Board of Directors

Tue 01 July 2025, 09:30 - 13:00

Yeovil Football Club Lufton Way Brympton d'Evercy Yeovil BA22 8YF

NHS Somerset NHS Foundation Trust

Agenda

09:30 - 09:35
5 min

1. Welcome and apologies for absence

Rima Makarem

0725 Public Board Agenda v4.pdf (3 pages)

09:35 - 09:40
5 min

2. Minutes of the Public Board meeting held on 6 May 2025

Decision *Rima Makarem*

Enclosure 01 Minutes of the 6 May 2025 Public Board meeting.pdf (11 pages)

09:40 - 09:40
0 min

3. Action log and matters Arising

Information *Rima Makarem*

Enclosure 02 Action Log.pdf (3 pages)

09:40 - 09:40
0 min

4. Registers of directors' interests and receive any declarations of interests relating to items on the agenda

Information *Rima Makarem*

Enclosure 03 Register of Board of Directors' Interests.pdf (5 pages)

09:40 - 10:05
25 min

5. Update on Paediatric and Maternity Services at Yeovil District Hospital and Community Hospitals

Information *Peter Lewis/ Andy Heron*

10:05 - 10:20
15 min

6. Questions from Members of the Public and Governors

Information *Rima Makarem*

10:20 - 10:30
10 min

Break

10:30 - 10:40
10 min

7. Chair's Remarks

Information *Rima Makarem*

Verbal

10:40 - 10:45
5 min

8. Fit and Proper Person Test Declaration

Decision *Jade Renville*

Enclosure 04 Fit and Proper Person Framework report.pdf (4 pages)

Enclosure 04 Annual Fit and Proper Person submission.pdf (3 pages)

10:45 - 10:55
10 min

9. Chief Executive and Executive Directors' Report

Discussion *Peter Lewis*

To receive the Chief Executive's report.

To approve the Terms of Reference of the new Executive Committee

Enclosure 05 CEO and Executive Director Report to Board.pdf (12 pages)

Aim 5 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture

10:55 - 11:05
10 min

10. Q1 risk management, assurance framework 2025/26 and corporate risk register

Discussion *Jade Renville*

Enclosure 06 Corporate Risk Register Report.pdf (12 pages)
Enclosure 06 Board Strategy Session - Risk Appetite - July 2025.pdf (8 pages)

11:05 - 11:10
5 min

11. Assurance Report of the People Committee meeting held on 4 June 2025

Discussion *Graham Hughes*

Enclosure 07 Assurance Report from People Committee 4 June.pdf (3 pages)

11:10 - 11:30
20 min

12. Integrated performance report

Information *Pippa Moger*

Enclosure 08 Integrated Performance Exception Report.pdf (59 pages)

11:30 - 11:40
10 min

13. Severe Mental Illness

Discussion *Melanie Iles*

11:40 - 11:50
10 min

14. Assurance report of the Quality and Governance Assurance Committee meetings held on 30 April and 28 May

Discussion *Inga Kennedy*

Enclosure 10 Assurance Report Quality and Governance Assurance Committee 30 April 28 May.pdf (4 pages)

11:50 - 12:00
10 min

Coffee Break

Aim 6 - Live within our means and use our resources wisely

12:00 - 12:20
20 min

15. Finance Report (M2)

Discussion *Pippa Moger*

Enclosure 11 Board finance Report M2 FINAL.pdf (7 pages)

12:20 - 12:25
5 min

16. Assurance report of the Audit Committee – 18 June

Information *Paul Mapson*

Enclosure 12 Assurance Report Audit Committee 18 June.pdf (3 pages)

12:25 - 12:30
5 min

17. Assurance Report of the Charity Committee

Information *Graham Hughes*

Enclosure 13 Charities Committee Assurance Report 23rd April 2025.pdf (5 pages)

12:30 - 12:35
5 min

18. 2025/26 NHSE Board Assurance Statement

Decision *Pippa Moger*

Board Assurance Framework Final v1.3.pdf (5 pages)

For Information

12:35 - 12:40
5 min

19. Follow up questions from the Public and Governors

Information *Rima Makarem*

12:40 - 12:45
5 min

20. Any Other Business

Information *Rima Makarem*

12:45 - 12:50
5 min

21. Risks identified

Information *Rima Makarem*

12:50 - 12:55
5 min

22. Evaluation of the Effectiveness of the Meeting

Information *Rima Makarem*

12:55 - 13:00
5 min

23. Items to be discussed at the Confidential Board Meetings

Information *Rima Makarem*

The items presented to the Confidential Board include: Chief Executive verbal report; colleague suspensions and exclusions report; minutes of the Finance Committee meeting; corporate costs reduction, business case approval for Bridgwater diagnostic centre; Symphony Healthcare services

13:00 - 13:00
0 min

24. Withdrawal of Press and Public

Information *Rima Makarem*

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

13:00 - 13:00
0 min

25. Date of Next Meeting

Information *Rima Makarem*

Tuesday 2 September 2025

13:00 - 13:00
0 min

26.

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 1 July 2025** at **9.30am** at Yeovil Football Club Lufton Way Brympton d'Evercy Yeovil BA22 8YF

If you are unable to attend, would you please notify David Seabrooke, Interim Trust Secretary by email david.seabrooke@somersetft.nhs.uk

Yours sincerely

Dr Rima Makarem
Chair

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**		Chair	09:30	Verbal
2.	**Minutes of the Somerset NHS Foundation Trust's public board meeting held on 6 May 2025**	Approve	Chair		Enclosure 01
3.	**Action log and matters arising**	Review	Chair		Enclosure 02
4.	**Registers of directors' interests and declarations of interests relating to items on the agenda**	Note and receive	Chair		Enclosure 03
5.	**Update on Paediatric and Maternity Services at Yeovil District Hospital and Community Hospitals**	Receive	Peter Lewis/ Andy Heron	09.40	Verbal
6.	**Questions from Members of the Public and Governors**	Receive	Chair	10.05	Verbal
	BREAK				
7.	**Chair's remarks**	Note	Chair	10.30	Verbal
8.	**Fit & Proper Test annual declaration**	Approve	Rima Makarem	10.40	Enclosure 04
9.	**Chief Executive and executive directors' report**	Receive	Peter Lewis	10.45	Enclosure 05

		Action	Presenter	Time	Enclosure
Aim 5 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture					
10.	**Q1 Board Assurance Framework and corporate risk management report**	Receive	Peter Lewis Jade Renville	10.55	Enclosure 06
11.	**Assurance report from the People Committee meeting held on 4 June**	Receive	Graham Hughes	11.05	Enclosure 07
Aim 2 – Provide the best care and support to people					
12.	**Integrated Performance Report**	Receive	Pippa Moger	11.10	Enclosure 08
13.	**Severe Mental Illness**	Receive	Dr Melanie Iles	11.30	Enclosure 09
14.	**Assurance report of the Quality and Governance Assurance Committee meetings held on 30 April and 28 May**	Receive	Inga Kennedy	11.40	Enclosure 10
Aim 6: Live within our means and use our resources wisely					
15.	**Finance report (M2)**	Receive	Pippa Moger	12.00	Enclosure 11
16.	**Assurance report of the Audit Committee – 18 June**	Receive	Paul Mapson	12:20	Enclosure 12
17.	**Assurance report of the Charity Committee**	Receive	Graham Hughes	12:25	Enclosure 13
18.	**2025/26 NHSE Board Assurance Statement**	Receive	Pippa Moger	12:30	Enclosure 14
For Information					
19.	**Follow-up questions from the public and governors**		Chair	12.35	Verbal
20.	**Any other business**		All		Verbal
21.	**Risks identified**		All		Verbal
22.	**Evaluation of the effectiveness of the Meeting**		Chair		Verbal
23.	**Items to be discussed at the confidential Board Meeting** Suspension and exclusion report Symphony Healthcare services				

Corporate Costs Reduction
Business case for the Diagnostic Centre in Bridgwater
Minutes of the Finance Committee meeting held on 30 May 2025

24. Withdrawal of Press and Public

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

25. Date of Next Public Meeting

Tuesday 2 September 2025 – Community Hospital, Enos Way, Frome, Somerset BA11 2FH

NHS
Somerset
NHS Foundation Trust

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 6 MAY 2025 AT THE MINEHEAD COMMUNITY HOSPITAL, LUTTRELL WAY, MINEHEAD

PRESENT

Rima Makarem	Chair
Graham Hughes	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Inga Kennedy	Non-Executive Director
Paul Mapson	Non-Executive Director
Alexander Priest	Non-Executive Director
Jan Hull	Non-Executive Director
Peter Lewis	Chief Executive
Andy Heron	Chief Operating Officer/Deputy Chief Executive
Pippa Moger	Chief Finance Officer
Melanie Iles	Chief Medical Officer
David Shannon	Director of Strategy and Digital Development
Kirstie Lord	Deputy Chief People Officer
Alison Wootton	Deputy Chief Nurse
Jade Renville	Director of Corporate Services

IN ATTENDANCE

Paul Foster	Consultant Vascular Surgeon and Learning from Deaths Lead (for item 15)
Fiona Reid	Director of Communications
Sally Bryant	Director of Midwifery
David Seabrooke	Interim Trust Secretary
Jack Torr	Governor
Jeanette Keech	Governor
Adekunle Akinola	Governor
Kate Butler	Lead Governor

1. WELCOME AND APOLOGIES FOR ABSENCE

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

It was noted that apologies had been received from Isobel Clements and Hayley Peters.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

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

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 4 MARCH 2025

The Board approved the minutes of the Somerset NHS Foundation Trust Public Board meeting held on 4 March 2025 as a true and accurate record.

