim to focus on tailored development and up-skilling for colleagues across People Services. This will increase capacity to support the organisation implement inclusive practice through local people plans, training delivery, and HR advice.

- We supported a learning event with the Human Resources Advisory team to reflect on the learning from the tribunal case against NHS England. The aim of this was to reflect on what steps need to be taken to ensure learning from this is recognised and taken forward locally.

5. RECOMMENDATION

5.1 The Board is asked to note and discuss the inclusion work.

Harriet Jones, Head of Inclusion

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Quality and Performance Report – YDH
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Performance and Reporting Manager
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Report sets out the key issues and actions 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:
	
	• Referral to treatment times:
	  ○ no patients had waited 104 weeks or more to be seen as at 31 March 2023.
	  ○ the number of patients waiting 52 weeks or more reduced from 408 as at 28 February, to 369 as at 31 March 2023, against a target of 577 or fewer.
	
	• Our performance against the two-week waiting time standard for suspected cancer improved from 65.0% in January 2023 to 84.7% in February 2023 (the latest data available), mainly as a result of a reduction in the number of breaches of the standard relating to dermatology.

	• Our sickness absence rate in March 2023 was 4.2%, against a target rate of 4.6% or lower. The 12-month rolling sickness absence rate was 4.5%. • 100% of complaints were responded to within 40 working days in March 2022 Areas in which we are not currently meeting complaince standards include: • the percentage of patients seen within four hours and spending longer than 12 hours, in our accident and emergency department • the percentage of people waiting under six weeks for a diagnostic test • performance in respect of 28-day faster cancer diagnosis • waiting times for the two-week, 31-day and 62-day cancer treatment standards.
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 Appendix B (Patient Safety / Quality)

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

The report provides an update on the position relating to statutory training, in Section 1 and also in Appendix C. (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 been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities

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

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

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

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

YDH | Operating Performance Overview

March 23

CONTENTS

Mortality Rates

Safe

March 23

Latest HSMR Jan-2022 to Dec - 2022	Weekend Mortality Relative Risk	Number of Trustwide Deaths	Crude Mortality Rate (Deaths / Discharges)
0.875	**0.922**	**80**	**1.90%**

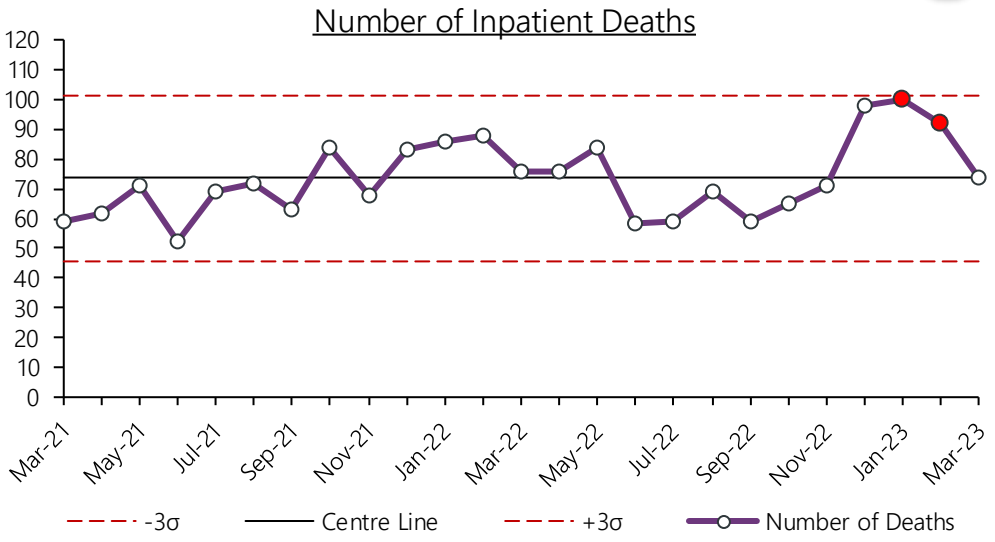
March 20

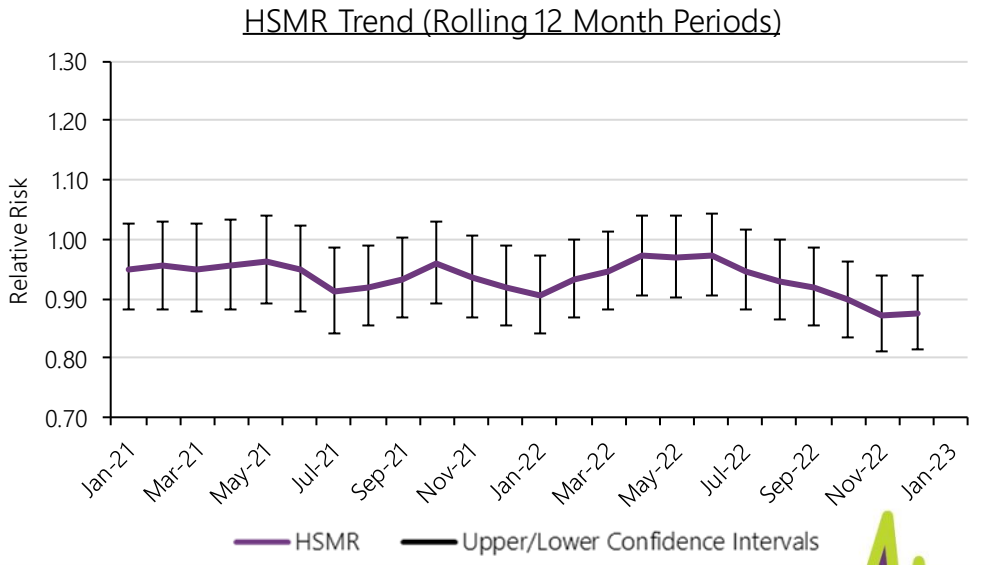
HSMR Jan-20 to Dec-20	Weekend Mortality Relative Risk	Number of Trustwide Deaths	Crude Mortality Rate (Deaths / Discharges)
0.919	**0.924**	**69**	**1.92%**

RAG status: Achieved

The trust's HSMR was 87.5 for the 12-month period up to December 2022, and is statistically lower than expected. The Trust continues to perform better than the National Average.

Further information is available in the quarterly mortality report.





Patient Falls and Pressure Ulcers

Safe

March 23

Patient Falls	Patient Falls Causing Harm	Patient Falls rate per 1000 bed days	Pressure Ulcers
82	**3**	**7.08**	**14**

March 20

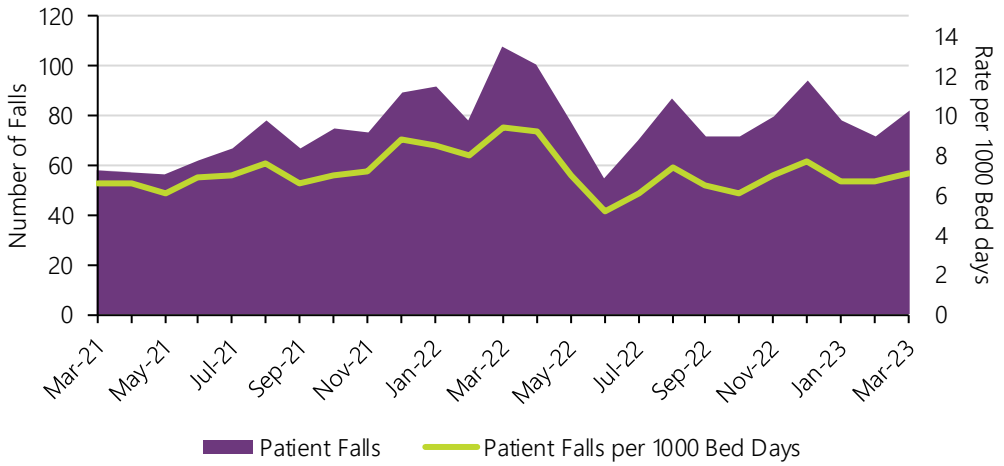
Patient Falls	Patient Falls Causing Harm	Patient Falls rate per 1000 bed days	Pressure Ulcers
70	**0**	**8.09**	**7**

Additional notes	Count	Diff	% Diff
• Patient Falls YTD:	**941**	**145**	**+18.22%**
• Patient Falls YTD 19/20:	796		
• Pressure Ulcers YTD:	**114**	**57**	**+100.00%**
• Pressure Ulcers YTD 19/20:	57		
• Pressure Ulcers 6M Avg:	**9.3**	**3.7**	**+64.71%**
• Pressure Ulcers 6M Avg	5.7		

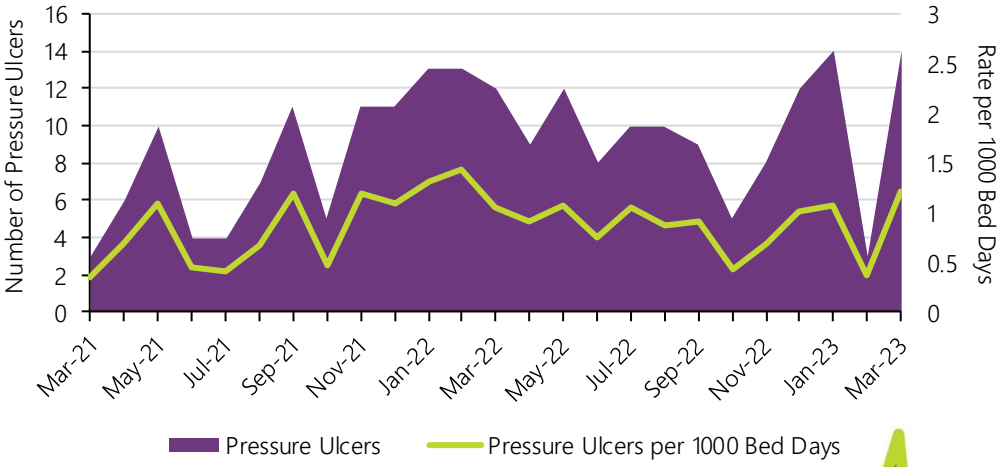
RAG status: Failed, close to achievement

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

Patient Falls



Pressure Ulcers +2



Infection Control

Safe

March 23

MRSA Bacteremia	C.Diff (Lapses in Care)	YTD C.Diff (Lapses in Care)	YTD C.Diff
0	0	0	9

E.Coli	P.Aeruginosa	Klebsiella spp.	Positive Covid-19 Cases
5	1	1	96

Additional notes

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

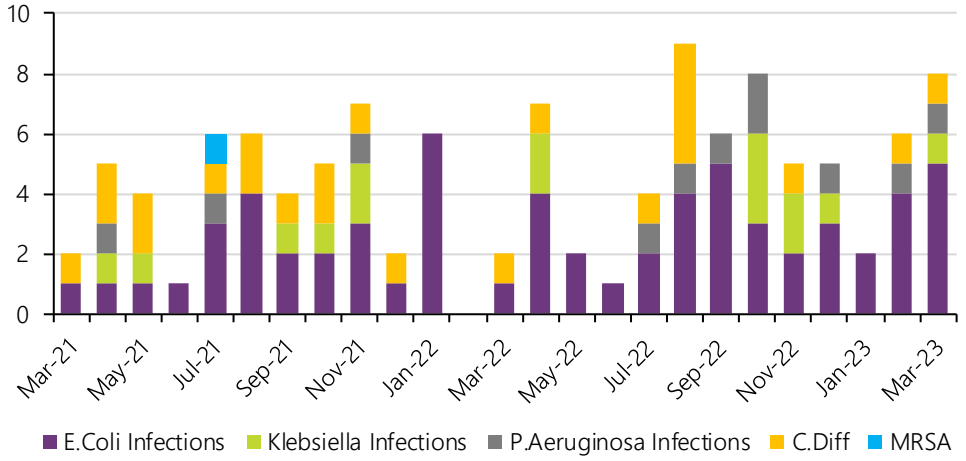
Jan 2023 Trust infection rate per 100,000 bed days;
E.Coli - 17.92, P.Aeruginosa - 0.00, Klebsiella - 0.00

Jan 2023 National infection rate per 100,000 bed days;
E.Coli - 29.04, P.Aeruginosa - 5.63, Klebsiella - 12.70
(All rates shown above are for hospital onset infections only)

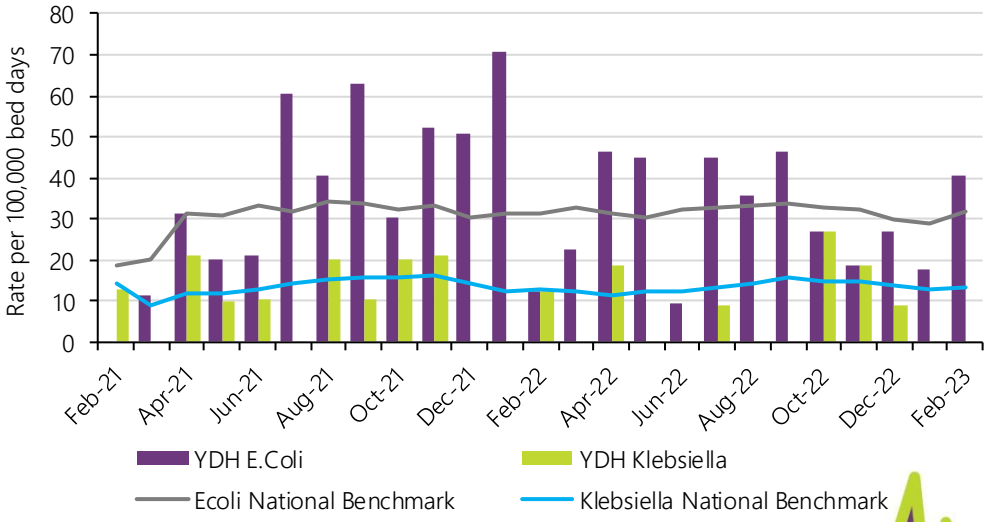
RAG status: Achieved

Targets Met.
There has been 9 reported C.Diff cases this financial year. The trust's C.Diff threshold for 22/23 is 15. Further information is available in the quarterly quality report.

Bloodstream and C.Diff Infections



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



Stroke Services

Effective

March 23

SSNAP Report - Oct-22 to Dec-22

YDH SSNAP Level	YDH SSNAP Score	90% Stay on Stroke Unit	12hr CT Scan
D	49.4	53.57%	96.15%
Targets			
B	**70**	**83.3%**	**83%**

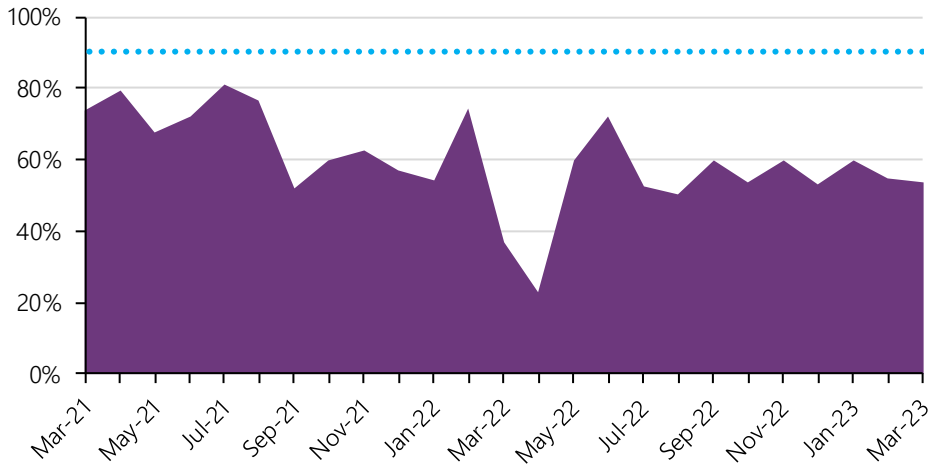
Additional notes

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

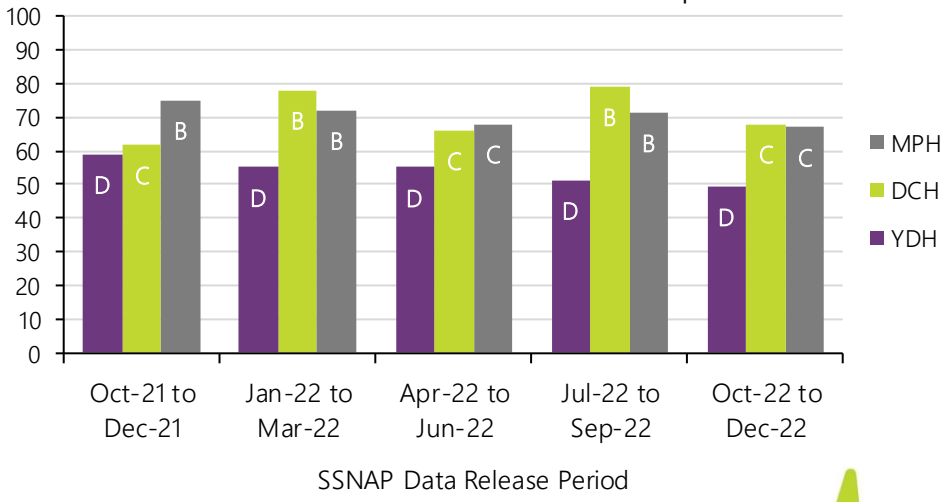
RAG status: Failed

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

90% Stroke Unit Stay Achievement



SSNAP Levels/Scores - Peer Trust Comparison



Admissions and LOS

Responsive

March 23

Elective Admissions	Non-Elective Admissions	Average Elective LOS	Average Non - Elective LOS
1,929	**2,282**	**1.78**	**5.27**

March 20

Elective Admissions	Non-Elective Admissions	Average Elective LOS	Average Non - Elective LOS
1,681	**1,919**	**2.05**	**5.20**

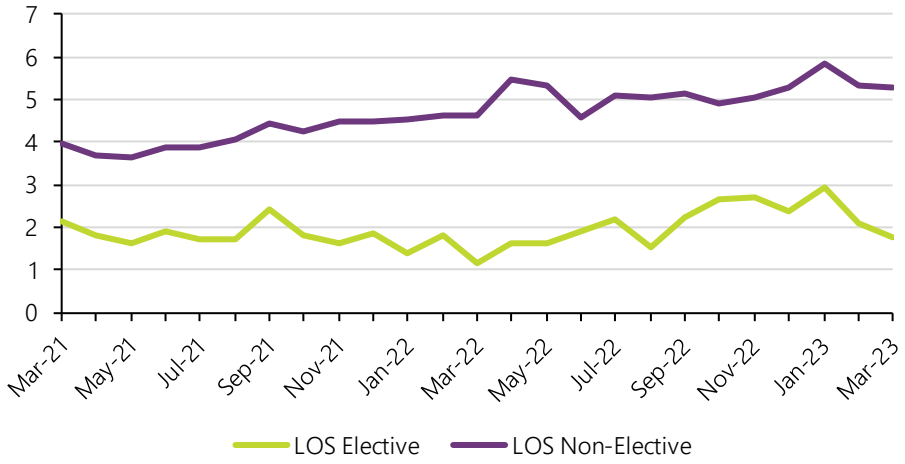
Additional notes	Count	Diff	% Diff
• Elective Admissions YTD:	**22,227**	**-1,693**	**-7.08%**
• Elective Admissions YTD 19/20:	23,920		
• Non-Elective Admissions YTD:	**25,458**	**-859**	**-3.26%**
• Non-Elective Admissions YTD 19/20:	26,317		
• Average Elective LOS vs 19/20 diff:		**-0.3**	**-13.20%**
• Average Non-Elective LOS vs 19/20		**+0.1**	**+1.34%**

RAG status: Failed, close to achievement

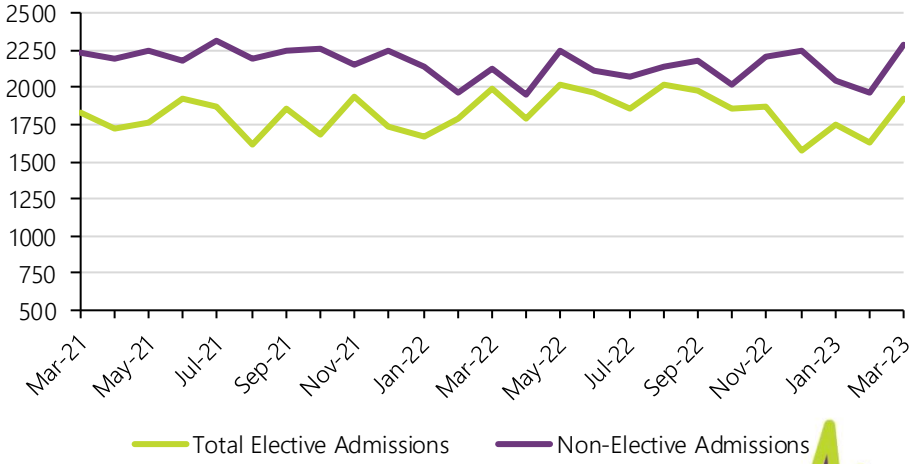
Targets Failed. Reason:

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

Average Length of Stay (Days)



Admissions



Readmissions

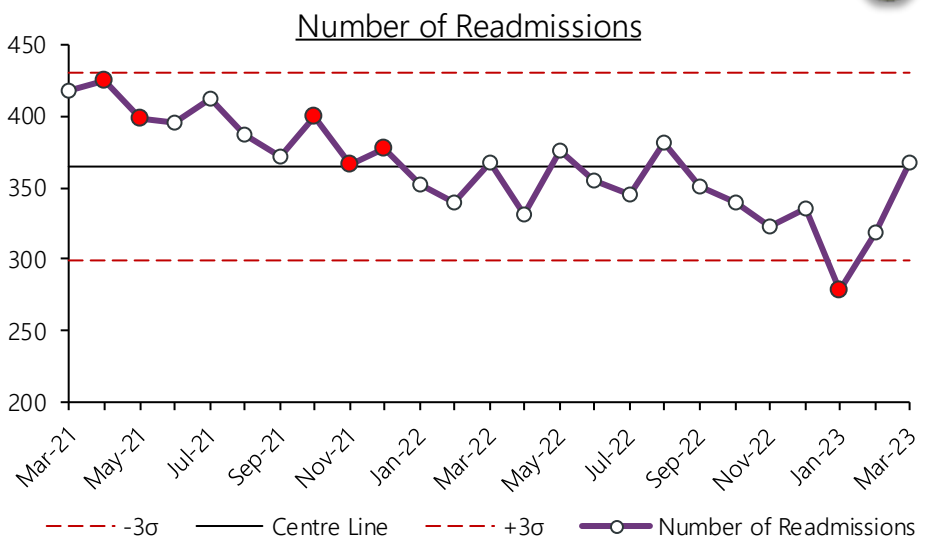
Responsive

March 23

Number of readmissions	Readmission Rate (Exc 0 day LOS)	Related Readmission Rate	Unrelated Readmission Rate
367	**8.34%**	**3.80%**	**4.92%**

March 20

Number of readmissions	Readmission Rate (Exc 0 day LOS)	Related Readmission Rate	Unrelated Readmission Rate
676	**17.56%**	**9.47%**	**9.31%**

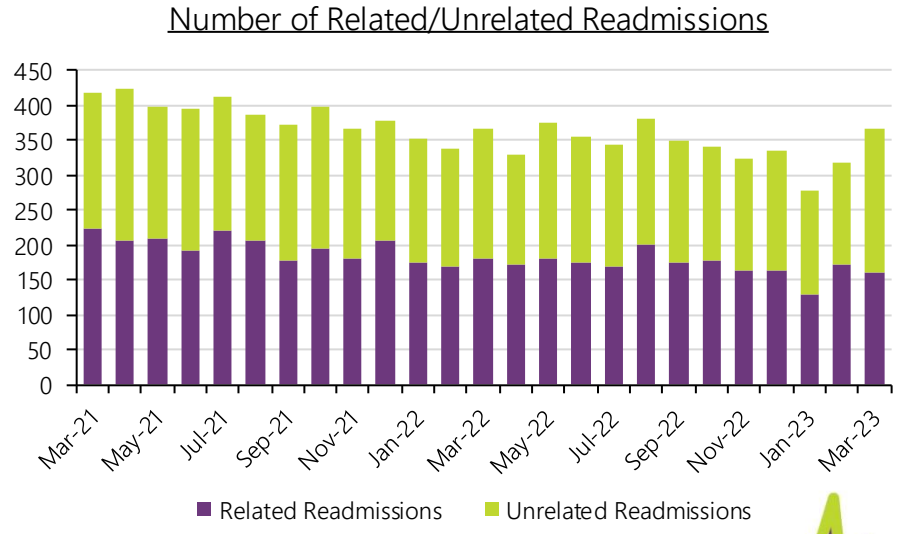


Additional notes	Count	Diff	% Diff
• Readmissions YTD: • Readmissions YTD 19/20:	**4,101** 9,909	**-5,808**	**-58.61%**
• Related Readmissions • Related Readmission 19/20:	**160** 341	**-181**	**-53.08%**
• Readmissions Rate (All) • Readmissions Rate (All) 19/20:	**8.33%** 18.12%	**-9.79%**	**--**

RAG status: Achieved

Targets Met.

Readmissions have remained within the expected range.



Criteria to Reside

Effective

March 23

Total Beddays with no criteria to reside	Beddays with no criteria to reside (Aged 65+)	Average Stranded Patients (21+ Days LOS)
2,751	**2,556**	**77.0**

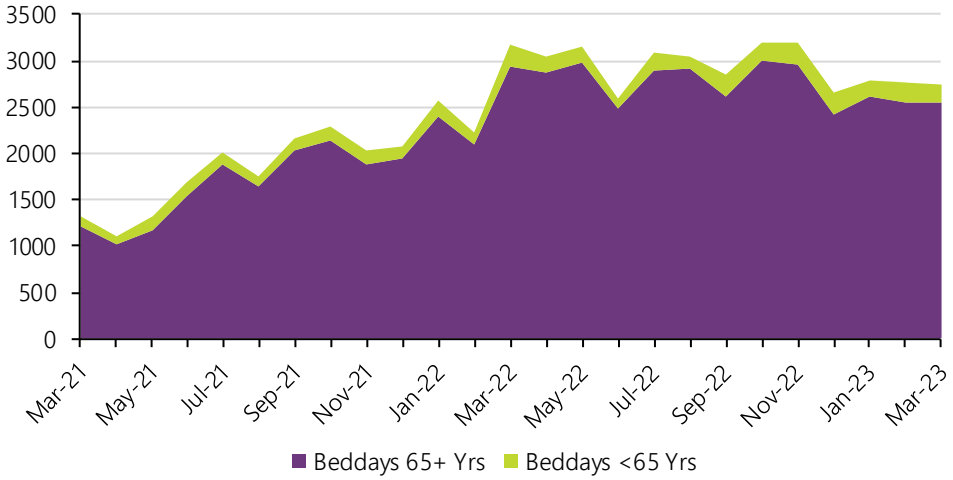
March 20

Total Beddays with no criteria to reside	Beddays with no criteria to reside (Aged 65+)	Average Stranded Patients (21+ Days LOS)
819	**751**	**42.0**

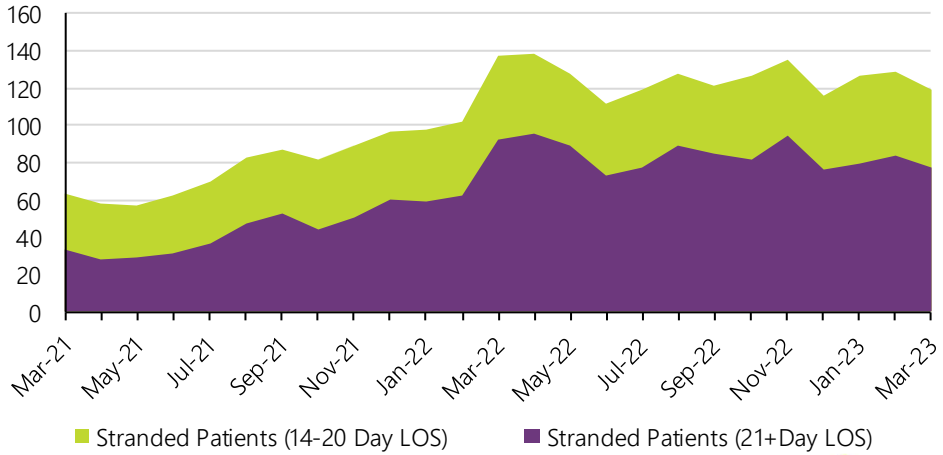
RAG status: Failed

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

Beddays that do not meet the 'criteria to reside'



Average number of daily Stranded Patients



Cancelled Operations

Responsive

March 23

On the Day Non-Clinical Reasons	YTD On the Day Non-Clinical Reasons	Rebooked within 28 Day Target	Urgent Cancellations
1	**114**	**100.00%**	**0**

March 20

On the Day Non-Clinical Reasons	YTD On the Day Non-Clinical Reasons	Rebooked within 28 Day Target	Urgent Cancellations
5	**69**	**100.00%**	**2**

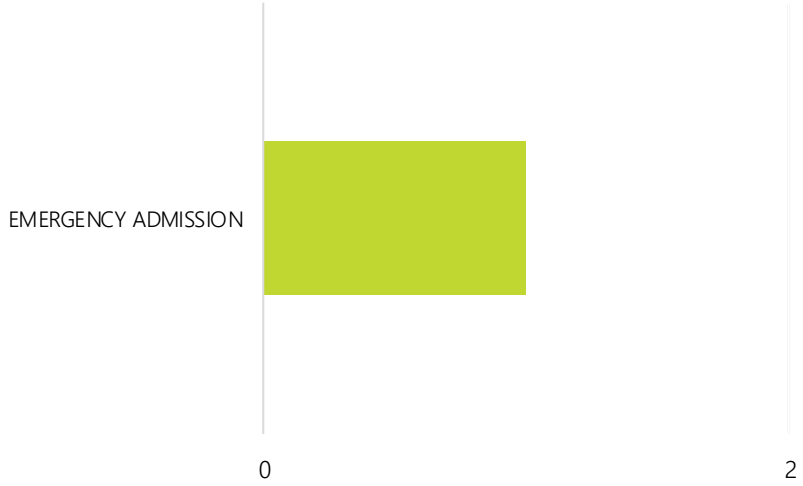
Additional notes

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

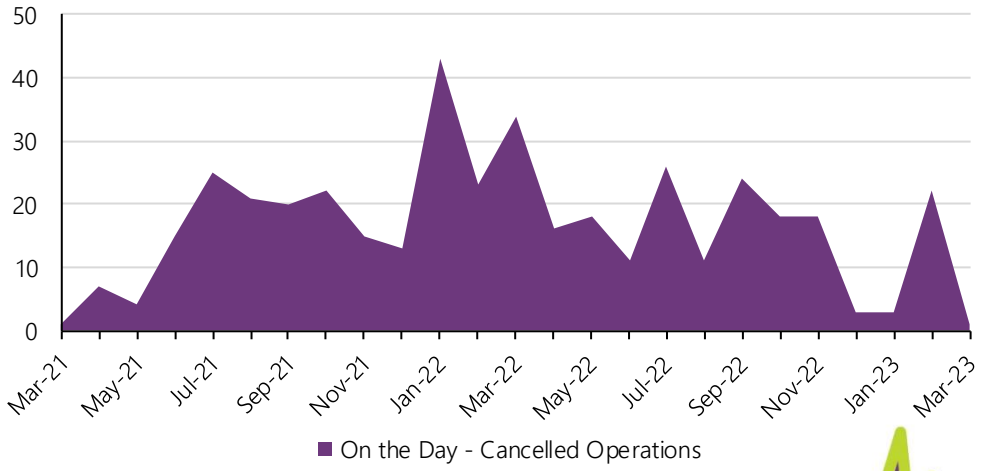
RAG Status: Failed, close to achievement

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

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



Number of Cancelled Operations



Diagnostic Waits

Responsive

March 23

Overall Diagnostic 6 Week Waits

66.06%

(Target 99.0%)

Additional notes

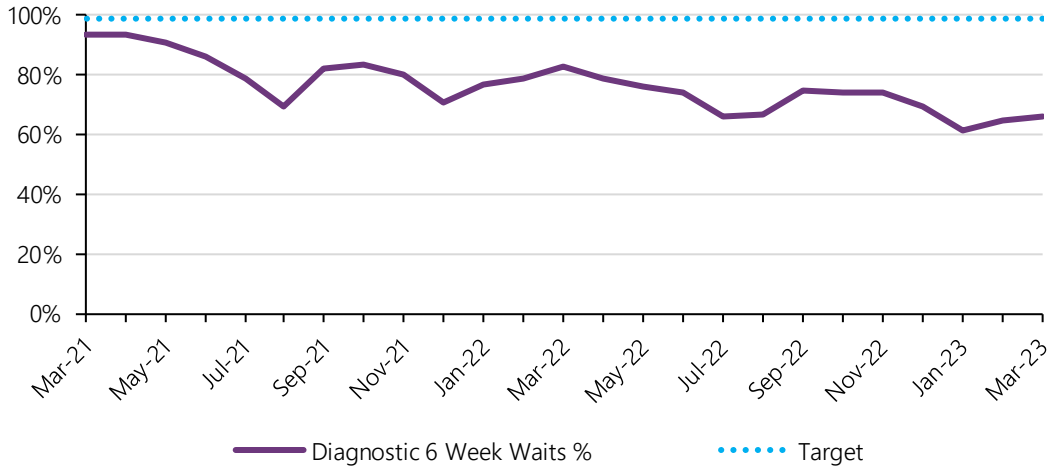
The area with the lowest diagnostics performance was:

Physiological Measurement	**37.67%**

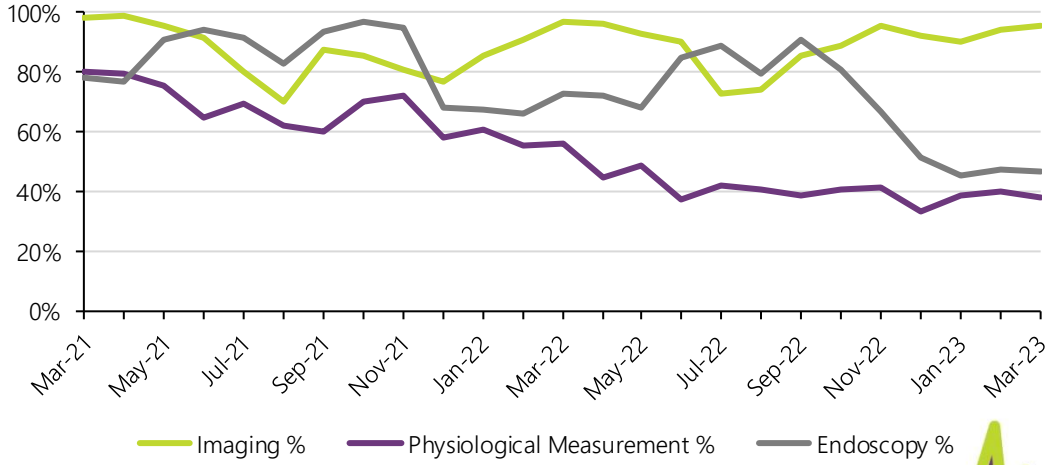
RAG status: Failed

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

Diagnostic 6 Week Waits %



Diagnostic Waits by Type of Test



RTT Performance

Responsive

March 23

18 Week Incomplete Pathways	> 52 Week Waits	> 104 Week Waits
67.80%	**369**	**0**

Target - 92%

March 20

18 Week Incomplete Pathways	> 52 Week Waits	> 104 Week Waits
85.38%	**2**	**0**

Additional Notes:

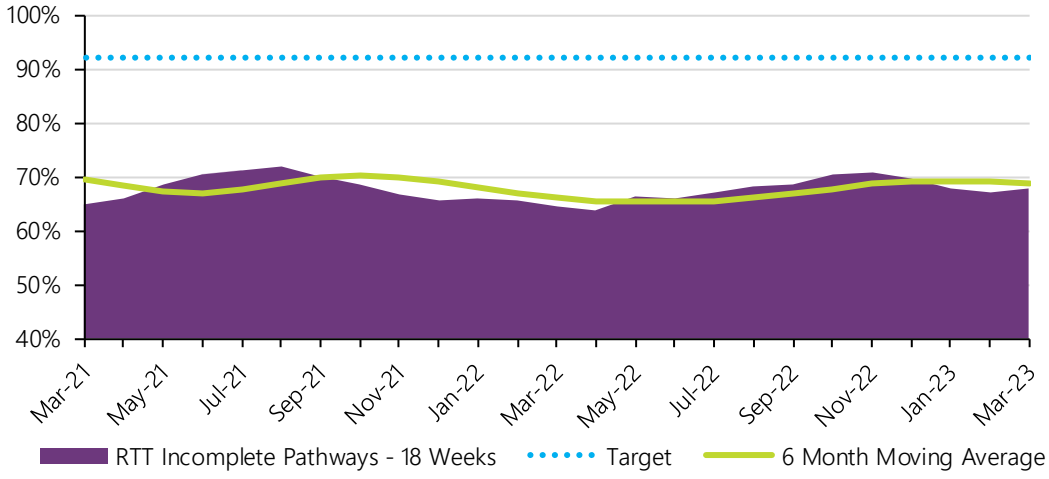
Specialties with the Lowest RTT Performance this month:

T&O - **41.12%**
Plastic Surgery - **48.79%**

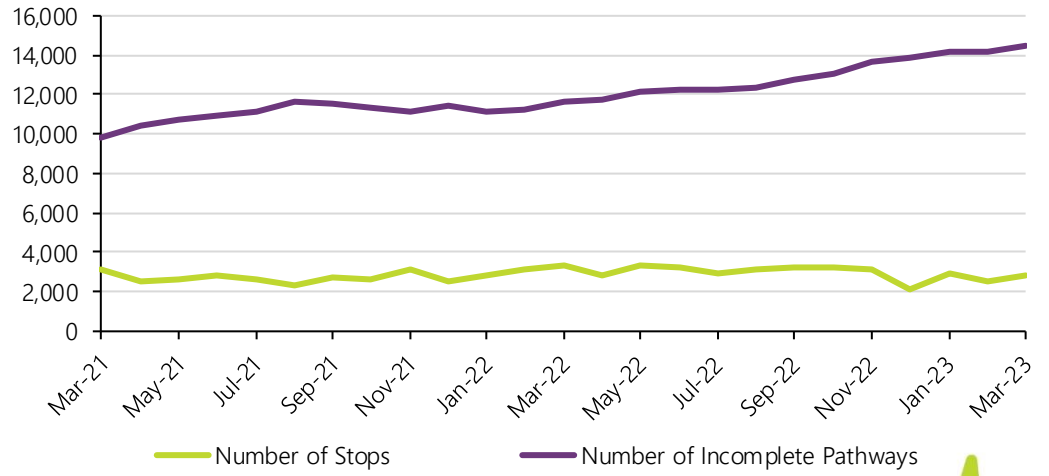
RAG status: Failed

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

RTT Incomplete Pathways - 18 Weeks



RTT Incomplete Pathways with All Stops



RTT Pathways

Responsive

March 23

Incomplete Pathways	Pathways > 18 Weeks	Pathways > 40 Weeks	Pathways > 78 Weeks
14487	**4665**	**875**	**8**

March 20

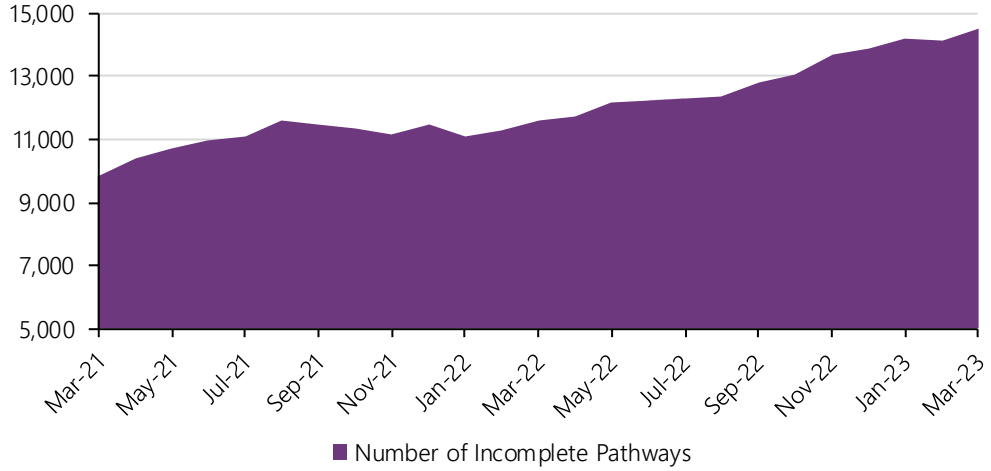
Incomplete Pathways	Pathways > 18 Weeks	Pathways > 40 Weeks	Pathways > 78 Weeks
9486	**1387**	**24**	**0**

Additional notes	Diff	% Diff
Number of Incomplete Pathways	**5001**	**52.72%**

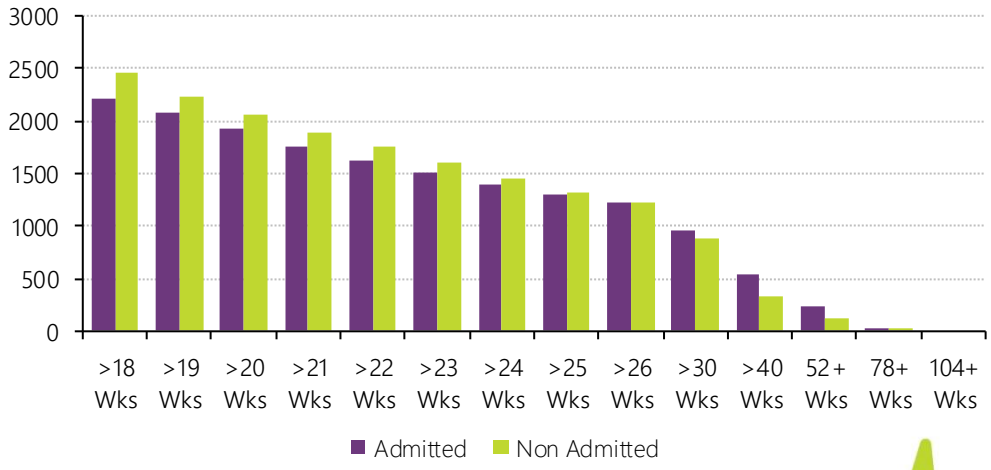
RAG status: Failed, close to achievement

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

RTT Incomplete Pathways (total waiting list size)



RTT Incomplete Pathways - Aging



Yeovil Hospital Healthcare

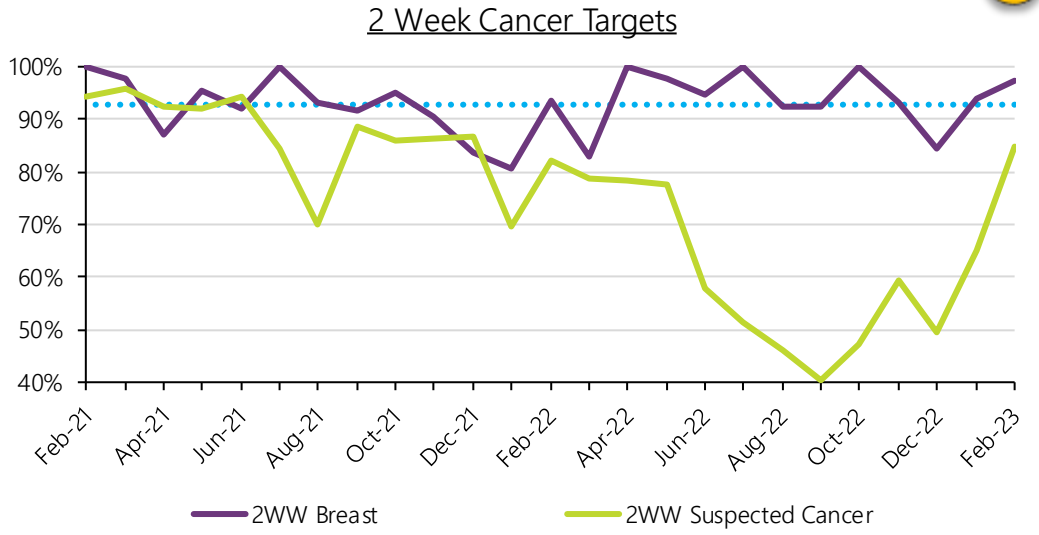
Cancer Performance

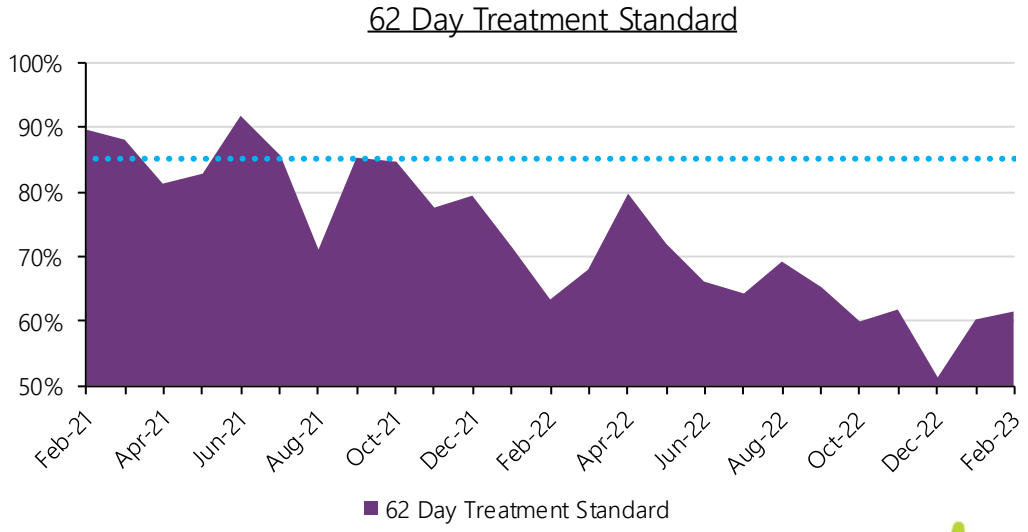
February 23

28 Day Faster Diagnosis	
71.23%	
(National Target - 75.00%)	
2 Week Suspected Cancer	2 Week Exhibited Breast Cancer Symptoms
84.67%	**97.44%**
(National Target - 93.00%)	(National Target - 93.00%)
31 Day Treatment First	62 Day Treatment Standard
88.30%	**61.43%**
(National Target - 96.00%)	(National Target - 85.00%)

RAG status: Failed, close to achievement

2WW – Failed: Poor performance however an improvement from the January position.
28 FDS – Failed: Poor performance in Gynae, Lower GI & Urology. Triaging to MRI started in Urology from Mar 23 so expecting an improvement in performance going forward.
62 Days – Failed: Breaches mainly in Colorectal, Skin and Urology, due to delays in the pathway and complex patients.