4. ACTION LOGS AND MATTERS ARISING

The Board received the action log and noted the two completed actions.

There were no matters arising from the minutes.

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

The Board received the Register of Directors' interests

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

6. CHAIR'S REMARKS

The Chair highlighted the following main points:

- Work on the Department of Health and Social Care and NHS England merger was progressing however the trust needed to focus on its own agenda. We were offering support in relation to any restructuring of the Integrated Care Board;
- She highlighted the Health Service Journal provider summit;
- The Chair had met with three of the local MP's and discussed their various issues and concerns;
- She noted that the recruitment of three non-executive directors was progressing through to a selection day later in May

7. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT

7.1. The Chief Executive presented the report which was received by the Board. The Report confirmed the Trust's 2025/26 strategic aims as follows:

1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities

2 Provide the best care and support to people

3 Strengthen care and support in local communities

4 Respond well to complex needs

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

6 Live within our means and use our resources wisely

7 Deliver the vision of the trust by transforming our services through innovation, research and digital transformation

7.2. These objectives and the Specific Objectives for 2025/26 would be formatted into the Board Assurance Report for the next meeting.

7.3. A balanced financial plan for Somerset had been submitted by the Trust and the ICB.

7.4. The following further points were noted:

- Dave Thomas had been appointed as Acting Chief Nurse and would be starting his role this month.
- He noted the useful discussion held at the 1st April board inclusion workshop and details were appended to the report
- The CEO had been asked by NHS England to lead a regional provider CEO advisory group in relation to the changes at NHS England and the commissioning sphere described in the report.

7.5. The Register of Seals 1 November 2024 – 31 March 2025 was noted.

7.6. The Board received a summary of proposed updates to Standing Financial Instructions and Standing Orders, detailed in the Reading Room. The updates were **approved**.

7.7. The Board received information about the required annual Self-Declaration – under Licence Condition 7. The Board **approved** statement 3a as detailed in the report.

8. Q4 RISK MANAGEMENT, ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

8.1. The Board received the report from the Director of Corporate Services**.** The principal risks were shown as:

Access to primary care / increasing ED demand (objective 2) – 20
Workforce shortages (objective 2) – 20
Age of acute and community estates (objective 2) - 20
Vacancy rates within senior doctor workforce (objective 6) – 20

Risk of EHR business case is not approved or delays to process (objective 8) – 20

8.2. It was noted that the committees had each undertaken their reviews in relation to their assigned objectives and this had been reported for assurance to the April Audit Committee.

8.3. The Board noted the report.

9. FREEDOM TO SPEAK UP GUARDIAN (FSUG)

9.1. The Chair welcomed Caroline Sealey to the meeting. The report provided an update regarding FTSU activity with an overview for 2024 – 2025 and further detail for the period October 2024 – March 2025. 412 cases had been raised in the year. 39% of concerns contained an element of working safety or wellbeing.

9.2. Ten new FSUG ambassadors had been appointed in the Trust, but it was felt that a greater diversity could be achieved in this area. The Neighbourhood service group had seen a concern being raised on a collective basis by 35 colleagues and, in line with the NGO guidance, these had to be reported as separate cases.

9.3. Principal issues raised were that processes and guidance were not always followed and that manager discretion where used needed to be applied fairly. Some colleagues raising concerns needed to have their expectations managed and it was acknowledged that the process could also be challenging for managers. Fear of consequences of raising a concern remained a factor.

9.4. It was noted that the Freedom to Speak Up Guardian had a monthly meeting with the Chief Executive to review concerns being raised. It was noted that complaints were logged as 'anonymous' at the point of first contact in line with national guidance. It was also noted that the colleague feedback forum brought together the various sources of employee feedback.

9.5. Following the departure of a previous incumbent, there was a vacancy for a non-executive director freedom to speak up champion. In the interim, concerns could be raised with the Chair of the Audit committee.

9.6. The chair thanked Caroline Sealey for attending today and the report was noted.

10. ASSURANCE REPORT FROM THE PEOPLE COMMITTEE MEETINGS HELD ON 14 JANUARY, 12 FEBRUARY (DEEP DIVE) AND 18 MARCH 2025

10.1. The Board received the report of the People Committee. Jan Hull highlighted the discussion the committee had had on staff experience. There was more to do on

controlling agency spend and in particular the use of off-framework temporary nursing.

10.2. The committee had also discussed the occasional lack of flexibility in the consultant recruitment process.

10.3. The board noted the report of the People Committee.

11. PATIENT STORY: PERSONALISED CARE – MATERNITY

11.1. The Chair welcomed Elizabeth Strong, Practice Development Lead to the meeting. Sally Bryant reflected that there had been a number of regulatory visits to the maternity service who had reflected on to the professionalism of the staff. Slides were shown.

11.2. Elizabath Strong explained that 4-5% of women experience some form of birth trauma and would benefit from a perinatal health service. Women did not always discuss concerns with their GP. The ERA care system provided a self check-in ahead of a GP appointment that generated a personal response, signposting available support for flagged symptoms. It did not generate new referrals. The project Elizabeth had led engaged with midwives to encourage them to offer this check over a 15-week period.

11.3. Engagement with the questionnaire had reached 62% and the project secondment had now finished. The ambition would be for the product to feature on the main NHS app. There were changes being made to the community service that would factor in the use of the ERA product and look to ensure staff had time to incorporate it in their work with patients.

11.4. The Chair thanked Elizabeth for the presentation to the Board.

12. QUALITY AND PERFORMANCE EXCEPTION REPORT

12.1. The Board received the report from the Chief Finance Officer. The Quality and Performance Exception Report set out the reasons for any significant changes. Areas in which performance has been sustained or has notably improved include:

- access to our perinatal service was significantly above the 10% national standard.
- the percentage of patients followed up within 72 hours of discharge from our adult mental health wards remained above 90%.
- the number of patients waiting 18 weeks or more from referral to be seen by our community services reduced.

• compliance in respect of patients seen within two hours by our urgent community response service remained significantly above the national reporting standard.

12.2. 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 people waiting under six weeks for a diagnostic test.
- the percentage of ambulance handovers completed within 30 minutes of arrival at our Emergency Departments
- the number of patients waiting 18 weeks or more to be seen by the community dental service

12.3. It was further noted that two of the cancer standards had been met. Against the current A&E standard of 78% we had achieved 72% of patients seen within 4 hours. There were 81 patients waiting over 65 weeks and 4 over 78 weeks. Under the use of restraint, 83 of the reported incidents related to the need for NGT feeding.

12.4. In the longer term it was planned to re-gain the national 18-week standard by 2029.

12.5. The Chief Financial Officer undertook to investigate the availability of SSNAP stroke data and the availability of Sepsis data. There were no other concerns about IPC data.

12.6. There continued to be high usage of A&E in Yeovil.

12.7. The Chief Medical Officer undertook to report to QCAG on extended complaints response times.

12.8. 231 beds (24%) were affected by no criteria to reside. The county council was investing in additional capacity in this area and this was expected to bring improvement from July. SFT was increasing its discharge to assess capacity.

12.9. The Board noted the report.

13. WELLBEING GUARDIAN REPORT

13.1. The Board received the report, presented by the Guardian. The following principal points were noted:

- The new Occupational Health Provider had received positive user feedback and had reduced wasted appointments
- There was concern that due to space constraints at both acute hospitals there was a lack of staff rest spaces

- A new contract with Cook had improved the availability of fresh food at night at the acute hospitals
- There was a concern that people were not being sufficiently support where they had experienced violence and aggression

13.2. It was also noted that Wellbeing portfolio has been reorganised to include Colleague Support and Wellbeing Services, and Mediation, resolution and coaching services. Future developments this year included Compassionate Leadership Training with Leadership and Organisational Development, Somerset Activity Sports Partnership (SASP) project, Health Fair Pilot, and Mediation, Resolution and Coaching Relaunch.

13.3. The Board noted the report.

14. SIX MONTHLY SAFE STAFFING ESTABLISHMENT REPORT

14.1. The Board received the report covering July-December 2024, presented by the Deputy Chief Nursing Officer. Maternity safe staffing was not covered in this paper as it was presented to the Quality and Governance Assurance Committee as part of the Maternity Incentive Scheme.

14.2. The Board was offered assurance that the Trust is taking all reasonable and available measures to ensure safe staffing levels in ward areas and where this is not possible, escalation and actions are followed to try and mitigate the risks of working with a compromised level of staffing.

14.3. The following ongoing pressures in the period were noted:
- Delays to discharge with high numbers of people who are medically fit for discharge, many of whom still have complex nursing needs.
- High pressures in emergency care.
- Ongoing use of escalation beds including the reopening of the community escalation beds towards the later end of the report period.
- High levels of respiratory illness causing both increased bed pressures in the acute hospitals due to higher admissions, higher level of acuity in patient mix, ward restrictions due to IPC and a higher level of colleague sickness causing compromised levels of staffing

14.4. The twice-yearly review process was outlined and it was noted that this was the second time of using the current SNCT assessment tool, which took account of patient throughput. Professional judgement was applied to the balance of non-qualified and qualified staff based on feedback from complaints and incidents. It was confirmed that that staffing resources were deployed daily according to fill rates. Wards had ceased the use of premium agency for nursing.

14.5. It was noted that a standard operating procedure was in place for times patients were care for in non-bedded areas – skill mix would appear in future reports. The next report would advise on the overall FTE staff numbers.

14.6. The Board approved the report for publication.

15. Q4 LEARNING FROM DEATHS FRAMEWORK: MORTALITY REVIEW PROGRESS REPORT

15.1. The Chair welcomed Paul Foster to the meeting and the report was received. The following points from the report were noted:

- Learning from the *Deaths :* learning appears to be aligned with our PSIRF priorities, themes of TEP, managing the deteriorating patient and communication with people who matter continue to be seen. We are also seeing themes around transfers of care.

- Learning from the *Detail -* Medical examiners are reviewing 100% of SFT deaths, totalling 612 in Quarter 4, with feedback being cascaded for 90 of these deaths. The Learning from Deaths team coordinate the triage of these so an agreement can be reached on a proportionate response.

- Learning from the *Data -* Our overall Trust Mortality Rate continues to be as expected – SHMI was 1.00.

15.2. Most deaths happened within a hospital setting, which is in line with the national findings for people with Learning Disability but is higher than in the general population. The most common causes of death related to diseases of the respiratory system.

15.3. During this reporting period, there were 52 new enquiries from the Coroner concerning the deaths of patients known to SFT. Formal statements have been requested for all cases. The Board reflected on the demands on staff arising from this, including the associated legal costs.

15.4. The Patient Safety Faculty would include a Head of Patient Safety and Learning and a new Associate Medical Director to promote clinical safety with divisional leaders.

15.5. The report was noted.

16. GUARDIAN OF SAFE WORKING FOR POSTGRADUATE DOCTORS REPORT – Q1

16.1. The Board received the report for the period 25 January to 17 April 2025. The Board was reminded that Exception reports are a mandatory requirement of

the 2016 Junior Doctor Contract. All doctors on this contract should report any hours worked above their standard contract. There were 424 doctors and dentists in training.

16.2. 178 Exceptions had been reported, nearly all of which were from Acute & General Medicine across the two sites. Issues discussed in the Post-Graduate Doctor Forum included rota, work schedules, teaching and training and the current method of exception reporting and the difficulties that doctors are having in navigating the reporting process.

16.3. Most agency spend was on vacancy cover. There was concern about the BMA balloting for industrial action. The Chief Medical Officer undertook to discuss with the Guardians the effect of the outstanding exception reports.

16.4. The Board noted the report.

17. ASSURANCE REPORT OF THE MENTAL HEALTH ACT COMMITTEE MEETING HELD ON 11 MARCH 2025

17.1. The Board received the report and the Chairman highlighted the positive report from Swan Advocacy received at the meeting and its discussion of the Mental Health Bill.

17.2. The Board noted the report.

18. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETINGS HELD ON 26 FEBRUARY (FOCUS) AND 26 MARCH 2025

18.1. The Board received the report and the appended Maternity & Neonatal safety & quality quarterly report for Q4 2025. It was noted that in relation to Maternity Safety Action 9, a new Safety Champion Board has been convened, and membership will consist of the most senior clinical leads in midwifery, neonates, obstetrics and anaesthetics. The Board level safety champion will be Hayley Peters and non-executive directors, Inga Kennedy and Alex Priest.

18.2. The report confirmed that bi-monthly walkabouts are held at each acute site, led by senior leaders and involving staff, MNVP reps, and service users

18.3. The committee further discussed the Section 29A Warning Notice relating to paediatric services at YDH. The deep dive on reducing inequality was highlighted.

18.4. The Chair requested that the Acting Chief Nurse be given specific objectives, including to take forward the proposed ward accreditation scheme.

18.5. The Committee recommended to the Trust Board that the Risk Appetite levels remain set as they were last year which was accepted.

19. FINANCE REPORT (M12)

19.1. The Board received the report from the Chief Financial Officer and the following main points were noted:

- An in-month surplus of £3m had been delivered leading to a breakeven a year-end position
- £2.1m agency spend was under plan but was £1.5m over the cap
- £64.4 of cost improvement had been delivered
- Cash at bank was £79m
- The capital plan of £96m had been delivered, but there was a need for improved governance in this area

20. AMENDMENTS TO STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS

20.1. This matter was agreed via the Chief Executive's report.

21. GOING CONCERN STATEMENT

21.1. The Board received a report from the Chief Financial Officer setting out the basis for the annual accounts 2024/25 to be prepared on a 'going concern' basis.

21.2. Taking into account the evidence in support of this, including the balanced financial plan 2025/26 and cash forecast presented, the Board approved the report.

22. ASSURANCE REPORT OF THE AUDIT COMMITTEE – 16 APRIL 2025

22.1. The Board received the report. It was noted that the internal audit opinion for 2024/25 was likely to be moderate assurance. Committees would be following up on the two limited assurance reports presented. A further five audits from 2024/25 were due to be presented. The procedures around the application of sanctions to staff in fraud cases was highlighted.

22.2. The Appointed Auditor's value for money report contained significant risks around maternity and paediatrics.

22.3. The Board noted the report.

23. VERBAL REPORT FROM THE FINANCE COMMITTEE MEETINGS HELD ON 24 FEBRUARY 31 MARCH AND 28 APRIL 2025

23.1. It was noted that all the Trust's Windows 10 devices would be moved to Windows 11 ahead of Windows 10 dropping out of support. One essential clinical system that was not compatible had been identified that would be moved to a standalone system.

24. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

There were no follow up questions from members of the public.

25. ANY OTHER BUSINESS

There were no matters of AOB.

26. RISKS IDENTIFIED

The Board did not identify any new risks.

27. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

The Board agreed that the meeting had been efficient and effective with detailed discussions and challenges.

28. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

28.1. The Chair highlighted the items for discussion at the confidential Board meeting and set out the reasons for including these items on the Confidential Board agenda.

- Suspension and exclusion report
- Wells Priory Refurbishment
- Symphony Healthcare Services Highlight Report and strategy
- Minutes of the Finance Committee meeting held on 31 March 2025

29. WITHDRAWAL OF PRESS AND PUBLIC

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

30. DATE OF NEXT MEETING

Tuesday 1 July 2025 – Yeovil District Hospital

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETING

HELD ON 6 MAY 2025

MINUTE	ACTION	BY WHOM	DUE DATE	PROGRESS
12 Quality & Performance Exception Report	Investigate the availability of SSNAP stroke data and the availability of Sepsis data.	Chief Financial Officer	June 2025	**Stroke**: Reporting was impacted by the national system provider and reporting not possible between October 2024 and February 2025. Information is now being presented can be backdated to May 2024. **Sepsis**: Audits were paused in December 2024 to allow for a full review. Data collection will began on 1 June 2025 using the new data collection tool for MPH and YDH. Information relating to PEWS has now been collated.
12 Quality & Performance Exception Report	Investigate extended complaints response times	Chief Medical Officer	June 2025	The complaints process has been fully reviewed and restructured in line with PSIRF principles and a compassionate engagement approach. When a formal complaint is received, the complainant is contacted within three working days. The complaints co-ordinator works with the complainant to understand their concerns and desired outcomes, sometimes resolving issues at this stage before escalating to a formal complaint. We now offer resolution meetings in about 60% of cases.