Outpatients Transformation

2022/23 YTD

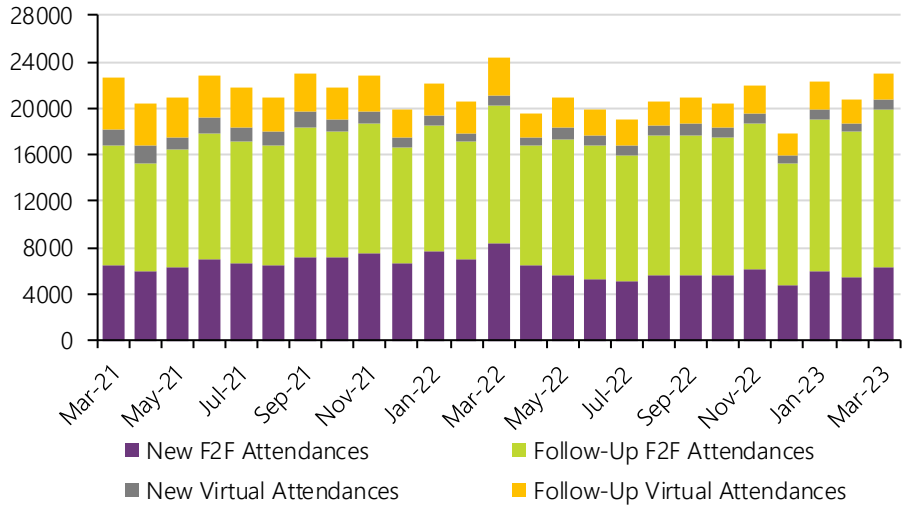
Total Outpatients Activity	Outpatient Procedures Proportion	Virtual Clinic Activity Proportion
246,949	**15.87%**	**14.0%**
ASI Rate	Average Wait to First OP (Weeks)	DNA Rate
104.23%	**9.84**	**6.18%**
All Appointment Cancellations	Patient Cancellations	Trust Cancellations
27.11%	**9.12%**	**17.99%**
Patients Offered PIFU Rate		
13.36%		

Comments

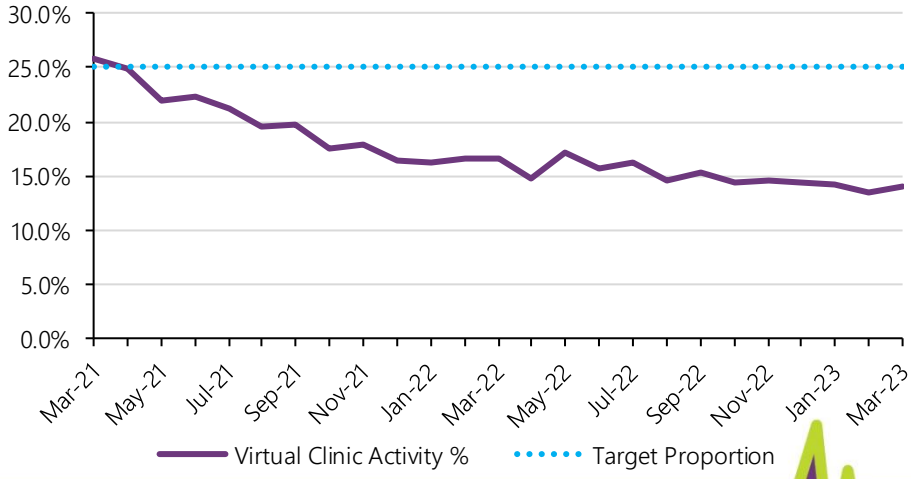
Please note that 'Virtual' Clinic activity includes Telephone follow-up clinics.

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

Number of Outpatient Attendances



Proportion of Virtual Clinic Activity



ED Transformation

March 23

Median Time to Triage (hh:mm)	Median Time in Department (hh:mm)	
00:11	**03:15**	

A&E 4 Hour Performance	Total A&E Attendances	Year on Year A&E Growth (2019)
70.26%	**5430**	**31.12%**

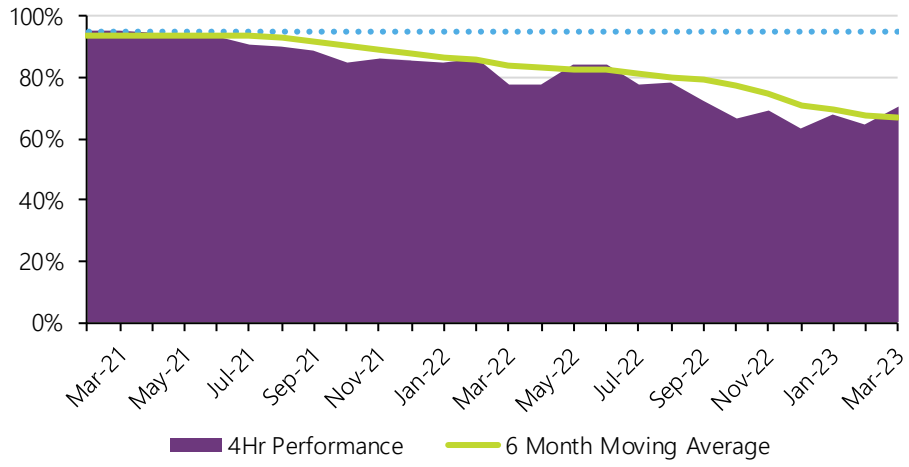
Attendances resulting in an Inpatient stay	12 Hour Trolley Waits	Handovers time lost >15 minutes
25.99%	**0**	**175:31:01**

Total Ambulance Handovers	Ambulance Handovers 30+ mins	Ambulance Handovers Performance
1279	**248**	**80.61%**

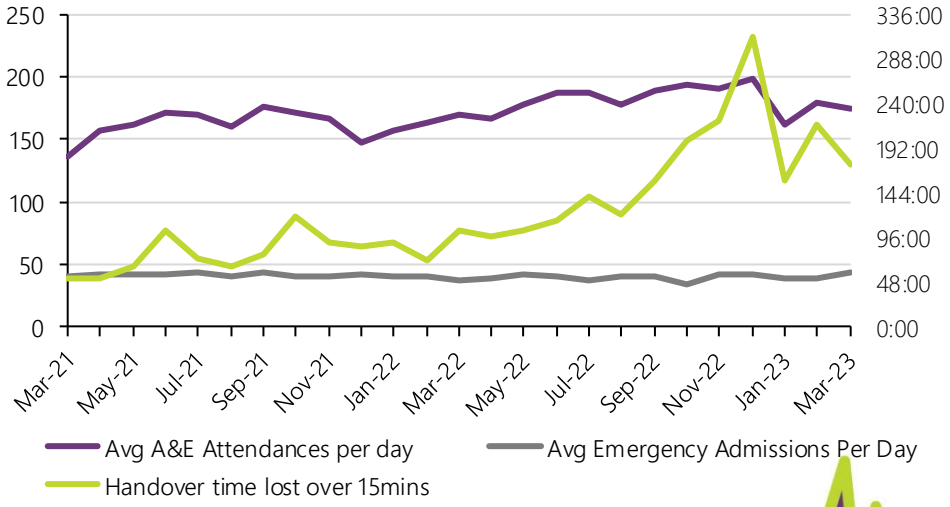
Comments

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

A&E 4 Hour Performance - All Attendances



Avg A&E Attendances per day



Patient Complaints and PALS

March 23

Complaints	PALs	PALS Concerns	PALS Enquiries
5	**223**	**52**	**171**

March 20

Complaints	PALs	PALS Concerns	PALS Enquiries
2	**114**	**46**	**68**

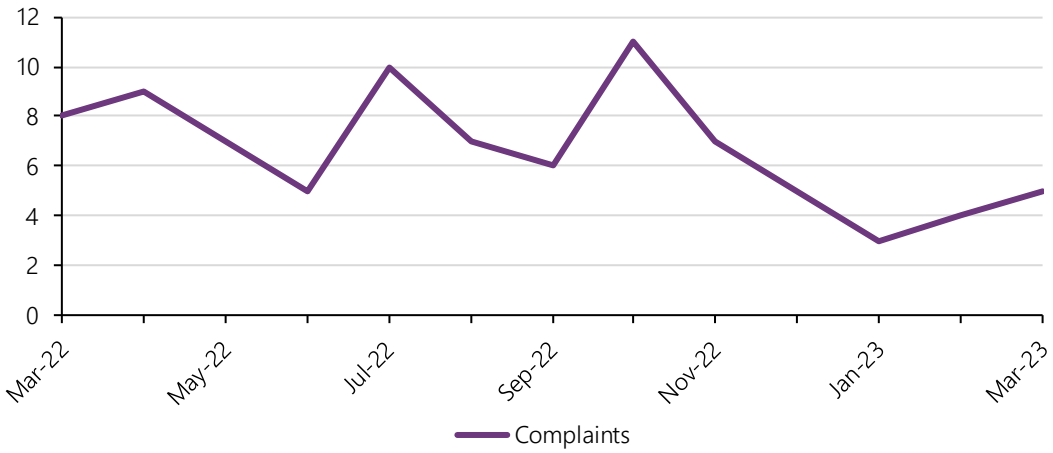
Additional notes

• Complaints YTD:	**79**	**+28**	**+54.90%**
• Complaints YTD 19/20:	51		
• PALs YTD:	**1939**	**+655**	**+51.01%**
• PALs YTD 19/20:	1284		

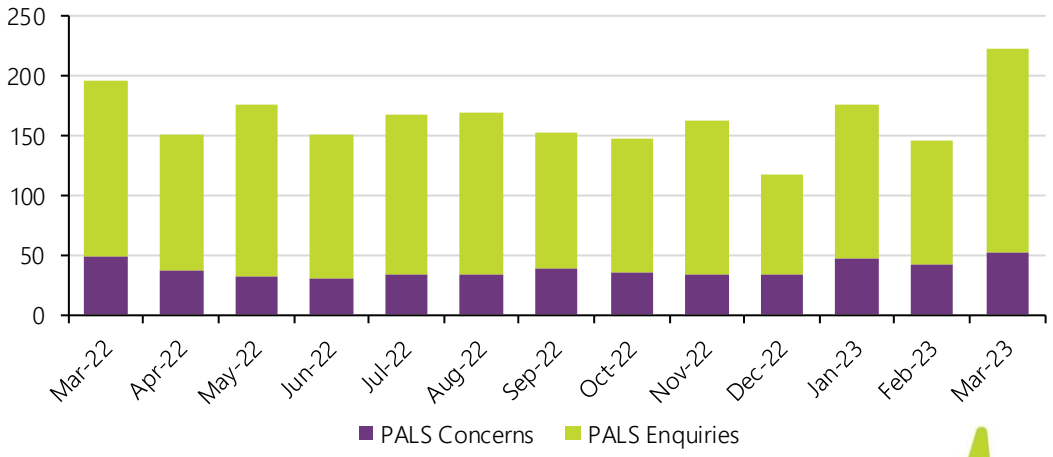
RAG status: Achieved

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

Number of Complaints



PALS Breakdown



YDH Group | Workforce Report Well Led - Staffing

March 23

Workforce Assurance

March 23

Workforce Assurance - **YDH Only**

Workforce	Monthly Position	Contracted FTE						
	Mar-20 Mar-23	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
	1893.5 2243.7	59.6	424.4	462.9	156.0	10.5	297.0	803.3

Workforce	Monthly Position	Labour Turnover						Rolling 12 Month Trend
Target	Mar-20 Mar-23	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
12% - 17%	16.14% 18.67%	27.93%	22.72%	22.14%	12.21%	7.41%	26.53%	12.63%

Workforce	Monthly Position	Sickness Absence - In Month						Rolling 12 Month Trend
Target	Feb-20 Feb-23	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
3%	3.22% 4.35%	5.40%	6.04%	3.23%	3.06%	0.68%	1.75%	5.38%

Workforce	Monthly Position	Mandatory Training						Rolling 12 Month Trend
Target	Mar-20 Mar-23	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
85%	89.46% 84.77%	89.72%	83.70%	87.54%	86.82%	91.30%	77.39%	85.93%

Workforce	Monthly Position	Appraisals						Rolling 12 Month Trend
Target	Mar-20 Mar-23	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
90%	85.35% 82.23%	89.04%	80.84%	77.46%	86.63%	53.85%	88.74%	82.25%

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

Contracted FTE

March 23

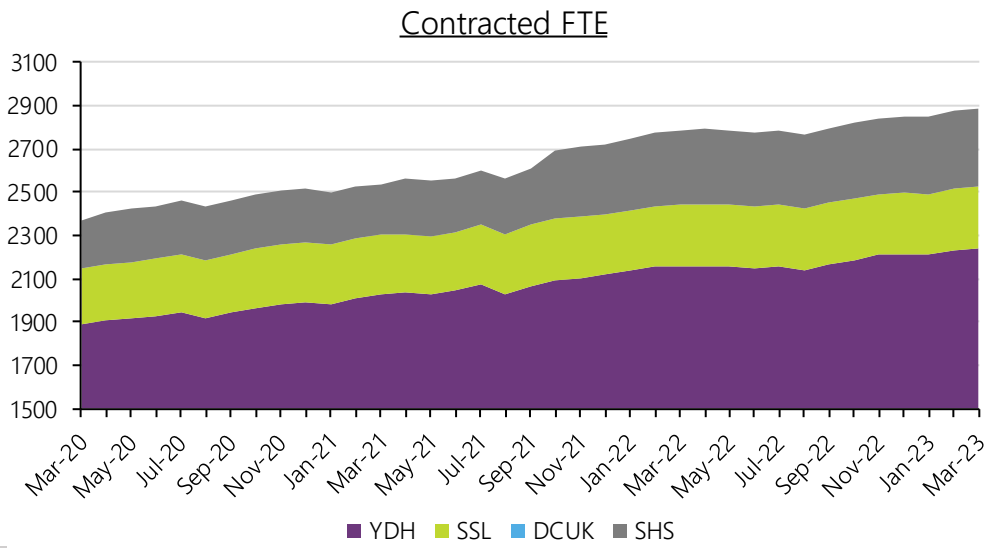
YDH Group	YDH	SHS	SSL
2888.2	**2243.7**	**356.8**	**287.7**

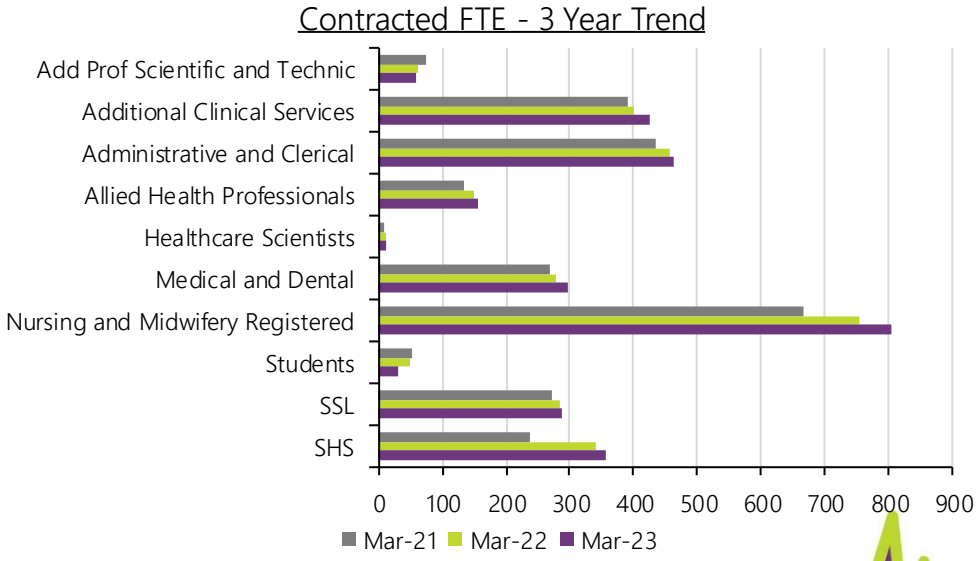
March 20

YDH Group	YDH	SHS	SSL
2369.3	**1893.5**	**222.3**	**253.6**

Additional notes	Count	Diff	% Diff
• Group FTE:	**2888.2**	**+519**	**+21.90%**
• Group FTE 19/20:	2369.3		
• Group FTE (Excl SHS):	**2531.4**	**+384**	**+17.90%**
• Group FTE (Excl SHS) 19/20:	2147.0		

Comments





Turnover

March 23

YDH Group	YDH	SHS	SSL
18.34%	**18.67%**	**15.37%**	**20.41%**

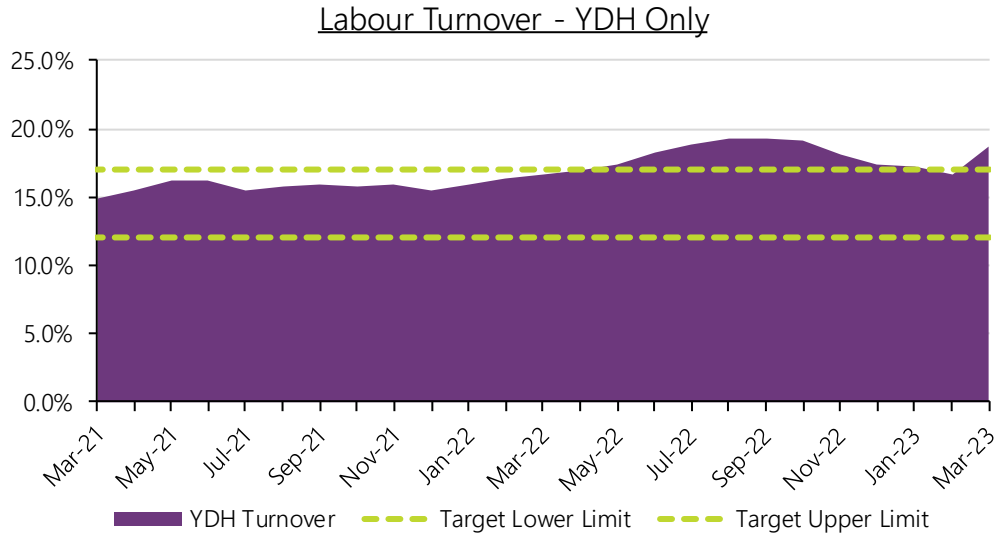
March 20

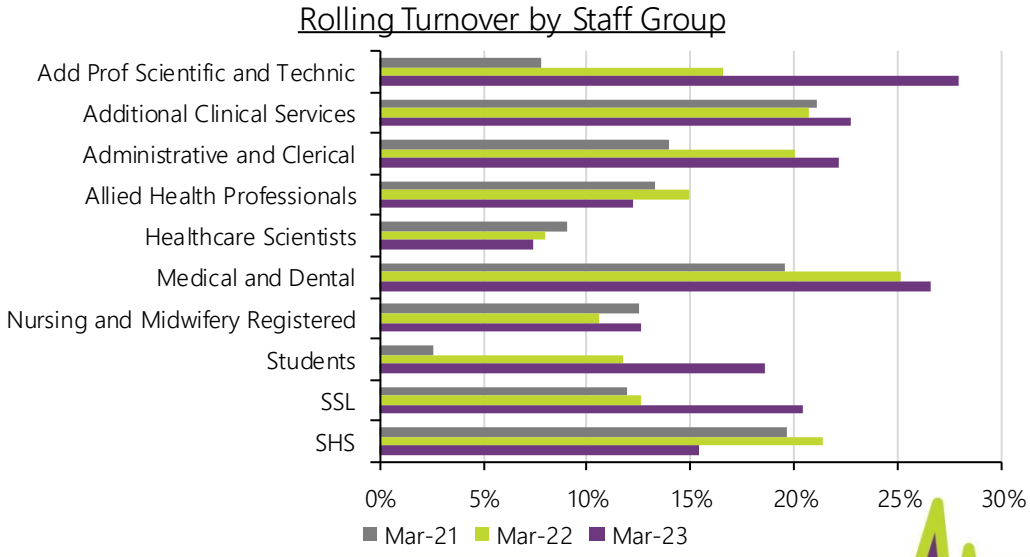
YDH Group	YDH	SHS	SSL
17.58%	**16.14%**	**29.43%**	**14.17%**

Additional notes	Achievement	Diff
• Group Turnover:	**18.34%**	**0.76%**
• Group Turnover 19/20:	17.58%	
• YDH Turnover:	**18.67%**	**2.53%**
• YDH Turnover 19/20:	16.14%	

Comments

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





Leaving Reasons - YDH

March 23

Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
408	**327**

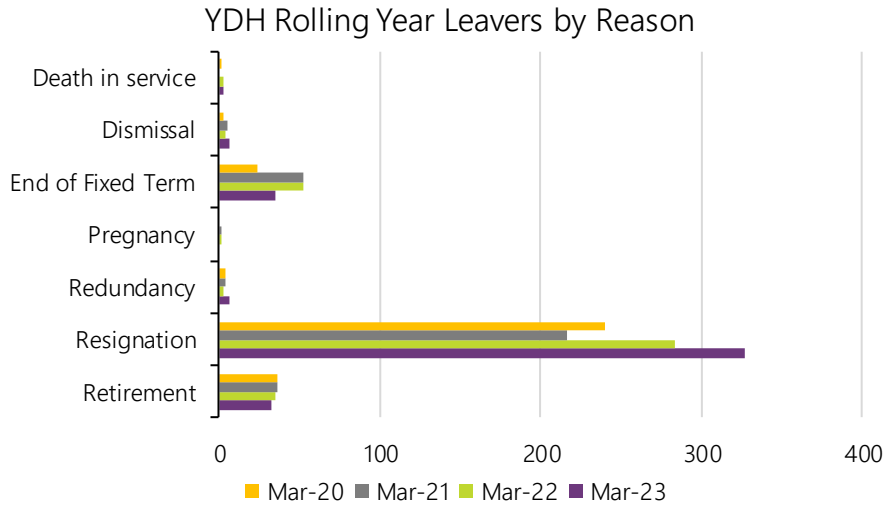
March 20

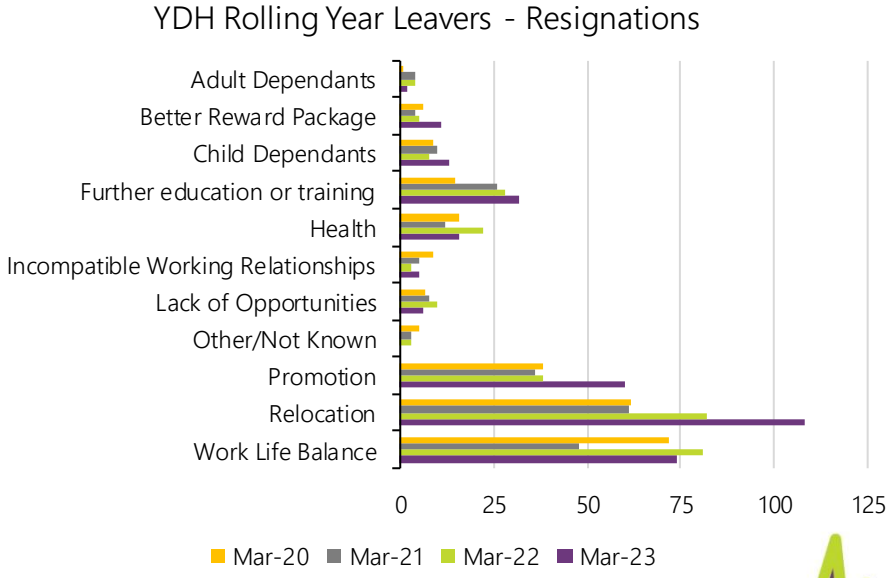
Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
315	**217**

Additional notes	Count	Diff	% Diff
• Rolling Year Leavers:	**408**	**+93**	**+29.52%**
• Rolling Year Leavers 19/20:	315		

Comments

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





Leaving Reasons - SSL

March 23

Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
60	**52**

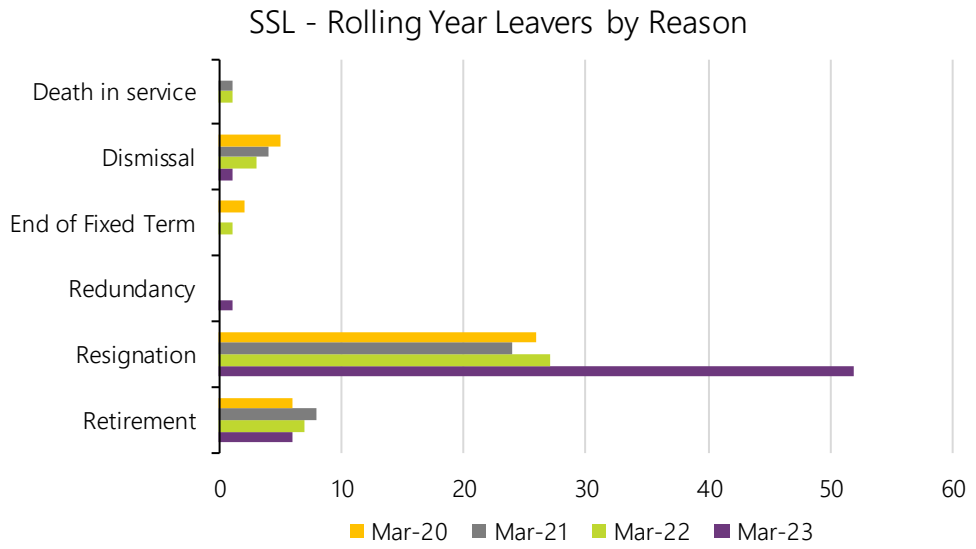
March 20

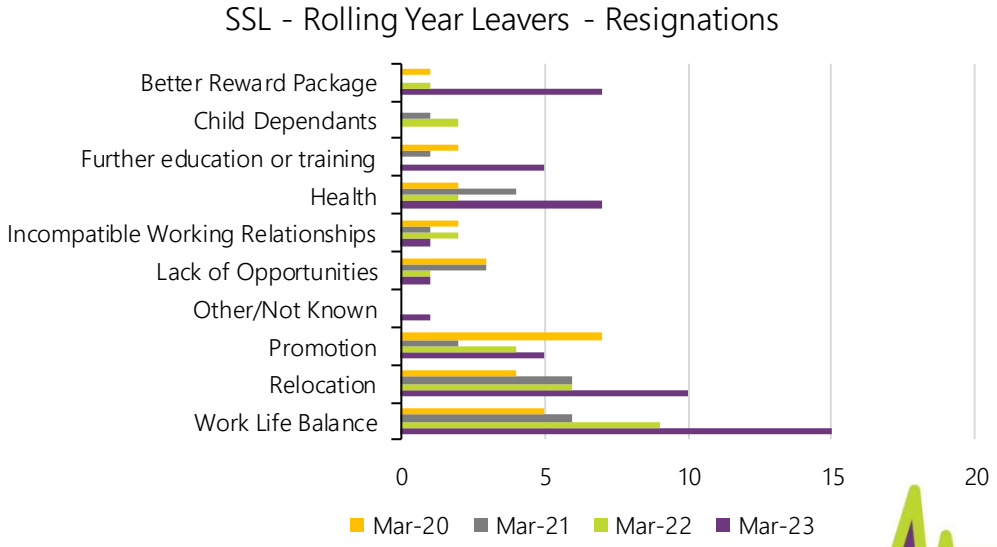
Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
39	**24**

Additional notes	Count	Diff	% Diff
• Rolling Year Leavers:	**60**	**+21**	**+53.8%**
• Rolling Year Leavers 19/20:	39		

Comments

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





Leaving Reasons - SHS

March 23

Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
97	**83**

March 20

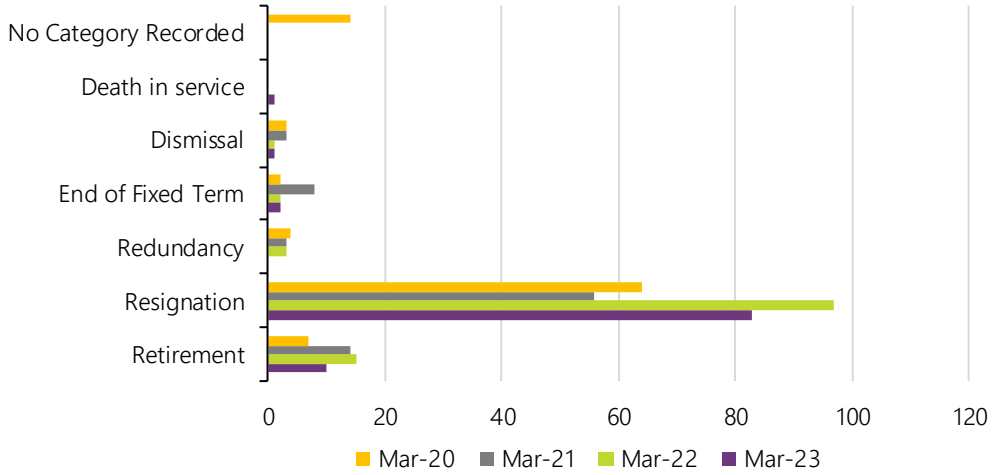
Number of Leavers - Rolling Year	Number of Resignations - Rolling Year
94	**64**

Additional notes	Count	Diff	% Diff
• Rolling Year Leavers:	**97**	**+3**	**+3.2%**
• Rolling Year Leavers 19/20:	94		

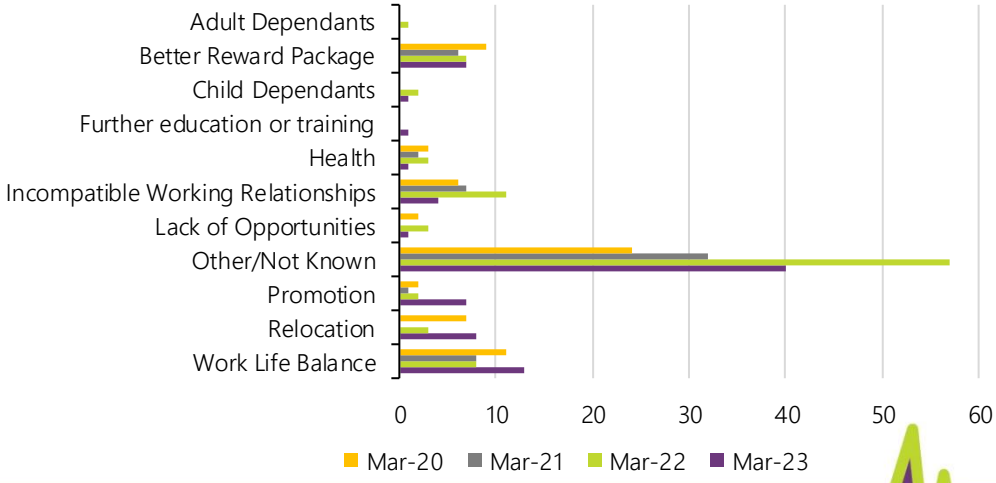
Comments

Reasons for resignations continue to be monitored by SHS.

SHS - Rolling Year Leavers by Reason



SHS - Rolling Year Leavers - Resignations



Leavers in Month

March 23

YDH Group	YDH	SSL	SHS
42	**30**	**5**	**7**

March 20

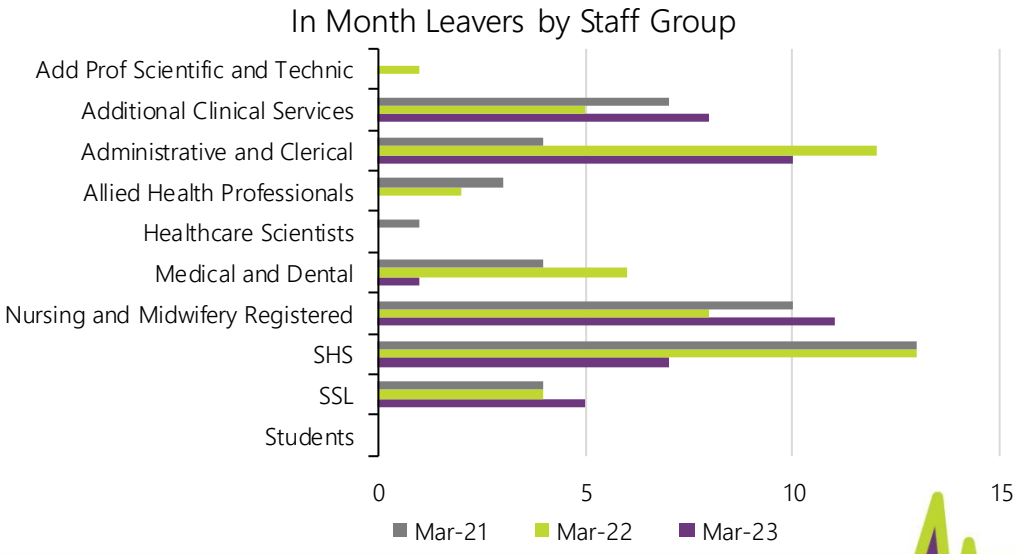
YDH Group	YDH	SSL	SHS
28	**23**	**4**	**1**

Additional notes	Count	Diff	% Diff
• In Month Leavers:	**42**	**+14**	**+50.00%**
• In Month Leavers 19/20:	28		

Comments

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

	Length of Service			
Staff Group	Less than 1 Yr	1 to 3 Yrs	Over 3 Yrs	**Total**
Add Prof Scientific and Technic	0	0	0	**0**
Additional Clinical Services	2	1	5	**8**
Administrative and Clerical	2	1	7	**10**
Allied Health Professionals	0	0	0	**0**
Healthcare Scientists	0	0	0	**0**
Medical and Dental	1	0	0	**1**
Nursing and Midwifery Registered	1	5	5	**11**
SSL	0	0	0	**0**
SHS	--	--	--	**10**
Total	**6**	**7**	**17**	**40**



Vacancies Being Recruited to - YDH Group

Vacancies being recruited to (FTE)	Dec-22	Jan-23	Feb-23
Additional Clinical Services	1.0	6.0	3.4
Additional Prof Scientific & Technical	17.0	4.6	5.0
Admin & Clerical	10.2	13.7	11.0
Allied Health Professionals	10.0	19.0	14.0
Ancillary	0.0	0.0	0.0
Estates	0.0	0.0	0.0
HCA's	27.0	23.0	13.0
Medical	17.0	30.4	27.4
Medical Training	6.0	7.0	7.0
Senior Managers	0.0	0.0	0.0
SSL	5.8	10.7	9.3
Specialist Nursing / Band 6	10.4	3.8	6.6
Nursing and Midwifery Qualified - Childrens	0.0	0.0	0.0
Nursing and Midwifery Qualified - Ward Areas	10.0	10.0	5.0
Nursing and Midwifery Qualified - EAU / ED	0.0	5.0	5.0
Nursing and Midwifery Qualified - ICU	0.0	0.0	5.0
Nursing and Midwifery Qualified - Outpatients	1.0	3.2	0.0
Nursing and Midwifery Qualified - Midwifery	0.0	0.0	0.0
Nursing and Midwifery Qualified - Theatres	0.0	0.0	5.0
Nursing and Midwifery Qualified - Total	**11.0**	**18.2**	**20.0**
Total	**115.4**	**136.4**	**116.7**

Additional notes

Sickness Absence

February 23

YDH Group	YDH	SHS	SSL
4.15%	**4.35%**	**3.58%**	**3.33%**

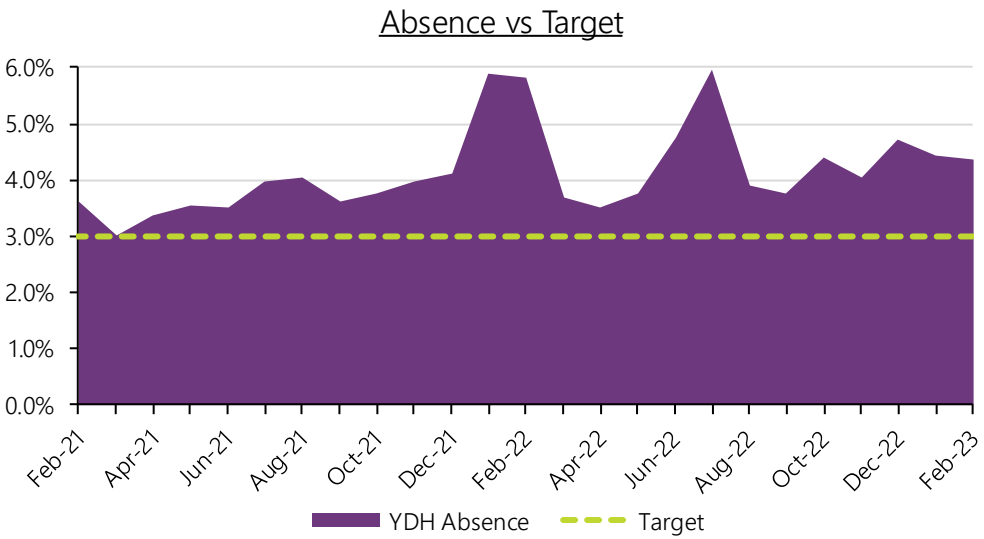
February 20

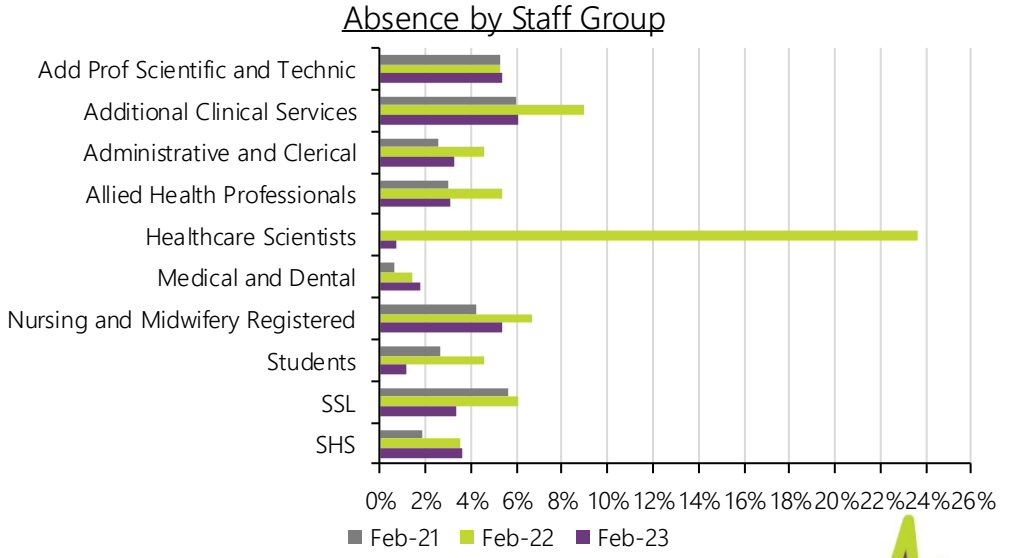
YDH Group	YDH	SHS	SSL
3.20%	**3.22%**	**2.94%**	**2.75%**

Additional notes	Count	Diff
• YDH Covid Absence (All absence):	**0.57%**	
• SSL Covid Absence (All absence):	0.91%	
• Group 12 month sickness absence:	**4.53%**	**1.67%**
• Group 12 month sickness absence 19/20:	2.86%	

Comments

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





Statutory Training

March 23

YDH Group	YDH	SHS	SSL
84.45%	**84.77%**	**78.29%**	**92.33%**

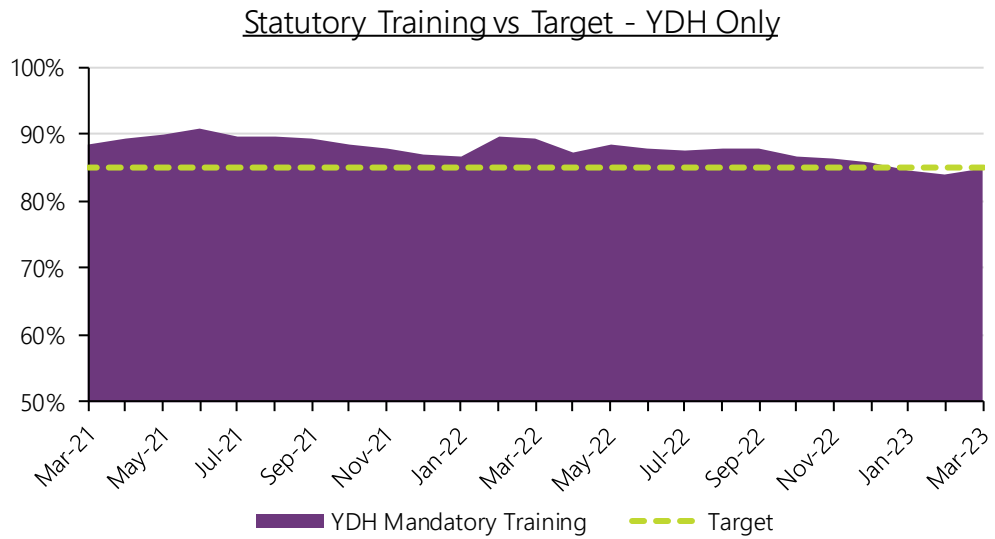
March 20

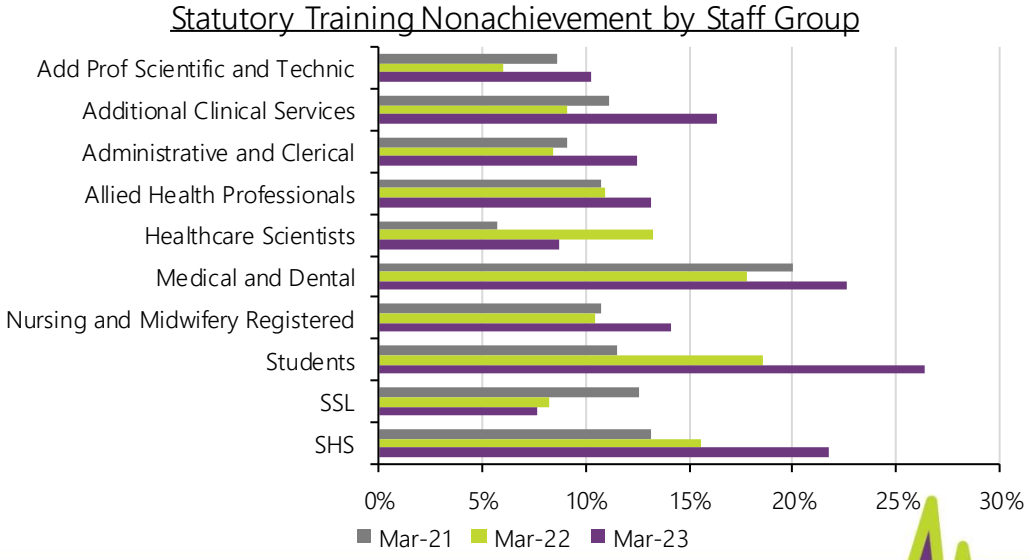
YDH Group	YDH	SHS	SSL
86.89%	**89.46%**	**76.04%**	**80.09%**

Additional notes	Count	Diff
• Group Statutory Training:	**84.45%**	**-2.44%**
• Group Statutory Training 19/20:	86.89%	
• YDH Statutory Training:	**84.77%**	**-4.69%**
• YDH Statutory Training 19/20:	89.46%	

Comments

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





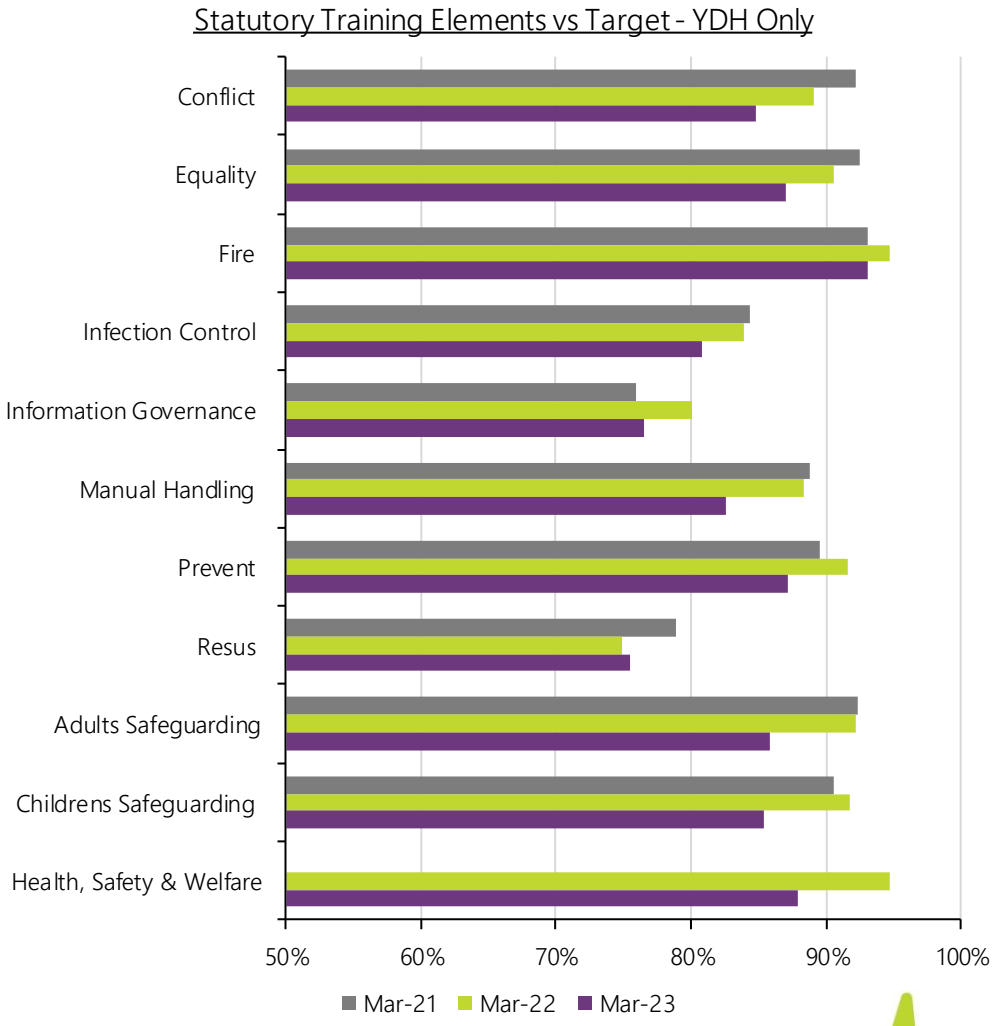
Statutory Training Elements

March 23

Overall Achievement	Conflict	Equality
84.45%	84.76%	87.01%
Fire	**Infection Control**	**Information Governance**
93.01%	80.79%	76.49%
Manual Handling	**Prevent**	**Resus**
82.55%	87.20%	75.41%
Childrens Safeguarding	**Adults Safeguarding**	**Health, Safety & Welfare**
85.38%	85.75%	87.93%

Comments

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



Safeguarding Training

March 23

Childrens Safeguarding	Adults Safeguarding
85.38%	**85.75%**

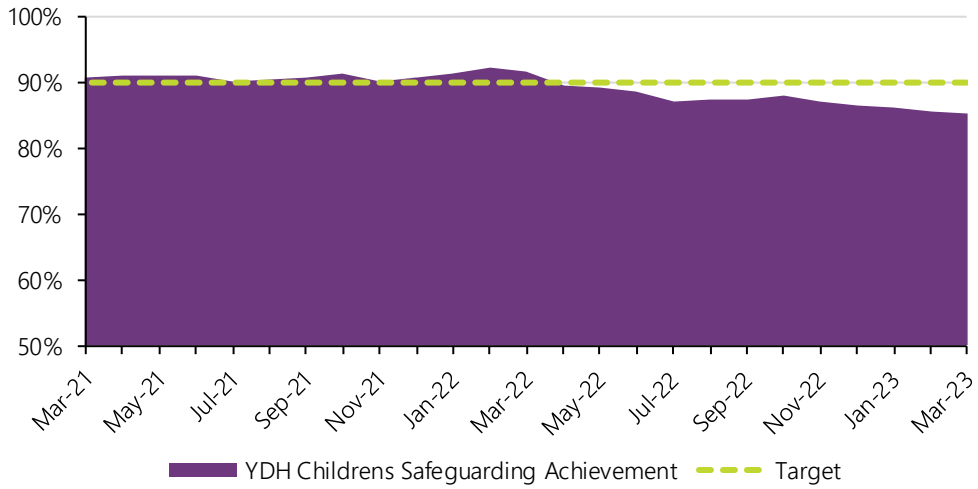
Childrens Safeguarding - Level 1	Childrens Safeguarding - Level 2	Childrens Safeguarding - Level 3
88.58%	**85.50%**	**88.13%**

Additional notes	Achievement
• Childrens Safeguarding Level 1 - YDH	**86.37%**
• Childrens Safeguarding Level 2 - YDH	**85.65%**
• Childrens Safeguarding Level 3 - YDH	**88.13%**
• Adults Safeguarding - YDH	**86.45%**

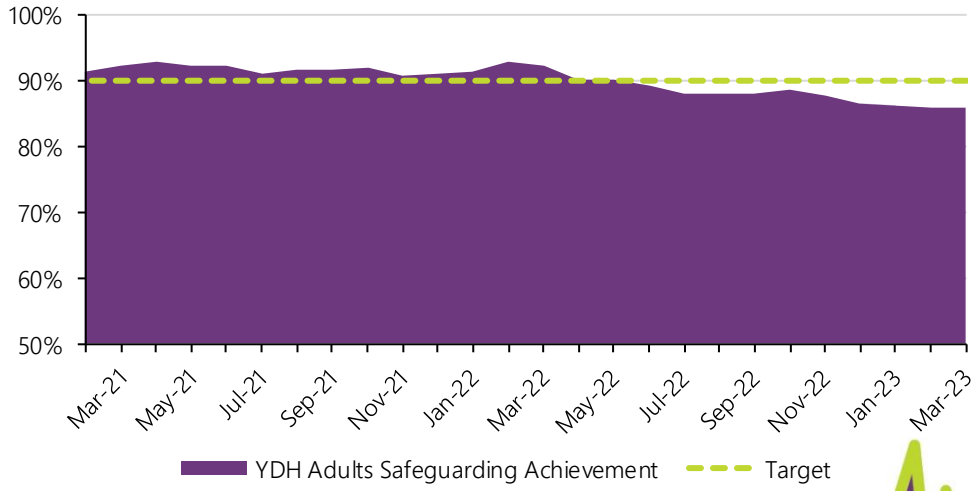
Comments

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

Childrens Safeguarding Achievement vs Target - YDH Only



Adults Safeguarding Achievement vs Target - YDH Only



Appraisals

March 23

YDH Group	YDH	SHS	SSL
85.27%	**82.23%**	**93.75%**	**94.79%**

March 20

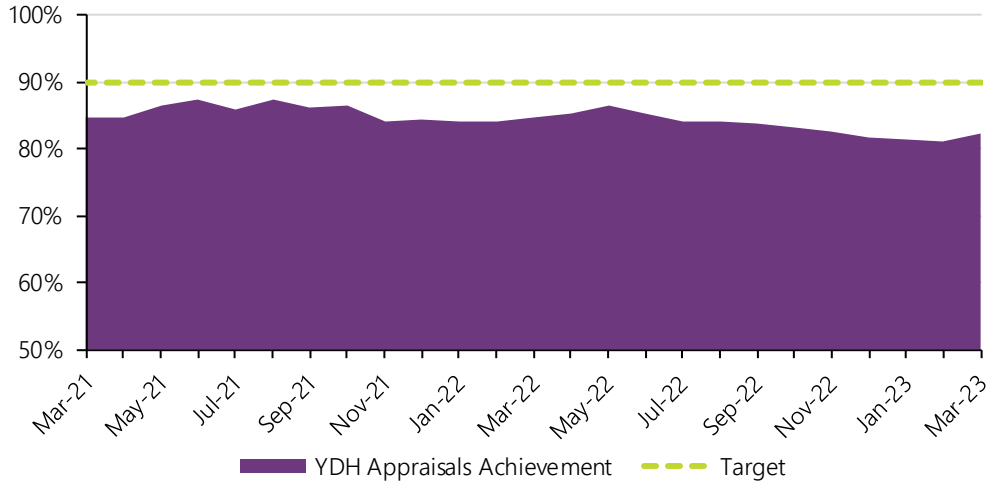
YDH Group	YDH	SHS	SSL
85.32%	**85.35%**	**87.30%**	**82.98%**

Additional notes	Count	Diff
• Group Appraisals:	**85.27%**	**-0.05%**
• Group Appraisals 19/20:	85.32%	
• YDH Appraisals:	**82.23%**	**-3.12%**
• YDH Appraisals 19/20:	85.35%	

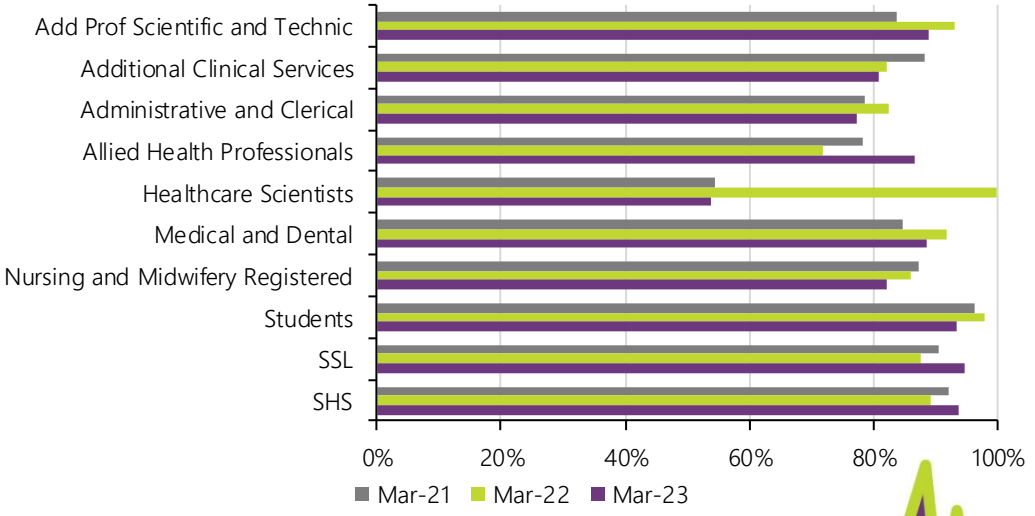
Comments

The YDH Group 12 month appraisals achievement in March was 78.3%. Appraisal performance is below target as expected because of Covid, however there is now a real focus on improving this over the following few months.

Appraisals vs Target - YDH Only



Appraisals by Staff Group



Appendix A - Slide Index

Slide Index - Performance

Appendix A - Slide Index

Slide Index - Workforce

Appendix B - YDH Quality Measures

March 23

Admissions	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Number of medical outliers in acute wards (beddays)	1333	1152	971	1033	1134	978	1183	1126	1354	1196	1326	1344	
MSA breaches: Acute wards	0	0	0	0	0	0	0	0	0	0	0	0	
Number of patients transferred between acute wards after 10pm	102	81	61	51	53	70	66	73	95	98	98	87	

Mortality (acute services)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Hospital Standardised Mortality Ratio (HSMR)	0.97	0.97	0.97	0.95	0.93	0.92	0.90	0.87	0.87	--	--	--	
Summary Hospital-level Mortality Indicator (SHMI)	95.80	96.27	95.00	94.29	94.11	91.92	89.84	--	--	--	--	--	

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

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

Appendix B - YDH Quality Measures (2)

March 23

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

Falls	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Number of patient falls - all services	101	78	55	70	87	72	72	80	94	78	72	82	
Rate of falls per 1,000 occupied bed days - all services	9.20	6.95	5.17	6.10	7.42	6.54	6.09	6.96	7.74	6.69	6.67	7.08	
Number of falls resulting in harm - all services	3	2	1	6	7	6	3	0	4	2	4	3	
Rate of falls resulting in harm per 1,000 occupied bed days - all services	0.27	0.18	0.09	0.52	0.60	0.55	0.25	0.00	0.33	0.17	0.37	0.26	

Pressure ulcer damage	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
Acute wards - number of incidents	987	1001	1144	1114	986	915	1026	922	931	954	952	895	
Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	0.91	1.07	0.75	1.05	0.87	0.92	0.42	0.70	1.01	1.07	0.36	1.21	

Cardiac Arrests	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend
No. ward-based cardiac arrests - acute wards	11.00	9.00	3.00	4.00	14.00	4.00	5.00	6.00	5.00	5.00	2.00	6.00	

Appendix C - YDH Corporate Scorecard

March 23

Accident & Emergency	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend	Threshold
4-hour performance: Accident and Emergency department (ED)	78.0%	84.5%	84.4%	78.0%	78.2%	72.2%	66.4%	69.1%	63.4%	68.2%	65.0%	70.3%		>=95% = Green >=85% - <95% = Amber <85% = Red
4-hour performance: Trust-wide	78.0%	84.5%	84.4%	78.0%	78.2%	72.2%	66.4%	69.1%	63.4%	68.2%	65.0%	70.3%		

Cancer	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend	Threshold
Maximum 2-week wait from GP referral (suspected cancer)	78.3%	77.7%	57.8%	51.5%	46.2%	40.3%	47.2%	59.4%	49.7%	65.0%	84.7%	--		>=93% = Green <93% = Red
Cancer - 28 days Faster Diagnosis All Cancers	75.1%	69.7%	75.4%	73.2%	76.7%	69.0%	75.9%	67.7%	70.7%	67.5%	71.2%	--		>=75% = Green <75% = Red
Cancer - maximum 31 day wait from diagnosis to first treatment	91.6%	93.4%	91.5%	92.2%	96.8%	87.8%	90.8%	91.5%	87.8%	86.5%	88.3%	--		>=96% = Green <96% = Red
Cancer - maximum 62 day wait from urgent GP referral	79.6%	71.9%	66.1%	64.2%	69.2%	65.2%	59.9%	61.9%	51.4%	60.2%	61.4%	--		>=85% = Green <85% = Red
Cancer: 62-day wait from referral to treatment for urgent GP referrals – number of patients treated on or after day 104	5	1	6	6	6	6	5	11	12	5	7	--		0 = Green >0 = Red

Appendix C - YDH Corporate Scorecard (2)

March 23

Referral to treatment (RTT)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend	Threshold
Diagnostic 6-week wait - acute services	78.8%	76.3%	74.4%	66.1%	66.5%	74.6%	74.0%	73.8%	69.4%	61.6%	64.7%	66.1%		>=99% = Green >=98% - <99% = Amber <98% = Red
Incomplete pathway: percentage of people waiting under 18 weeks	63.9%	66.2%	65.9%	67.1%	68.4%	68.6%	70.5%	70.8%	69.7%	67.9%	67.2%	67.8%		>=92% = Green <92% = Red
52 week RTT breaches	837	811	805	827	799	743	646	564	558	497	408	369		0 = Green <= Plan = Amber > Plan = Red
78 week RTT breaches	219	174	103	90	92	96	72	62	58	51	29	8		N/A
104 week RTT breaches	30	12	2	0	0	0	4	1	2	0	0	0		0 = Green <= Plan = Amber > Plan = Red
Referral to Treatment (RTT) incomplete pathway waiting list size	11722	12157	12230	12285	12388	12781	13062	13705	13874	14194	14117	14487		<= Plan = Green > Plan = Red

Intermediate Care	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend	Threshold
Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1	83.5%	83.5%	86.1%	82.6%	82.9%	84.0%	84.1%	79.8%	80.6%	79.5%	77.8%	80.8%		>=95% = Green >=85% - <95% = Amber >85% = Red

Appendix C - YDH Corporate Scorecard (3)

March 23

Workforce	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Trend	Threshold
Mandatory training: percentage completed	87.3%	88.0%	87.2%	86.3%	87.0%	86.8%	87.0%	86.8%	85.9%	85.6%	84.6%	84.5%		All courses >=90% = Green Overall rate <80% = Red Any other position = Amber
Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)	3.0%	4.1%	5.2%	4.3%	4.8%	4.1%	4.4%	5.3%	4.6%	5.5%	4.6%	--		<=5% = Green >5% to <=7.5% = Amber >7.5% = Red
Sickness absence levels - rolling 12 month average (Trust-wide)	4.2%	4.5%	4.6%	4.8%	4.7%	4.7%	4.7%	4.8%	4.8%	4.6%	4.5%	4.5%		<=4.6% = Green >4.6% to <=5.1% = Amber >5.1% = Red
Sickness absence levels - monthly average (Trust-wide)	3.7%	4.0%	4.7%	5.8%	4.2%	3.8%	4.6%	4.2%	5.0%	4.3%	4.2%	4.2%		<=4.6% = Green >4.6% to <=5.1% = Amber >5.1% = Red
Reduce the number of working days lost due to stress and anxiety (Trust-wide)	458.6	497.5	512.2	555.4	583.4	532.4	607.9	670.9	638.3	486.4	559.0	610.3		Monitored using Special Cause Variation Rules. Report by exception.
Retention / turnover rates (Trust-wide)	17.5%	17.8%	18.7%	19.3%	19.6%	19.6%	19.3%	18.6%	17.5%	17.5%	16.8%	18.3%		=<12% = Green 12% to <15% = Amber >15% = Red
Career conversations (12 months) - formerly 'Performance review (12-month)'	78.6%	79.1%	77.9%	77.7%	79.0%	79.2%	79.0%	77.0%	77.1%	78.4%	77.1%	78.3%		Trajectory to be agreed

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Quality and Performance Exception Report - SFT
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Associate Director – Planning and Performance Senior Performance Manager Chief of People and Organisational Development Deputy Chief Nurse Director of Elective Care
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	Our Quality and Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. Covid-19 continues to have a significant impact on a range of access standards, whilst restoration work is being undertaken to reduce the number of patients waiting and to shorten waiting times. As referrals recover to pre-Covid-19 levels this will also have an impact on services and numbers waiting. Urgent and emergency patients continue to be prioritised, to receive the treatments they need. Areas in which performance has been sustained or has notably improved include: • Compliance in respect of waiting times inside of six weeks for Adult, Learning Disabilities, Older Persons and Children and Young People's mental health services. • CAMHS Eating Disorders - Urgent referrals to be seen within one week and Routine referrals to be seen within four weeks, both of which are now above the national standard.

	• Reducing the numbers of patients waiting 52 and 78 weeks from referral to treatment with our acute services. • The percentage of Talking Therapies patients moving to recovery. • Patients followed up within 72 hours of discharge from an adult mental ward. Areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • the percentage of patients seen within four hours and spending longer than 12 hours, in our accident and emergency department and minor injury units. • Talking Therapies, percentage of people waiting under six weeks for their first therapy session. • 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 been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE EXCEPTION REPORT: MARCH 2023

1. PURPOSE

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

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

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

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

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

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

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

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

CHIEF FINANCE OFFICER

Overview

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

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

Safe

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

Current performance (including factors affecting this)

- **MRSA –** There were no Trust-attributed MRSA bloodstream infections (BSIs) reported during March 2023. The total number of cases for 2022/23 was one.
- **C. diff** - There were two Trust-attributed cases in March 2023. The total number of cases for 2022/23 was 49 against a threshold of 41.
- **MSSA –** Six Trust-attributed MSSA BSIs were reported during March. The total number of cases for 2022/23 was 48, against an internal threshold of 30.
- **E. coli** - Seven Trust-attributed E. coli BSIs were reported in March 2023. The total number of cases for 2022/23 was 87 against a threshold of 73.
- **Klebsiella –** Three Trust-attributed Klebsiella BSIs were reported in March 2023. The total number of cases for 2022/23 was 39 against a threshold of 23.
- **Pseudomonas –** One Trust-attributed Pseudomonas aeruginosa BSI was reported in March 2023. The total for 2022/23 was 7 against a threshold of 12.

Respiratory Viral Infections

- **COVID-19:** 192 inpatient cases of COVID-19 were identified during March 2023, of which 66 were healthcare-attributed. During 2022/23 over 2,348 inpatient cases of COVID-19 were identified.
- **Influenza:** eight inpatient cases were identified during March 2023. During 2022/23 a total of 439 inpatient cases occurred, most of which were between October and December 2022.
- **Respiratory Syncytial Virus (RSV):** six inpatient cases of RSV were identified during March 2023, mostly adults. During 2022/23 a total of 90 inpatient cases occurred between December 2022 and March 2023.

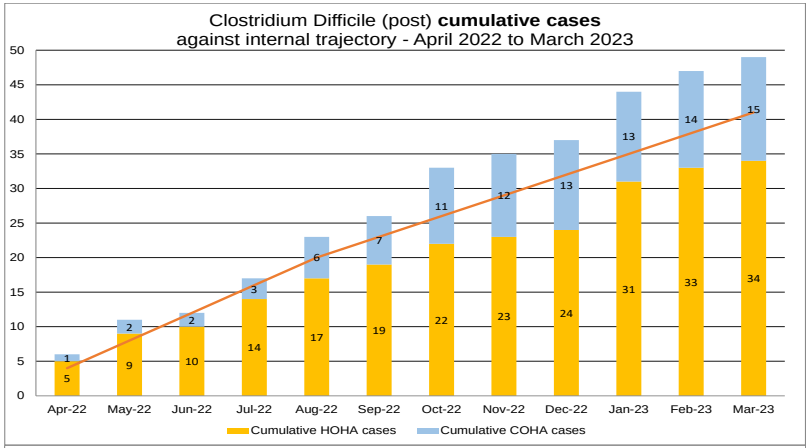
Outbreaks

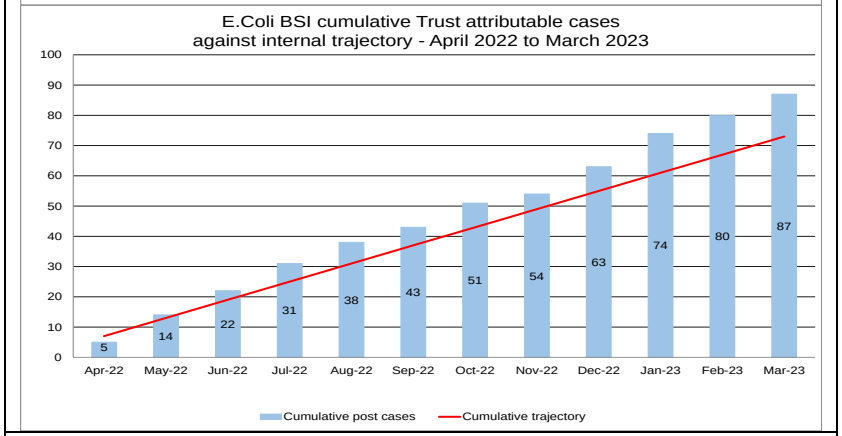
- During March there were a total of 16 outbreaks affecting inpatient wards. Two of the outbreaks was due to norovirus, the rest were all due to COVID-19.

Challenges

- The most significant challenge in the last year has been the impact of the 3 main respiratory viruses over the winter months. Whilst the pressure of influenza and RSV have abated the pressure from COVID-19 continues. However, as we enter April COVID numbers appear to be reducing.
- Of the mandatory reportable HCAIs thresholds have been exceeded in all except Pseudomonas aeruginosa. A general increase is being seen in other trusts nationally and regionally. Trust and regional work is in place to identify reasons for this and make improvements.

Line/Bar Charts





Recent performance

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

Safe

Medication Incidents: Total number of incidents reported via RADAR. Our aims are to maintain high rates of reporting, and have a low proportion of serious incidents.

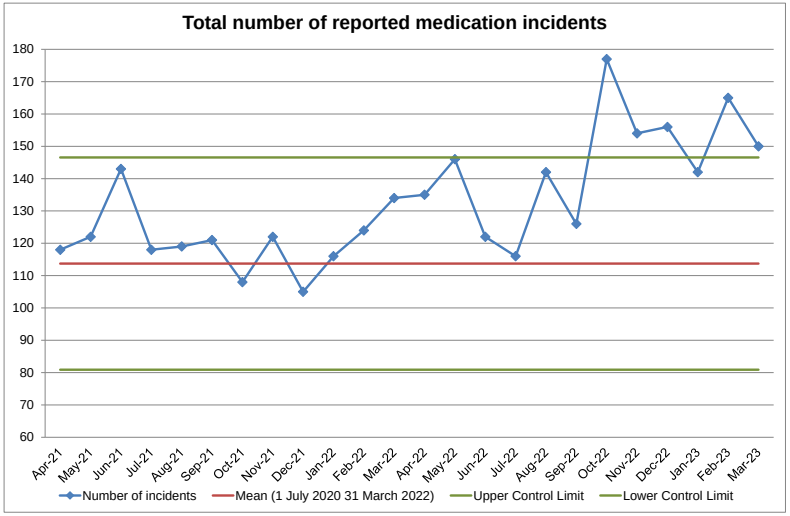
Current performance (including factors affecting this)

- There were 150 medication incidents reported during March 2023, a reduction compared to February 2023. Of the numbers reported, 106 related to drug errors, representing 70.7% of all incidents reported.
- Of the 150 incidents recorded, 27 (18%) resulted in minor harm and two (1.3%) resulted in moderate harm.

Focus of improvement work

- Reported incidents are managed at department level with local investigations and actions put in place. Significant events are subject to a 72-hour report and where appropriate further investigation.
- Medication incidents are reviewed quarterly by topic leads to identify common themes and system-wide learning. The Medicines Incidents Review Group provides overarching scrutiny of reported incidents and arrangements are proceeding to provide this scrutiny across reported incidents throughout the entire Trust.
- The Governance Support Team will be developing a specific medication analytics dashboard within our incident reporting system, RADAR, to aid the review of common themes and trends.
- Indicators of reported incidents are more of a measure of a safety culture (recognition of safety-related incidents and openness) rather than patient harm. Work to encourage reporting of medication incidents is ongoing and has recently been a focus of our Integrated and Urgent Care matrons and as a result of the implementation of the electronic prescribing and medicines administration (ePMA) solution in the acute setting.

SPC Chart



How do we compare

The number of reported incidents during March 2023 decreased compared to February 2023.

Recent performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
Total reported	177	154	156	142	165	150

Safe

Unexpected Deaths - To assess whether there are any underlying themes or changes which can be made to improve the way in which we respond to patient needs, we monitor the incidence of unexpected deaths in patients who have been in contact with our services.

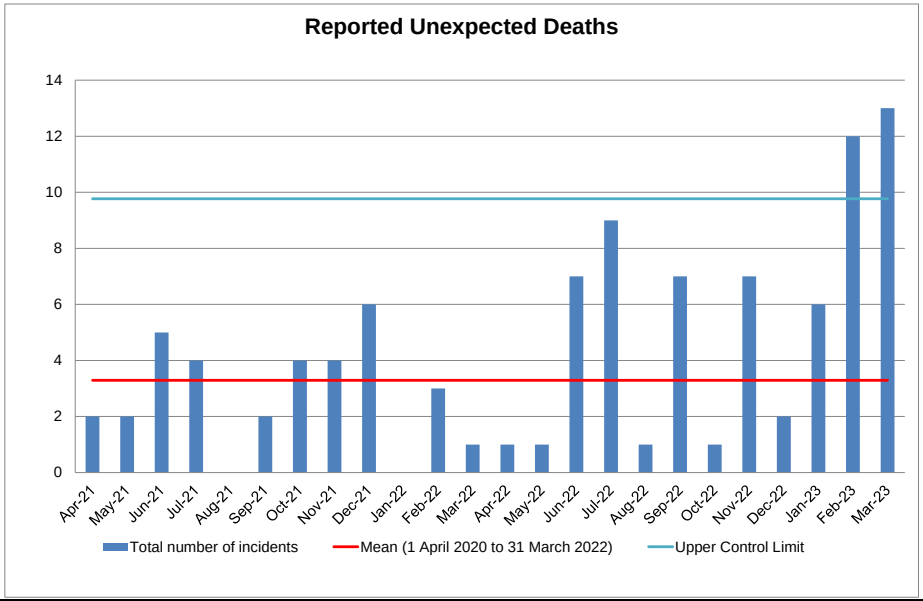
Current performance (including factors affecting this)

- During March 2023 a total of 13 unexpected deaths were reported via the incident reporting system.
- The numbers recorded include unexplained deaths which may be of natural causes but will be reviewed before closing the incident or escalating to a Serious Incident Requiring Investigation (SIRI).
- During March 2023 one SIRI was reported.

Focus of improvement work

- All reported incidents are validated and reviewed to ascertain the circumstances and to determine the cause.
- Unexpected deaths are subject to coronial processes, which can take a significant length of time.
- An initial "72 hour" review meeting is held for all unexplained deaths to identify any potential for immediate learning, ensure that appropriate support has been offered to relatives, carers and colleagues, and to agree the appropriate next steps for investigation.
- When considered serious, an incident becomes a SIRI, which is investigated using Root Cause Analysis (RCA) methodology, to establish any learning points, which we can use to improve the care which we provide to patients, and to share learning.
- The Trust's mental health serious incident review group has been reviewing the recent data, and findings from the initial review meetings, to identify any areas of concerns and look for any specific themes. No themes have yet been identified and the general increase may be due to the increase in population covered by mental health services.

SPC Chart



How do we compare

Although during March 2023, the number of reported incidents increased compared to February 2023.

Recent Performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number of reported incidents	1	7	2	6	12	13

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.

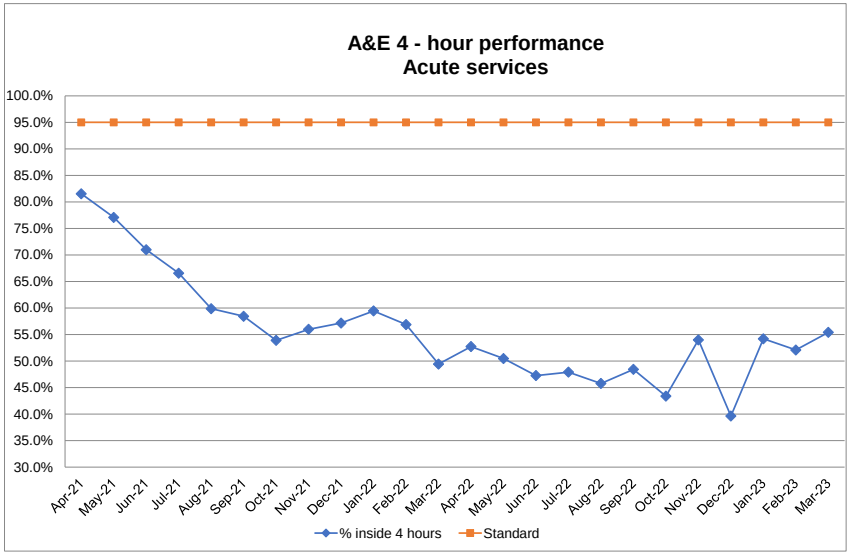
Current performance (including factors affecting this)

- A&E 4-hour performance for March 2023, at 55.4%, was the highest monthly rate recorded since February 2022 (56.9%). Compliance within Minor Injury Units (MIUs) was 96.7%. Overall compliance was 78.5%, hence still below the 95% national standard.
- The number of patients spending more than 12 hours in the department decreased to 2.6%, the lowest over the 12-month reporting period.
- A&E attendances in March 2023 were 6.3% above March 2019 levels and 1.5% above March 2022 levels. Overall, emergency admissions in March 2023 were 1.6% above pre-COVID levels, with a significant increase in zero length of stay admissions. However, hospital stays of one or more days were down by 0.6%. This pattern is in contrast to what has been seen in recent months, with patients being admitted to an inpatient bed having longer stays, consistent with the low rate of discharge for medically fit patients due to a shortfall in domiciliary care capacity and bedded care packages.

Focus of improvement work

1. Continued review of the ED recovery plan.
2. Embed changes after successful tests to improved ED patient flow for ambulatory patients.
3. Revised standard operating procedure for failed GP and health professional referrals to support direct admission to specialist teams.
4. Successful electronic referral to the Acute Medical Unit medical team to be extended to nursing handovers as test of change.
5. Continued focus in embedding new Surgical Decision Unit (SDU) pathways including surgical and orthopaedic GP “expected” streamed directly to SDU.
6. The Hospital Ambulance Liaison Officer continues actively to support ambulance arrivals and handovers.
7. A system-wide approach to reducing/improving inpatient lengths of stay.

Line Chart



How do we compare

National average performance for Trusts with a major Emergency Department was 56.8% in March 2023. Our performance was 55.4%. We were ranked 62 out of 110 trusts. With Minor Injury Unit attendances included, we were ranked 17, with performance of 78.5%.

Recent performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
Actual	43.4%	54.0%	39.6%	54.2%	52.1%	55.4%

Responsive

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

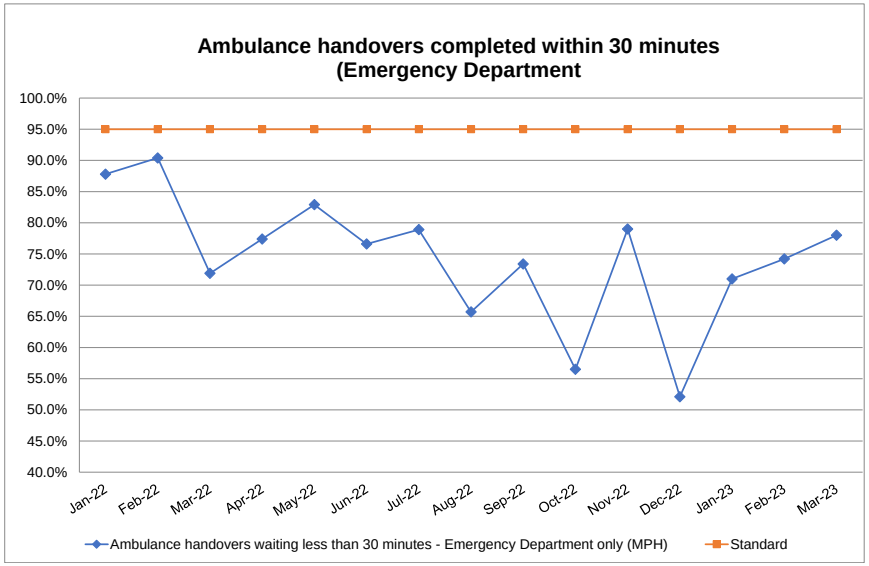
Current performance (including factors affecting this)

- During March 2023, of 2,173 patient arrivals by ambulance received into our Emergency Department (ED), a total of 1,695 (78.0%) were completed within 30 minutes, up from 74.2% in February 2023.
- In March 2023, 47.6% of all ambulance handovers were completed within 15 minutes, up from 42.6% in February 2023. The average performance across all hospitals served by SWAST in March 2023 was 26.4%.
- Arrivals by ambulance accounted for 32.3% of all patients attending ED during March 2023, up from 31.7% of arrivals during February 2023.

Focus of improvement work

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

Line Chart



How do we compare

In March 2023, 78.0% of all ambulance handovers at Musgrove Park Hospital were completed within 30 minutes. The average performance across all hospitals served by SWAST was 52.0%.