				While delays do occur - as outlined in the board exception report – complainants are kept in the loop with this and usually agree to extensions.
9. Freedom To Speak Up Guardian	Fill vacancy for non-executive Champion role	Chair	August 2025	

NHS
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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Directors' Interests
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Rima Makarem, Chair
DATE:	1July 2025

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

Executive Summary and Reason for presentation to Committee/Board	The Registers of Interests are presented to the Board at every meeting and reflect the interests of Board members as at 23 June 2025.
Recommendation	The Board is asked to: • Note the Register of Interests. • Declare any changes to the Register of Interests. • Declare any conflict of interests in relation to the agenda items.

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

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

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

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

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

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

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

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

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25/06/2025 15:10:21

REGISTERS OF DIRECTORS' INTERESTS

NON EXECUTIVE DIRECTORS	
Rima Makarem Chairman	• Chair, Sue Ryder – non-remunerated • Chair, Queen Square Enterprises – remunerated • Lay member, General Pharmaceutical Council – remunerated
Alexander Priest Non-Executive Director	• Chief Executive Mind in Somerset
Martyn Scrivens Non-Executive Director (Deputy Chairman)	• Non Executive Director and Chair of Audit Committee of Hampshire Trust Bank Limited • Wife works as a Bank Vaccinator for the Trust ▪ Member of the Boards of Directors of the Ardonagh Group – consisting of the following companies: – Ardonagh Holdco Limited (Jersey) – Ardonagh New Midco 1 Limited (Jersey) – Ardonagh Group Holdings Limited (UK) – Ardonagh New Midco 3 Limited (Jersey) – Ardonagh Midco 1 Limited (Jersey) – Ardonagh Midco 2 plc (UK) – Ardonagh Midco 3 plc (UK) – Ardonagh Finco plc (UK) • Director of Ardonagh International Limited • Chair of Symphony Healthcare
Graham Hughes Non-Executive Director	• Chairman of Simply Serve Limited • Parish Councillor of Babcary Parish Council
Paul Mapson Non-Executive Director	Nothing to declare.
Inga Kennedy Non-Executive Director	• IJKennedy Healthcare Consultancy - Position - Director (however this Ltd Company is registered as not trading at this time.) • Trustee of the White Ensign Association

EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Management Board Member, Somerset Estates Partnership (SEP) Board • Director, Somerset Estates Partnership Project Co Limited
Jade Renville	• Executive Director of Corporate Services, Somerset ICB Board • Chair, Richard Huish Multi-Academy Trust (voluntary capacity) • Father is Director and owner of Renvilles Costs Lawyers
Isobel Clements Chief of People and Organisational Development	• Sister in law works in the pharmacy department at MPH • Nephew works as a physio assistant within MPH. • Governor at Weston College
Andy Heron Chief Operating Officer/Deputy Chief Executive	• Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services) • Director of the Shepton Mallet Health Partnership • Executive Director for SHS
Pippa Moger Chief Finance Officer	• Stepdaughter works at Yeovil District Hospital • Son works for the Trust • Director of the Shepton Mallet Health Partnership • Director of Somerset Estates Partnership Project Co Limited • Member of the Southwest Pathology Services (SPS) Board • Shareholder Director for SSL
David Shannon Director of Strategy and Digital Development	• Member of the Southwest Pathology Services (SPS) Board • Daughter is employed as a healthcare assistant at Musgrove Park Hospital • Member of the Symphony Health Care Services (SHS) Board • Director of Symphony Health Services (SHS) • Wife works within the Neighbourhood's Directorate. • Management Board Member, Somerset Estates Partnership (SEP) Board • Director Predictive Health Intelligence Ltd • Shareholder Director of SSL

Melanie Iles Chief Medical Officer	None to declare
Dave Thomas Interim Director of Nursing	Army Reservist, currently Commanding 243 Multi-role Medical Regiment

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Fit and Proper Person Annual Submission
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Jade Renville
DATE:	1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	The Fit and proper Person Test (FPPT) Framework was published by NHS England on 2 August 2023 in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. A report on the changes to the Framework was presented to the February 2024 Board meeting. This report sets out the actions taken to ensure that Board member, continue to meet the requirements of the Fit and Proper Person Framework.
Recommendation	The Board is asked to accept the assurance that all Board members and deputy directors meet the Fit and Proper Persons requirements. The Board is further asked to approve the signing and submission of the Fit and Proper Person Annual Submission to NHS England.

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

- ☐ Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
- ☐ Aim 2 Provide the best care and support to people
- ☐ Aim 3 Strengthen care and support in local communities
- ☐ Aim 4 Respond well to complex needs
- ☐ Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☐ Aim 6 Live within our means and use our resources wisely
- ☐ Aim 7 Deliver the vision of the Trust by transforming our services through, innovation, research and digital transformation

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

Equality and Inclusion

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

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

No impact on people with protected characteristics has been identified as part of the attached report.

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

Public/Staff Involvement History

How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.

Public or staff involvement or engagement has not been required for the attached report but engagement has taken place by NHS England during the development of the Framework.

Previous Consideration

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

This report has not previously been considered.

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

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

Seabrooke,David
25/06/2025 15:10:21

SOMERSET NHS FOUNDATION TRUST

FIT AND PROPER PERSON ANNUAL SUBMISSION 2025

1. BACKGROUND

1.1. The updated Fit and Proper Person Test (FPPT) Framework was published by NHS England in August 2023. The Framework takes account of the guidance produced by the Care Quality Commission "Regulation 5: Fit and Proper Persons: Directors Information for NHS Bodies" published in March 2015. The Trust has a local policy setting out its approach to these requirements.

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

1.3. The Framework applies to the board members of NHS organisations, irrespective of voting rights or contractual terms. The Trust has chosen to include a number of deputies within the scope of the FPPT Framework.

1.4. The annual check refers to people in post at 30 June 2025. The three NEDs and Associate NED offered roles this year have been subject to the FPPR test as new entrants.

2. ANNUAL CHECKS AND SELF-ATTESTATIONS

2.1. The FPPT process was undertaken during May and June 2025; the following checks were carried out:

- Social Media
- Employment Tribunal Judgements
- Disqualified Charity Trustee Register
- Insolvency Register
- Disqualified Director Register

2.2. Where applicable, professional registration checks have been completed. Everyone in the process has a current Disclosure & Barring check.

2.3. Evidence of all checks is placed on file and the dates and status of completed checks will be included onto the electronic staff record (ESR).

2.4. Everyone in the process was required to sign a self-attestation declaring their continuing compliance with the Fit and Proper Person requirements.

2.5. No concerns about Directors' continuing fitness or ability to carry out their duties or information about a director not being of good character have been identified as part of the checks or brought to the attention of the Chair.

2.6. The Chair therefore provide the Board with assurance that Board Directors meet the requirements of the Fit and Proper Persons Test Framework.

3. RECOMMENDATIONS

3.1. The Board is asked to accept the assurance that all Board members and Directors as specified in the Fit and Proper Person Policy continue to meet the Fit and Proper Persons requirements.

3.2. The Board is further asked to approve the signing and submission of the Fit and Proper Person Annual Submission to NHS England.

INTERIM TRUST SECRETARY

Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
Somerset NHS Foundation Trust	Rima Makarem	30 June 2025

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

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Board Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	6	6	0		1	3
Executive board members	7	7	0		1	1
Partner members (subsidiary)	1	1	0		0	0
Dedicated deputy directors	0	0	0		0	0
Total	14	14	0		2	2

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

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	No	No

Part 2: FPPT reviews / inspections

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

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR Somerset NHS Foundation Trust October 2024 to June 2025				
For the SID/deputy chair to complete:				
FPPT for the Chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Senior Independent Director	Graham Hughes		Yes

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

As Chair of Somerset NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.

Chair signature:	
Date signed:	

For the regional director to complete:	
Name:	
Signature:	
Date:	

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25/06/2025 15:10:21

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive/Executive Director Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	This report provides information on national, regional, and local issues impacting on the organisation. It also updates the Board on the activities of the executive and senior leadership team and/or points of note which are not covered in the standing business and performance reports, including media coverage and any key legal or statutory changes affecting the work of the Trust.
Recommendation	The Board is asked to note the report.