Recent performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
Actual	56.5%	79.0%	52.1%	71.0%	74.2%	78.0%

Responsive

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

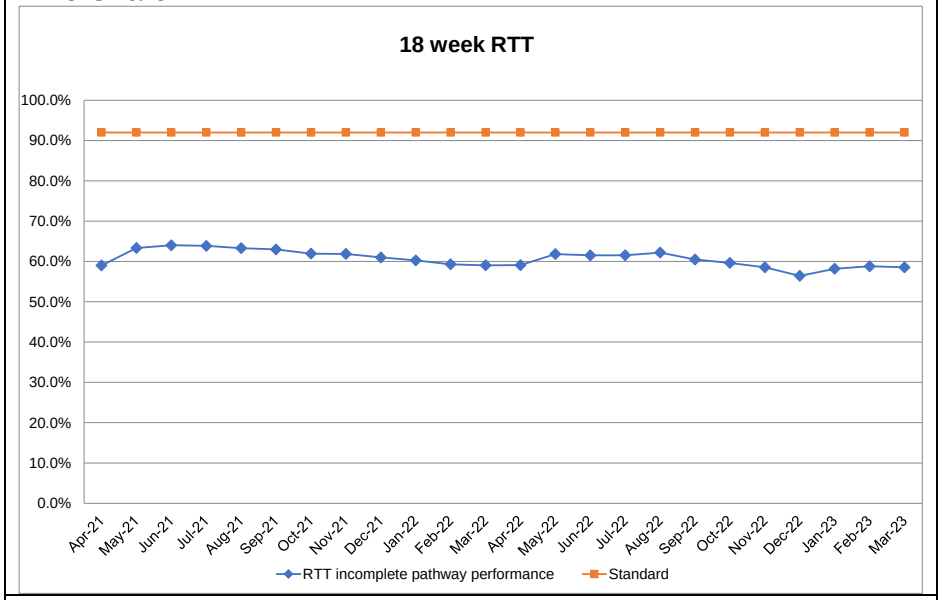
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 58.5% (acute + community) in March 2023.
- The over 18-week backlog increased by 487 pathways. The total waiting list size increased by 957 pathways, and was 5,856 above (i.e. worse than) trajectory (38,382 actual vs. 32,526). There was an increase in both acute and community pathways.
- RTT clock starts (i.e. referrals) in March 2023 were 16.8% above average pre-COVID levels (working days adjusted).
- 52-week waiters increased by 10 pathways in March 2023 to 1,818 pathways, against a trajectory of 2,537 or fewer. The number of patients waiting 78+ weeks decreased by 90 pathways to 60. We reported three patients waiting over 104 weeks (all due to clinical complexity).
- Until November 2021 the Trust remained one inpatient theatre's worth of capacity down due to the conversion of a theatre into critical care capacity. This, along with other factors, has resulted in a backlog of more complex, longer routine cases on the waiting list.
- Significant bed pressures, and to a lesser extent, theatre staff shortages continue to limit full restoration of inpatient activity, along with other factors such as increasing patient complexity.

Focus of improvement work

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

Line Chart



How do we compare

The national average performance was 58.5% in February 2023, the latest data available. Our performance was 58.8%. National performance improved by 0.2% between January and February 2023; our performance improved by 0.6%. The number of 52-week waiters nationally decreased by 16,747 to 362,498 (representing 5.0% of the national waiting list compared with 4.7% for the Trust).

Performance trajectory: 104+ and 78 week wait performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
104 week trajectory	16	16	16	8	4	0
104 week actual	7	1	3	3	2	3
78 week trajectory	333	432	660	559	420	300
78 week actual	262	219	257	201	150	60

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

Responsive

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

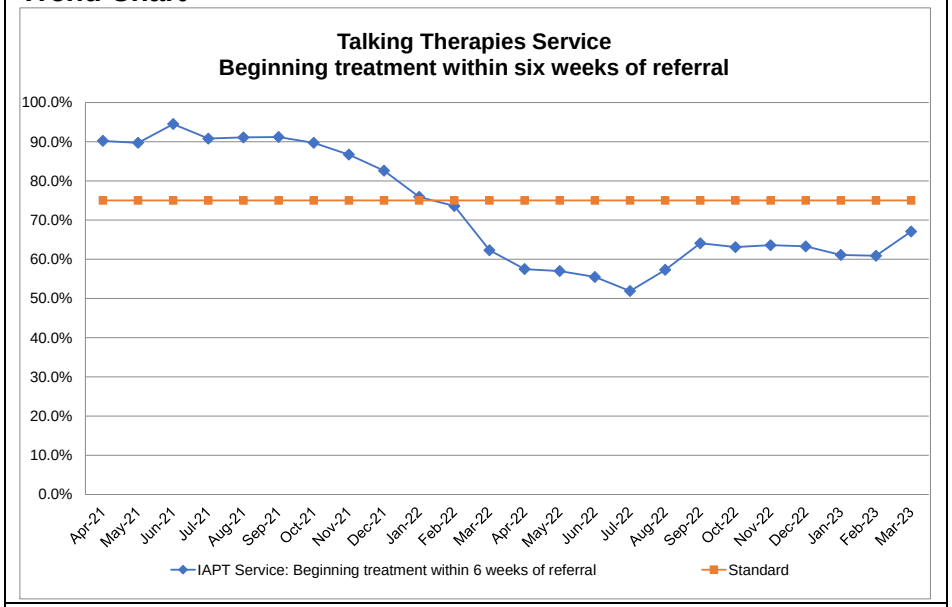
Current performance (including factors affecting this)

- During March 2023, compliance was 67.1%, up from 60.9% in February 2023.
- The fall in compliance that has occurred since February 2022 has been primarily due to rising levels of demand and a shortfall in capacity within the service. Between 1 April 2021 and 31 March 2022 referrals into the service increased by 26.7% compared to the same months of 2020/21 and by 17.1% compared to same months of 2019/20.
- Referrals between 1 April 2022 and 31 March 2023 were 2.6% lower than the same months of 2021/22, but 14.0% higher than the same months of 2019/20.
- The position continues to be exacerbated by vacancy levels, long term sickness and maternity leave.

Focus of improvement work

- Recruitment continues to be challenging, which is reflected nationally, although several recent appointments have been made with varying commencement dates. Once new colleagues commence in post, their contribution will be gradual until they are fully up to speed.
- A deep dive into the service is in progress to review demand and capacity and to formulate appropriate actions.
- The service has reasserted the commissioned eight-session treatment model, to offset against too many extensions to treatment.
- The service is also employing locums and is continuing to use external online providers creatively.

Trend Chart



How do we compare

National average performance against the six-week standard in January 2023 (the latest published data) was 90.1%; our performance was 61.1%.

Recent Performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
Total Discharges	401	420	379	411	468	526
First treatment inside of six weeks	253	267	240	251	285	353
Compliance %	63.1%	63.6%	63.3%	61.1%	60.9%	67.1%

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.

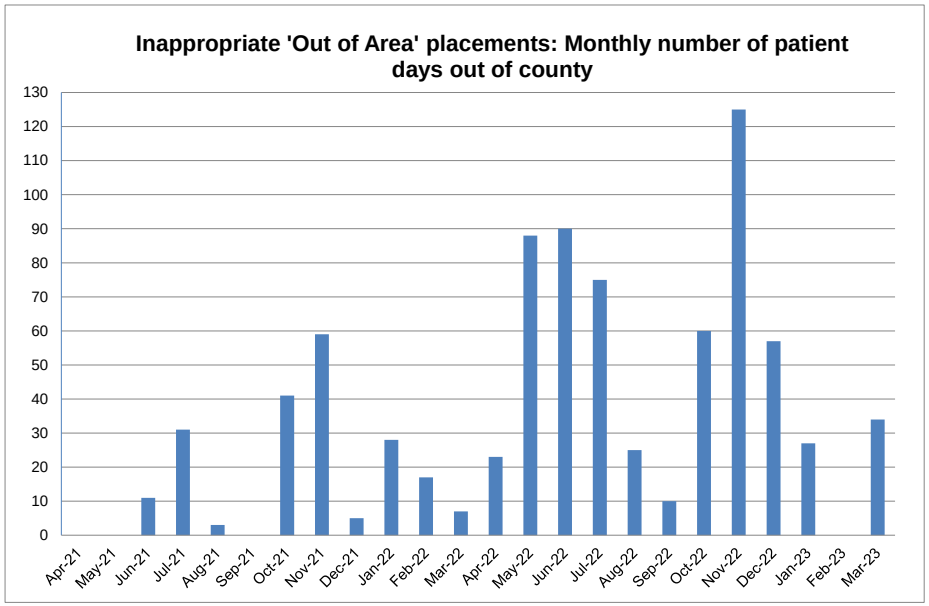
Current performance (including factors affecting this)

- During March 2023, two patients were placed out of area, for a total of 34 days.
- The patients who were both placed out of county during March 2023, remain so placed.

Focus of improvement work

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

Bar Chart



How do we compare

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

Recent Performance

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
Number of Days	60	125	57	27	0	34
Number of patients	5	6	4	1	0	2

Responsive

Waiting Times – One of our key priorities is to ensure that patients are able to access our services in as timely a manner as possible, and without unnecessary delays. Our aim is to 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.

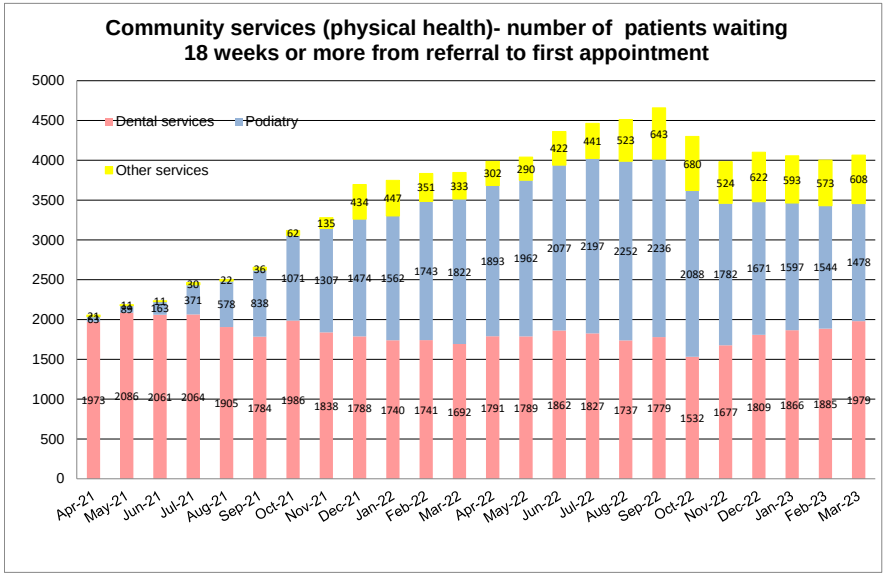
Current performance (including factors affecting this)

- As at 31 March 2023, the number of patients waiting 18 weeks or more totalled 4,065, an increase of 63 patients compared to the position as at 28 February 2023.
- The number of people waiting 18 weeks or more to be seen by our Podiatry service reduced to 1,478 patients, from 1,544 as at 28 February 2023, the seventh month in a row that the number have fallen. The Podiatry service continues to have significant levels of vacancies, which is a national issue.
- Our Somerset and Dorset dental service had 1,979 patients waiting 18 weeks or more to be seen, up from 1,885 as at 28 February 2023 (Somerset: 1,743 patients, up from 1,681 and Dorset: 236 patients, up from 204).
- Of the numbers within 'Others', 48% related to our Musculoskeletal Physiotherapy (MSK) service, which increased from 268 as at 28 February 2023 to 292 as at 31 March 2023.

Focus of improvement work

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

Bar Chart



How do we compare

The number of patients waiting 18 weeks or more as at 31 March 2023 increased by 63 when compared to 28 February 2023.

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	4,300	3,983	4,102	4,056	4,002	4,065

Responsive

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

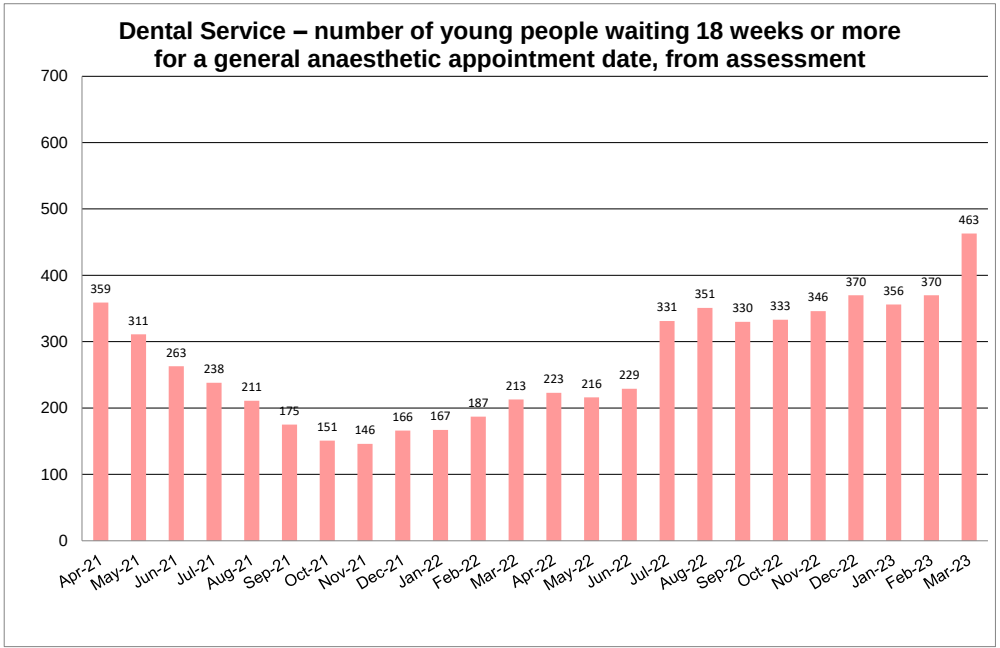
Current performance (including factors affecting this)

- As at 31 March 2023, 463 young people had waited 18 weeks, an increase of 93 compared to 28 February 2023.
- Of the 463 patients waiting, 385 related to our Dorset service (up from 330 as at 28 February 2023), and 78 related to our Somerset service (up from 40 as at 28 February 2023).
- The service continues to have significant levels of vacancies, which is a national issue, exacerbated by sickness/absence that affects capacity within the service, as well as the loss of some theatre slots.

Focus of improvement work

- The service is reviewing its recruitment programme and clinical delivery structure and other initiatives to recruit. Several recent appointments have been made with varying commencement dates. Once new colleagues commence in post, their contribution will be gradual until they are fully up to speed.
- The number of children per list has been increased to five where possible but many of the children with additional needs require more than one slot due to complexities, reducing the number of children who can be seen on a list.
- Theatre utilisation capacity work meetings have been held with both commissioning organisations within Somerset and Dorset to improve efficiency of the limited capacity, as there remain challenges with theatre availability due to current demand pressures of other specialities.

Bar Chart



How do we compare

The number of young people waiting 18 weeks or more as at 31 March 2023 increased by 93 compared to 28 February 2023.

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	333	346	370	356	370	463
% > 18 weeks	55.0%	51.3%	51.7%	48.2%	51.4%	59.7%

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 2023, 91.5% of patients aged 65 or over who were discharged from acute hospital beds within Somerset were transferred onto Pathway 0 or Pathway 1.

Pathway 0

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

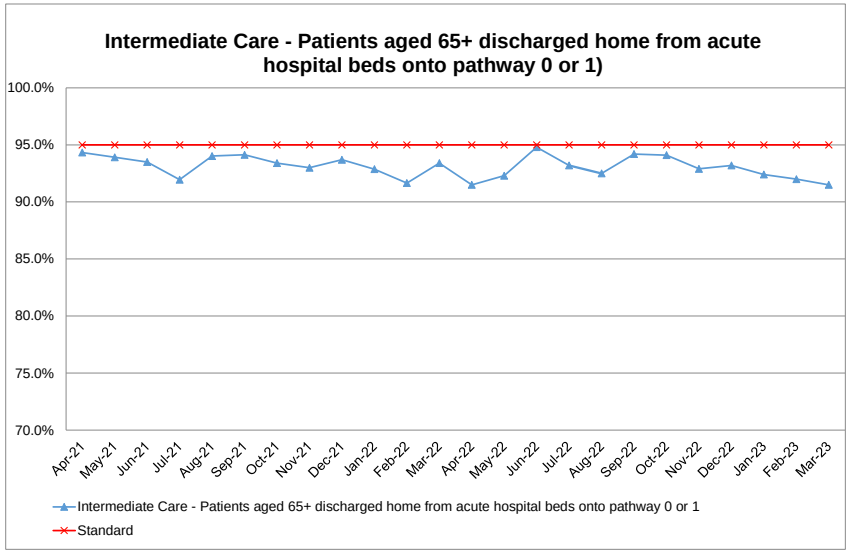
Pathway 1

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

Focus of improvement work

1. Increase Pathway 0 discharges from acute wards.
2. Pathway 1 operational and commissioning redesign – a business case is to be presented on 2 May 2023.
3. De-escalation of escalation beds – upon successful achievement of acute triggers, such as an improved No Criteria To Reside (NCTR) position.
4. End of pathway delays – good progress has been made in the sourcing of packages of care. More focus is now needed on:
    a. Reducing the number of outstanding social work assessment delays.
    b. Reducing the number of people awaiting long-term placement.
5. Community Hospital length of stay – an improvement plan is being produced. March 2023 data shows a slight increase in the number of monthly discharges, a reduction in the community hospital NCTR figures and a reduction in the number of people with lengths of stay over 100 days.
6. Streamlining the transfer of care hub continues. The next milestone is the introduction of telephone call referrals to the bedded care pathway (already operational for Pathway 1).

Line Chart



How do we compare

The percentage of patients aged 65 or more transferred onto pathway 0 or 1 during March 2023 compliance decreased slightly compared to February 2023.

Performance over the last six months

Area	Oct	Nov	Dec	Jan	Feb	Mar
Total Discharges	2,665	2,804	2,799	2,713	2,632	2,937
Pathway 0	2,324	2,398	2,443	2,301	2,267	2,525
Pathway 1	183	207	166	207	155	163
% onto P0 or P1	94.1%	92.9%	93.2%	92.4%	92.0%	91.5%

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.

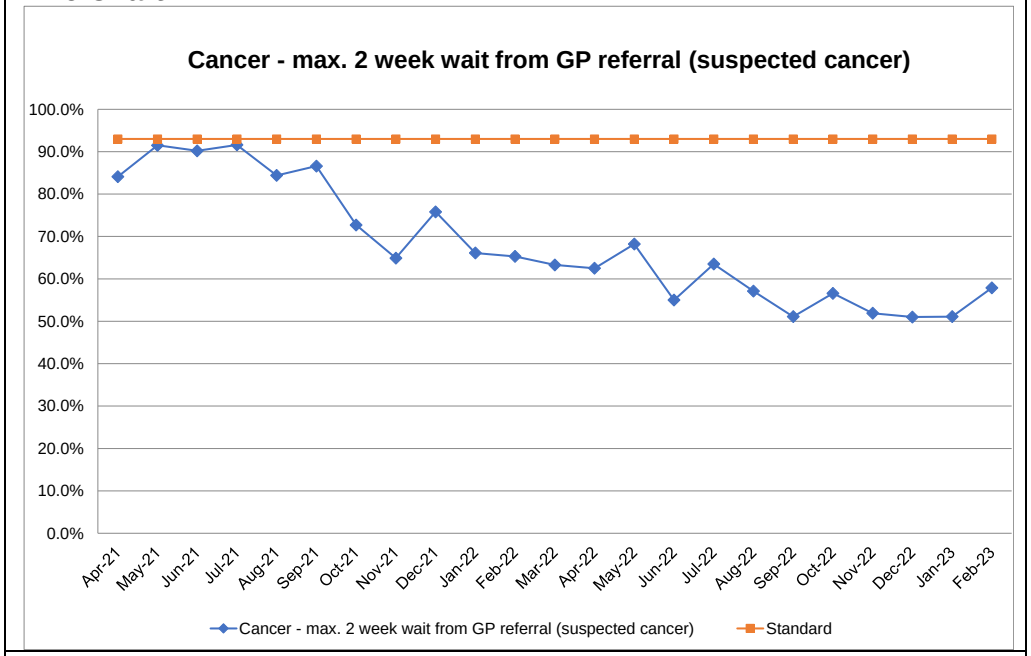
Current performance (including factors affecting this)

- The percentage of patients seen within 14 days of referral by their GP for a suspected cancer was 57.9% in February 2023, up from 51.1% in January 2023, but below both the 93% national standard and the national average.
- Breast made up 42% of the two-week wait breaches in February 2023. Changes to service capacity due to a departure from the team last year has limited the ability of the service to meet demand and keep waits within two weeks, although the 28-day Faster Diagnosis Standard is now being consistently met again.
- Colorectal made up a further 30% of breaches. The triage time has reduced significantly in recent weeks. The primary care-based colorectal referral hub, funded by Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance, is also helping to reduce pathway delays as far as possible. However, waiting times for colonoscopies, which are the two-week wait step for more than a third of lower GI referrals, remain longer than optimal due to the recent very high levels of demand.
- The breast symptomatic (cancer not suspected) 93% two-week wait standard was not achieved in February 2023, with performance of 11.4% and 70 breaches, 68 due to capacity problems described above.

Focus of improvement work

- A review was undertaken of the breast service capacity and demand and a number of actions taken to provide additional capacity. With the recruited GPs now trained to run clinics independently, there has been a significant improvement in the 28-day Faster Diagnostic Standard performance (please see the exception report). However, consistently meeting the two-week wait standard will remain a challenge.
- Funding has been agreed to support the recruitment of a trained nurse endoscopist, which will increase colonoscopy capacity.
- Please see the Diagnostics exception report for actions to address the increase in colonoscopy waiting times.

Line Chart



How do we compare

National average performance in February 2023, the latest data available, was 86.1%. Our performance was 57.9%. We were ranked 139 out of 140 providers.

Recent Performance

Area	Sep	Oct	Nov	Dec	Jan	Feb
% seen in two weeks	51.1%	56.6%	51.9%	51.0%	51.1%	57.9%
Patient choice breaches	50	54	63	49	40	54
Other breaches (including capacity, and delayed blood tests)	510	393	498	427	434	395

Responsive

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

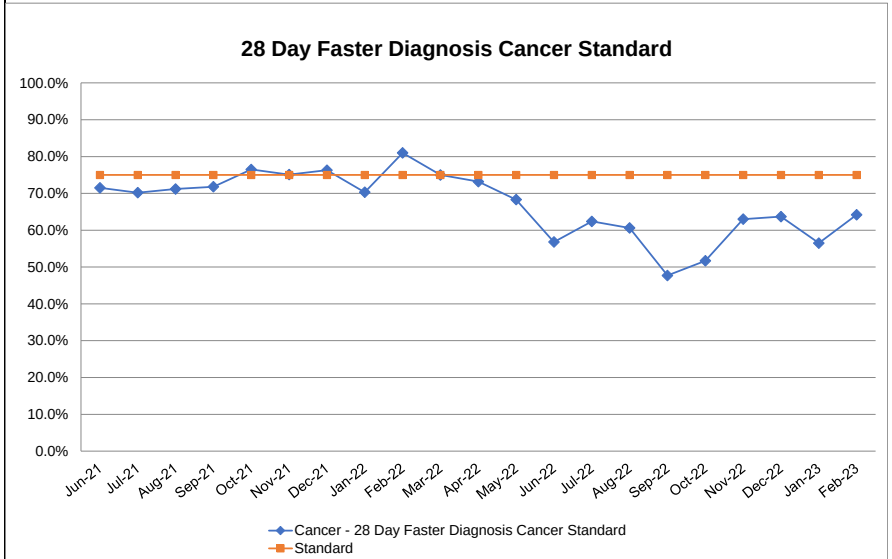
Current performance (including factors affecting this)

- The percentage of patients diagnosed with a cancer or given a benign diagnosis within 28 days of referral was 64.2% in February 2023 and remained below the national average.
- The higher-volume tumour sites not meeting the 75% national standard in February 2023 were: colorectal (23% against the 75% standard), urology (59%) and gynaecology (38%). Overall colorectal made up 51% of all the breaches of the 28-day standard and gynaecology 22%. Colorectal and gynaecology have seen a 3% and 37% growth in referrals in recent months, respectively, relative to pre-COVID levels.
- The recent improvement in performance against the 28-day Faster Diagnosis Standard has largely been due to breast achieving the standard again. Breast achieved the 28-day standard in November 2022, for the first time since last achieving in April 2022, following the additional capacity put in place with GPs recruited and trained to run two-week wait clinics, support provided by Yeovil District Hospital (YDH), and evening clinics established by the team.

Focus of improvement work

- A new lead nurse post has been introduced within the Faster Diagnosis Team, to bring together and streamline the processes across the MPH and YDH sites. This should help to speed-up the management of colorectal patients for this phase of their pathway.
- A new community-based/self-referral gynaecology pathway for post-menopausal bleed patients will commence in June 2023. This will comprise a one-stop clinic appointment and ultrasound scan. Patients for whom a benign cause of their bleeding cannot be identified, and those requiring additional investigations, will be referred to secondary care. Patients will be able to self-refer to the clinic from September 2023.

Line Chart



How do we compare

National average performance for providers was 75.0% in February 2023, the latest data available. Our performance was 64.2%. We ranked 130 out of 140 providers.

Recent performance

Performance in recent months was as follows:

28-day Faster Diagnosis performance

Area	Sep	Oct	Nov	Dec	Jan	Feb
Compliance	47.7%	51.7%	63.0%	63.7%	56.5%	64.2%

Responsive

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

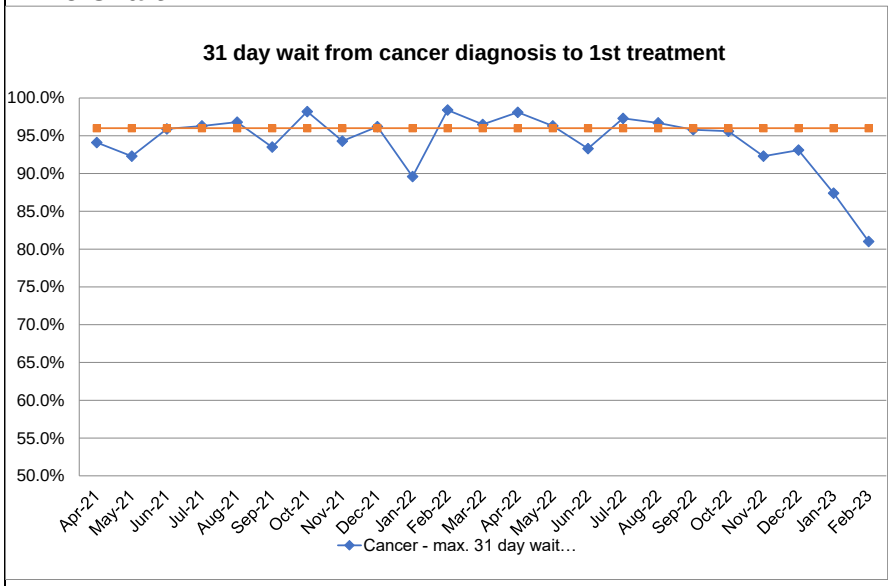
Current performance (including factors affecting this)

- Performance against the 31-day first definitive treatment standard was 81.0% in February 2023, and below the 96% national standard and national average performance.
- There were 40 breaches of the first definitive treatment standard, of which 26 were for breast pathways. This represents an unusually high number of breaches of the 31-day standard for breast patients. This mainly relates to a bulge in the waiting list as a result of additional capacity being put in to the diagnostic phase of the pathway two to three months ago, which has led to more patients needing treatment at the same time. The number of breaches for breast, and for all tumour sites as a whole, reduced in March 2023.
- There were smaller numbers of breaches of the 31-day standard across a range of tumour sites. In most cases these breaches related to surgical capacity. Industrial action and bed pressures have had a minimal impact on planned cancer treatments. However, any delays or cancellations of surgery are clinically risk-assessed on a case-by-case basis by the operating surgeon.

Focus of improvement work

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

Line Chart



How do we compare

National average performance for providers was 92.0% in February 2023, the latest data available. Our performance was 81.0%. We ranked 138 out of 140 providers.

Recent performance

28-day Faster Diagnosis performance

Area	Sept	Oct	Nov	Dec	Jan	Feb
Compliance	95.8%	95.6%	92.3%	93.1%	87.4%	81.0%

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.

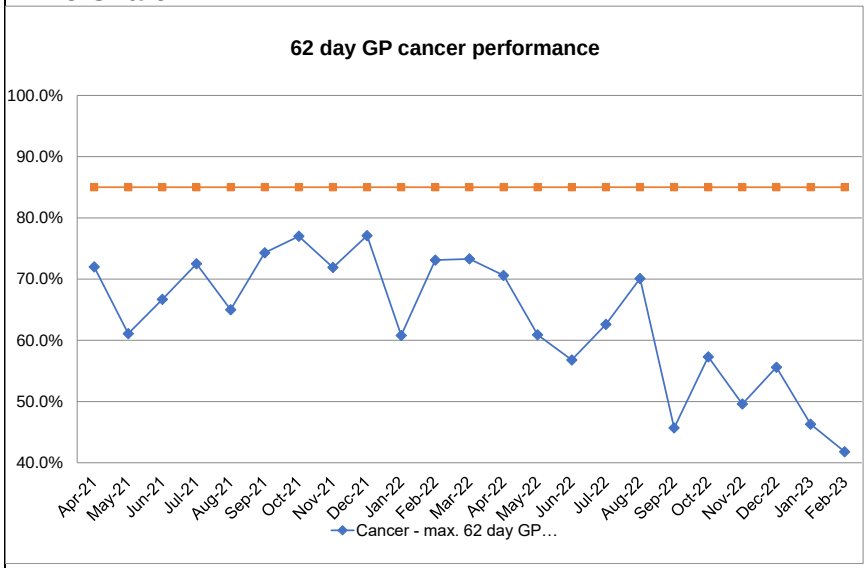
Current performance (including factors affecting this)

- The percentage of cancer patients treated within 62 days of referral by their GP was 43.8% in February 2023. In line with this continued dip in performance has been a reduction in the number of patients waiting over 62 days on the waiting list, as these patients are diagnosed and treated.
- The main breaches of the 62-day GP standards were in urology (45% of breaches), breast (14%) and colorectal (12%). The main causes of the breaches were very high growth in demand in urology (up 16% over the last three months, relative to the same pre-COVID period) and an associated increase in diagnostic waiting times. There are also delays in patients undergoing prostate surgery at another provider due to high demand.
- Twenty-two patients were treated in February 2023 on or after day 104 (the national 'backstop'). For further details please see Appendix 5a.
- The number of patients waiting over 62 days at the end of February 2023 was above (i.e. worse than) the recovery trajectory (128 against a plan of 80), but 11 lower than the previous month. The high level of the backlog relative to pre-COVID levels mainly reflects the growth in colorectal referrals received in recent months (52% above 2019/20 levels), and the breast staffing challenges.

Focus of improvement work

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

Line Chart



How do we compare

National average performance for providers was 58.2% in February 2023, the latest data available. Our performance was 43.8%. We were ranked 128 out of 140 trusts.

Recent performance

62-day GP cancer performance

Area	Sep	Oct	Nov	Dec	Jan	Feb
Compliance	45.7%	57.3%	49.6%	55.6%	46.3%	43.8%

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

Responsive

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

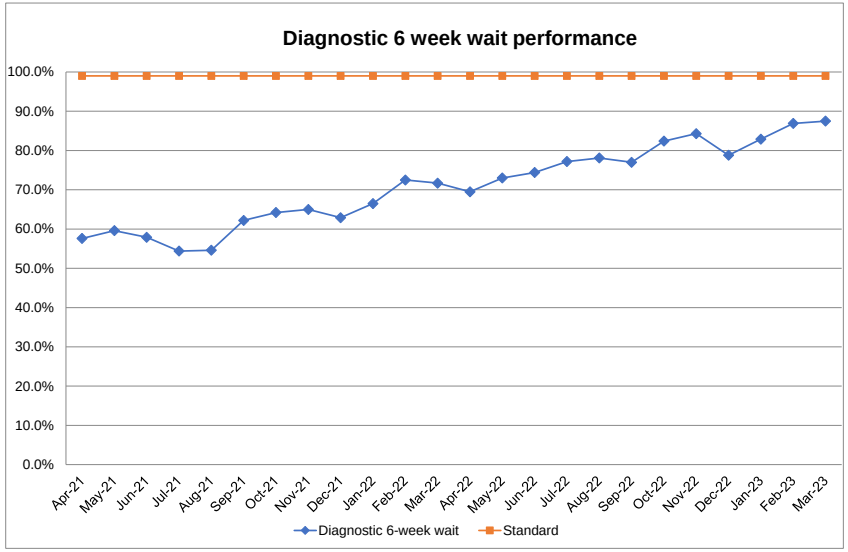
Current performance (including factors affecting this)

- The percentage of patients waiting under six weeks for their diagnostic test increased to 87.5% in March 2023, the highest percentage since February 2020, and continuing to meet the regional March 2023 ambition of greater than 75%.
- The number of patients waiting over six weeks remained similar to previous month, having increased by five to 860; the highest numbers of patients were waiting for a Colonoscopy (decreased from 256 to 234), CT (from 191 to 151), MRI (from 128 to 106) and an Audiology test (from 73 to 81) together making up 67% of the long waiters.
- The total waiting list size increased by 5%, largely due to an increase in ultrasound referrals in the period.
- The majority of the CT and MRI over six-week waiters are waiting for a routine but specialist scan. The high level of colonoscopy over six-week waiters remains due to very high cancer referral demand for a prolonged period, with the need to use routine capacity to reduce urgent waits.

Focus of improvement work

- Funding has been agreed to support the recruitment of a trained nurse endoscopist, which will increase colonoscopy capacity.
- Additional insourcing endoscopy sessions are being run in-week whenever possible, as well as at the weekend.
- Additional in-house clinics are being run in audiology, to support backlog clearance, on top of the existing outsourcing contract. A business case has been approved to increase staffing levels to provide additional in-house capacity later in the year; recruitment is underway.
- Additional sessions for specialist scans continue to be established as often as possible.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 74.1% in February 2023, the latest data available. Our performance was 86.9%. We were ranked 67 out of 159 trusts for the 15 high volume diagnostic tests.

Recent performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
Actual	82.4%	84.3%	78.8%	82.9%	86.9%	87.5%

Responsive

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

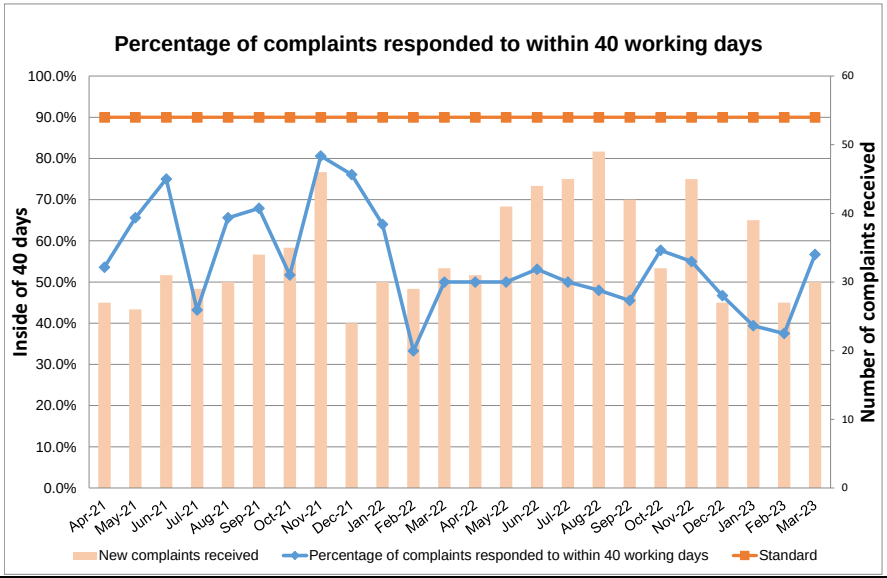
Current performance (including factors affecting this)

- During March 2023, a total of 30 responses were sent, compared to 48 responses sent in February 2023.
- Of the 30 complaints responded to during March 2023, a total of 17 (56.7%) were responded to within the 40 working day standard, up from 37.5% in February 2023.
- The overall number of open complaints has reduced from 85 to 79 since the last report to the Board.
- The Trust received 30 new complaints in March 2023, up from 27 in February 2023.
- The highest number of complaints remains in the Surgical directorate, which is experiencing difficulties due to staff absence and recruitment. A process is currently underway for the appointment of a governance co-ordinator. This will, however, have an impact on the responses being reviewed and processed in a timely manner in the meantime. However, Surgery have held the position over the last month and there has been no further deterioration despite their ongoing challenges.
- A number of complaints received over recent months have required responses from different services, which can increase the complexity in compiling responses and the time required to do this effectively.

Focus of improvement work.

- A member of the complaints team continues to assist the Surgical team for two days a week, specifically to address the oldest cases, working closely with service managers and matrons to assist in finalising and writing responses.
- The complaints team continues to meet bi-weekly with directorate co-ordinators/Associate Directors of Patient Care to review the progress and co-ordination of every open complaint.
- Two new posts, Director and Head for Patient Experience, continue to review resources and processes to align services.
- A test of change is currently being devised for a single service group to enhance and improve the service currently being provided. This launched on 1 April 2023 and an update will be provided in the next report.

Line Chart



How do we compare

During March 2023 the percentage of complaints responded to within 40 working days increased compared to February 2023.

Recent Performance

Our performance in recent months is as follows:

Area	Oct	Nov	Dec	Jan	Feb	Mar
% within 40 working days	57.7%	55.0%	46.7%	39.4%	37.5%	56.7%

Current open complaints:

Directorate	Within date	Late	Total
Surgery	16	15	31
Integrated	9	5	14
Families	4	3	7
Mental Health	8	2	10
Primary Care	0	1	1
Clinical Support	10	2	12
Centrally Coordinated	3	1	4
Totals:	**50**	**29**	**79**

Well Led

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

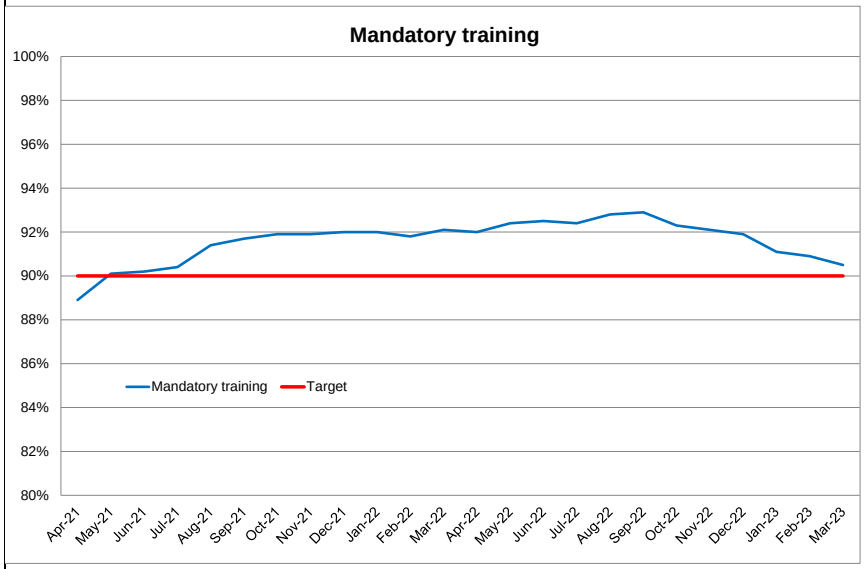
Current performance (including factors affecting this)

- As at 31 March 2023, our overall mandatory training rate was 90.5%, down slightly from 90.9% as at 28 February 2023, the sixth month in a row that the rate has fallen.
- To be compliant, all eleven core training subjects must have compliance rates above 90%. Of the 33 courses within these eleven core subjects, the 90% target has been met for 16.
- Eleven of the 17 courses below 90% compliance relate to resuscitation.
- Operational pressures, and limited resource capacity for areas with large backlogs such as life support and safeguarding continue to remain a challenge to full recovery.
- 'Failure to attend' rates also remain high, reflecting the operational pressures, for face-to-face and increasingly virtual courses.

Focus of improvement work

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

Run Chart



How do we compare

The compliance rate as at 31 March 2023 was 0.4% lower than the rate as at 28 February 2023.

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 %	92.3%	92.1%	91.9%	91.1%	90.9%	90.5%

Well Led

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

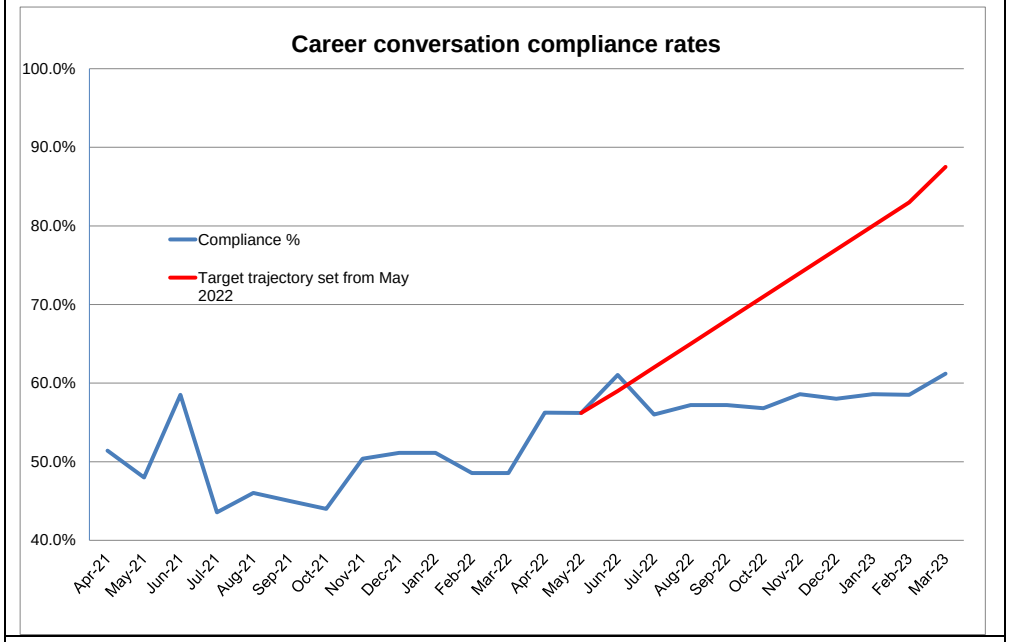
Current performance (including factors affecting this)

- Compliance as at 31 March 2023, in respect of career conversation reviews being undertaken at least annually, increased to the highest recorded rate but was still below the set trajectory.
- The rate recorded as at 31 March 2023 was 61.2%, which was 26.3% below the target trajectory set to restore compliance to 92% by 30 April 2023.
- Operational pressures continue to affect compliance.

Focus of improvement work

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

Run Chart



How do we compare

Compliance as at 31 March 2023 increased compared to the rate as at 28 February 2023.