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

- ☒ Aim 1 Contribute to improving the health and wellbeing of population and reducing health inequalities
- ☐ Aim 2 Provide the best care and support to people
- ☐ Aim 3 Strengthen care and support in local communities
- ☐ Aim 4 Respond well to complex needs
- ☐ Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☐ Aim 6 Live within our means and use our resources wisely
- ☐ Aim 7 Deliver the vision of the trust by transforming our services through innovation, research and digital transformation

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
The report includes a number of references to work involving colleagues, patients and system partners.

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

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1 BACKGROUND AND PURPOSE

1.1 This report provides information on national, regional, and local issues impacting on the organisation.

1.2 It also updates the Board on the activities of the executive and senior leadership teams and/or points of note which are not covered in the standing business and performance reports, including media coverage and any key legal or statutory changes affecting the work of the Trust.

1.3 The following items require Board approval:

- Executive Committee Terms of Reference

2 NATIONAL AND REGIONAL DEVELOPMENTS / POLICY UPDATES

Urgent and Emergency Care Plan 2025/26

2.1 Published in June 2025, NHS England's new urgent and emergency care (UEC) plan outlines several priority actions aimed at improving winter performance and patient outcomes:

- Ambulance wait times for Category 2 patients (e.g., stroke, heart attack) to be reduced by over 14%.
- Ambulance handover delays to be eradicated by meeting a 45-minute maximum standard.
- A&E performance targets raised to ensure 78% of patients are admitted, transferred, or discharged within 4 hours.
- Mental health crisis care improvements to reduce 24-hour ED stays.
- Discharge delays addressed, targeting 30,000 patients annually who stay 21+ days post-discharge readiness.
- Children's emergency care to be expedited, with more seen within 4 hours.
- Winter planning includes expanding urgent care outside hospitals and increasing vaccination uptake among frontline staff.

2.2 More detail on the plan can be found here.

Spending Review 2025

2.3 As part of the government's fiscal planning, the Spending Review 2025 was published in June and outlines key funding priorities and expectations for the NHS over the coming years. It provides a framework for how the health service is expected to deliver care within a constrained financial environment while continuing to meet rising demand.

2.4 The review confirms real-terms growth in NHS England's budget through to 2028–29, with targeted investment to reduce elective care backlogs, improve urgent and emergency care, and expand primary and community services.

2.5 Capital funding will continue through to 2029–30, supporting digital transformation, estate upgrades, and new hospital builds. It also supports the NHS Long Term Workforce Plan, with funding for expanded training, retention, and international recruitment. Additional investment will enhance digital infrastructure, AI diagnostics, and research partnerships. NHS organisations are expected to deliver efficiency savings through productivity improvements and digital reform, aligning with the 2025/26 operational planning guidance.

Update on NHS Performance Assessment Framework

2.6 During May 2025, NHS England launched a further consultation on its revised Performance Assessment Framework, building on earlier engagement and reflecting significant changes in the operating context. This framework replaces the previous Oversight Framework and is designed to provide a clearer, more consistent, and transparent view of performance across NHS trusts and Integrated Care Boards (ICBs).

2.7 The May consultation focused on simplifying the framework by streamlining the number of metrics and aligning it more closely with the government's 2025 mandate and NHS priorities for 2025/26. It aims to support improvement, enhance public accountability, and ensure that performance assessments are proportionate and focused on outcomes.

NHS Providers Survey

2.8 NHS Providers have published the findings of their latest survey, which provides a snapshot of the implications of the NHS financial 'reset' for hospital, mental health, ambulance and community services across England.

2.9 The survey findings include:

- Nearly half (47%) of those surveyed told us that they will have to scale back service provision to deliver their financial plan and a further 43% have this currently under consideration.
- Over a third (37%) of respondents said their organisation will cut substantive clinical posts to deliver their financial plan, with a further 40% saying this is currently under consideration.
- 86% of respondents said they will have to cut substantive non-clinical posts in order to deliver their financial plan this year, a further 13% have this under consideration.
- 45% of those surveyed were extremely (25%) or moderately (20%) concerned that the actions they are having to take to deliver their financial plan will compromise patient experience.
- Close to three in five respondents said patient experience (61%), work to address health inequalities (60%) and access to timely care (57%) were most at risk of being impacted in order to deliver financial plans.

2.10 You can read the full survey findings through the NHS providers press release.

Peter Lewis sixth in HSJ list of top 50 chief executives

2.11 This week the Health Service Journal (HSJ) published its 2025 list of the top 50 chief executives in the NHS.

2.12 The list was compiled with the input of leading figures in and around the NHS. The judging panel looked at the following criteria:

- **The performance of the chief executive over the last year.** Chief executives who have steered their organisations through difficult times, including supporting staff and ensuring patients get the best care possible, given the constraints trusts face. The panel also looked at other aspects of leadership, including chief executives' leadership style and behaviours – such as their approach to mentoring and developing more junior staff, encouraging inclusive leadership, how they work with their board (both executives and non-executives), and their standing among their peers and personal qualities.

- **The performance of the organisation they lead, given the circumstances it is in.** This included looking at the results of the staff survey and any recent Care Quality Commission reports, while acknowledging many organisations are struggling with the traditional metrics around waiting times.

- **The contribution the chief executive has made to the wider health and social care system.** This might be through leading on important projects, either nationally or locally, or taking on additional roles, such as chairing integrated care partnerships, with a focus on chief executives who work for the benefit of the system as a whole rather than only protecting the interests of their own organisations.

3 CORPORATE UPDATES

Chief Nurse Appointment

3.1 Following the announcement of Hayley Peters' departure as Chief Nurse, Somerset NHS Foundation Trust launched a national recruitment campaign to appoint her successor. The role attracted significant interest, reflecting the Trust's strong reputation and the opportunity to lead nursing across a fully integrated acute, community, mental health, and primary care system.

3.2 The recruitment process concluded with final interviews held on 17 June 2025. An announcement regarding the successful candidate will be made shortly, with a focus on ensuring a smooth transition and continued leadership in delivering high-quality, inclusive care across Somerset.

3.3 We would like to extend our sincere thanks to Dave Thomas, who is serving as Interim Chief Nurse during this transitional period. His leadership, dedication, and support are greatly valued, and he is playing a key role in maintaining continuity and quality of care across the Trust.

4 REPORTS AND ASSURANCE UPDATES (INCLUDING UPDATES FROM OPERATIONAL LEADERSHIP TEAM)

Executive Committee and Governance Update

4.1 Following a recent governance review, in order to assist the visibility of operational delivery and assurance discussions, the Operational Leadership Team meetings have been reconstituted as the Executive Committee, with revised terms of reference as appended to this report (Appendix 1).

4.2 The Executive Committee will focus on triangulating data and insights from across the organisation, including assurance reports, operational meetings, to identify key issues and prioritise action in line with national guidance. It will serve as a critical link between day-to-day delivery and Board-level oversight, with a clear escalation route both to and from the Board and its subcommittees. The committee will begin meeting in its new format from 30 June 2025, with further work underway to align Board meeting dates to support timely reporting.

4.3 The Board are asked to **approve** the Executive Committee terms of reference.

Assurance Report from the Operational Leadership Team meeting held on 2 June 2025

4.4 The June Operational Leadership Team (OLT) meeting focused on key strategic and operational developments across the Trust. Updates were provided on the evolving NHS performance assessment framework and segmentation model, with implications for how Trusts are monitored and supported nationally. Financial performance for month one showed a breakeven position against plan, though concerns were raised about the delivery of cost improvement plans (CIPs) and the balance between financial targets and service quality.

4.5 The group reviewed high-level corporate risks, including neonatal services, data protection, and pressures on specific clinical pathways. Two internal audit reports, on the Patient Safety Incident Response Framework and Clinical Supervision, received limited assurance, prompting action plans to strengthen oversight, training, and consistency across service groups.

4.6 The meeting also approved the transformation of the OLT into a new Executive Committee, aimed at improving triangulation of assurance and operational delivery. Additionally, car parking and accommodation charges at the Yeovil site were reviewed, with further work planned to align pricing structures across sites and ensure affordability for staff.

5 **COMMUNICATIONS UPDATES**

Somerset FT in the news

5.1 **Sentencing of David Parish**
Coverage across regional and national publications about how a man who escaped a secure psychiatric unit (Rydon ward) through an unlocked door and went on to kill a church warden has been jailed. We issued a statement to media. The BBC News Online article is here and Daily Mail here.

5.2 **New relatives' room on Dunkery stroke unit**
Following a press release from the trust, there was coverage about fundraising for a new relatives' room on the Dunkery stroke unit at Musgrove Park Hospital. The Apple FM article is here and Somerset Live here.

5.3 **Yeovil Hospital maternity unit and special care baby unit**
BBC News Online: Sickness and bullying behind Yeovil maternity unit closure, MP claims - BBC News

Adam Dance, MP for Yeovil, adjournment debate: https://parliamentlive.tv/event/index/bd097976-c76c-4e02-92e0-824b6ccfeed7?in=19:04:25

5.4 **Bowel cancer self-referral service in Bridgwater**
Following a proactive media pitch to the regional BBC, there was coverage on the BBC Radio Somerset breakfast show about our new self-referral service for people getting checked for bowel cancer, which has launched first in Bridgwater due to the demography – this includes an interview with Mr Richard Bamford, one of our consultant colorectal surgeons. The BBC News Online article is here. It was also covered on BBC Points West, although the link is no longer available.

5.5 **Somerset hospital receives major funding boost for vital repairs**
Coverage about how Burnham-On-Sea Hospital, Musgrove Park Hospital and Yeovil Hospital are the three Somerset hospitals that have been allocated a total of £8,567,000 by the Department of Health to fund vital repairs to their buildings. The BBC News Online article is here and Burnham-on-Sea Online article is here.

5.6 **Burnham-On-Sea MP Ashley Fox's column: MIU move**
In Ashley Fox's latest newspaper column, he talks about a recent meeting he had with the trust about the proposed move of the minor injuries unit to the nearby GP practice. Read more here.

5.7 **Some community hospital beds could be reduced under new plans**
A petition has been launched by local politicians over proposed changes to the inpatient unit at Frome Community Hospital by Anna Sabine, MP for Frome and East Somerset, and Cllr Adam Boyden. The BBC News Online article is here and Somerset Live article is here and Greatest Hits Radio here.

Appendix 1

EXECUTIVE COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1 The Board hereby resolves to establish the Executive Committee (the Committee). The Committee is the executive decision-making committee of the Trust. It has the executive powers specifically delegated in these Terms of Reference.

1.2 The Committee will oversee development and delivery of the Trust's strategic objectives, performance, operational delivery, service development, improvement and transformation.

1.3 The Committee is authorised to investigate any activity within its terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

1.4 The Committee may require the attendance at its meetings of any officer of the Trust and the production of any document.

1.5 The Committee is authorised through the Chief Executive to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

1.6 Any issues identified for escalation to the Trust Board will be included in the Chief Executive and Executive Directors' report to the Board.

1.7 The Committee will identify any issues to be included in the Executive Team Brief for all colleagues arising from matters considered at the meetings.

2. Purpose, Duties and Responsibilities

2.1 The Committee is the executive decision-making committee of the Trust, its purpose being to make management decisions on issues within the remit of the executive directors and to support individual executive directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information and resolution of issues.

2.2 The Committee will ensure timely operational decision making and risk mitigation processes in delivering the Trust's strategic objectives and priorities.

2.3 The Committee will monitor and review the following key areas:

- the Trust's performance against key national and local targets, CQC fundamental standards, delivery of its strategic priorities, and other organisational objectives, including service development and recovery,

identifying issues for escalation to the Board
- actions arising from core monitoring reports, including the Quality and Performance Report and Finance Report
- action plans where remedial steps are indicated to improve quality and performance, including CQC inspections and other external reviews
- the effectiveness of the management and mitigations of significant corporate and operational risks
- colleague experience, engagement and communication to ensure all colleagues are engaged in service development and activity and are kept up to date on Trust wide issues
- the effectiveness of workforce planning, including succession planning
- patient experience and engagement
- Freedom to Speak up (FTSU) and equality, diversity and inclusion matters
- potential service developments and their implementation, including quality and equality impact assessments
- progress in implementing / addressing national policy and guidance
- key reports prior to submission to the Board of Directors to ensure their accuracy and quality
- significant planning and change management initiatives

2.4 The Committee will do this by receiving and reviewing:

Monthly

- Quality and performance exception reports reviewing the Trust's performance and service delivery and considering any factors and risks that may be relevant to future performance
- Finance reports (including quarterly reports on capital planning and overpayments)
- The corporate risk register and the actions identified to manage and mitigate the risks identified
- Exception reports from the Quality Assurance Group, Patient Safety Board and Data Review Group
- Escalation reports from Service Group Governance meetings

Bi-monthly

- Escalation reports from Quality Outcomes Finance and Performance Meetings
- Digital strategy and EHR implementation updates

Quarterly

- Exception reports from:
  - Patient Experience and Engagement Committee
  - Colleague Engagement Committee
  - Health and Safety Committee
  - Learning from Deaths
  - Guardian of Safe Working Hours
  - EPRR Group

Six Monthly

- Reports from the Freedom to Speak Up Guardians

- Exception reports from the following committees:
  - Safeguarding Committee
  - Infection Prevention and Control Committee
  - Medicines Management
  - Strategic Sustainability Group (including the Green Plan update)
  - Strategic Estates Group

- Exception reports from the Trust's Research & Development Lead again setting out key issues that are relevant to the Trust's historic and future performance, including information about the Trust's plans for supporting and encouraging R&D and innovation.

- Annual Staff Survey feedback results and action plans

- Other reports, as determined from time to time by the Committee, from Service Groups and other committees/project boards, as appropriate, to enable the Committee to carry out its responsibilities, including reports from the Care Quality Commission, Health & Safety Executive, Parliamentary and Health Service Ombudsman and other external regulators

- Internal and external audit reports identifying limited assurance and/or high risk findings and recommendations, to oversee implementation of agreed management actions
- Regular updates on business developments and new business cases for significant service developments and service changes, including plans for engagement and consultation with staff, patients and the public
- Updates on significant national and local policy changes affecting the services provided, or potentially provided, by the Trust.

2.5 The Committee will promote and embed the Trust's values of Kindness, Teamwork and Respect and reinforce a culture of quality improvement and engagement.

3. Membership, Attendance and Quorum

3.1 The core membership of the Committee will comprise:

- Chief Executive (Chair)
- Chief Operating Officer (Deputy Chair)
- Chief Finance Officer
- Chief Medical Officer
- Chief Nurse
- Director of Strategic Development and Digital Development
- Chief of People
- Director of Corporate Services
- Service Group Directors (x6)
- Service Group Director for Acute Patient Flow

- Managing Director of Simply Serve Limited (SSL)
- Managing Director of Symphony Healthcare Services (SHS/Symphony)
- Director of Estates & Facilities
- Director of Communications

3.2 A quorum shall be at least 10 members including the Chair or nominated Deputy Chair, three other executive directors and representation from each of the operational service group triumvirates.

3.3 Where a member is unable to attend, they may nominate a deputy from the triumvirate in the case of service group or site directors, or a suitable individual in other cases to attend in their place provided this is agreed in advance with the Chair.

3.4 The Committee may extend invitations to other personnel with the relevant skills, experience or expertise as necessary to deal with the business on the agenda or to support the delivery of particular programmes of work.

3.5 Attendance will be recorded within the notes of each meeting and monitored annually.

4. Administration of Meetings

4.1 The Committee shall meet monthly. An annual schedule of proposed dates shall be prepared in advance. Extraordinary meetings may be called at the request of the Chair.

4.2 Meetings may be held by electronic means and their decisions accepted as valid and binding. Some meetings may be held face to face and scheduled into diaries accordingly.

4.3 The Executive Assistant to the Chief Executive shall produce the agenda and all necessary papers. The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible.

4.4 In agreement with the Chair or Deputy-Chair, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

4.5 The minutes of each meeting shall be formally recorded.

5. Review of effectiveness

5.1 The Committee will provide a report to the Board annually on its effectiveness.
5.2 During this review the Committee will be assessed to ensure that it has performed in accordance with these terms of reference

6. Review

6.1 These terms of reference must be reviewed at least on an annual basis, or more frequently in the event of significant political, organisational, staff or policy changes.

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Chief Executive
REPORT BY:	Deputy Director of Integrated Governance
PRESENTED BY:	Chief Executive
DATE:	: 1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks*. Each Board Assurance Committee will receive the Corporate Risk Register report with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework. The highest areas of risk for the organisation are: • insufficient capacity to meet demand, deliver against referral to treatment times and reduce waiting lists • workforce recruitment and retention • financial position • aging estates - acute and community • pressures in social care; intermediate care; and primary care • delivery of digital transformation
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust Corporate Risk Register on 16 June 2025. The report focuses on the high risks scoring 15+ on the risk matrix and includes corporate risks and service group risks. The Board are asked to note the report and the risks identified.