Recent performance

The compliance rates in recent months were as follows:

Area	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	71.0%	74.0%	77.0%	80.0%	83.0%	87.5%
Monthly rate	56.8%	58.6%	58.0%	58.6%	58.5%	61.2%

Well Led

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

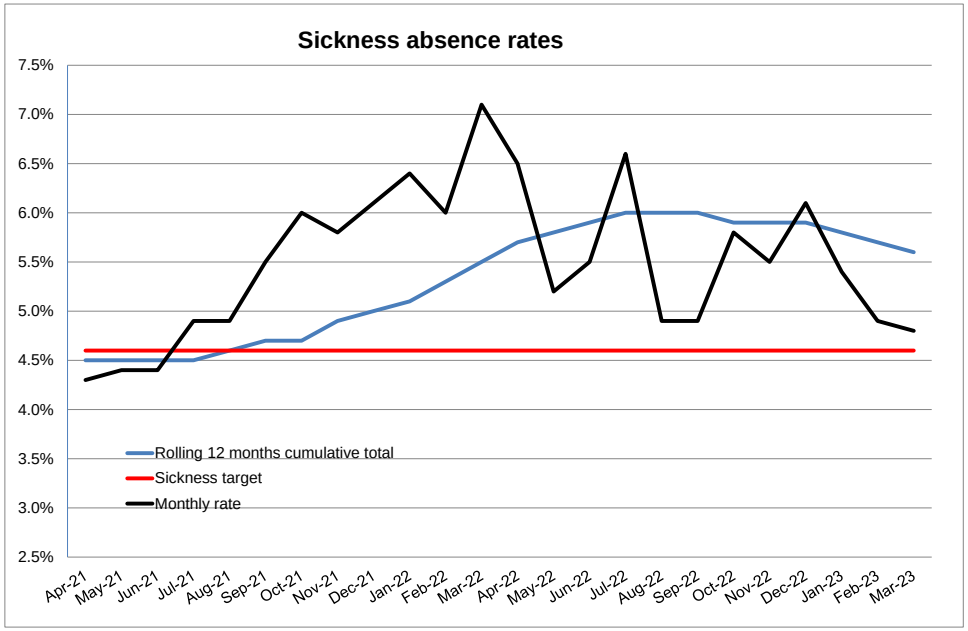
Current performance (including factors affecting this)

- The 12-month rolling sickness absence rate for the period ending March 2023 reduced slightly to 5.6%, the lowest level since March 2022. The monthly rate of sickness absence also decreased to 4.8% in March 2023, from 4.9% in February 2023, the lowest monthly recorded rate since June 2021.
- The number of working days lost due to stress and anxiety totalled 284, down from 295 reported in February 2023.
- COVID-19 accounted for 14.5% of all sickness absence in the 12 months to 31 March 2023. The monthly percentage of all absence that was due to COVID-19 in March 2023 increased to 6.5%, from 4.8% recorded during February 2023.

Focus of improvement work

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

Run Chart



How do we compare

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

Recent performance

The sickness absence rates in recent months were as follows:

Area	Oct	Nov	Dec	Jan	Feb	Mar
12 monthly rate	5.9%	5.9%	5.9%	5.8%	5.7%	5.6%
Monthly rate	5.8%	5.5%	6.1%	5.4%	4.9%	4.8%

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.

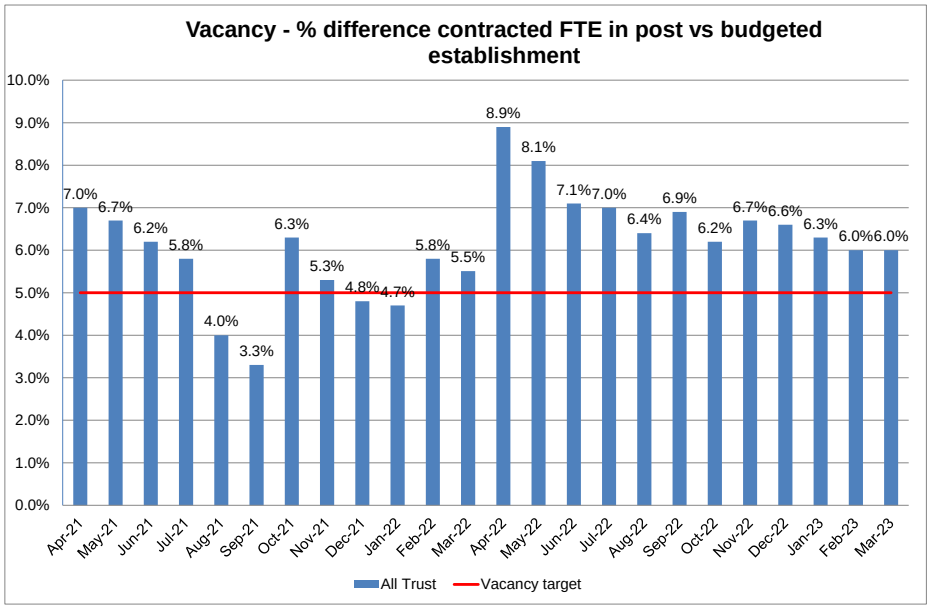
Current performance (including factors affecting this)

- The vacancy rate as at 31 March 2023 remained the same as at 28 February 2023, at 6.0%.
- Many areas where vacancies are of particular concern are recognised nationally as areas of shortage, including psychologists, podiatrists, registered mental health nurses, theatres, and a range of medical staffing including orthogeriatric, orthodontic, endoscopy, cardiology and respiratory consultants.
- Retaining healthcare support workers also continues to be a challenge.

Focus of improvement work

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

Run Chart



How do we compare

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

Recent performance

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

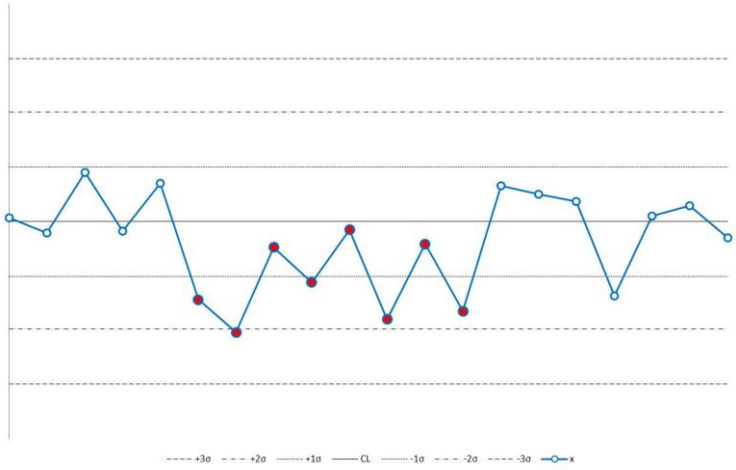
Area	Oct	Nov	Dec	Jan	Feb	Mar
Vacancy rate	6.2%	6.7%	6.6%	6.3%	6.0%	6.0%

Appendix 1 - Procedure for Interpreting Run Charts

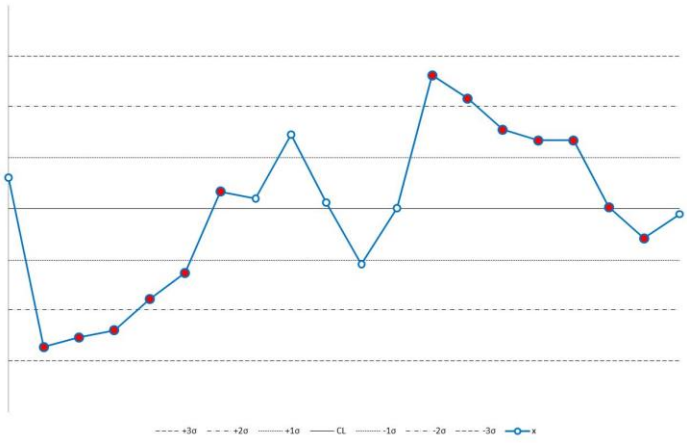
Special Cause Variation Rules

1. A single point outside the control limits

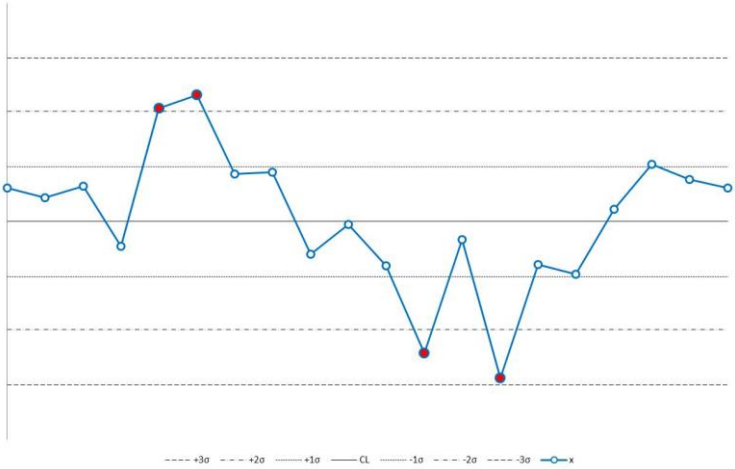
2. A run of eight or more points in a row above (or below) the centreline



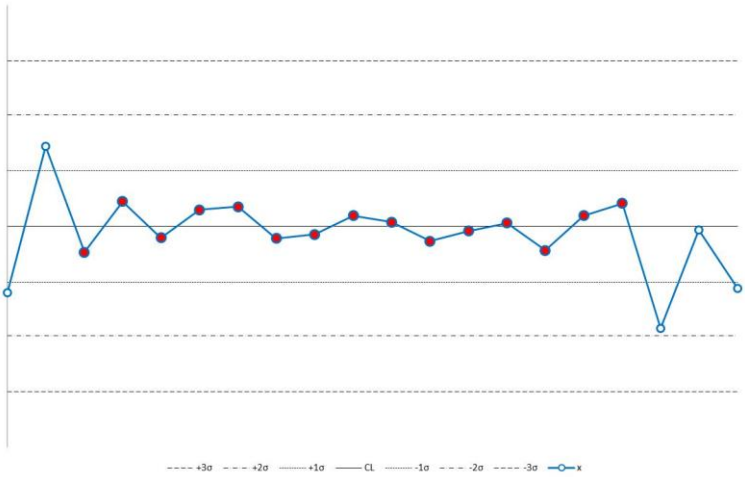
3. Six consecutive points increasing (trend up) or decreasing (trend down)



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



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



APPENDIX 2

OUR CARE QUALITY COMMISSION RATINGS

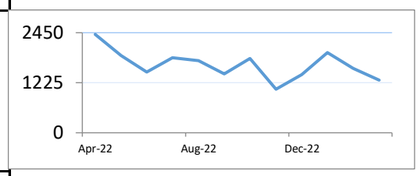
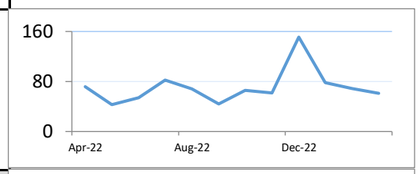
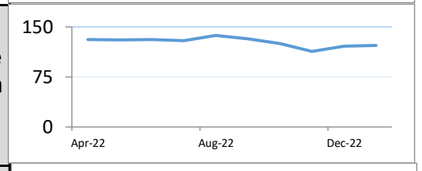
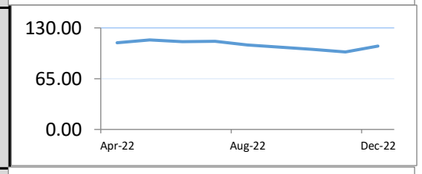
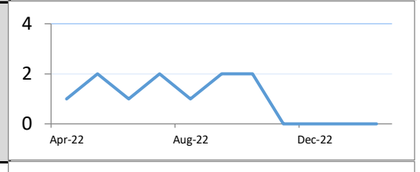
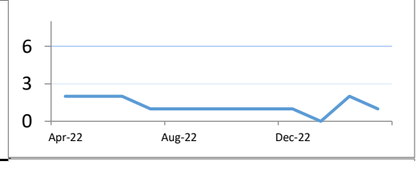
Our current Care Quality Commission ratings are as follows:

	Somerset NHS Foundation Trust
Overall rating for the Trust	Good

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

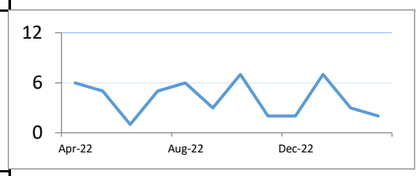
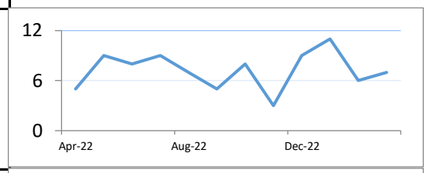
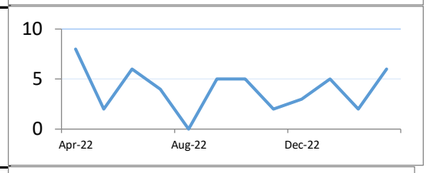
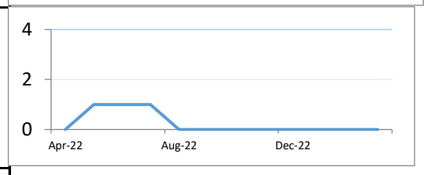
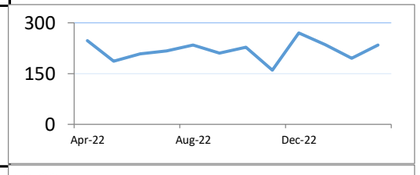
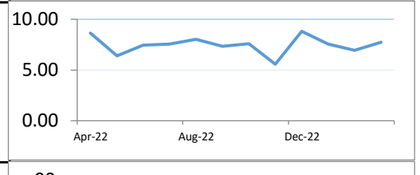
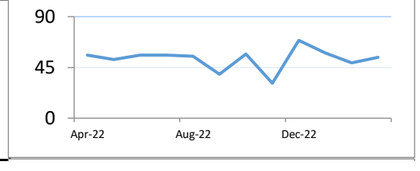
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
Admissions	1	Number of medical and surgical outliers in acute wards		2410	1893	1489	1835	1770	1442	1824	1067	1424	1964	1579	1293	
	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		72	43	54	82	68	44	66	62	151	78	69	61	
Mortality (acute services)	6	Hospital Standardised Mortality Ratio (HSMR)		130.96	130.32	131.12	129.34	137.20	132.32	125.22	113.27	121.40	122.13	February 2023 to be reported after March 2023		
	7	Summary Hospital-level Mortality Indicator (SHMI)		110.96	114.59	112.52	112.97	107.96	105.25	102.55	99.18	106.68	January 2023 to be reported after March 2023			
Incident reporting	8	No of Serious Incidents Requiring Investigation (SIRIs)/Never Events - acute services		1	2	1	2	1	2	2	0	0	0	0	Data awaited	
	9	Number of recorded Serious Incidents Requiring Investigation - community and mental health services		2	2	2	1	1	1	1	1	1	0	2	1	

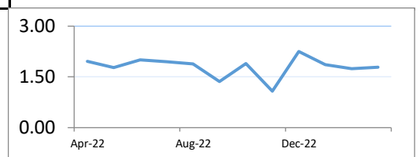
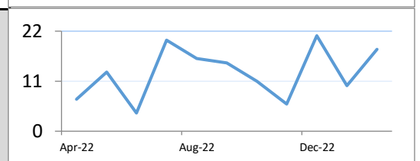
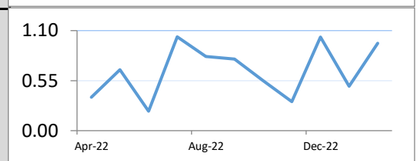
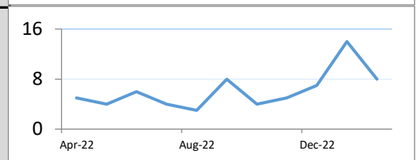
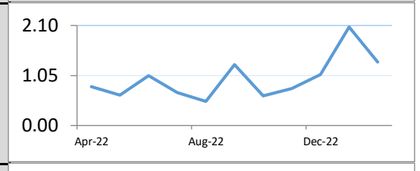
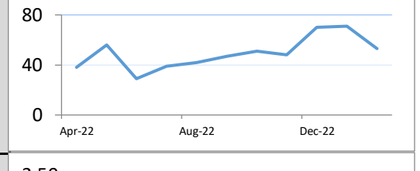
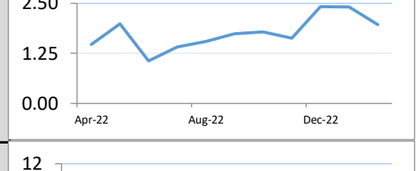
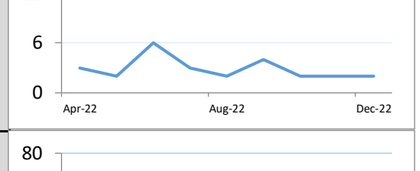
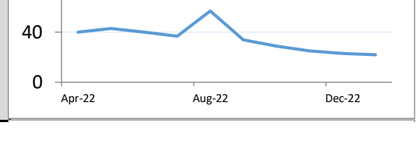
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
Infection Control	10	Clostridium Difficile cases HOHA cases (Hospital Onset Hospital Acquired) and COHA cases (Community Onset Hospital Acquired)	6	5	1	5	6	3	7	2	2	7	3	2	
Infection Control (acute services)	11	MRSA bacteraemias (post)	0	0	0	0	0	1	0	0	0	0	0	0	
	12	E. coli bacteraemia	5	9	8	9	7	5	8	3	9	11	6	7	
	13	Methicillin-sensitive staphylococcus aureus	8	2	6	4	0	5	5	2	3	5	2	6	
Maternity	14	No. of still births	0	1	1	1	0	0	0	0	0	0	0	0	
	15	No. of babies born in unexpectedly poor condition	0	0	0	0	0	0	0	0	0	0	0	0	
Falls	16	Number of patient falls - all services	247	187	208	217	234	210	228	160	270	235	195	234	
	17	Rate of falls per 1,000 occupied bed days - all services	8.65	6.39	7.43	7.54	8.03	7.32	7.58	5.57	8.81	7.55	6.94	7.72	
	18	Number of falls resulting in harm - all services	56	52	56	56	55	39	57	31	69	58	49	54	

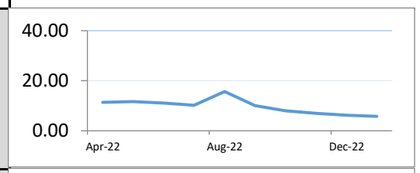
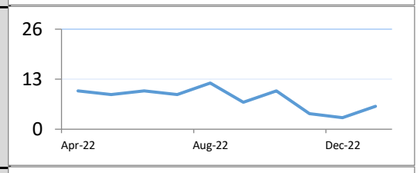
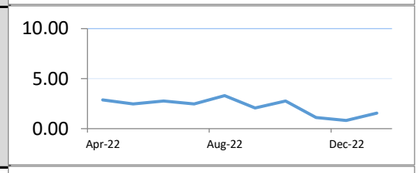
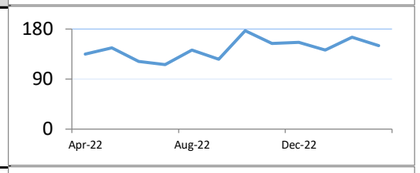
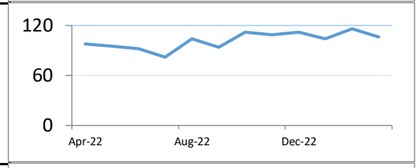
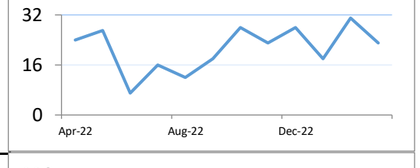
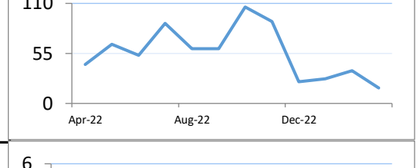
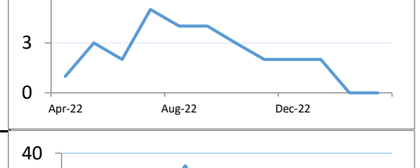
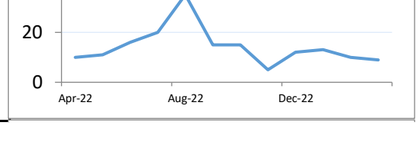
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
Falls	19	Rate of falls resulting in harm per 1,000 occupied bed days - all services	1.96	1.78	2.00	1.95	1.89	1.36	1.89	1.08	2.25	1.86	1.74	1.78	
Pressure ulcer damage	20	Acute wards - number of incidents	7	13	4	20	16	15	11	6	21	10	18	Data awaited	
	21	Rate of pressure ulcer damage per 1,000 acute ward occupied bed days	0.37	0.67	0.21	1.03	0.82	0.79	0.55	0.32	1.03	0.49	0.96	Data awaited	
	22	Community hospitals - number of incidents	5	4	6	4	3	8	4	5	7	14	8	Data awaited	
	23	Rate of pressure ulcer damage per 1,000 community hospital occupied bed days	0.82	0.64	1.05	0.70	0.51	1.28	0.62	0.78	1.07	2.07	1.33	Data awaited	
	24	District nursing - number of incidents	38	56	29	39	42	47	51	48	70	71	53	Data awaited	
	25	Rate of pressure ulcer damage per 1,000 district nursing contacts	1.48	1.99	1.06	1.41	1.54	1.74	1.79	1.63	2.42	2.41	1.97	Data awaited	
Cardiac Arrests	26	No. ward-based cardiac arrests - acute wards	3	2	6	3	2	4	2	2	2	Data awaited	Data awaited	Data awaited	
Restraints (mental health wards)	27	Total number of incidents	40	43	40	37	57	34	29	25	23	22	Data awaited	Data awaited	

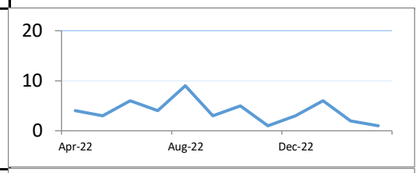
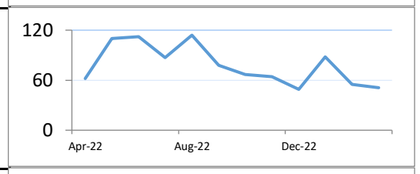
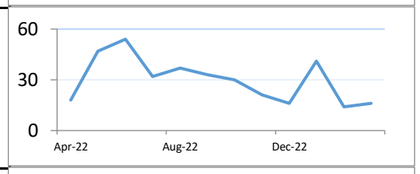
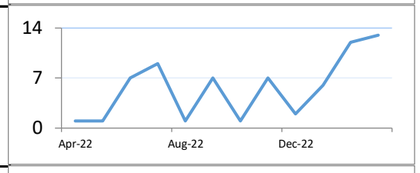
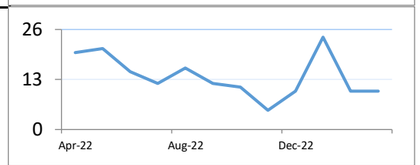
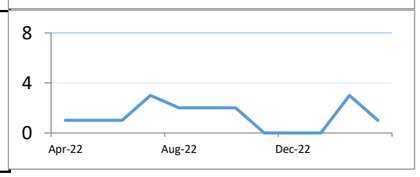
SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
Restraints (mental health wards)	28	Restraints per 1,000 occupied bed days	11.44	11.74	11.13	10.15	15.69	10.06	8.00	7.02	6.25	5.77	Data awaited	Data awaited	
	29	Number of prone restraints	10	9	10	9	12	7	10	4	3	6	Data awaited	Data awaited	
	30	Prone restraints per 1,000 occupied bed days	2.86	2.46	2.78	2.47	3.30	2.07	2.76	1.12	0.82	1.57	Data awaited	Data awaited	
Medication incidents - community and mental health wards	31	Total number of medication incidents	135	146	122	116	142	126	177	154	156	142	165	150	
	32	Medication incidents - drug errors	98	95	92	82	104	94	112	109	112	104	116	106	
	33	Medication incidents - incorrect storage	24	27	7	16	12	18	28	23	28	18	31	23	
Ligatures and ligature points - mental health wards	34	Ligatures: Total number of incidents	43	65	53	88	60	60	106	90	24	27	36	17	
	35	Number of ligature point incidents	1	3	2	5	4	4	3	2	2	2	0	0	
Aggression - d mental health rds	36	Violence and Aggression: Number of incidents patient on patient (inpatients only)	10	11	16	20	35	15	15	5	12	13	10	9	

SOMERSET NHS FOUNDATION TRUST

QUALITY MEASURES - 2022/23

Area	Ref	Measure	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
Violence and community and wa	37	Violence and Aggression: Incidents resulting in harm - patient on patient (inpatient only)	4	3	6	4	9	3	5	1	3	6	2	1	
Violence and Aggression - community and mental health services	38	Violence and Aggression: Number of incidents patient on staff	62	110	112	87	114	78	67	64	49	88	55	51	
	39	Violence and Aggression: Incidents resulting in harm - patient on staff	18	47	54	32	37	33	30	21	16	41	14	16	
Unexpected deaths	40	Unexpected Deaths: Total number of incidents to be investigated - community and mental health services	1	1	7	9	1	7	1	7	2	6	12	13	
Seclusion - mental health wards	41	Number of Type 1 -Traditional Seclusion	20	21	15	12	16	12	11	5	10	24	10	10	
	42	Number of Type 2 -Short term Segregation	1	1	1	3	2	2	2	0	0	0	3	1	

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2022/23

No.	Description		Links to corporate objectives	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Thresholds
1	Accident and Emergency / Minor Injury Unit 4-hour performance	Accident and Emergency department (ED)	4, 6, 9	52.7%	50.5%	47.3%	47.9%	45.8%	48.4%	43.4%	54.0%	39.6%	54.2%	52.1%	55.4%	>=95%= Green >=85% - <95% =Amber <85% =Red
2		Minor Injury Units	4, 6, 9	98.0%	97.9%	97.4%	97.1%	96.9%	96.8%	97.0%	97.6%	93.9%	96.3%	96.8%	96.7%	
3		Trust-wide	4, 6, 9	78.6%	77.4%	76.4%	75.9%	75.6%	75.8%	73.1%	77.9%	70.5%	77.8%	77.4%	78.5%	
4	Accident and Emergency / Minor Injury Units: percentage of patients spending more than 12-hours in the department	Accident and Emergency department (ED)	4, 6, 9	7.0%	3.7%	4.1%	4.7%	8.8%	4.2%	8.4%	2.9%	10.2%	7.1%	5.3%	2.6%	<=2%= Green >2% - <=5% =Amber >5% =Red
5		Minor Injury Units	4, 6, 9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
6	Ambulance handovers waiting less than 30 minutes - Emergency Department only (MPH)		4, 6, 9	77.4%	82.9%	76.6%	78.9%	65.7%	73.4%	56.5%	79.0%	52.1%	71.0%	74.2%	78.0%	>=95%= Green >=85% - <95% =Amber <85% =Red
7	Cancer - maximum 2-week wait from GP referral (suspected cancer)		3, 4, 9	62.5%	68.2%	55.0%	63.5%	57.1%	51.1%	56.6%	51.9%	51.0%	51.1%	57.9%	Data awaited	>=93%= Green <93% =Red
8	Cancer - 28 days Faster Diagnosis All Cancers		3, 4, 9	73.2%	68.3%	56.8%	62.4%	60.6%	47.7%	51.7%	63.0%	63.7%	56.5%	64.2%	Data awaited	>=75%= Green <75% =Red
9	Cancer - maximum 31 day wait from diagnosis to first treatment		3, 4, 9	98.1%	96.3%	93.3%	97.3%	96.7%	95.8%	95.6%	92.3%	93.1%	87.4%	81.0%	Data awaited	>=96%= Green <96% =Red
10	Cancer - maximum 62 day wait from urgent GP referral		3, 4, 9	70.6%	60.9%	56.8%	62.6%	70.1%	45.7%	57.3%	49.6%	55.6%	46.3%	43.8%	Data awaited	>=85%= Green <85% =Red
11	Cancer: 62-day wait from referral to treatment for urgent GP referrals – number of patients treated on or after day 104		3, 4, 9	3	10	18	12	10	13	11	10	10	15	22	Data awaited	0= Green >0 = Red
12	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week (rolling 12 months)		3, 4, 9	86.2%	85.2%	83.3%	82.6%	80.0%	80.0%	80.0%	85.0%	84.2%	88.9%	93.5%	100.0%	>=95%= Green >=85% - <95% =Amber <85% =Red
13	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks (rolling 12 months)		3, 4, 9	75.0%	74.0%	79.0%	80.4%	84.7%	85.4%	90.2%	91.5%	91.1%	91.4%	92.5%	95.4%	>=95%= Green >=85% - <95% =Amber <85% =Red
14	Mental health referrals offered first appointments within 6 weeks	All mental health services	4, 6, 9	89.5%	93.4%	91.9%	93.2%	93.8%	90.4%	90.8%	91.9%	89.0%	91.3%	94.6%	94.4%	>=90%= Green >=80% - <90% =Amber <80% =Red
15		Adult mental health services	4, 6, 9	86.4%	90.2%	87.9%	94.7%	93.6%	87.4%	89.2%	90.0%	86.3%	90.2%	92.7%	94.0%	>=90%= Green >=80% - <90% =Amber <80% =Red
16		Older Persons mental health services	4, 6, 9	90.1%	95.1%	93.1%	92.0%	93.0%	90.2%	90.0%	90.8%	89.8%	91.1%	95.2%	94.4%	>=90%= Green >=80% - <90% =Amber <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2022/23

No.	Description		Links to corporate objectives	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Thresholds
17	Mental health referrals offered first appointments within 6 weeks	Learning disabilities service	4, 6, 9	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	88.9%	92.3%	100.0%	92.9%	>=90%= Green >=80% - <90% =Amber <80% =Red
18		Children and young people's mental health services	4, 6, 9	98.3%	98.6%	98.9%	91.9%	100.0%	100.0%	97.3%	100.0%	95.9%	95.1%	96.5%	95.4%	>=90%= Green >=80% - <90% =Amber <80% =Red
19	Diagnostic 6-week wait - acute services		4, 9	69.5%	73.0%	74.4%	77.2%	78.1%	77.0%	82.4%	84.3%	78.8%	82.9%	86.9%	87.5%	>=99%= Green >=98% - <99% =Amber <98% =Red
20	RTT incomplete pathway performance: percentage of people waiting under 18 weeks		4, 6, 9	59.1%	61.8%	61.5%	61.5%	62.2%	60.5%	59.6%	58.6%	56.4%	58.2%	58.8%	58.5%	>=92%= Green <92% =Red
21	52 week RTT breaches		4, 6, 9	1,923	1,934	1,984	1,952	1,915	1,952	1,955	1,841	1,860	1,801	1,808	1,818	At or below trajectory = Green Above trajectory = Red
22	78 week RTT breaches		4, 6, 9	427	427	400	373	330	297	262	219	257	201	150	60	From April 2022 At or below trajectory = Green Above trajectory = Red
23	104 week RTT breaches		4, 6, 9	80	61	33	17	16	13	7	1	3	3	2	3	From April 2022 At or below trajectory = Green Above trajectory = Red
24	Referral to Treatment (RTT) incomplete pathway waiting list size		4, 6, 9	33,822	34,349	35,000	34,392	34,826	35,513	36,342	36,707	36,831	37,050	37,425	38,382	From April 2022 At or below trajectory = Green Above trajectory = Red
25	Average length of stay of patients on Musgrove Park wards (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).		4, 9	7.8	7.2	6.5	6.5	7.0	6.6	6.6	6.9	6.6	7.2	6.8	Data awaited	Monitored using Special Cause Variation Rules. Report by exception.
26	Waiting times: number of people waiting over 18 weeks from referral to first appointment - community services including dental		4, 6, 9	3,986	4,041	4,361	4,465	4,512	4,658	4,881	3,983	4,102	4,056	4,002	4,065	< 82 patients (2017/18 outturn) = Green >=82 - <86 = Amber >86 = Red
27	Community dental services - Child GA waiters waiting 18 weeks or more		4, 6, 9	223	216	229	331	351	330	333	346	370	356	370	463	0 = Green >=0 - =<50 =Amber >50 =Red
28	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		4, 6, 9	63.2%	75.0%	76.9%	63.6%	69.2%	66.7%	75.0%	58.8%	61.9%	60.9%	68.8%	83.3%	>=60%= Green <60% =Red
29	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT : percentage of people waiting under 6 weeks		4, 6, 9	57.5%	57.0%	55.5%	51.9%	57.3%	64.1%	63.1%	63.6%	63.3%	61.1%	60.9%	67.1%	>=75%= Green <75% =Red
30	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) RTT: percentage of people waiting under 18 weeks		4, 6, 9	97.9%	98.4%	98.3%	98.6%	98.6%	98.0%	97.5%	98.1%	98.7%	98.5%	97.6%	98.9%	>=95%= Green <95% =Red
31	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		4, 7, 9	66.8%	64.0%	62.8%	58.7%	59.9%	64.5%	56.3%	60.9%	58.4%	62.2%	58.8%	64.0%	>=50%= Green <50% =Red
32	Adult mental health inpatients receiving a follow up within 72 hrs of discharge		4, 9	97.1%	90.2%	97.2%	91.4%	100.0%	96.6%	100.0%	97.4%	100.0%	93.9%	90.3%	100.0%	>=80%= Green <80% =Red

SOMERSET NHS FOUNDATION TRUST

CORPORATE SCORECARD 2022/23

No.	Description	Links to corporate objectives	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Thresholds
33	Inappropriate Out of Area Placements for non-specialist mental health inpatient care (monthly number of patient days)	4, 5, 9	23	88	90	75	25	10	60	125	57	27	0	34	0= Green >0 = Red
34	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1	4, 5, 9	91.5%	92.2%	94.8%	93.2%	92.4%	94.2%	94.1%	92.9%	93.2%	92.4%	92.0%	91.5%	>=95%= Green >=85% - <95% =Amber >85% =Red
35	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	4, 9	76.0%	96.0%	90.0%	89.0%	85.0%	82.0%	83.0%	93.0%	89.0%	100.0%	Data awaited	Data awaited	>=90%= Green >=80% - <90% =Amber <80% =Red
36	Percentage of emergency patients screened for sepsis - acute services	4, 9	75.0%			86.0%			Due to capacity within the Governance Team required audits have been delayed. A reporting solution using electronic forms is currently being tested by the Trust's Digital Team.						>=90%= Green >=49% - <90% =Amber <49% =Red
37	Percentage of patients receiving antibiotics within one hour of red flag diagnosis of sepsis - acute services	4, 9	47.1%			75.0%									>=90%= Green >=49% - <90% =Amber <49% =Red
38	Percentage of patients with a NEWS of 5 or more acted upon appropriately - registered nurse should immediately inform the nurse in charge	4, 9	Reporting criteria reviewed and updated. Bi-monthly reporting will recommence from April 2023 and will cover February/March 2023										Data being validated		>=90%= Green >=80% - <90% =Amber <80% =Red
39	Percentage of patients with a NEWS of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient	4, 10											Data being validated		
40	District nursing - cumulative increase / (reduction) in external referrals from 1 April 2021 to 31 March 2022 compared to same months of 2019/20	9	-8.9%	-9.4%	-6.6%	-6.1%	-3.5%	-2.0%	-2.4%	0.1%	1.1%	1.9%	2.1%	2.9%	TBC
41	Percentage of complaints responded to within 40 working days - Trust-wide	9	50.0%	50.0%	53.1%	50.0%	48.0%	45.5%	57.7%	55.0%	46.7%	39.4%	37.5%	56.7%	>=90%= Green >=75% - <90% =Amber >75% =Red
42	Mandatory training: percentage completed	1, 8, 9	92.0%	92.4%	92.5%	92.4%	92.8%	92.9%	92.3%	92.1%	91.9%	91.1%	90.9%	90.5%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber
43	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)	8, 9	8.9%	8.1%	7.1%	7.0%	6.4%	6.9%	6.2%	6.7%	6.6%	6.3%	6.0%	6.0%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red
44	Sickness absence levels - rolling 12 month average (Trust-wide)	8, 9	5.7%	5.8%	5.9%	6.0%	6.0%	6.0%	5.9%	5.9%	5.9%	5.8%	5.7%	5.6%	<=4.6%= Green >4.6% to <=5.1% =Amber >5.1% =Red
45	Sickness absence levels - monthly average (Trust-wide)	8, 9	6.5%	5.2%	5.5%	6.6%	4.9%	4.9%	5.8%	5.5%	6.1%	5.4%	4.9%	4.8%	<=4.6%= Green >4.6% to <=5.1% =Amber >5.1% =Red
46	Reduce the number of working days lost due to stress and anxiety (Trust-wide)	8, 9	341	361	314	330	279	301	351	326	306	332	295	284	Monitored using Special Cause Variation Rules. Report by exception.
47	Retention / turnover rates (Trust-wide)	8, 9	11.9%	11.9%	11.2%	10.9%	11.0%	10.8%	11.0%	11.3%	11.2%	11.1%	10.9%	10.8%	=<12%= Green 12% to <15% =Amber >15% =Red
48	Career conversations (12 months) - formerly 'Performance review (12-month)'	8, 9	56.2%	56.2%	61.0%	56.0%	57.2%	57.2%	56.8%	58.6%	58.0%	58.6%	58.5%	61.2%	From May 2022 At or above trajectory = Green Below trajectory = Red

Appendix 5a – Specialty and tumour-site level performance

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

RTT specialty	Over 18 week waiters	Over 52 week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	214	42	393	45.5%
Urology	974	167	1931	49.6%
Trauma & Orthopaedics	1890	379	5266	64.1%
Ear, Nose & Throat (ENT)	1533	84	3508	56.3%
Ophthalmology	2182	245	4271	48.9%
Oral Surgery	1078	119	2496	56.8%
Plastic Surgery	1	0	6	83.3%
Cardiothoracic Surgery	0	0	10	100.0%
General Medicine	0	0	2	100.0%
Gastroenterology	1125	10	2260	50.2%
Cardiology	750	13	2098	64.3%
Dermatology	52	2	257	79.8%
Thoracic Medicine	408	1	1168	65.1%
Neurology	351	6	1001	64.9%
Rheumatology	201	4	549	63.4%
Geriatric Medicine	142	2	440	67.7%
Gynaecology	1032	122	2744	62.4%
Other – Medical Services	916	134	2316	60.4%
Other - Paediatric Services	311	12	1190	73.9%
Other - Surgical Services	2530	474	5602	54.8%
Other – Other Services	220	2	874	74.8%
Total	**15,910**	**1,818**	**38,382**	**58.5%**

Table 2 – Performance against the 62-day GP cancer standard in February 2023.

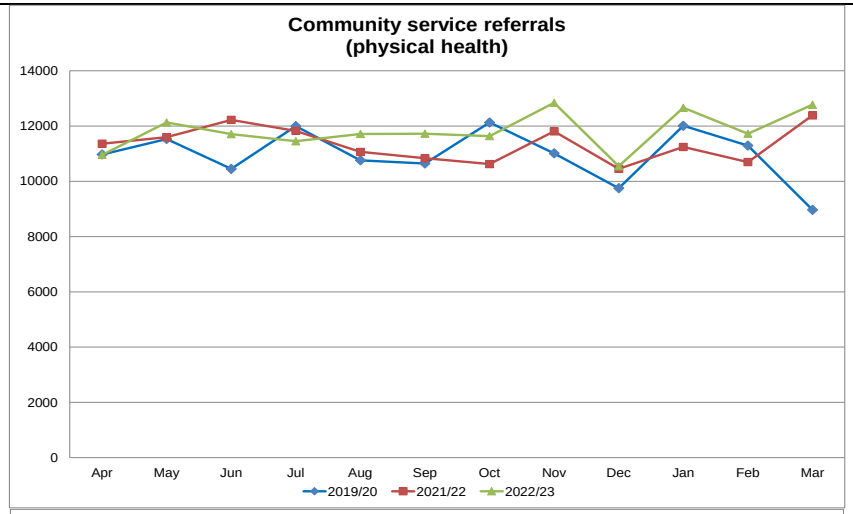
Tumour site	No of breaches	Trust performance
Breast	8.0	33.3%
Colorectal	7.0	30.0%
Gynaecology	2.0	55.6%
Haematology	1.5	66.7%
Head & Neck	2.5	50.0%
Lung	6.0	45.5%
Other	0.0	100.0%
Skin	2.0	20.0%
Upper GI	2.0	82.6%
Urology	25.5	30.1%
Total	**56.5**	**43.8%**

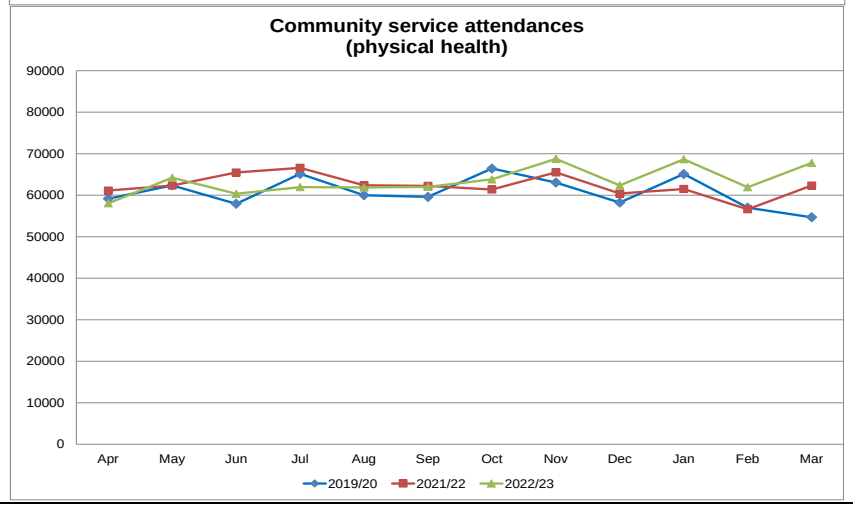
Twenty-two patients were treated in February 2023 on or after day 104 (the national 'backstop'). Nineteen were assessed as having unavoidable delays, with three pathways having been impacted with capacity problems. A breakdown of the breaches is as follows:

- Ten patients had a complex pathway, including pts requiring additional diagnostics, transferring from a different cancer pathway and treatment plan changing.
- Eight pathways had some internal delays related to capacity, were delayed for unavoidable reasons including, the patient requiring additional tests prior treatment planning, patient choice to delay investigations and treatment planning, and wait times for a molecular test (external). These pathways were further delayed for unavoidable reasons including patient choice to delay investigations, thinking time for treatment options and an additional investigation prior to treatment.
- Two patients had their pathway further delayed as a result of elective capacity at the treating provider they were referred to.
- One patient transferred to us late for treatment.
- One pathway was significantly delayed by patient choice.