06

Links to Joint Strategic Aim (Please select any which are impacted on / relevant to this paper)	
☒ Aim 1	Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
☒ Aim 2	Provide the best care and support to people
☒ Aim 3	Strengthen care and support in local communities
☒ Aim 4	Respond well to complex needs
☒ Aim 5	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ Aim 6	Live within our means and use our resources wisely
☒ Aim 7	Deliver the vision of the Trust by transforming our services through innovation, research and digital transformation

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
☒ This report has been assessed against the Trust's People 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 People 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)
Not applicable

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

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

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

SOMERSET NHS FOUNDATION TRUST
CORPORATE RISK REGISTER REPORT 16 JUNE 2025

1. INTRODUCTION

1.1 In line with the Trust's Risk Management Strategy, the Board will receive and review the Corporate Risk Register via the Board Assurance Committees, and the Assurance Framework quarterly. The Board Assurance Framework (BAF) forms part of the Trust's Risk Management Strategy and is the framework for identification and management of strategic risks. Further details can be found in Appendix 2.

2. PURPOSE OF THE REPORT

2.1 To present the Corporate Risk Register to the Board of Directors.

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 16 June 2025 as shown within Appendix 1.

2.3 The risks recorded within this report including Appendix 1 only include the high-level summary title of the risks. The full description of the risks, which meet the minimum dataset requirements as outlined within the Risk Management Policy, are recorded within the risk register entries on Radar.

2.4 The validation process of risks within SFT has been included within Appendix 3.

2.5 The report also includes the corporate risks identified by Simply Serve Limited (SSL) and Symphony Healthcare Services (SHS) which are wholly owned subsidiary companies of SFT. These risks will either be shown as additional corporate risks for SFT (2191 & 2192) or mapped into existing SFT corporate risks (Risks 2409, 2683, 2692 & 2812).

3. CORPORATE RISK REGISTER

3.1 At the end of Quarter 1 2025/26, there are currently twenty-five risks on the Corporate Risk Register detailed within the circle heat map, nine of which score 20 or 25:

- Risk 3110 Inability to deliver safe, effective and sustainable neonatal service (YDH) (25)
- Risk 0004 Demand (20)
- Risk 0012 Waiting times (20)
- Risk 1611 Failure to secure necessary infrastructure due to the assurance of availability of capital funding either locally or through national programmes (20)
- Risk 1789 Unsafe premises and environment (20)
- Risk 2192 SHS not becoming self-sustaining (20)
- Risk 2923 Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas (20)

- Risk 3058 Delivery of CIP 2025/26 (20)

- Risk 3059 Failure to deliver financial plans 2025/26 (20)

New Risks

3.2 There have been five new risks added to the Corporate Risk Register during Quarter 1 2025/26:

- Risk 2838 - Inability to provide a transition service for young people with complex needs post March 2025 due to the project funding ceasing
- Risk 3016 - Risk of suicide or self-harm by ligature by patients during community hospital inpatient admissions
- Risk 3058 - Delivery of CIP 2025/26
- Risk 3059 - Failure to deliver financial plan
- Risk 3110 - Inability to deliver safe, effective and sustainable neonatal service (YDH)

Increased Risks

3.3 There have been three risks which have increased during Quarter 1, 2025/26 which have been included on the Corporate Risk Register:

- Risk 1517 - Risk of enforcement action from the Information Commissioners Office as a result of non-compliance with Data Protection Act due to the increased volume of subject access requests
- Risk 3058 - Delivery of CIP 2025/26
- Risk 3059 - Failure to deliver financial plan

Risks which have Reduced

3.4 There have been three risks which have reduced during Quarter 1, 2025/26 from the Corporate Risk Register:

- Risk 1624 - Failure to secure necessary digital, data and technology infrastructure due to inadequate investment and portfolio delivery
- Risk 2044 - Long standing vacancies within some specialities where there are chronic national shortages within the senior doctor workforce
- Risk 2993 - GP Collective Action

Risks which have been Archived

3.5 There have been three risks which have been archived from the Corporate Risk Register during Quarter 1, 2025/25:

- Risk 0006 - Delivery of CIP 2024/25
- Risk 0960 - Failure to deliver financial plan
- Risk 3016 - Ligature risks within Community Hospitals

Risk Appetite & Risk Tolerance

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

3.8 It is important for the Board and the Board Assurance Committees are aware of the risks that fall outside of the set risk appetite levels and to use this information to focus their discussions on these risks. Further information on risk appetite and risk tolerance can be found in Appendix 4.

Emerging Risks

3.9 Risk management activities must be dynamic and responsive to emerging risks. Horizon scanning is about identifying, evaluating, and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the organisation. Additionally, horizon scanning can identify positive areas for the Trust to develop its services, taking opportunities where these arise. By implementing mechanisms to horizon scan the Trust will be better able to respond to changes or emerging issues in a coordinated manner.

3.10 It is a responsibility of the Board to horizon scan and identify external risks that may impact on the delivery of its strategy. The Deputy Director Integrated Governance and the Trust's Risk Managers will monitor the emerging risks scoring 12 on the Service Group and Corporate services risk registers and highlight these within the report that is received by the Board Assurance Committees.

4. RISK MANAGEMENT ARRANGEMENTS UPDATE

4.1 Work continues to implement the aligned risk management processes with training and support being provided to individuals and teams across the organisation. The Audit Committee will be kept up-to-date on a regular basis through this report on the progress with the implementation plan included within the Trust's Risk Management Strategy and Policy.

4.2 Work continues with the intensive implementation programme across the organisation to develop Radar as the Trusts Risk Management System and train colleagues in the use of the Radar system. This covers all elements of the system including but not limited to; incident reporting; PALS and complaints; claims; etc.

4.3 Specifically in relation to the risk register element of the system, work remains underway to review all risks on Radar to ensure these meet the minimum standard as specified within the approved Risk Management Policy.

4.4 Progress reports against the Risk Management Strategy performance indicators are presented to the Audit Committee on a quarterly basis as part of the monitoring of the implementation of the Strategy. The Board Assurance Committees undertake deep dives into areas of significant risk that fall within the remit of the Committees and assurance is provided to the Audit Committee on a six monthly basis.

5. CONCLUSION

5.1 The Trust continues to respond and manage to an exceptionally high level of risk. There has been progress in mitigating a number of risks but the position remains challenging due to workforce challenges; operational and financial pressures within the Trust and in social care and primary care across the County.

6. RECOMMENDATION

6.1 The Board of Directors are asked to review the Corporate Risk Register.

Corporate Risk Register 16 June 2025

NHS Somerset NHS Foundation Trust

People Committee

16	R2044	Vacancies rates within senior doctor workforce
↓	SA5	
16	R2191	Reduced colleague resilience due to workplace pressures and prolonged increased demand on services ***(SHS Risk)***
↔	SA5	
16	R2307	Current medical workforce establishment not mapped to year on year increasing demand
↔	SA5	
16	R2770	Inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients due to systemic discrimination
↔	SA5	
15	R2306	Vacancies rates within trainee doctor workforce as a result of national shortage of trainees; Deanery allocations; and the structure of run throughs
↔	SA5	

Financial Committee

20	R1611	Failure to secure necessary infrastructure due to the assurance of availability of capital funding either locally or through national programmes
↔	SA6	
20	R2192	SHS not becoming self-sustaining ***(SHS Risk)***
↔	SA6	
20	R3058	Delivery of CIP 2025/26
↑	SA6	
20	R3059	Failure to deliver financial plan 2025/26
↑	SA6	

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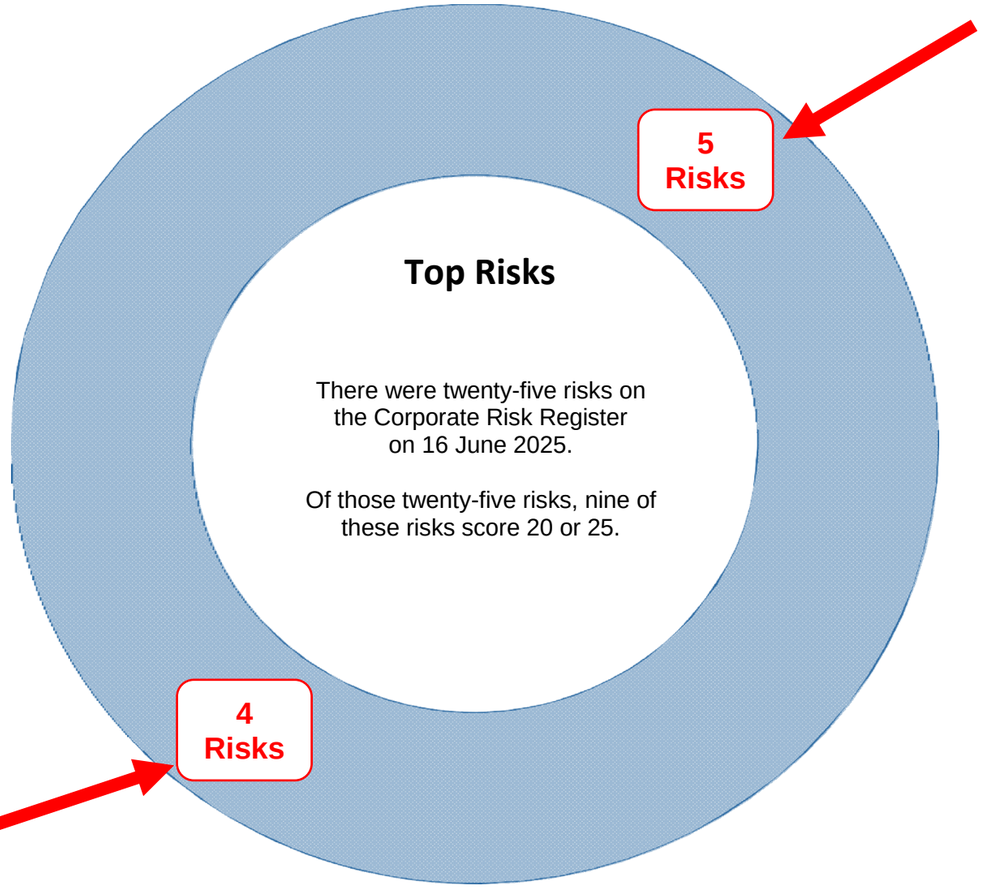