Operational context

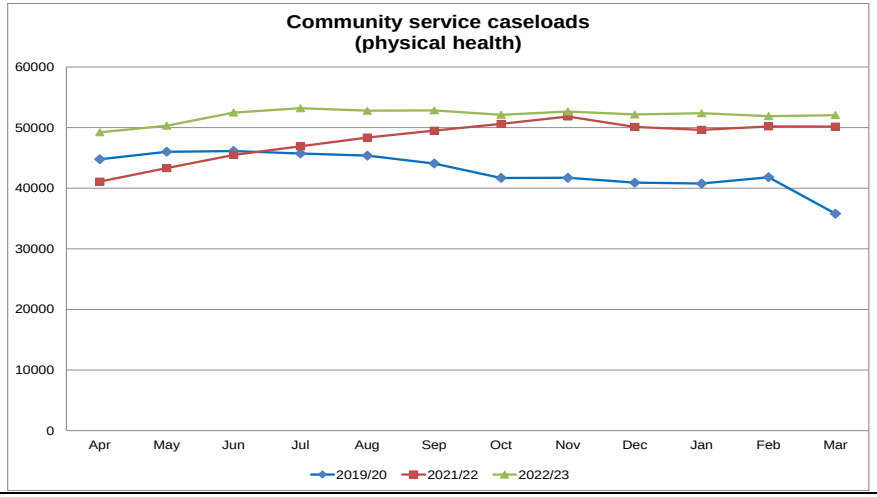
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





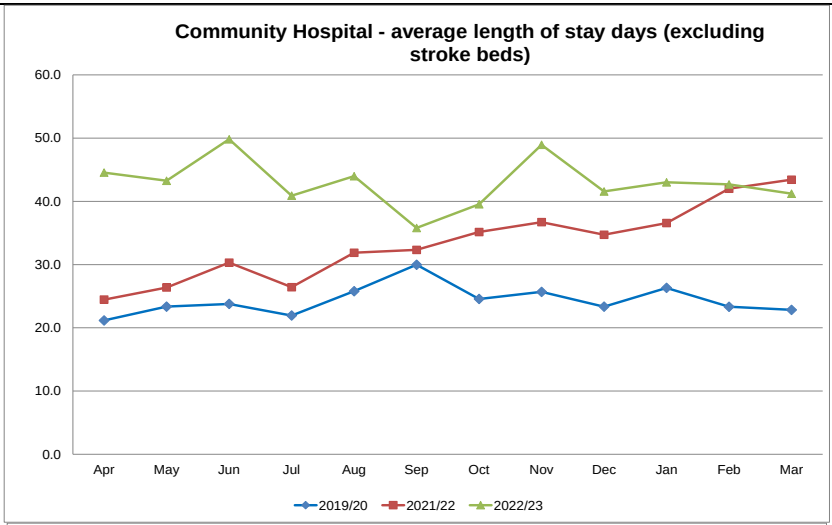
Summary:

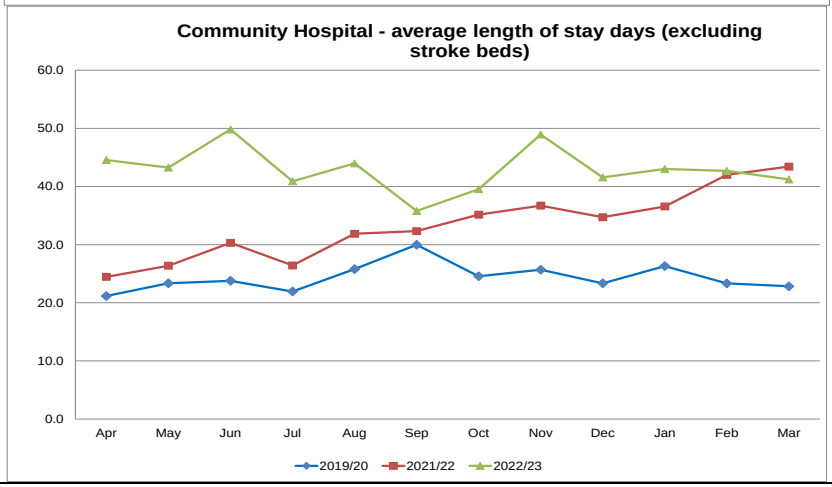
- Direct referrals to our community physical health services between 1 April 2022 and 31 March 2023 were 4.2% higher than in the same months of 2021/22 and 7.9% higher than in the same months of 2019/20.
- Attendances for the same period were 1.9% higher than the same months of 2021/22 and 4.5% higher than the levels of 2019/20.
- Community service caseload levels as at 31 March 2023 were 3.8% higher than as at 31 March 2022, and were 45.4% above 31 March 2021 levels.



perational context

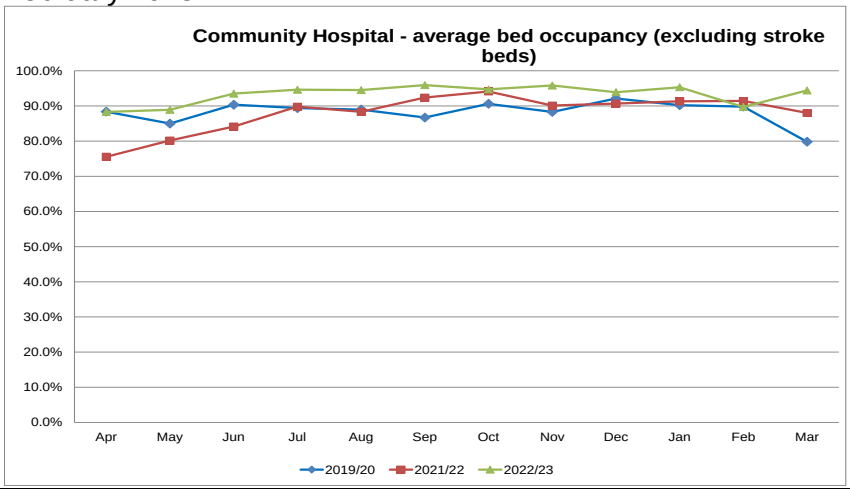
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





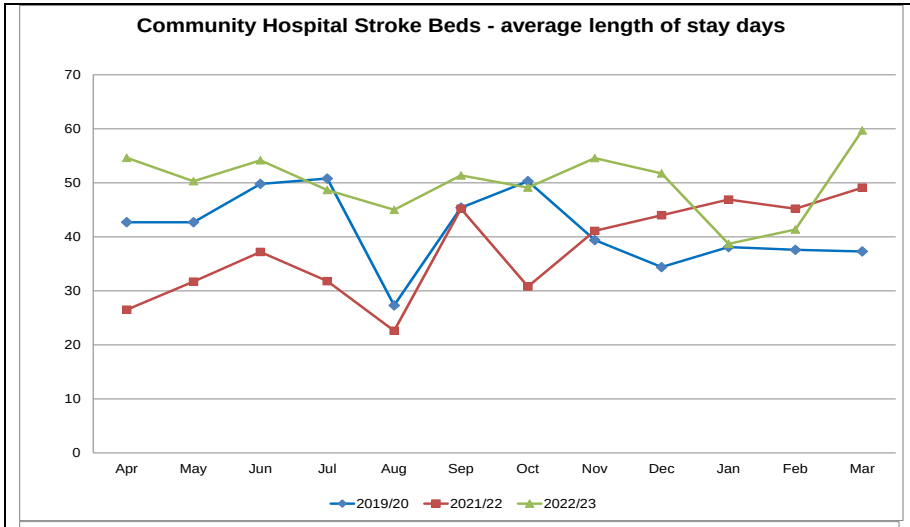
Summary:

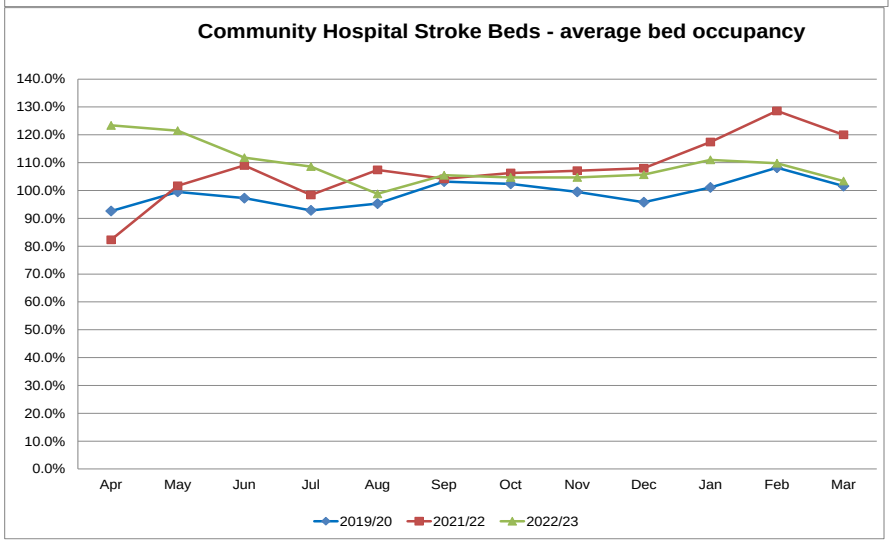
- Between 1 April 2022 and 31 March 2023, the number of Minor Injury Unit attendances was 6.6% higher than the same months of 2021/22 and 5.4% higher the same months of 2019/20. During March 2023, 96.7% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 95%.
- The average length of stay for non-stroke patients in our community hospitals in March 2023 was 41.2 days, a decrease compared to February 2023. Seven patients with stays longer than 100 days were discharged; the longest was 225 days for a patient at Bridgwater community hospital.
- The community hospital bed occupancy rate for non-stroke patients in March 2023 increased to 94.4%, from 89.7% in February 2023.



Operational context

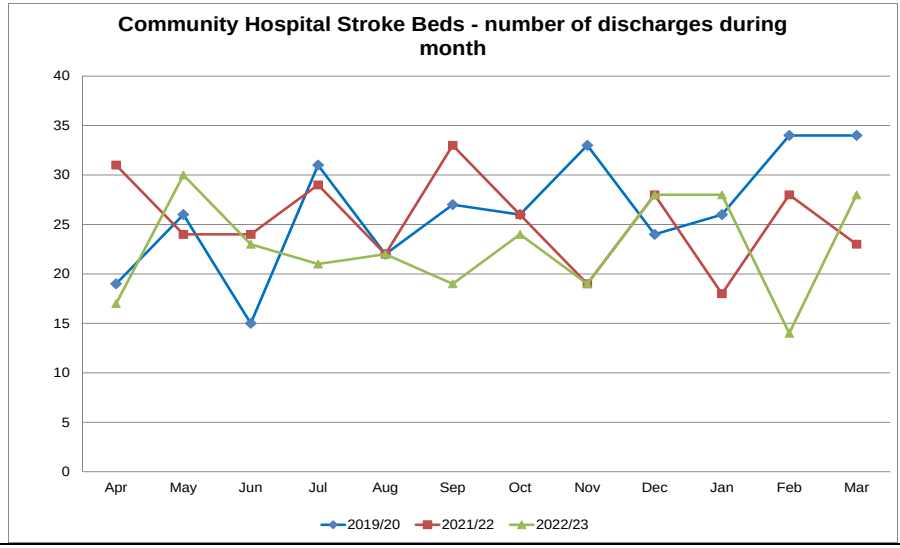
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





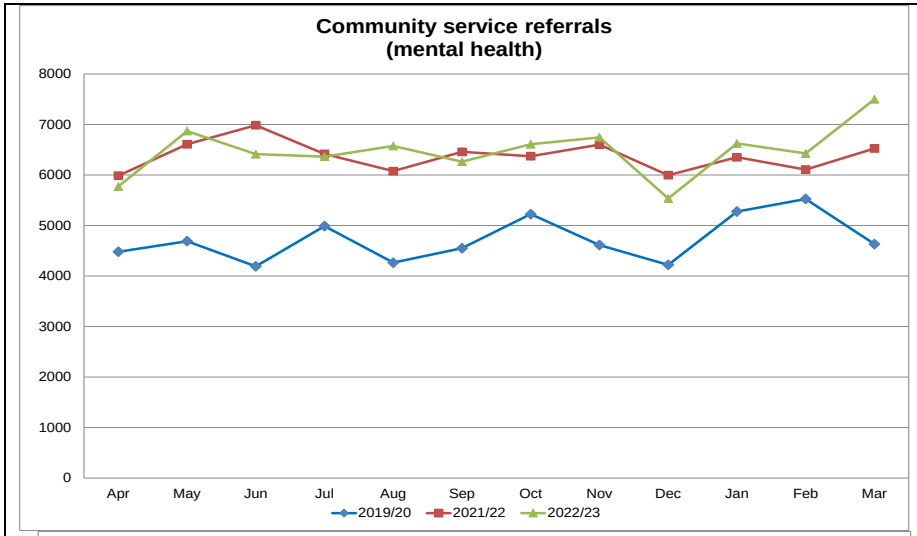
Summary:

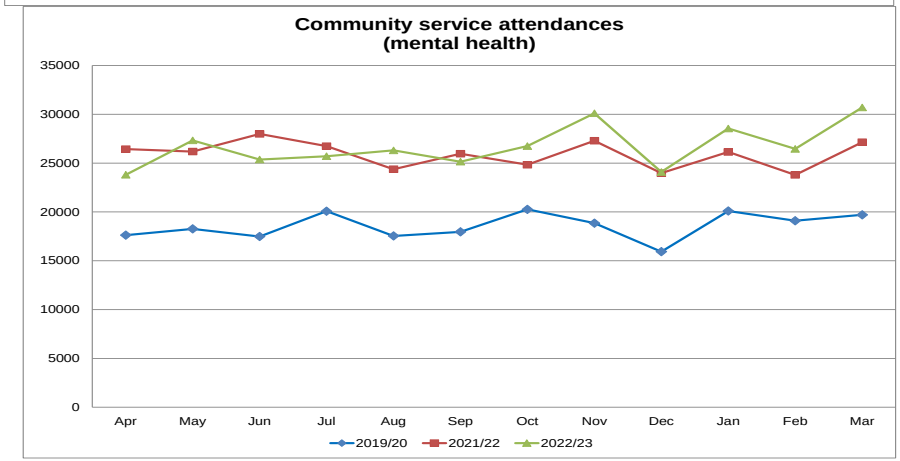
- The average length of stay for stroke patients in our community hospitals in March 2023 increased to 59.7 days, from 41.4 days in February 2023. Three patients with stays longer than 100 days were discharged; the longest was 205 days for a patient at Williton community hospital.
- Stroke bed occupancy in March 2023 decreased compared to February 2023.
- During March 2023 there were 28 discharges of stroke patients, up from 14 during February 2023. The monthly average number of stroke patients discharged from our community hospitals in 2021/22 was 25.



Operational context

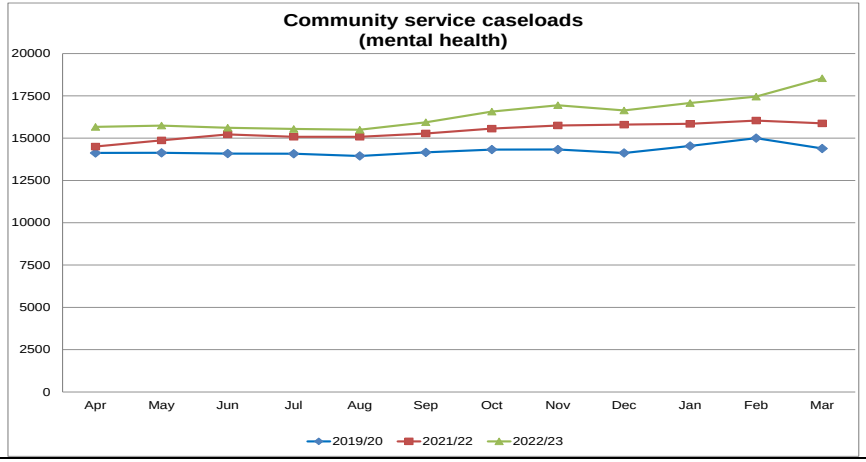
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





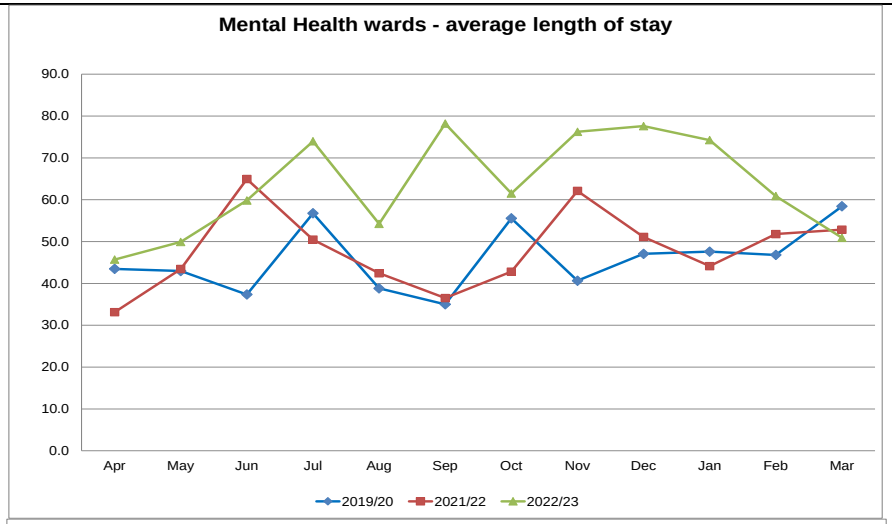
Summary:

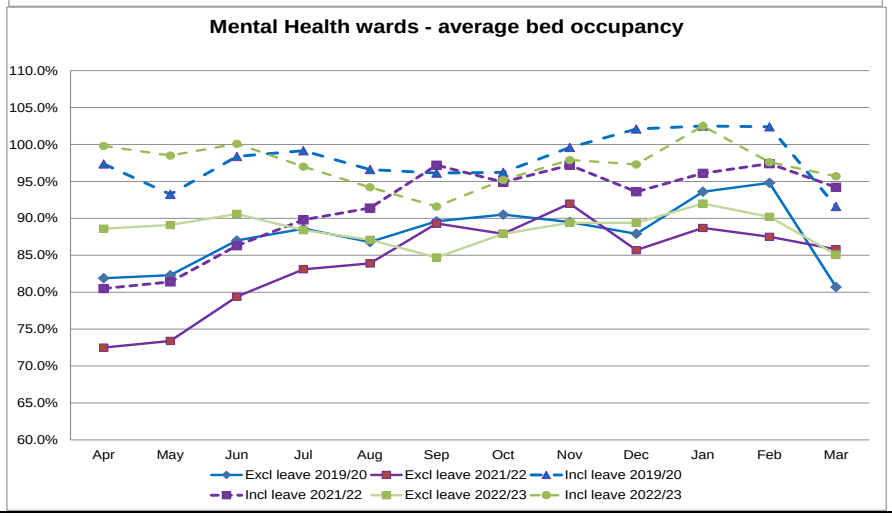
- Referrals to our community mental health services between 1 April 2022 and 31 March 2023 were 2.7% higher than in the same months of 2021/22 and 38.6% higher than the same months of 2019/20. Significant increases in referrals during March 2023 were seen by our Crisis and Home Treatment service, which is also reflected in increases in attendances. The reason for the increase is being followed up with the service.
- Attendances for the same period were 3.0% higher than the corresponding months of 2021/22 and 43.7% higher than in 2019/20.
- Community mental health service caseloads as at 31 March 2023 increased by 16.8% when compared to 31 March 2022 and were 28.8% higher than as at 31 March 2021. It should be noted that investment facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

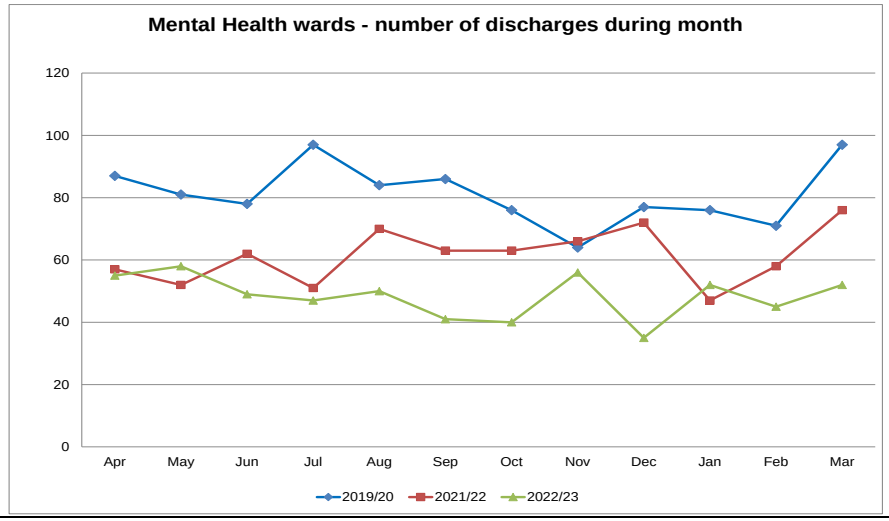
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





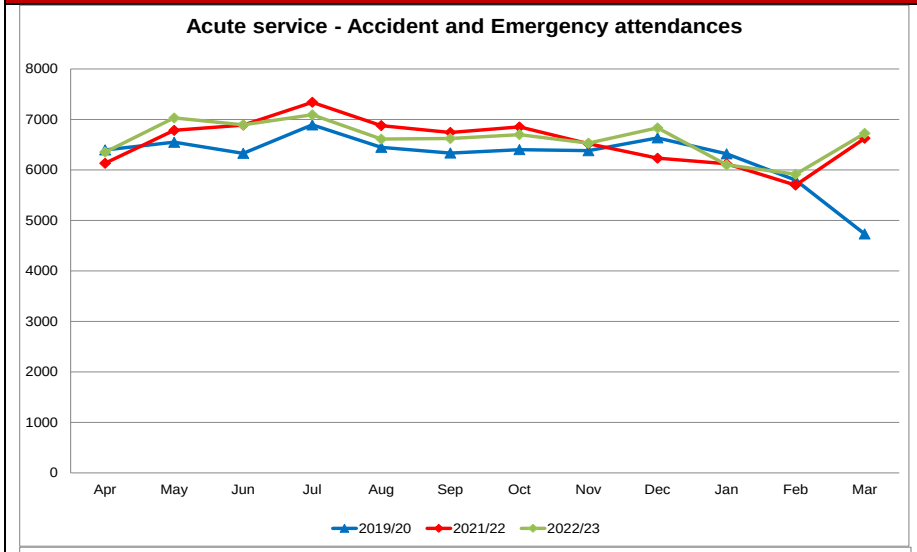
Summary:

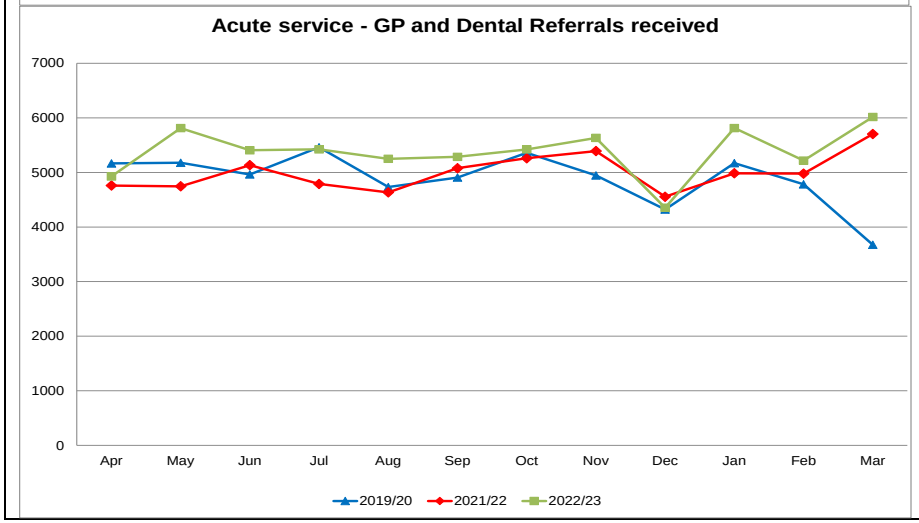
- The average length of stay in our mental health wards in March 2023 was 50.9 days, a decrease compared to February 2023. Seven patients discharged in March 2023 had lengths of stay of 100 days or more. Increases in delayed transfers of care and the responsiveness / availability of step-down options have resulted in longer lengths of stay in our mental health wards.
- The mental health bed occupancy rate in March 2023, based on excluding and including leave decreased compared to February 2023.
- A total of 52 patients were discharged in March 2023, up from 45 in February 2023.



Operational context

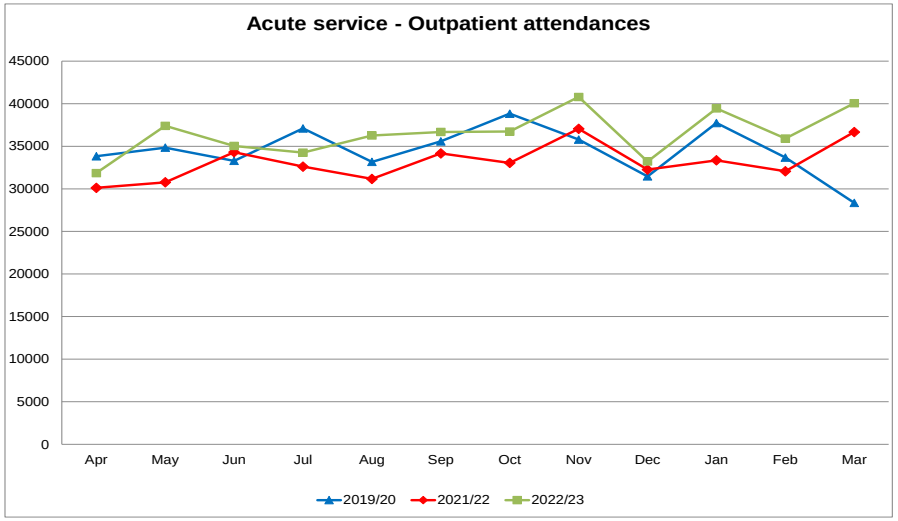
Acute services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





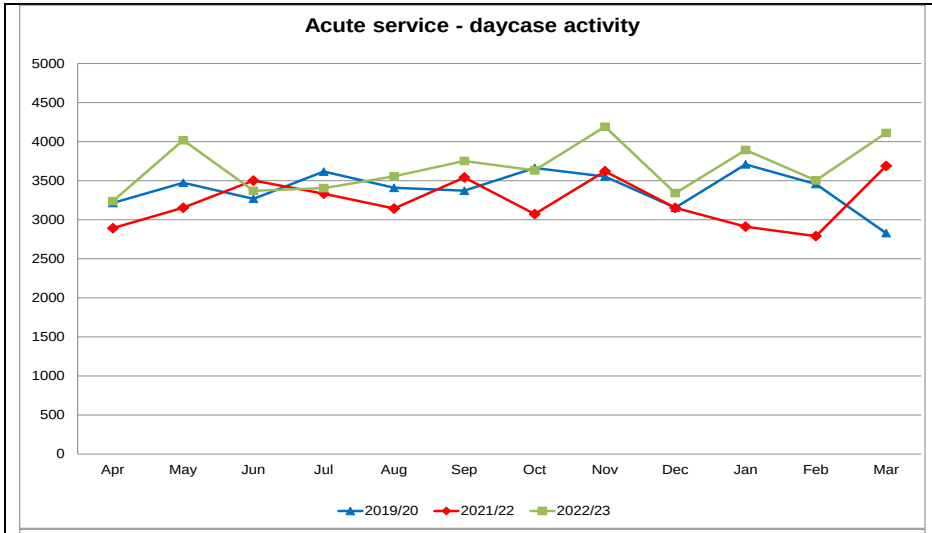
Summary:

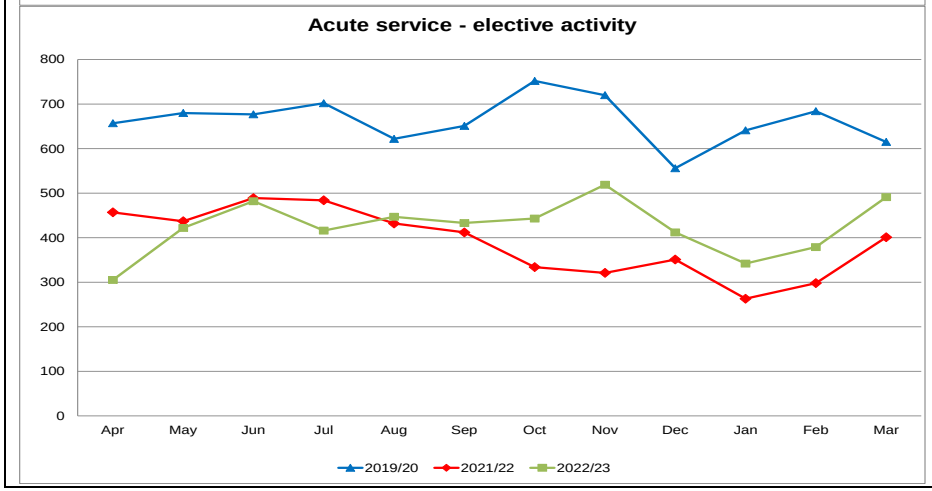
- Between 1 April 2022 and 31 March 2023 attendances to Accident and Emergency were 0.7% higher than the same months of 2021/22, and 5.6% higher than the same months of 2019/20. In March 2023, 55.4% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 95%.
- GP and Dental referrals between 1 April 2022 and 31 March 2023 were 7.6% higher than the same months of 2021/22, and 10.1% higher than the same months of 2019/20.
- Outpatient attendances for the same period were 10.1% higher than the same months of 2021/22, and 5.8% higher than the same months of 2019/20.



Operational context

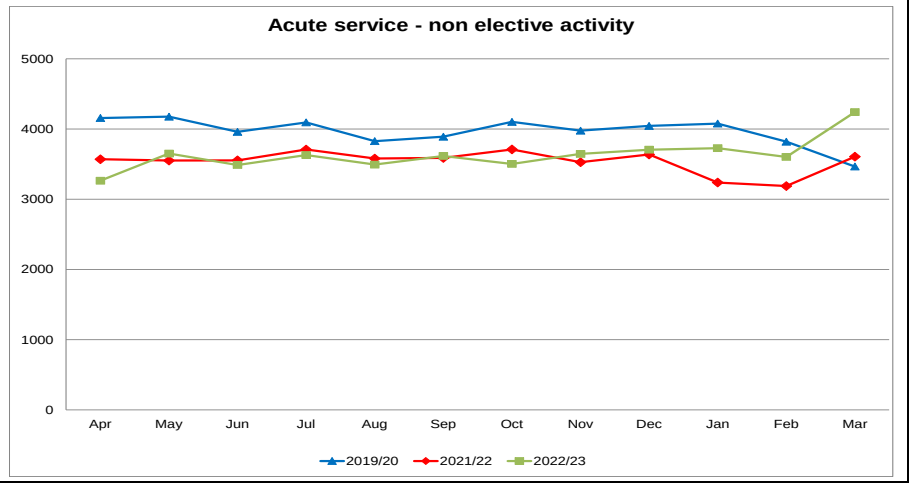
Acute services: This section of the report provides a summary of the levels of day case, elective, and non elective activity during the reporting period, compared to the previous months and prior year.





Summary:

- The number of day cases undertaken by our acute services between 1 April 2022 and 31 March 2023 increased by 13.4% compared to the same months of 2021/22 and was 8.1% higher than the same months of 2019/20.
- Over the same period elective admissions were 8.8% higher than the same months of 2021/22, but 36.0% lower than the same months of 2019/20, which reflects the significant operational pressures experienced at Musgrove Park Hospital over recent months.
- Non elective admissions between 1 April 2022 and 31 March 2023 were 2.6% higher than the same months of 2021/22 but were 8.4% lower than the same months of 2019/20.



Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	YDH/SFT Merger Update
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Transformation
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	David Shannon, Director of Strategy and Digital Transformation
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report provides an update following the merger between Yeovil District Hospital NHS Foundation Trust and Somerset NHS Foundation Trust, including an update on: • Day 1 Corporate Merger Tasks • Clinical Service Group Integration • NHS England Quality and Financial Governance Action plan update
Recommendation	The Board is asked to note the post-merger update.

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

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

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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
Oversight of the merger progress is monitored by the Merger Programme Board and the Clinical Integration Merger Programme Board.

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

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

SOMERSET NHS FOUNDATION TRUST

YDH/SFT MERGER UPDATE

1. INTEGRATION PROJECTS

1.1. The Post Transaction Implementation Plan (PTIP) summarised our plans to integrate Yeovil District Hospital NHS Foundation Trust (YDHFT) and Somerset NHS Foundation Trust (SFT). The PTIP outlined how we will implement the vision for the merged Trust through delivery of the clinical model and integration of support functions.

1.2. The formal process of merger and key day one activities were delivered effectively and ensued a smooth transition to the new organisation on 1st April 2023.

1.3. It is recognised that it will take time and resource to fully integrate our two Trusts. Designing an effective implementation strategy is key to the success of the merger and achieving our vision. From early on in the transaction process, we started developing our pre and post-merger integration plans with a focus on maximising the benefits of integrations without jeopardising 'business as usual'.

1.4. We split our integration planning process into two key stages:

- Activities required by Day 1 and by Day 100 to provide a 'safe landing' for the merged Trust; and

- Activities which integration our clinical and corporate services and support the transformation we need to deliver.

1.5. We have categorised our corporate integration projects as follows:

- Day 1 business critical – these are projects that must be completed by Day 1 to ensure:

    - no significant patient safety risk
    - the new Trust can operate legally; and
    - there is no major risk to infrastructure or other service delivery.

- Supporting a good Day 1 – these are projects that are not business critical but that it would be advantageous to complete by Day 1.

- Day 100 – these are projects that will be completed by the 100th day after transaction date.

- Other corporate merger projects - projects that do not need to be completed by Day 1 or Day 100, but which support integration of corporate services.

1.6. This report provides the Trust Board with an update on the Day 1 / Day 100 tasks as of 21 April 2023.

2. MERGER DAY 1 INTEGRATION PROGRAMME

2.1. There were 44 overall tasks that are identified as meeting the business-critical definition as above. It is confirmed that all Day 1 tasks have been completed as outlined below.

	Task RAG Status				
	Red	**Amber**	**Green**	**Complete**	**Grand Total**
Day one projects	**0**	**0**	**0**	**44**	**44**

2.2. These main projects are broken down across the workstreams as below and RAG status ratings have been provided against these.

	Task RAG Status				
	Red	**Amber**	**Green**	**Complete**	**Grand Total**
Charities				1	1
Clinical Governance				5	5
Corporate Governance				10	10
Digital				5	5
EPRR				3	3
Estates and Soft FM				1	1
Finance				1	1
Information Governance				3	3
People and OD				2	2
Procurement				4	4
Safeguarding				7	7
Security Management				2	2
Grand Total	**0**	**0**	**0**	**44**	**44**

2.3. The RAG scoring was based upon the following:

Red – Major issue(s) exists which needs to be addressed urgently to ensure we deliver project as planned in a safe, legal and reputationally sound way.
Amber – Some issue(s) which needs to be addressed to enable us to realise the full benefits of the project, OR an area of concern which requires additional attention to bring back on track.
Green – Minor or no issues identified, project on track to deliver as planned.

2.4. Of the supporting a strong day 1 tasks 43 out of the 53 tasks have been complete with the 10 remaining tasks all are in the process of being completed with no issues identified for completion.

2.5. There are an additional 68 further tasks identified as part of the merger plan that remain outstanding and are all on track for delivery as per the milestones set out within the PTIP.

3. CLINICAL INTEGRATION PROGRAMME

3.1. The integration of clinical services is overseen by the Clinical Integration Merger Programme Board meetings, which take place monthly. Service Group Directors provide consolidated reports on the range of services provided within their Service Group.

3.2. Our Clinical Integration Team, Improvement team and PMO work closely to support clinical teams to plan, implement, monitor and report on their projects. It is agreed that the full integration of all teams/services will take place at an agreed time based on priorities. This prioritisation is based on the following criteria (all of which have their own sub-criteria):

- **Patient benefits** (does integration offer significant patient benefits)
- **Readiness to integrate**
- **Fragility of services**
- **Colleagues**
- **Enablers**
- **Capacity**
- **National requirements**

3.3. An overall summary update from each Service Group is provided below. It is recognised that whilst progress is being made on the integration of services based upon the above criteria the clinical integration process in many services has only recently commenced and as a result there remain gaps in the achievement of the longer-term strategic priorities for the merged Trust, including the recurrent achievement of our Cost Improvement Plans. In addition, it is clear that ongoing operational challenges , including the recent industrial action, has hindered the ability for teams to come together and plan the integration of their services over the past few months.

3.4. The table below provides a snapshot of the current position of our service integration. A full detailed report will be provided at the end of the first quarter.

Name of Service Group	Clinical Support & Cancer Services	**Report Date**	Apr-23
Service Group Summary Update:	All teams within the Service Group are continuing to meet and work together. There continues to be no high-risk issues raised by the integration of services. The next milestone for most teams will be for the creation of a single leadership structure across the two acutes sites and community teams which will take place in Q1 2023/24. This involves 10 teams and is a significant piece of work which is likely to consume a significant portion of the senior leadership capacity.		
Name of Service Group	Children & Young People and Families Group	**Report Date**	Apr-23
Service Group Summary Update:	Successful launch integration meetings have occurred in Paediatrics and Obstetrics and Gynaecology to help shape transformation plans which will have clear direction over the next month.		
Name of Service Group	Medical Services	**Report Date**	Apr-23
Service Group Summary Update:	Progress with the integration of Services within the Medical Service Group has been limited due to some significant staffing pressures resulting in limited capacity within the teams to progress discussions; Doctors in Training strikes has also impacted the level of engagement. A number of services have required some further input to develop a shared direction of integration.		
Name of Service Group	Neighbourhoods and Community Services	**Report Date**	Apr-23
Service Group Summary Update:	The current focus remains on delivering on the hospital at home service and the development of the Acute Home Treatment. Dementia and Delirium Service and care of the elderly services are progressing well and ensuring equity of frailty services across the county. This work is aligned with the last 1000 days frailty flagship programme.		
Name of Service Group	Surgical Services	**Report Date**	Apr-23
Service Group Summary Update:	April has seen further progress across joint services with initial or further meetings between teams to build relationships or start setting out the scope or merged services. The process of integrating the senior leadership team will be commencing during this quarter which will be a key step in supporting the service integration programme.		
Name of Service Group	Mental Health Services	**Report Date**	Apr-23
Service Group Summary Update:	Mental Health services have not commenced reporting on clinical integration as the PTIP focused on acute and community services. Work continues on how the clinical pathways are developed and embedded across the Trust.		

4. RECOMMENDATION

4.1. The Board is asked to note the post-merger update on corporate integration tasks and Clinical Service Group integration.

Somerset NHS Foundation Trust

Action Plan - NHS England Financial and Quality Governance Review
April 2022 Update

	NHSE Recommendation	Trust Response/Update	Exec Lead/ Action Holder	Due By	Status	Comment
Quality Governance Domain 1: Leadership and behaviours						
1	A number of Non-Executive Directors (NEDs) are approaching the end of their respective terms. The enlarged trust would benefit from reviewing its succession plans for its NEDs to ensure that there are no gaps in the skills and experience needed at Board level as they move forward with integration and to build on the work done to date on Board diversity. Specifically, the trust should consider how it will ensure NEDs have active clinical expertise as well as both acute and non-acute experience within their skills and experience mix.	In 2022, the Board completed a thorough skill mix review for the proposed post-merger Non-Executive Directors and this skill mix highlighted strong areas of expertise in: strategy and planning; governance; finance; and performance management. This was followed by expertise in HR; and Mental Health and Learning Disabilities. The areas of expertise for possible focus for future Non-Executive Director appointments are: primary care; voluntary sector and social care. In addition, from 2024 onwards, there will be a need to also focus on financial expertise and consider the gender balance on the Board. The skills mix will be reviewed at the time of any recruitment to take account of changing circumstances.	**Exec Lead**: Phil Brice **Action Holder**: Ben Edgar-Attwell	Ongoing		The Trust has recently commenced recruitment for Associate Non-Executive Directors as part of succession planning to ensure there are no gaps in the skills and experience needed.
2	The enlarged trust should put in place a checkpoint review towards the end of 2023 to ensure that the trust's Quality Governance Framework remains effective and fit for purpose across the 3-tier model as services integrate and the new operating model embeds. We would recommend this checkpoint involves the NHS England South West regional team. Moving forward there should be an	The Trust will complete a review of its Quality Governance Framework as part of its regular review of corporate governance processes to ensure that they are fit for purpose.	**Exec Lead**: Phil Brice **Action Holder**: Ben Edgar-Attwell	Q3 23/24		This action is not yet due.

	annual review in line with standard corporate governance processes.					
3	The enlarged trust should continue to plan their Board development days for 2023/24 so they can review and reflect on post transaction integration plan (PTIP) milestones and integration plans.	The Trust will continue with its Board development days. Oversight of the PTIP milestones and integration plans will also form part of the post-merger governance processes. Quarterly updates will be provided to the Trust Board reviewing integration and PTIP delivery.	**Exec Lead**: David Shannon **Action Holder**: Victoria Keilthy			We remain committed to reporting our integration progress to the board on a quarterly basis with the first such update planned for July 2023.
Quality Governance Domain 2: Data and reporting						
4	The trusts will benefit from integrating their performance reporting approach at Board and subcommittee level for the new enlarged organisation. This includes considering enhancing the use of SPC charts in "Making Data Count" guidance to help increase familiarity with process limits, comparison (benchmarking), seasonality and rolling averages and how to make information more digestible, for example explore the wider use of summary icons. This will support agenda planning at Board, quicker identification of special cause variation and assist in focusing time and give greater scrutiny given the breadth of the new organisation's activities.	We will build upon the work already been taken to integrate performance reporting across the two Trusts and establish a commonality of approach, including the production of a single performance presentation to the Board, spanning both Trusts, and the establishment of consistent arrangements for performance review at directorate level. The SFT quality and performance report identifies exceptions using SPC, as outlined in "Making Data Count", and includes guidance on how to interpret SPC charts. We will make this approach consistent across the breadth of performance reporting to the Board of the merged organisation, and consideration will also be given to the use of summary icons, also as outlined in "Making Data Count", with a view to making information more digestible. We will also seek to expand the use of benchmarking information, to facilitate comparison with other organisations nationally, and we will build	**Exec Lead**: Pippa Moger **Action Holder**: Lee Cornell			Ahead of the merger, we took steps to implement consistent arrangements for monthly performance management review meetings with service directorates across the two Trusts. We also produced a single performance presentation to the Board, spanning both Trusts. The SFT quality and performance report identifies exceptions using SPC, as outlined in "Making Data Count", and includes guidance on how to interpret SPC charts. Our aim remains to make this approach consistent across the breadth of performance reporting to the Board of the merged organisation, and to expand the use of benchmarking information, to facilitate comparison with other organisations nationally, and to build upon the use of trend information for key indicators to

		upon the use of trend information for key indicators to illustrate seasonal patterns of demand and performance.				illustrate seasonal patterns of demand and performance.
5	The trusts should continue plans to harmonise incident reporting, risk management and complaints arrangements and continue with its joint plan to prepare for the implementation of the PSIRF by August 2023. Post-implementation, the enlarged trust should ensure it has reviews in place to ensure this has embedded effectively.	Harmonisation of arrangements for incident reporting, risk management and complaints form a key part of integration plans. The details for risk management are included in point 6 below. The integration of the governance teams is due to be complete by April 2023, with incident processes aiming to be aligned as part of the "Diagnostic and discovery" phase of PSIRF implementation. A senior lead for implementation of PSIRF has been included in the governance team structure as part of the move towards integration, with a core implementation team working in line with the national PSIRF implementation timetable to deliver the patient safety incident response policy and plan by August 2023. All our governance processes are subject to regular review as part of our monitoring and assurance processes. In addition to this, we will be including regular auditing, measurement, and review as part of the "Embedding sustainable change and improvement" phase of PSIRF implementation.	**Exec Lead**: Phil Brice **Action Holder**: Steve Thomson	April 2023 February 2024		Integration of the Governance Support Team was completed for the start of April 2023. Work on the implementation of PSIRF continues, led by the Head of PSIRF Implementation, with the diagnostic and discovery phase coming to an end and the Trust moving into the governance and quality monitoring phase. The Head of PSIRF Implementation will be presenting to the Patient Safety Board and the Quality & Governance Assurance Committee in May 2023.
6	The trusts should ensure that there are effective controls in place with regard to decisions to escalate to the corporate risk	Currently under development are the Risk Management Framework documents (Strategy & Policy). These will be shared	**Exec Lead**: Phil Brice			The revised Risk Management Framework documents were shared with key stakeholders

	register. For example, if a risk score is set at 15 but is related to a wider thematic risk already on the register, such as workforce capacity, a clear rationale and explanation should be recorded as to why it has not been directly included. Internal audit plans for 2023/24 and beyond should include a review of risk register controls to ensure that they are robust.	with key shareholders as part of the consultation period during February 2023 and will be presented to the Trust Board in March 2023. The Framework will include the escalation route from department/divisional/specialty levels through to the Corporate Risk Register. The Corporate Risk Register report is currently under development and will include a section within the report which outlines the risks scoring 15 or above from a service group level which feed directly into a wider thematic Corporate risk. This will be in place by April 2023. This will be an ongoing piece of work throughout 2023/24 to educate and train colleagues on the new Risk Management Framework which will include educating staff on the agreed process for escalating risks onto the Corporate Risk Register and the relationship between service group and corporate risks.	**Action Holder**: Sam Hann	April 2023 2023/24		and presented/approved by the Board in March 2023. The other actions are ongoing in line with the agreed timeframe.
Financial Governance Domain 1: Leadership and behaviours						
7	The trusts should continue with their proposal to align workforce and financial planning more closely between the People and Finance subcommittees.	We continue to work on ensuring that our finance and workforce plans and reporting triangulate to support effective oversight and scrutiny.	**Exec Lead**: Pippa Moger and Bel Clements **Action Holder**: Michael Scott and Ryan Garland	Ongoing		This is an ongoing piece of work to ensure our workforce data is aligned across the Trust with our financial reporting. The merge of SFT and YDH ESR accounts could not be scheduled in prior to the formal merger being ratified. This is now scheduled to take place in August 2023, we are awaiting final confirmation from the national ESR team to approve this date. Once that has

						taken place, our finance and workforce information should be much easier to align. In the interim, People Business Partners and Finance Business Partners continue to work closely together to ensure data is as aligned as possible.
8	The Board's understanding of the underlying position can be aided by analysis of 'one-off' adjustments and non-recurrent sources of funding used to meet the year-end target. The Better Payments Practice Code (BPPC) metric should be amended within monthly finance reports so the year-to-date trend is shown alongside performance in-month.	The format and content of internal financial reporting is currently being revised. This process is considering the existing reports for both Trusts to ensure we continue to use the most effective elements of both. We are also reviewing how other Trusts report their financial performance to ensure we incorporate other areas of best practice. A small group of Finance Committee Non-Executive Directors will review the development before Go Live.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	April 2023		The Finance Committee in Common have reviewed the content and format of the revised monthly financial reporting. Revised reporting will be in place for the April period & is being presented to the June Finance Committee.
9	The Finance Committee should consider the level of challenge raised on the detail of finances across the organisation.	As we consider the format of reporting into the Finance Committee for the merged Trust, that will reveal the level of detail that we think is necessary to enable us to challenge adequately.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	April 2023		The revised reporting format has been agreed and will be in place for reporting from April 2023.
10	We would encourage the Finance Committee to consider if more opportunities could be taken to translate comments raised into formal actions.	The finance committee have reviewed and noted the recommendations of this review.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	Complete		Action complete
Financial Governance						

Domain 2: Reporting						
11	The new format of reporting for the enlarged organisation should retain analysis of agency, CIP and capital spend and rolling cash flow forecasts. In addition, the following improvements are suggested for consideration: • Directorate reports should be made consistent in format and presentation and include sufficient narrative as well as summaries of key risks and mitigations • Narrative across all finance reports (directorate/committee/Board) should explain drivers of key trends. Reports should clearly set out the 'so-what', risks and mitigations • An estimate of the underlying position could be added to each finance subcommittee and Board finance report • The Finance Committee could be presented with summaries of directorate performance, alongside the corporate level summary. This could be accompanied by 'heat map' exception reporting highlighting areas of underperformance at the divisional, directorate or service level. This can show any significant swings within particular services • Forecast outturns should be added to Board and Finance Committee reports, alongside plan and year-to-date as at present • Include explanations for all aged debt over 90 days	The format and content of internal financial reporting is currently being revised and will take into consideration the financial and governance review findings. The reporting review will look at the existing reports for both Trusts to ensure we continue to use the most effective elements of both. We are also reviewing how other Trusts report their financial performance to ensure we incorporate other areas of best practice.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	April 2023		Revised internal service group level reports which mirror (where possible) the Trust level finance reporting are being developed and will be used to support service group discussions. Additional information on service group performance will be included within the revised monthly financial report. Forecast information will be included from month 3 onwards. Revised CIP reporting within the main finance report will detail progress on CIP and merger savings.

	• Consider greater use of charts and other visualisation methods within the Board report, as well as a concise 'dashboard' summary of key risks and issues • Ensure both clinical and corporate synergies are clearly reported as separate to overall CIP achievement • Consider which operating metrics the members of the Finance Committee would find most useful for inclusion within the monthly finance report					
12	We would encourage the enlarged organisation to review internal financial reporting approximately one-year post-transaction, once the new reporting has been embedded, to monitor and ensure effectiveness of this.	We encourage Finance Committee members to provide feedback on reporting on an ongoing basis and have provided additional analysis to aid understanding during the year. We will formally review the revised reporting format one year post merger as recommended.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	April 2024		Action not yet due.
13	The 23/24 business plan should be clearly linked to the transaction strategy. As clinical models are worked up in detail, we recommend the trust embed business partnering resource to ensure that the digital, estates and other enablers of these models are costed.	The Trust's 2023/24 business plan will reflect the organisational strategy as set out in the merger case as far as practical and where sufficient progress has been made to allow the impact to be fully quantified and embedded within the plan for next year. Finance staff will continue to work closely with their clinical and non-clinical colleagues to refine the financial impact of the clinical model as it emerges in greater detail.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	Ongoing		The Trust has approved it's 2023/24 financial plan. This incorporates benefits outlined in the merger case. Service groups are working on their integration plans and identified synergies/benefits will form an element of their CIP plans once finalised.
14	The trusts should proceed with their plan to align risk scoring methodology and create an appropriate framework to	The joint Trust Board agreed the risk scoring matrix to be used by the organisation in July 2022. This saw a	**Exec Lead**: Phil Brice			The revised Risk Management Framework documents were shared with key stakeholders

	escalate material issues from divisional level.	change in the risk escalation levels at YDH which was communicated and shared with the risk owners, risk leads & risk actions in July 2022 and changes made to the YDH Risk Register module on Ulysses, the Trust's Risk Management system. The risk scoring matrix will be included within the Risk Management Framework documentation (see below). Training on the risk scoring matrix is included in the risk management training provided to colleagues. Currently under development are the Risk Management Framework documents (Strategy & Policy). These will be shared with key shareholders as part of the consultation period during February 2023 and will be presented to the Trust Board in March 2023. The Framework will include the escalation route from department/divisional/specialty levels through to the Corporate Risk Register.	**Action Holder**: Sam Hann	March 2023		and presented/approved by the Board in March 2023. The other actions are ongoing in line with the agreed timeframe.
15	We understand that Internal Audit will perform a cyclical review of key financial systems and controls in early 2023. The proposed control framework for the enlarged trust and plans to transition key financial systems should also be reviewed by internal audit and signed off by the Finance Committees and Board.	The Finance Committee and Board have reviewed and approved the SFI's and Scheme of Delegation for the new organisation which is the basis of the control framework. Internal Audit completed the cyclical review of key financial systems in December 2022 before the Trust received this recommendation, however the Finance Committee and Board have been kept updated on the financial ledger project as it forms part of the merger charter work programme. Any risks will be reported on an exception basis.	**Exec Lead**: Pippa Moger **Action Holder**: Mark Hocking	April 2023		Internal Audit will report on the outcome of any finance related audits via Audit Committee. Other risks and issues will form part of business as usual reporting to the Finance Committee.

Status Legend	Definition
	Action running behind target and escalated to action plan sponsor
	Action risks slippage
	Action on track and running to plan
	Action complete

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance report from the Audit Committee meeting held on 14 April 2023
SPONSORING EXEC:	Barbara Gregory, Chairman of the Audit Committee
REPORT BY:	Secretary to the Trust
PRESENTED BY:	Barbara Gregory, Chairman of the Audit Committees
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Audit Committee meeting held on 14 April 2023 and the assurance received by the Committee. The meeting was conducted as a video conference call. The Committee received assurance in relation to: • The Corporate Risk Register • The YDH and SFT Counter Fraud progress reports • The SFT Counter Fraud Recommendations Tracker • The SFT Workplan for 2023/24 • The SFT and YDH Internal Audit progress reports • The SSL governance audit report • The YDH internal audit follow up report • The YDH Annual Internal Audit Report for 2022/23 • The Disability Confident Audit Report • The IPC Cleaning Standards Audit Report • The Data Security and Protection Toolkit Audit Report • The Audit Plan for 2023/24

	• The YDH and SFT External Audit Progress and Benchmarking Reports • The SFT and YDH Value for Money reports • The Going Concern Statements • The YDH and SFT Losses and Special Payments Reports • The YDH and SFT Single Quotation/Tender Waiver action report The Committee identified the following areas of concern or for follow up: • The Board Assurance Framework • The SFT Counter Fraud Progress Report relating to the agency invoicing controls • The YDH Internal Audit Progress Report relating to the delay in providing management responses • The SFT Internal Audit Follow Up report in view of the large number of recommendations due • The SFT Internal Audit Report for 2022/23 • The Six Monthly Report from the Quality and Governance Assurance Committee The Committee did not identify any areas or concerns to be reported to the Board and/or Board Committees.
Recommendation	The Board is asked to note the assurance and areas of concern or follow up identified by the Audit Committee. The Board is further asked to note the areas to be reported to the Board.

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

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

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

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

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

V

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

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SOMERSET NHS FOUNDATION TRUST

AUDIT COMMITTEE MEETING HELD ON 14 APRIL 2023

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 14 April 2023, the assurance received by the Committee and any areas of concern or follow up identified.

2. ASSURANCE RECEIVED

Corporate Risk Register

2.1. The Committee received the report and noted that the Q4 report had been amalgamated into a single report and that any duplicate risks had been removed. In addition, all corporate and service level risks had been mapped.

2.2. The Committee noted that several risks had reduced with only seven risks rated at 20 or above.

2.3. The Committee noted that the revised Risk Management Strategy and Risk Appetite statement had been disseminated across the trust and that two separate risk management systems will be maintained for the majority of the 2023/24 financial year.

YDH Counter Fraud Progress Report

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

2.5. The Committee discussed the proactive work relating to PO and non PO (purchase order) arrangements and noted that the performance data will be reported to and monitored by the Finance Committee.

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

SFT Counter Fraud Progress Report

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

SFT Counter Fraud Recommendations Tracker

2.8. 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.

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SFT Workplan 2023/24

2.9. The Committee received and approved the workplan for 2023/24.

2.10. The Committee discussed the low response rate to the counter fraud questionnaire and noted that counter fraud awareness will continue to be monitored. Any referrals will be logged and monitored by the team to be able to identify whether further training will be required in specific areas.

Internal Audit progress report - YDH

2.11. The Committee received the internal audit progress report and agreed that good progress was being made.

SSL Governance audit report

2.12. The Committee received the audit report and noted that, due to the advisory nature of the report, no assurance rating had been provided. The overall conclusion was that subsidiary governance was maintained but four medium priority recommendations had been made.

2.13. The Committee agreed that the findings provided the Committee with good assurance.

Internal audit follow up report – YDH

2.14. The Committee received the internal audit recommendations follow up report and noted that all 2021/22 recommendations had been completed. Good progress was being made in relation to the 2022/23 recommendations.

Annual report 2022/23

2.15. The Committee received the draft report and noted that the draft Head of Internal Audit Opinion provided a moderate assurance opinion. This opinion was in line with previous years and was a fair and reasonable opinion of the work completed in year.

2.16. The Committee agreed that the report provided significant assurance.

Internal Audit progress report - SFT

2.17. The Committee received the internal audit progress report and agreed that good progress was being made. The remaining Research and Development audit report will be presented to the July 2023 Committee meeting.

Disability Confident audit report

2.18. The Committees received the audit report and noted that the report provided limited assurance for design and design effectiveness with three high priority recommendations.

2.19. The Committee noted that the findings in relation to reasonable adjustments and individuals not wanting to escalate concerns further will be raised with the People Committee.

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IPC Cleaning Standards audit report

2.20. The Committee received the audit report and noted that the report provided moderate assurance for design and design effectiveness with three medium and low priority recommendations.

Data Security and Protection Toolkit audit report

2.21. The Committee received the audit report and noted that the report provided a moderate rating for the risk assessment but a high confidence rating in the toolkit submission. The Committee noted that two medium priority recommendations had been made.

Audit Plan 2023/24

2.22. The Committee received the audit plan for 2023/24 and noted that the plan linked in with the key risks on the BAF. The Committee approved the plan in principle.

YDH and SFT External Audit Progress Report and Technical Update

2.23. The Committee received the external audit progress report and noted the work completed since January 2023 and the work to be completed over the next quarter.

SFT and YDH Benchmarking Report 2022/23 Q3

2.24. The Committee received the reports and noted that the position had not significantly changed from the previous quarter.

YDH and SFT Value for Money reports

2.25. The Committee received the report and noted that no significant risks had been identified as per the month nine and ten data.

Going Concern Statements

2.26. The Committee received the Going Concern statement covering both YDH and SFT and agreed to recommend the approval of the statement to the Board. The Committee noted that the projections in the statement will need to be extended by a further three months, e.g. until the end of June 2024.

Losses and Special Payments – SFT and YDH

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

2.28. The Committee agreed that the reports did not highlight any areas of concern.

Single Quotation/Tender Waiver Action report

2.29. 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.

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3. AREAS OF CONCERN/FOLLOW UP

Board Assurance Framework

3.1. The Committee discussed the Board Assurance Frameworks (BAF) and noted that the actions had been updated. The Committee noted that it had been agreed that the Q4 report will not be presented to the May 2023 Board meeting but will be reviewed by the relevant Committees.

3.2. The Committee noted that the BAF reflected the level of risk that the organisation continued to carry. Some of the Amber rated risks showed gaps in controls and assurances but the majority of these risks were linked to system wide risks which had been discussed at the recent Board Development Day. The Committee noted that the Integrated Care Board (ICB) was working on the development of their BAF and strategic priorities.

3.3. The Committee noted that the 2023/24 BAF will be developed with executive lead and Board Committee involvement with the recommendation to carry the existing strategic objectives forward but with a review of the KPIs, controls and assurance in relation to the merged trust arrangements.

3.4. The Committee felt that it was only able to provide a limited level of assurance about the management of some risks as e.g. the Committee did not receive an assurance report from the People Committee. The Committee agreed to a review of the way the committees currently work and report.

SFT Counter Fraud Progress Report

3.5. The Committee discussed the findings from the agency invoicing work as discussed at the previous meeting and noted that every invoice of the relevant agency had been checked and that discussions with the agency were ongoing.

3.6. The Committee discussed the controls in place and noted that the temporary staffing team did not have the capacity to check every invoice in terms of rates charged. The Committee felt that there remained a weakness in control and asked for this to be followed up with the executive team,

Internal Audit progress report - YDH

3.7. The Committee noted that management responses to two internal audit reports – Clinical Validation of Waiting Lists and Consultant Job Planning - had not been received despite them available in draft format for an extended period of time. The Committee agreed that it was disappointing that the reports had not been finalised and it was agreed to escalate this to the executive team.

Internal audit follow up report - SFT

3.8. The Committee received the internal audit recommendations follow up report and noted that 41 recommendations were due at the end of March 2023. Eight recommendations, including two high priority recommendations were overdue.

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3.9. The Committee noted that the implementation of the recommendations, particularly the high priority recommendations, was closely linked to the Head of Internal Audit Opinion and progress will continue to be closely monitored.

Annual report 2022/23

3.10. The Committee received the draft report and noted that the draft Head of Internal Audit Opinion provided a moderate assurance opinion. The Committee noted that this opinion was subject to the implementation of a large number of audit recommendations.

Six monthly report from the Quality and Governance Assurance Committee

3.11. The Committee received the six monthly report from the Quality and Governance Assurance Committee and agreed that the report provided significant assurance about the activity of the Committee. The Committee agreed that reports may also need to be considered from the other Committees.

3.12. The Committee agreed that the report did not set out how the Committee managed controls and risks and the format of the report may need further review.

4. RISKS

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

CHAIRMAN OF THE AUDIT COMMITTEE

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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Finance Report – Month 12 - YDH
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The 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: 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 planned to mitigate any identified inequalities

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
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 2023

Month 12 | Contents

Executive summary

In month, the Group reported a £0.092m deficit which was in line with the plan. Year to date the Group has achieved a break-even position, also consistent with plan.

Services continue to be under significant pressure from high levels of demand and difficulties in discharging patients in a timely manner although this has eased from the very high levels seen during winter.

The recently announced non-consolidated Agenda for Change pay uplift has been accounted for in month along with additional central funding (£4.4m). The retrospective impact of the healthcare support workers (HCSW) rebanding has also been provided for in month along with the financial impact of the Post graduate doctors in training strike backfill. The usual provisions for outstanding leave etc have also been made. An additional £5m has been recorded in month in relation to the extra 6.3% employer superannuation contribution which is paid directly by NHSE to the Pensions Agency on our behalf – this is fully offset by additional income.

The Trust has achieved £4.563m in CIP (in line with plan). However, of this only £1.009m (22%) is recurrent. Work is continuing as we look to increase the level of recurrent CIP into 2023/24.

There has been a significant impairment (£13.305m) in month which is classified as an operating expense but is removed for the purposes of assessing our overall financial performance. The impairments have arisen due to the annual valuation undertaken by our valuers (based on physical site visits) across land, buildings, and dwellings. There are a number of drivers of the impairment - further detail is given in the SFT finance report as the issues are largely common.

Performance on a financial trajectory basis	1.	In Month	The Group reported an in month deficit of £0.092m against a planned deficit of £0.092m, and is therefore in line with the plan in month.
		YTD	The Group has a balanced postion at the end of 2022/23.
Cash	2.	The total cash balance and working cash balance at the 31st March was £22.239m.	
Capital	3.	YTD	There is a full capital update report under separate cover.
CIP performance	4.	YTD	The Trust has delivered all of the £4.562m planned efficiencies; 22% of which have been achieved recurrently.

Group I&E - Summary

March 2023			£'000'	YTD			Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)	
32,026	19,952	12,074	Operating Income	261,481	240,404	21,077	240,404
(23,875)	(13,202)	(10,673)	Staff Expenditure	(174,453)	(158,123)	(16,330)	(158,123)
(8,994)	(6,539)	(2,455)	Operating Expenditure	(85,048)	(78,750)	(6,298)	(78,750)
(843)	**211**	**(1,054)**	**Operating I&E**	**1,980**	**3,530**	**(1,551)**	**3,530**
752	(303)	1,054	Non-Operating Expenditure	(1,980)	(3,531)	1,551	(3,531)
(92)	**(92)**	**0**	**Adj to Financial Improvement Trajectory (FIT) Basis**	**0**	**(0)**	**0**	**(0)**
(12,791)	476	(13,267)	Donated Assets, impairments and other adjustments excluded from FIT	(5,970)	11,819	(17,789)	11,819
(12,882)	**384**	**(13,267)**	**I&E surplus/(deficit)**	**(5,970)**	**11,819**	**(17,789)**	**11,819**

Key headlines:

Operating Income - The year to date position includes £7.457m of pay award funding above plan (including £4.404m for newly proposed non consolidated award), plus £4,982 additional pension contribution central funding and an additional £1.357m reimbursement of COVID-19 costs (testing) incurred outside of the system funding envelope. Other reimbursements for extra escalation/winter costs in YDH and higher SHS income (£3.649m fav) have also been seen, including part of £1.2m further funding towards SHS pressures.

Staff Expenditure - SHS costs remain higher than plan due to primary care operational pressures which have been funded by increased ICB support. Whilst reduced, extra shifts and agency and bank premium costs relating to escalation capacity/activity continue to drive adverse variances across the group, offset in part by income reimbursement as described above. Total variance due to cost of back-dated pay award YTD is £8.622m offset by income stated above giving net adverse variance £1.165m YTD.

Operating Expenditure - Adverse variances YTD include COVID-19 impact of £0.882m YTD due to testing costs which are offset by income. Additional overspends seen due to inflation, also driven by escalation and activity, non COVID pathology testing, in tariff funded drugs, one off system costs and the impact of non-elective demand on elective expenditure.

Group I&E - Detail

March 2023			£'000'	YTD			Annual Plan
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)	
27,276	16,020	11,256	NHS Acute Income	205,767	191,970	13,796	191,970
2,586	1,766	820	NHS Primary Care Income	28,385	22,180	6,206	22,180
88	457	(369)	Non NHS Clinical Income	3,233	5,536	(2,304)	5,536
2,013	1,709	303	Other Income	22,739	20,242	2,497	20,242
64	0	64	Top Up income	1,357	476	882	476
32,026	**19,952**	**12,074**	**Total Operating Income**	**261,481**	**240,404**	**21,077**	**240,404**
(5,877)	(3,944)	(1,933)	Medical Staff Expenditure	(51,281)	(47,441)	(3,841)	(47,441)
(7,078)	(3,836)	(3,242)	Nursing Staff Expenditure (Registered)	(51,097)	(45,733)	(5,364)	(45,733)
(10,920)	(5,422)	(5,498)	Other Staff Expenditure	(72,075)	(64,950)	(7,125)	(64,950)
(23,875)	**(13,202)**	**(10,673)**	**Total Staff Expenditure**	**(174,453)**	**(158,123)**	**(16,330)**	**(158,123)**
(1,986)	(1,764)	(222)	Drugs	(22,462)	(21,299)	(1,163)	(21,299)
(1,774)	(1,386)	(388)	Clinical Supplies & Services	(18,643)	(16,847)	(1,797)	(16,847)
(5,234)	(3,389)	(1,845)	Other Operating Expenditure	(43,943)	(40,604)	(3,339)	(40,604)
(8,994)	**(6,539)**	**(2,455)**	**Total Operating Expenditure**	**(85,048)**	**(78,750)**	**(6,298)**	**(78,750)**
(843)	**211**	**(1,054)**	**Total Operating I&E**	**1,980**	**3,530**	**(1,551)**	**3,530**
752	(303)	1,054	Non-Operating Expenditure	(1,980)	(3,531)	1,551	(3,531)
(92)	**(92)**	**0**	**Adj to Financial Improvement Trajectory (FIT) Basis**	**0**	**(0)**	**0**	**(0)**
(13,305)	0	(13,305)	Impairment of Fixed Assets	(13,305)	0	(13,305)	0
514	476	38	Donated Assets	7,335	11,819	(4,484)	11,819
0	0	0	Other adjustments excluded from FIT	0	0	0	0
(12,882)	**384**	**(13,267)**	**I&E surplus/(deficit)**	**(5,970)**	**11,819**	**(17,789)**	**11,819**

COVID-19 Financial Summary (excl SHS)

Included with Plan

COVID19 Related Expenditure £'000	2022/23 YTD															
	Annual Plan	Plan YTD	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Actual M10	Actual M11	Actual M12	Actual YTD	Variance YTD (adverse)/ favourable
Medical Staff Expenditure	982	982	58	96	73	83	129	93	98	96	98	81	94	89	1,087	(105)
Nursing Staff Expenditure	1,780	1,780	164	119	178	176	143	131	140	131	149	146	127	126	1,729	51
Other Staff Expenditure	387	387	81	35	23	25	26	24	24	23	25	27	24	26	364	23
Total Staff Expenditure	**3,149**	**3,149**	**302**	**250**	**274**	**283**	**298**	**248**	**263**	**250**	**272**	**255**	**245**	**241**	**3,180**	**(31)**
Drugs	2	2	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Clinical Supplies & Services	14	14	0	0	1	0	0	0	9	0	0	0	0	(0)	10	4
Other Operating Expenditure	231	231	4	(1)	4	24	2	2	1	1	2	0	1	2	40	191
Total Non-Staff Operating Expenditure	**247**	**247**	**4**	**(1)**	**5**	**25**	**2**	**2**	**9**	**1**	**2**	**0**	**1**	**2**	**51**	**196**
Total	**3,396**	**3,396**	**306**	**249**	**279**	**308**	**299**	**250**	**272**	**250**	**274**	**255**	**246**	**242**	**3,231**	**165**

Outside of Envelope

COVID19 Expenditure to be Reimbursed £'000	2022/23												
	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Actual M10	Actual M11	Actual M12	Actual YTD
Nursing Staff Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Staff Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Supplies & Services	246	301	79	178	68	(17)	52	66	72	155	92	64	1,357
Total	**246**	**301**	**79**	**178**	**68**	**(17)**	**52**	**66**	**72**	**155**	**92**	**64**	**1,357**

Key headlines:

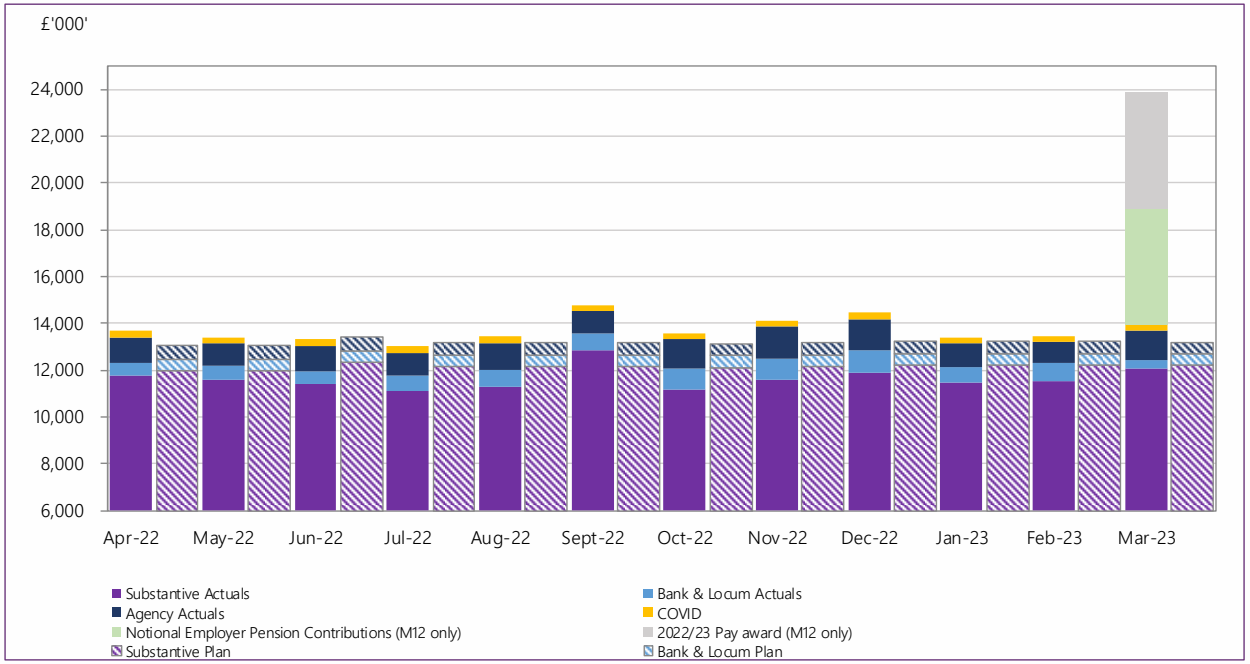
Costs in relation to COVID-19 continue to be reviewed across the trust and system to confirm what additional planned expenditure can be removed aligned to the relaxation in infection prevention and control measures. The level of specific Covid funding the system will receive in 2023/24 has significantly reduced from 2022/23 levels.

Outside of envelope is completely reimbursable from NHSE and relates to COVID testing. This will move to a fixed population based allocation to the ICB in 2023/24.

Group staff expenditure

March 2023

vs Plan in month	£10.673m adverse
vs Plan YTD	£16.33m adverse

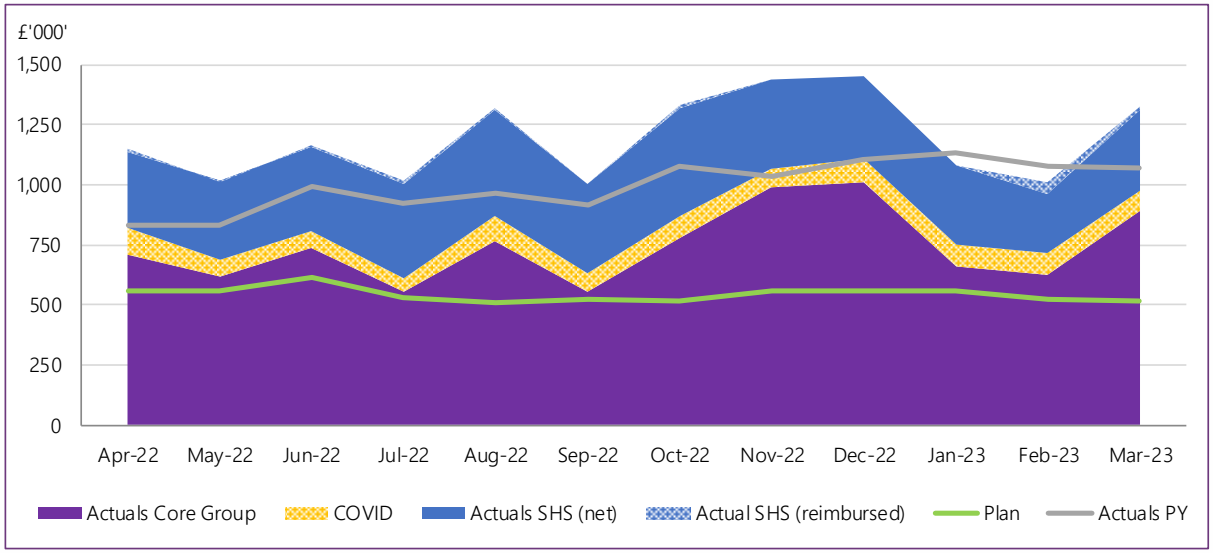


March 2023 Actual	March 2023 Plan	March 2023 Variance fav/(adv)	£'000'	YTD Actual	YTD Plan	YTD Variance fav/(adv)	Comments* *excluding pay award and notional pension contribution funded variance	Annual Plan
7,078	3,836	(3,242)	Registered Nursing, Midwifery and Health Visiting Staff	51,097	45,733	(5,364)	Pressures due to SHS, escalation and agency/bank usage due to specialing, acuity and sickness.	45,733
2,209	1,069	(1,141)	Registered Scientific, therapeutic and technical staff	15,024	12,892	(2,133)	Adverse in SHS pharmacists and YDH ODPs. Favourable in Therapists/AHPs.	12,892
146	50	(96)	Registered ambulance service staff	1,036	595	(441)	Part of Emergency Department pressure from high activity, largely ambulatory care.	595
5,185	2,121	(3,063)	Support to Clinical Staff	30,363	25,315	(5,048)	Majority of the adverse pressure is in support to nursing (HCAs - see nursing reasons above).	25,315
3,380	2,182	(1,198)	NHS Infrastructure support	25,652	26,148	496	Overspends in housekeeping but underspends in SHS, IT and O/seas Recruitment.	26,148
5,877	3,944	(1,933)	Medical and Dental	51,281	47,441	(3,841)	Continued pressures from escalation, SHS and temporary staffing. Strike action impact offset by extra funding received.	47,441
23,875	**13,202**	**(10,673)**	**Total**	**174,453**	**158,123**	**(16,330)**		**158,123**

Group agency expenditure

March 2023

Group plan YTD	£6.357m
Actuals vs Plan YTD	£7.901m adv
Actuals vs prior year YTD	£9.75m over



	Variance to Plan fav/(adv)	
£'m	In month	YTD
Nursing	(0.024)	(1.042)
Medical	(0.678)	(5.246)
Other Pay	(0.148)	(1.614)
Total	**(0.850)**	**(7.901)**

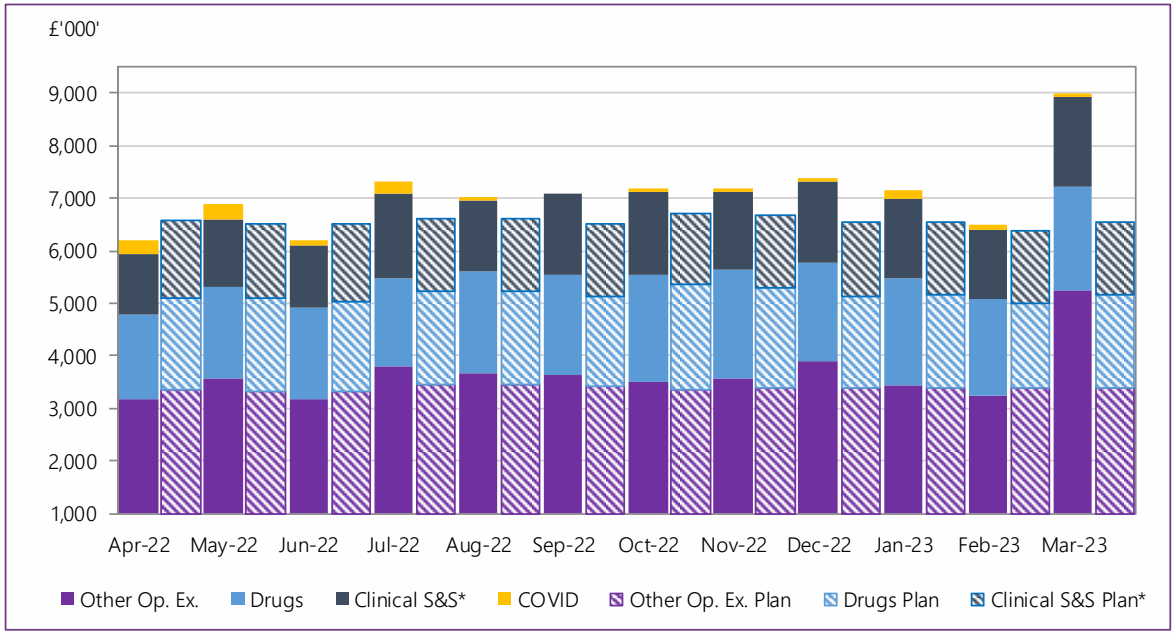
March 2023			£'000'	YTD		
Actual	Plan	Variance fav/(adv)		Actual	Plan	Variance fav/(adv)
704	239	(465)	Medical	5,965	2,956	(3,009)
115	139	24	Nursing	2,117	1,682	(435)
145	12	(134)	Other Pay	1,162	151	(1,011)
964	***389***	***(575)***	***YDH total***	***9,244***	***4,789***	***(4,455)***
15	0	(15)	Other Pay	579	0	(579)
15	***0***	***(15)***	***SSL total***	***579***	***0***	***(579)***
338	125	(213)	Medical	3,804	1,568	(2,236)
48	0	(48)	Nursing	607	0	(607)
0	0	0	Other Pay	24	0	(24)
386	***125***	***(261)***	***SHS total***	***4,435***	***1,568***	***(2,867)***
1,365	**514**	**(850)**	**Group Total**	**14,258**	**6,357**	**(7,901)**

Group operating expenditure

March 2023

vs Plan in month	£2.455m adverse
vs Plan YTD	£6.298m adverse

	Variance to Plan fav/(adv)	
£'m	In month	YTD
Clinical Supplies & Services	(0.388)	(1.797)
Drugs	(0.222)	(1.163)
Other Operating Expenditure	(1.845)	(3.339)
Total	**(2.455)**	**(6.298)**



*From Apr-22 category changed to allign to NHSE/I reporting, 2021/22 months data relates to consumables only

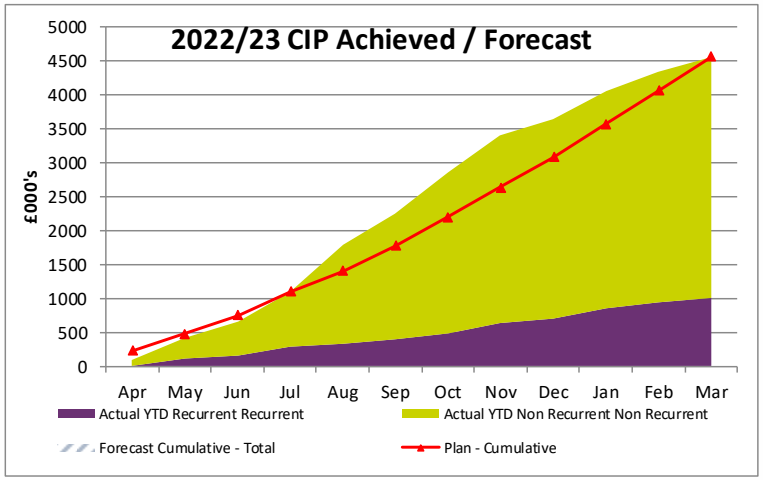
Key headlines:

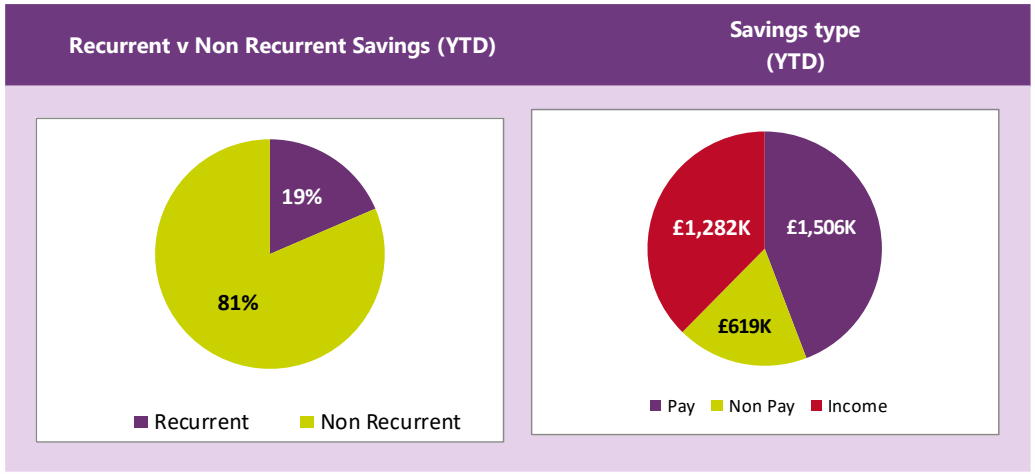
Clinical Supplies & Services - Overspends in pathology testing (excl COVID costs) continuing from high non-elective demand, £0.745m adverse YTD and radiology reporting. Variance also includes private patient medical LLP costs (partly offset by income) and £0.882m adverse YTD from virus testing expenditure funded by additional income outside the funding envelope.

Drugs - YTD slight overspend on high cost/pass-through drugs, £74k. Remaining adverse variance is reflecting increased activity and escalation areas causing higher than planned spend on in-tariff funded drugs.

Other Operating Expenditure - adverse variances include provisions (catering) driven by escalation and prices and one-off system costs in month and year to date. Underspends continue within recruitment (overseas recruitment, offset by lower income).

Trust CIP summary





Category	In Month					Year To Date					Full Year Plan
	Actual Recurrent	Actual Non Recurrent	Total Achieved	Plan	Variance	Actual Recurrent	Actual Non Recurrent	Total Achieved	Plan	Variance	
Corporate	33	32	64	88	(24)	473	644	1,117	878	240	878
Elective Care	14	45	60	138	(78)	331	686	1,017	1,138	(121)	1,138
Urgent Care	6	33	38	174	(136)	60	1,401	1,461	1,400	61	1,400
SHS	0	0	0	35	(35)	0	367	367	546	(179)	546
SSL	14	43	57	64	(7)	145	455	600	600	(0)	600
Total	**67**	**153**	**219**	**499**	**(280)**	**1,009**	**3,553**	**4,562**	**4,562**	**0**	**4,562**

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Finance Report – Month 12 - SFT
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	The 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: 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 planned to mitigate any identified inequalities

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT TO 31 MARCH 2023

1. SUMMARY

1.1 In March 2023, the Trust recorded a surplus of £2.300m, which was £1.280m favourable compared with the plan for the month. This means the Trust has ended the year at breakeven.

1.2 There has been a significant impairment (£38.644m) in month. This is classified as an operating expense but is removed for the purposes of assessing our overall financial performance. The impairments have arisen due to the annual valuation undertaken by our valuers (based on physical site visits) across land, buildings, and dwellings.

1.3 Final CIP delivery was £13.330m, £0.851m below the plan which considering the operational challenges that services have been managing all year should be seen as a success. On a less positive note, of the savings delivered only 40% (£5.3m) were recurrent.

1.4 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 2023: -

Table 1: Income and Expenditure Summary

Statement of Comprehensive Income	Annual Plan	Current Month 12			Year to date		
		Plan	Actual	Fav./ (Adv.) Variance	Plan	Actual	Fav./ (Adv.) Variance
	£000	£000	£000	£000	£000	£000	£000
Income							
NHS clinical income	594,754	49,587	80,742	31,155	594,754	661,000	66,246
Non-NHS clinical income	3,166	264	512	248	3,166	3,612	446
Non-clinical income	37,628	3,134	28,175	25,041	37,628	79,840	42,212
Total operating income (excl STF)	**635,548**	**52,985**	**109,429**	**56,445**	**635,548**	**744,453**	**108,904**
Employee expenses	(436,147)	(35,356)	(84,525)	(49,169)	(436,147)	(509,745)	(73,598)
Drugs	(37,828)	(3,214)	(4,674)	(1,459)	(37,828)	(48,137)	(10,309)
Clinical Supplies	(34,557)	(2,936)	(4,461)	(1,525)	(34,557)	(39,484)	(4,927)
Non-clinical supplies	(86,070)	(7,069)	(10,814)	(3,745)	(86,070)	(108,720)	(22,650)
PFI expenses	(3,753)	(313)	(306)	7	(3,753)	(3,558)	195
Depreciation charges	(27,646)	(2,304)	(2,459)	(155)	(27,646)	(26,777)	869
Impairments	0	0	(38,644)	(38,644)	0	(38,644)	(38,644)
Total operating expenses	**(626,000)**	**(51,193)**	**(145,883)**	**(94,690)**	**(626,000)**	**(775,065)**	**(149,064)**
EBITDA	**9,548**	**1,792**	**(36,454)**	**(38,246)**	**9,548**	**(30,612)**	**(40,160)**
Other income	189	16	206	190	189	1,272	1,083
PDC dividend expense	(7,461)	(622)	58	680	(7,461)	(6,933)	528
Other financing costs	(1,893)	(174)	145	318	(1,893)	(1,795)	99
Overall Surplus/(Deficit)	**382**	**1,012**	**(36,045)**	**(37,057)**	**382**	**(38,068)**	**(38,451)**
Adjustments to control total	**(382)**	**8**	**38,345**	**38,337**	**(382)**	**38,068**	**38,450**
Adjusted Financial Performance	**0**	**1,020**	**2,300**	**1,280**	**0**	**0**	**0**

2.2 The recently announced non-consolidated Agenda for Change pay uplift has been accounted for in month along with additional central funding (£17.8m).

2.3 An additional £19.2m has been recorded in month in relation to the extra 6.3% employer superannuation contribution which is paid directly by NHSE to the Pensions Agency on our behalf – this is fully offset by additional income.

2.4 The variances in non-pay expenditure relate predominantly to pass-through and cancer drugs, imaging, pathology, radiology, and diagnostic hub activity – much of which is offset by additional funding as pass-through costs or additional funding which will be added to the block contract through contract variations.

2.5 An impairment of £38.644m was also recorded in month. The main factors driving this are:

- Building cost index reduction
- Increased obsolescence
- Revised Modern Equivalent Asset (MEA) model, (2 models for SFT-CH/MH and Acute). MEA is a hypothetical model and allows for a significant reduction through reduced duplication e.g., plant areas,
- Under an MEA model office space, training rooms, agile working etc has meant a 40% reduction in space post-covid
- A large impairment on the SDU (surgical decision unit) which is normal for new builds in the NHS which often have a large impairment in first year of operation
- Community services – reduced from 5 hubs to 3, driving reduction in space requirements

2.6 Although the impairment is classified as an operating expense, for the purposes of external assessment by NHSE they are removed and effectively treated below the line so do not impact on our overall financial performance.

3. COST IMPROVEMENT PROGRAMME

3.1 The Cost improvement programme has delivered £13.330m of savings. This is an overall shortfall of £0.851m compared with the plan of £14.181m. The year end position is better than forecast and reflects the continuous focus CIP has within services.

3.2 In total, £5.323m of recurrent savings have been delivered. At 40%, this is less than planned, but must be seen in the context of the operational challenges services have been under all year.

3.3 Services are working hard on their 2023/24 plans. The Board will recall the CIP requirement next year is £33.8m (3.4%). This represents a significant step up and combined with the ambition to increase recurrent delivery to 75% means there is a greater challenge for services to identify efficiencies. Work is already well underway, but progress remains challenging

3.4 Final analysis by area is shown in the table below: -

Chart 1: CIP Summary

Somerset NHS Foundation Trust

Cost Improvement Programme 22/23 Trustwide

Directorate	Current Year Plan	Plan vs Actual: Plan to Date	Actual to Date: R	Actual to Date: NR	Actual to Date: TOTAL	Variance to Date: R Shortfall	Variance to Date: Total	Out-turn: R	Out-turn: NR	Out-turn: TOTAL	Variance: R Shortfall	Variance: Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Integrated & Urgent Care Directorate	2,088	2,088	221	1,089	1,310	(1,867)	(778)	221	1,089	1,310	(1,867)	(778)
Surgical Directorate	3,090	3,089	815	1,176	1,991	(2,274)	(1,099)	815	1,176	1,991	(2,275)	(1,099)
Clinical Support & Specialist Services Directorate	2,022	2,022	633	1,389	2,022	(1,389)	(0)	633	1,389	2,022	(1,389)	(0)
MH&LD Directorate	1,157	1,157	679	568	1,247	(478)	90	679	568	1,247	(478)	90
Families Directorate	1,307	1,307	653	1,164	1,817	(653)	510	653	1,164	1,817	(653)	510
Operational Management	411	411	118	440	558	(294)	147	118	440	558	(294)	148
Estates	787	787	662	125	787	(125)	0	662	125	787	(125)	0
Primary Care & Neighbourhoods Directorate	1,540	1,540	526	1,014	1,540	(1,014)	(0)	526	1,014	1,540	(1,014)	(0)
Director of Corporate Services	160	160	79	80	160	(80)	(0)	79	80	160	(80)	(0)
Chief Finance Officer	183	183	150	52	202	(33)	19	150	52	202	(33)	19
Chief Nurse	101	101	40	61	101	(61)	0	40	61	101	(61)	0
Chief of People & OD	242	242	181	61	242	(61)	0	181	61	242	(61)	0
Director of Strategy & Digital	513	513	432	109	541	(81)	28	432	109	541	(81)	28
Central	582	582	134	679	813	(448)	231	134	679	813	(448)	231
	14,181	**14,181**	**5,323**	**8,007**	**13,330**	**(8,858)**	**(851)**	**5,323**	**8,007**	**13,330**	**(8,859)**	**(851)**

4. CASH

4.1 Cash balances as at 31 March were £42.5m which is slightly higher than forecast.

5. CAPITAL

5.1 Total reported expenditure on internally funded schemes was £22.710m compared with the plan of £22.680m, overspending by £0.030m. Expenditure on externally PDC funded schemes was in line with plan at £19.433m.

5.2 There were a number of schemes where final expenditure varied significantly from the original capital budget. Expenditure on some schemes was accelerated to ensure slippage on other schemes was able to be utilised in year. The Finance Committee received a detailed report on the capital outturn at their meeting on 24 April 2023.

6. CONCLUSION AND RECOMMENDATION

6.1 The year has been exceptionally challenging operationally, which in turn created a complex set of financial pressures and risks. We have worked closely with the ICB all year to ensure we have been able to secure additional funding to meet the costs of unplanned escalation.

6.2 This additional support combined with a culture of strong financial grip and control has meant we have delivered a breakeven position.

6.3 The Board are asked to note the financial performance for March and year end position.

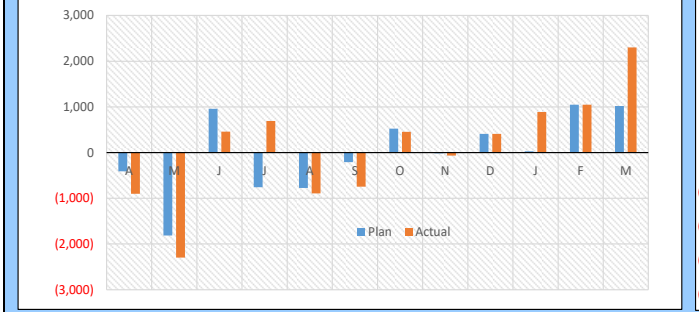
CHIEF FINANCE OFFICER

Appendix 1

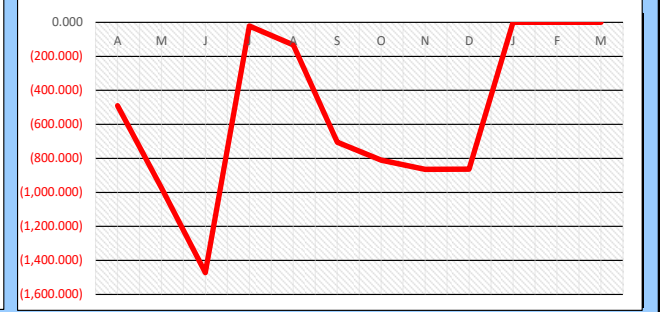
EXECUTIVE SUMMARY AT 31 MARCH 2023

Financial Performance	Annual Plan	Current Month 12			Year to date		
		Budget £m	Actual £m	Variance £m	Plan	Actual	Fav/(Adv) Variance
Income	635.5	52.99	109.43	56.44	635.55	744.45	108.90
Expenditure	-626.0	-51.19	-145.88	-94.69	-626.00	-775.06	-149.06
Operating Surplus/(Deficit)	**9.54**	**1.80**	**-36.45**	**-38.25**	**9.55**	**-30.61**	**-40.16**
Financing costs	-9.16	-0.77	0.41	1.18	-9.16	-7.45	1.71
Overall Surplus/(Deficit) for the period	**0.38**	**1.030**	**-36.04**	**-37.07**	**0.39**	**-38.06**	**-38.45**
Adjustments to financial performance	-0.38	-0.01	38.34	38.35	-0.39	38.06	38.45
Adjusted financial performance Surplus/(Deficit)	**0.00**	**1.02**	**2.30**	**1.28**	**0.00**	**0.00**	**0.00**

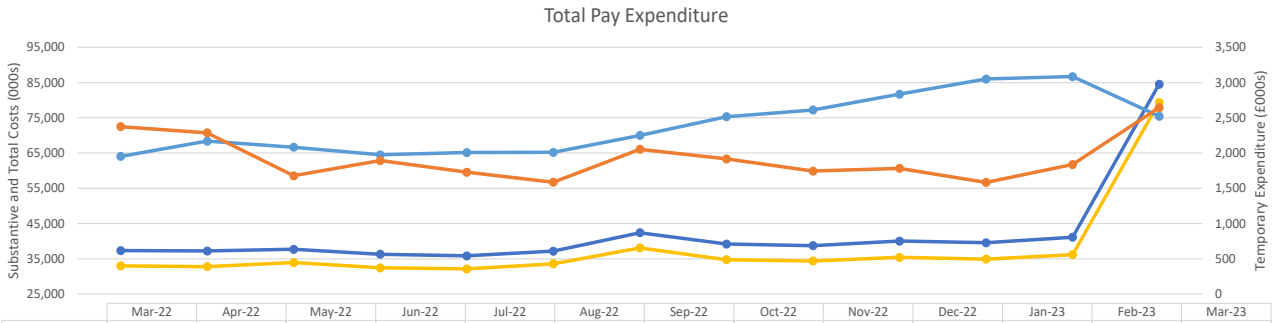
MONTHLY FINANCIAL PERFORMANCE



YEAR TO DATE VARIANCE FROM PLAN

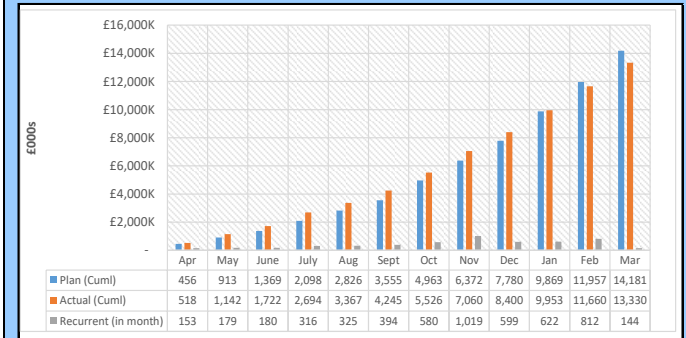


TOTAL PAY EXPENDITURE



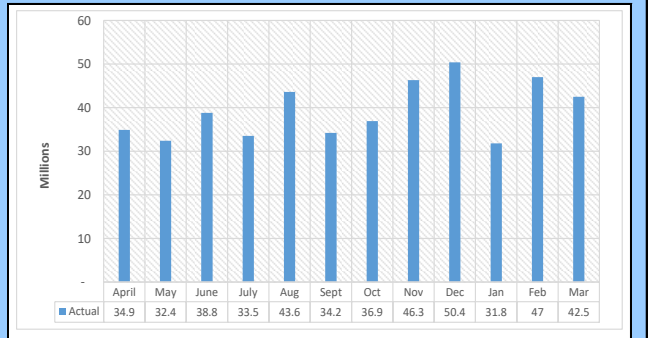
	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total	37,333	37,229	37,683	36,299	35,848	37,178	42,397	39,170	38,738	40,021	39,547	41,108	84,525
Substantive	33,006	32,773	33,922	32,431	32,112	33,582	38,093	34,738	34,383	35,404	34,913	36,185	79,359
Agency	1,952	2,169	2,083	1,975	2,008	2,010	2,250	2,515	2,610	2,835	3,050	3,085	2,523
Bank	2,374	2,287	1,678	1,893	1,728	1,587	2,054	1,917	1,744	1,782	1,583	1,838	2,643

CIP DELIVERY



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Plan (Cuml)	456	913	1,369	2,098	2,826	3,555	4,963	6,372	7,780	9,869	11,957	14,181
Actual (Cuml)	518	1,142	1,722	2,694	3,367	4,245	5,526	7,060	8,400	9,953	11,660	13,330
Recurrent (in month)	153	179	180	316	325	394	580	1,019	599	622	812	144

CASH BALANCE



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual	34.9	32.4	38.8	33.5	43.6	34.2	36.9	46.3	50.4	31.8	47	42.5

COMMENTARY

- A revised financial plan was agreed at the Joint Board meeting on 20 June 2022. The revised plan now means that the system and each organisation will have a balanced position. Escalation pressures continue to have a significant impact on financial performance.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Going Concern Statement
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Chris Upham, Assistant Director - Financial Services
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	International Accounting Standard 1 Presentation of financial statements (IAS 1) requires management to make an assessment of an entity's ability to continue as a going concern when preparing that entity's financial statements. This report provides the Board with an overview of their responsibilities and evidence to support the going concern assessment in respect of Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust.
Recommendation	The Board is asked to approve the application of the Going Concern concept to the preparation of the 2022/23 accounts Somerset NHS Foundation Trust and Yeovil District Hospital 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: N/A
Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
☒ This report has not been assessed against the Trust's Equality Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
☐ This report has been assessed against the Trust's Equality Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
The report was presented to the April 2023 Audit Committee 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

GOING CONCERN REPORT

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 7 June 2023.

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 2023/24 Financial Plan was approved by the Finance Committee, with delegated authority from the Board, on 27 March 2023, ahead of the annual accounts being signed. Guidance from NHS England 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:

2022/23 Going Concern Assessment

Conditions	Criteria	Evidence
Financial	1. meeting the planned annual financial targets	1. Financial performance achieved during 2022/23 in line with plan.
	2. any necessary interim financing facilities are agreed	2. None required.
	3. existence of significant operating losses, historical and projected	3. None.
	4. anticipated or actual major loss of commissioner income	4. Nothing anticipated outside of plan.
	5. major cost improvement programme with high risk of non-achievement	5. CIP plans in progress and confident of plan delivery.
	6. major losses or cash flow problems which have arisen since the balance sheet date	6. Not anticipated.
Operating	7. loss of key management without replacement	7. None anticipated.
	8. loss of key staff without replacement and/or industrial relation difficulties	8. Not expected.
	9. significant failure to achieve Care Quality Commission standards resulting in any restrictions on services provided	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 12. pending legal or regulatory proceedings against the trust that may, if successful, result in claims that are unlikely to be satisfied 13. changes in legislation or government policy expected to adversely affect the trust 14. issues which involve a range of possible outcomes so wide that an unfavourable result could affect the appropriateness of the going concern basis 15. significant concerns about finance or quality raised by regulators	11. None. 12. None. 13. None expected. 14. None expected. 15. None.

3. CONCLUSION AND RECOMMENDATION

3.1 The Trust has received approval from the Secretary of State for Health and Social Care for the merger 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.

3.2 The merged Trust has submitted detailed financial plans for the financial year to NHS England to the end of March 2024 (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.

3.3 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 Board is requested to approve the application of Going Concern.

CHIEF FINANCE OFFICER

Appendix 1

Monthly cash flow forecast	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Opening Cash Balance	68,648	55,220	52,254	47,447	44,447	42,475	39,462	39,542	39,259	38,831	37,726	42,878	46,055	44,457	42,313
Surplus/(Deficit) from operations	87	(464)	(427)	671	712	683	1,492	2,038	2,059	2,417	3,373	2,642	87	(464)	(427)
Non-cash flows in operating surplus/(deficit)	3,299	3,299	3,299	3,299	3,299	3,299	3,299	3,299	3,299	3,299	3,299	3,299	3,500	3,500	3,500
Operating cash flows before movements in working capital	**3,386**	**2,835**	**2,872**	**3,970**	**4,011**	**3,982**	**4,791**	**5,337**	**5,358**	**5,716**	**6,672**	**5,941**	**3,587**	**3,036**	**3,073**
Increase/(decrease) in working capital	(15,451)	(2,833)	(2,769)	(2,364)	(1,580)	(1,379)	(133)	(526)	(1,293)	(779)	864	985	(1,000)	(1,000)	(1,000)
Net cash inflow/(outflow) from operating activities	**(12,065)**	**2**	**103**	**1,606**	**2,431**	**2,603**	**4,658**	**4,811**	**4,065**	**4,937**	**7,536**	**6,926**	**2,587**	**2,036**	**2,073**
Capital expenditure	(2,178)	(3,788)	(4,870)	(6,384)	(7,324)	(7,216)	(2,516)	(8,785)	(7,318)	(9,864)	(6,251)	(1,490)	(5,000)	(5,000)	(2,500)
Investing activities	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51
Net cash inflow/(outflow) before financing	**(14,192)**	**(3,735)**	**(4,716)**	**(4,727)**	**(4,842)**	**(4,562)**	**2,193**	**(3,923)**	**(3,202)**	**(4,876)**	**1,336**	**5,487**	**(2,362)**	**(2,913)**	**(376)**
Net cash inflow/(outflow) from financing activities	764	769	(91)	1,727	2,870	1,549	(2,113)	3,640	2,774	3,771	3,816	(2,310)	764	769	(50)
Net increase/(decrease) in cash and cash equivalents	(13,428)	(2,966)	(4,807)	(3,000)	(1,972)	(3,013)	80	(283)	(428)	(1,105)	5,152	3,177	(1,598)	(2,144)	(426)
Closing cash balance	**55,220**	**52,254**	**47,447**	**44,447**	**42,475**	**39,462**	**39,542**	**39,259**	**38,831**	**37,726**	**42,878**	**46,055**	**44,457**	**42,313**	**41,887**

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Approval of 2023/24 Revenue budget
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	9 May 2023

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

Executive Summary and Reason for presentation to Committee/Board	This report presents the Board with the 2023/24 annual revenue budget including information on the cost improvement programme, forecast cashflow and statement of financial position.
Recommendation	The Board is requested to approve the 2023/24 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: 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 planned to mitigate any identified inequalities

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – e.g. 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

APPROVAL OF 2023/24 REVENUE BUDGET

1. INTRODUCTION

1.1 The Finance Committee in Common approved the final version of the 2023/24 annual plan at its meeting on 27 March 2023. The Trust submitted this final version to NHSE on 30 March 2023 in accordance with the national timescale. 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

1.2 In addition, the Somerset ICS submitted a system wide plan which is a consolidation of the ICB and SFT plans for 2023/24.

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 was developed with reference to the national planning guidance and locally determined priorities. The NHSE 2023/24 priorities and operational planning guidance (initially published in December 2022) set out three key tasks for the year: -

i) Recover core services and productivity;

ii) Make progress in delivering the key ambitions in the Long Term Plan (LTP) and;

iii) Continue to transform the NHS for the future.

2.2 The Autumn statement in 2022 announced additional funding of £3.3bn in 2023/24 and 2024/25 to enable the NHS to respond to the significant pressures it is facing. ICB allocations are flat in real terms with additional funding made available to expand capacity.

2.3 A change to the contract approach for elective care was made for 2023/24 with most planned elective care now falling under a payment for activity delivered basis with stretch targets to improve elective performance against a baseline of 2019/20.

2.4 Planning has been undertaken collaboratively with the ICB to ensure we are able to meet the national objectives and local priorities and deliver a balanced

net financial position. The Committee will be familiar with this work through the updates on the progress of the plan at previous meetings.

3. INCOME AND EXPENDITURE

3.1 The summary level Statement of Comprehensive Income (SOCI) budget at Trust level is shown below:

Statement of comprehensive income	2022/23 Outturn £'000	2023/24 Annual Budget £'000
Operating income from patient care activities	918,055	908,685
Other operating income	94,297	55,308
Employee expenses	(684,592)	(644,817)
Operating expenses excluding employee expenses	(362,525)	(303,893)
Operating Surplus/(Deficit)	**(34,765)**	**15,283**
Finance Costs	(8,937)	(13,296)
Corporation Tax	(338)	(787)
Surplus/(Deficit) 2023/24	**(44,040)**	**1,200**
Adjustments to Financial Performance	44,040	(1,200)
Adjusted Financial Performance Surplus/Deficit	**0**	**0**

Note: 2022/23 is for information only and cannot be used as a direct comparison. It contains a number of non-recurrent adjustments (e.g., additional pay award/pension costs/funding) which are not included in the 2023/24 plan.

3.2 Service group budgets are set out below. These are net of the agreed cost improvement targets. Funding currently held in reserves will be released to service groups to fund investments, inflation etc during the year: -

Service Group	Operating Income From Patient Care Activities £000	Other Operating Income £000	Employee Expenses £000	Operating Expenses £000	Operating Surplus/(Deficit) £000	Finance Costs £000	Corporation Tax £000	Surplus/(Deficit) 2023/24 £000	WTE
Clinical Support & Cancer Services Group	1,462	2,999	(69,422)	(70,970)	**(135,931)**	(1,306)	0	(137,237)	1,427
CYP & Families Services Group	131	674	(62,041)	(7,858)	**(69,094)**	0	0	(69,094)	1,169
Medical Services Group	35	255	(114,521)	(26,374)	**(140,606)**	0	0	(140,606)	2,100
Mental Health & LD Services Group	0	55	(66,122)	(9,519)	**(75,586)**	0	0	(75,586)	1,225
Neighbourhood Services Group	827	1,733	(72,671)	(10,799)	**(80,910)**	0	0	(80,910)	1,832
Operational Management	0	68	(5,882)	(3,705)	**(9,519)**	0	0	(9,519)	125
SHS	34,130	0	(26,392)	(7,339)	**398**	(398)	0	0	380
Surgical Services Group	5,507	3,303	(135,419)	(38,927)	**(165,535)**	0	0	(165,535)	2,555
Reserves	6,138	4,573	(4,226)	(22,748)	**(16,264)**	(1,979)	0	(18,243)	0
Corporate	860,455	41,648	(88,120)	(105,652)	**708,331**	(9,613)	(787)	697,930	2,163
TOTAL	**908,685**	**55,308**	**(644,817)**	**(303,892)**	**15,284**	**(13,296)**	**(787)**	**1,200**	**12,976**
					Less: adjustments to financial performance			**(1,200)**	
								0	

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 By Department	Operating Income From Patient Care Activities £000	Other Operating Income £000	Employee Expenses £000	Operating Expenses £000	Operating Surplus/(Deficit) £000	Finance Costs £000	Corporation Tax £000	Surplus/(Deficit) 2023/24 £000	WTE
Chief Nurse	0	258	(3,602)	(193)	**(3,537)**	0	0	**(3,537)**	68
Clinical Income	858,304	0	0	(39)	**858,265**	0	0	**858,265**	0
Central budgets	1,304	29,822	(11,283)	(43,110)	**(23,267)**	(9,375)	(787)	**(33,429)**	0
Central income	0	3,225	(938)	(463)	**1,824**	0	0	**1,824**	0
Director of Corporate Services	0	269	(9,305)	(21,567)	**(30,603)**	0	0	**(30,603)**	183
Chief Finance Officer	0	4,595	(9,007)	(2,761)	**(7,173)**	(168)	0	**(7,341)**	212
Chief Medical Officer	0	611	(2,762)	(27)	**(2,178)**	0	0	**(2,178)**	48
Chief of People & OD	38	5,332	(13,590)	(4,952)	**(13,172)**	0	0	**(13,172)**	293
Estates & Facilities	809	25,076	(22,483)	(24,332)	**(20,930)**	(1)	0	**(20,931)**	710
Director of Strategy & Digital	0	6,622	(15,150)	(6,040)	**(14,567)**	0	0	**(14,567)**	364
Simply Serve	0	(34,162)	0	(2,168)	**(36,330)**	(70)	0	**(36,400)**	287
TOTAL	**860,455**	**41,648**	**(88,120)**	**(105,652)**	**708,330**	**(9,614)**	**(787)**	**697,930**	**2,163**

3.4 A more granular income and expenditure position is set out in the table below. This is net of the £33.8m efficiency programme.

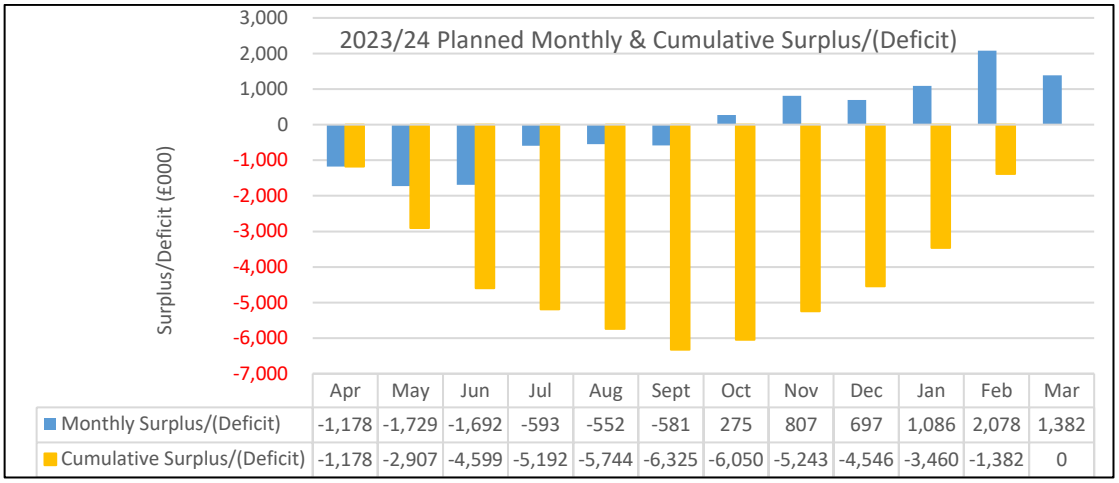
Statement of comprehensive income	2022/23 Outturn £'000	2023/24 Annual Budget £'000
Operating income from patient care activities		
Integrated Care Boards	733,418	745,135
NHS England	147,944	102,669
NHS Trusts/Private & overseas patients/local authorities/other	36,693	60,881
sub-total	**918,055**	**908,685**
Other operating income		
Research & Development	3,897	3,024
Education & Training	35,277	25,052
Parking	965	828
Other	54,158	26,404
sub-total	**94,297**	**55,308**
Total operating income	**1,012,352**	**963,993**
Operating expenditure		
Staff costs	(684,592)	(644,817)
Supplies & services - clinical	(51,094)	(45,150)
Supplies & services - general	(28,810)	(28,008)
Drug costs	(69,099)	(71,390)
Establishment & premises costs	(39,706)	(38,544)
Depreciation & amortisation	(37,255)	(42,180)
Clinical negligence	(18,834)	(22,560)
Impairments	(51,949)	0
Other	(65,778)	(56,061)
sub-total	**(1,047,11)**	**(948,710)**
Operating Surplus/(Deficit)	**(34,765)**	**15,283**
Finance Costs		
Interest receivable	1,679	613
Interest payable	(2,517)	(2,391)
PDC dividends payable	(8,697)	(11,518)
Other gains/(losses)	598	0
Corporation Tax	(338)	(787)
Surplus/(Deficit) 2023/24	**(44,040)**	**1,200**

Remove capital donations	(7,909)	(1,200)
Add back impairments	51,949	0
Adjusted Financial Performance Surplus/Deficit	**0**	**0**

3.5 Staff costs represent 68% of Trust operating expenses. A breakdown of the total staffing budget by staff type including whole time equivalent information for 2023/24 is shown in the table below:

Staff costs detail	2022/23 Outturn £'000	2023/24 Annual Budget £'000	2023/24 Plan WTE
Clinical substantive staff (non-medical)			
Registered nursing & midwifery staff	(172,225)	(173,586)	3,319
Allied Health professionals	(61,824)	(53,245)	1,176
Other therapeutic, scientific & technical staff	(34,355)	(38,766)	594
Support to clinical staff	(111,261)	(100,986)	3,098
	(379,665)	**(366,583)**	**8,187**
Medical & dental substantive staff			
Consultants	(73,017)	(69,991)	516
Career/Staff grades/Trainees	(56,674)	(61,143)	726
	(129,691)	**(131,134)**	**1,242**
Non-medical/non-clinical substantive staff			
NHS infrastructure support & others	**(78,976)**	**(93,147)**	**2,598**
Total substantive staff costs	**(588,332)**	**(590,864)**	**12,027**
Bank Staff			
Registered nursing & midwifery staff	(11,214)	(10,716)	158
Allied Health professionals	(1,432)	(5,035)	78
Support to nursing staff	(14,047)	(6,592)	280
Medical staff	(4,240)	(3,948)	13
NHS infrastructure support	(1,880)	(3,088)	40
Total bank staff costs	**(32,813)**	**(29,379)**	**569**
Agency staff			
Registered nursing & midwifery staff	(14,291)	(6,878)	206
Allied Health professionals	(3,322)	(2,349)	20
Support to nursing staff	(2,222)	(1,758)	16
Medical staff	(21,778)	(15,368)	114
NHS infrastructure support	(1,128)	(1,370)	20
Others	0	(351)	4
Total agency staff costs	**(43,371)**	**(28,074)**	**380**
Additional 6.3% pension contribution	(24,217)	0	
Less: capitalised staff	4,141	3,500	
Total staff costs	**(684,592)**	**(644,817)**	**12,976**

3.6 The monthly phased Trust budget is shown in the chart below:



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Surplus/(Deficit)	-1,178	-1,729	-1,692	-593	-552	-581	275	807	697	1,086	2,078	1,382
Cumulative Surplus/(Deficit)	-1,178	-2,907	-4,599	-5,192	-5,744	-6,325	-6,050	-5,243	-4,546	-3,460	-1,382	0

3.7 The Board will note that the Trust is planning a deficit for the first 6 months. This reduces over the next 6 months through the surpluses generated in each month -primarily as the delivery CIP increases.

4. CIP

4.1 The total savings programme is £33.8m in 2023/24. This is composed of three key elements:

Core CIP	£26.1m
Merger	£2.7m
System stretch	£5m
Total	**£33.8m**

4.2 For 2023/24 an options paper was presented to the Executive Team who agreed the allocation process for this year. This new approach is intended to be used in the medium term but will be reviewed during the business planning process for next year to review the impact it has made.

4.3 The full target (less stretch & merger savings) has been allocated using the following methodology:

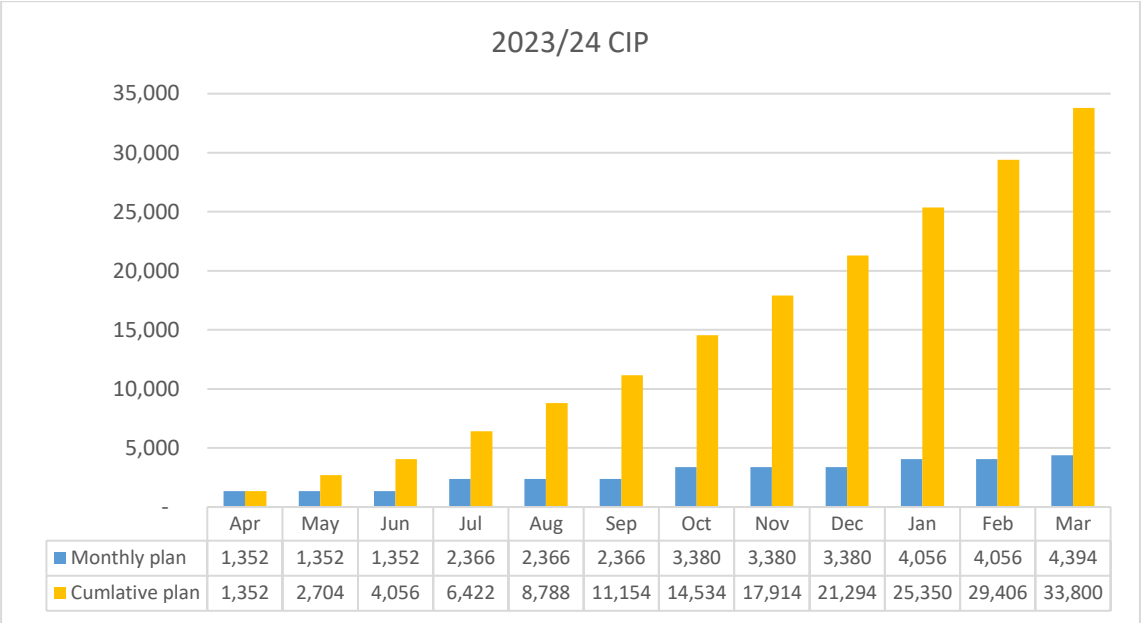
- previous non-recurrent delivery,
- implied efficiency within funding uplifts (1.1% deflator),
- a minimum requirement for all services of at least 1.8%,
- an allocation based on benchmarked opportunity (for acute services only)

This approach was agreed as the most equitable and is also expected to incentivise services to focus on more recurrent schemes as this methodology will form the basis of target setting for future years.

4.4 The programme by service/corporate team is shown below:

Service Group/Corporate Team	2023/24 CIP Target £'000	% of Total
Clinical Support & Cancer Services Group	4,199	12.4%
Medical Services Group	5,096	15.1%
Surgical Services Group	5,450	16.1%
Mental Health & LD Services Group	1,873	5.5%
CYP & Families Services Group	2,261	6.7%
Neighbourhood Services Group	2,492	7.4%
Operational Management	480	1.4%
Estates	1,147	3.4%
Director of Corporate Services	1,794	5.3%
Chief Finance Officer	711	2.1%
Chief Nurse	427	1.3%
Chief of People and OD	833	2.5%
Chief Medical Officer	161	0.5%
Director of Strategy and Digital	504	1.5%
SSL	876	2.6%
Stretch	5,000	14.8%
Central	496	1.5%
TOTAL	**33,800**	

4.5 This level of efficiency savings represents c3.4% of operating expenses and is a significant increase from the level of CIP delivered in 2022/23. The plan is profiled based on the makeup of individual schemes and increases from 12% in quarter 1 to 37% in quarter four. The monthly and cumulative trajectory is shown below: -



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly plan	1,352	1,352	1,352	2,366	2,366	2,366	3,380	3,380	3,380	4,056	4,056	4,394
Cumlative plan	1,352	2,704	4,056	6,422	8,788	11,154	14,534	17,914	21,294	25,350	29,406	33,800

4.6 An ambition to deliver 75% of the programme recurrently was set out in the merger business case. The current scheme split, risk rating and stage of development is summarised below:

	Pay £'000	**Non Pay £'000**	**Income £'000**	**Plan £'000**	**R £'000**	**NR £'000**
High Risk	7,674	6,699	2,213	16,586	1,600	14,989
Medium risk	5,951	4,283	1,166	11,400	9,951	1,449
Low Risk	3,951	1,844	19	5,814	4,752	1,059
Total Efficiencies	**17,576**	**12,826**	**3,398**	**33,800**	**16,303**	**17,497**
Fully Developed	2,375	1,229	19	3,623	2,628	995
Plans in Progress	3,930	2,323	1,000	7,253	7,199	54
Opportunity	5,097	2,575	266	7,938	6,476	1,459
Unidentified	6,174	6,699	2,113	14,986	-	14,989
Total Efficiencies	**17,576**	**12,826**	**3,398**	**33,800**	**16,303**	**17,497**

4.7 Services are continuing to work hard on their CIP plans in the face of ongoing operational pressures. Plans that are already in development are being progressed to implementation phase, while they continue to scope areas of opportunity to close the current gap.

4.8 We continue to work with the ICB to identify wider opportunities to secure savings as part of the £10m system stretch target. We are currently reviewing data including the efficiency SW opportunity matrix produced by NHSE. This a consolidation of existing data (Model System, productivity, reference costs etc) and will signpost possible areas of improvement.

5. CASH

5.1 The cash flow statement is driven by the planned operating surplus/(deficit), the impact of non-cash transactions such as depreciation and movements in working capital and the impact of investment activities, namely the Trust capital programme expenditure both in terms of capital expenditure and capital funding (PDC) received.

5.2 The summary of cash flows is set out in the table below and is based on the final income and expenditure plan and capital programme for the year:

Statement of Cash flows	Plan for y/e 31/03/24 £'000
Operating surplus/(deficit)	**15,283**
Non-cash income & expense	
Depreciation/amortisation	42,180
Income in respect of capital donations	(2,592)
Amortisation of PFI credit	(264)
Increase/(decrease) in trade/other payables/liabilities	(26,769)
Increase/(decrease) in provisions	(860)
Tax (paid/received	(225)
Net cash generated/(used in) operations	**27,613**
Cash flows from investing activities	
Interest received	612
Purchase of intangible assets	(11,269)
Purchase of property, plant & equipment	(56,715)
Net cash used in investing activities	**(67,372)**
Cash flows from financing activities	
Public dividend capital received	43,268
Loans from DH repaid	(848)
Other loans repaid	(968)
Capital element of lease payments	(7,556)
Capital element of PFI	(2,803)
Interest paid	(341)
Interest element of lease payments/PFI	(2,066)
PDC dividend (paid)/refunded	(11,520)
Net cash generated from/(used in) financing activities	**17,166**
Increase/(decrease) in cash & cash equivalents	**(22,593)**
Cash & cash equivalents at start of period	**68,648**
Cash & cash equivalents at end of period	**46,055**

5.3 The cash flow statement demonstrates that the Trust will have sufficient cash available to meet its obligations and planned commitments and there is no planned additional borrowing in the period.

6. STATEMENT OF FINANCIAL POSITION

6.1 The statement of financial position (balance sheet) is derived principally from the final revenue plans set out above and planned capital expenditure programme. The SOFP sets out the assets owned by the Trust and liabilities which it owes. These sum to the total net assets of the organisation and in the case of NHS bodies, are funded by the taxpayers' equity.

6.2 The movement in current assets and liabilities and other working capital are based on the business as usual activities of the Trust.

6.3 The final year ending 31/03/2024 planned position is shown in the table below:

Statement of Financial Position	Plan for y/e 31/03/24 £'000
Non-current assets	
Intangible assets	26,120
On-SoFP IFRIC 12 assets	27,317
Other property, plant and equipment (excludes leases)	449,653
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	78,455
Investments in associates and joint ventures	1,037
Other investments/financial assets	14
Receivables: due from NHS and DHSC group bodies	2,860
Receivables: due from non-NHS/DHSC Group bodies	403
Total non-current assets	**585,859**
Current assets	
Inventories	9,957
Receivables: due from NHS and DHSC group bodies	15,048
Receivables: due from non-NHS/DHSC Group bodies	33,409
Cash and cash equivalents: GBS/NLF	41,623
Cash and cash equivalents: commercial/in hand/other	4,432
Total current assets	**104,469**
Current liabilities	
Trade and other payables: capital	(15,626)
Trade and other payables: non-capital	(74,976)
Borrowings	(8,831)
Provisions	(3,160)
Other liabilities: deferred income including contract liabilities	(12,506)
Other liabilities: other	(259)
Total current liabilities	**(115,358)**
Total assets less current liabilities	**574,970**
Non-current liabilities	
Trade and other payables: non-capital	(99,481)
Other liabilities: deferred income/other	(6,811)
Total non-current liabilities	**(106,292)**
Total net assets employed	**468,678**
Financed by:	
Public dividend capital	418,954
Revaluation reserve	90,921
Other reserves	(2,471)
Income and expenditure reserve	(38,726)
Total taxpayers' and others' equity	**468,678**

7. RECOMMENDATION

7.1 The Board are asked to note and approve the Trust's 2023/24 annual revenue budget as set out above.

CHIEF FINANCIAL OFFICER