Key:
Risk Score = 15-25 R = Risk 01 = Unique Risk Reference
Risk Appetite:
Within Risk Appetite for the Strategic Aim (SA) risk is assigned to
Outside of Risk Appetite for the Strategic Aim (SA) risk is assigned to

Quality & Governance Committee

25	R3110	Inability to deliver safe, effective and sustainable neonatal service (YDH)
NEW	SA2	
20	R0004	Demand
↔	SA2	
20	R0012	Waiting Times
↔	SA2	
20	R1789	Unsafe premises and environment
↔	SA2	
20	R2923	Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas
↔	SA2	
16	R0007	Referral to Treatment Times
↔	SA2	
16	R0673	Current capacity and future resilience of primary care in Somerset
↔	SA3	
16	R1238	Fire Compartmentation
↔	SA2	
16	R1878	Inefficient use of Safeguarding resource due to the current need to develop workarounds for using the multiple systems to ensure delivery of a safe Safeguarding Service
↔	SA7	
16	R2273	Insufficient intermediate care capacity
↔	SA3	
16	R2838	Inability to provide a transition service for young people with complex needs post March 2025 due to the project funding ceasing
NEW	SA4	
15	R0862	Use of escalation beds across SFT
↔	SA2	
15	R1517	Risk of enforcement action from the Information Commissioners Office as a result of non-compliance with Data Protection Act due to the increased volume of subject access requests
↑	SA7	
15	R2053	Increased risk of harm due to development of episode of care pressure ulcers
↔	SA2	
15	R2462	Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for decontamination due to not having a dedicated decontamination lead in place
↔	SA2	
15	3016	Risk of suicide or self-harm by ligature by patients during community hospital inpatient admissions
NEW	SA4	

7. BOARD ASSURANCE FRAMEWORK & CORPORATE RISK REGISTER

7.1 In line with the Trust's Risk Management Strategy, the Board will receive and review the Corporate Risk Register via the Board Assurance Committees, and the Assurance Framework quarterly. The Board Assurance Framework (BAF) forms part of the Trust's Risk Management Strategy and is the framework for identification and management of strategic risks.

Board Assurance Framework

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

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

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

7.5 One of the purposes of the BAF is to ensure that all principal risks are mitigated to an appropriate or acceptable level. It is expected that not all risks will be able to have mitigating controls that reduce the risk to the target level.

Corporate Risk Register

7.6 The Corporate Risk Register is a central repository for the most significant operational risks scoring 15+ arising from the Service Group or departmental risk registers that cannot be controlled, or risks that have significant impact on the whole organisation and require Executive oversight and assurance on their management.

7.7 These risks represent the most significant risks impacting the Trust ability to execute its strategic objectives and therefore align with the principal strategic risks overseen by the Board. These risks may still be managed at Service Group or departmental level but require Executive oversight or will be managed by an Executive Director.

7.8 The Board sub-committees will review the Corporate Risk Register at least once a quarter to ensure that risks are being managed effectively and that lessons and risk information are being shared across the organisation. These reviews will inform the Audit Committee and Board of Directors decision in

respect of the recommendation to approve the Trust's Annual Report which contains the annual governance statement which provides assurance of the level at which the Trust's system of internal control is managing organisational.

7.9 Risks recorded on the Corporate Risk Register may also appear on the BAF if they have the potential to compromise delivery of strategic objectives. Not every high scoring risk on the Corporate Risk Register will appear on the BAF, and not all BAF entries will appear on the Corporate Risk Register, which is the tool for the management of operational risk.

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

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

8. VALIDATION OF RISKS

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

8.2 By defining the level of risk that is to be managed at each tier of the organisation, risks can be managed by the correct level of seniority and each tier has oversight of risks managed in the tier below. The tiers within the organisation can be found in the Trust's Risk Management Strategy.

8.3 Every specialty/department within the organisation is responsible for maintaining its own local risk register, and departmental managers are authorised to manage all risks on their risk registers (i.e. risks rated up to, and including, 8).

8.4 Service Groups Triumvirates and Corporate Service Directors ensure the risk registers within their Service Group/Corporate Service are reviewed regularly (at least monthly) at the Service Group/Corporate Service governance meetings for risks scoring 8 or above.

8.5 Where a significant specialty/departmental risk scoring 12 or above is identified, following appropriate scrutiny from the risk owner, it will be reported into the Service Group/Corporate Service governance meeting and Quality, Outcomes, Finance and Performance (QOFP/F&P) meeting. The Service Group/Corporate Service will re-assess the risk in the context of the Service Group/Corporate Service and either agree to accept the risk or provide advice to the risk owner on the effective management.

8.6 The formal review of the risks scored between 12 and 25 at the monthly QOFP/F&P meetings is one mechanism by which significant operational risks will be escalated for inclusion on the corporate risk register and also where feedback will be provided by the Triumvirates regarding the status of previous escalations.

8.7 Service Group/Corporate Services risk registers are used by the Executive team to inform the discussions at QOFP/F&P meetings to ensure that risk is considered collectively and holistically, along with financial and operational performance. These meetings are the mechanism by which Service Groups and Corporate Services Management Teams are held to account for the management of all aspects of their services, including the management of service risks.

8.8 Risks on the Corporate Risk Register are discussed, monitored and reviewed at the monthly Board Assurance Committee Meetings and Operational Leadership Team meetings.

9. RISK APPETITE AND RISK TOLERANCE

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

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

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

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

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

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

9.7 Each of the risks on the Corporate Risk Register have been assigned to the most relevant strategic objective (*figure 1*) for the organisation, including for SSL where relevant (*figure 2*) for 2024/25. The risk has then been RAG rated to

demonstrate whether the risk is within or outside of the agreed risk appetite level for the strategic objective the risk has been assigned to.

Figure 1

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

Figure 2

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

9.8 The SFT Board reviewed and approved their strategic aims in the Board meeting on 6 May 2025 (figure 3). The Board and its Committees will review and approve the risk appetite levels per strategic aim. Appendix 1 has been updated to reflect the revised strategic aim with the proposed risk appetite level.

Figure 3

Somerset NHS Foundation Trust Strategic Aims	
1	Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
2	Provide the best care and support to people
3	Strengthen care and support in local communities
4	Respond well to complex needs
5	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
6	Live within our means and use our resources wisely
7	Deliver the vision of the Trust by transforming our services through innovation, research and digital transformation

NHS Somerset NHS Foundation Trust

Risk Appetite 2025/26

Kindness, Respect, Teamwork
Everyone, Every day

Peter Lewis

July 2025

Aim of the Session

NHS Somerset NHS Foundation Trust

- To receive and discuss recommendations from the Board Committees on the proposed risk appetite level for strategic aims 2-6
- To discuss and agree on the risk appetite level for strategic aims 1 & 7 which are under the remit of the Board
- To discuss and review the risk appetite levels across all of the strategic aims to ensure there is a joined-up approach to the Trust's risk appetite

Risk Appetite – What is it?

NHS Somerset NHS Foundation Trust

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

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

Applying risk appetite matrix

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

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

Risk Appetite Levels

NHS Somerset NHS Foundation Trust

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

Risk Appetite Levels

NHS Somerset NHS Foundation Trust

Strategic Aims	Current Risk Appetite	Proposed Risk Appetite
Contribute to improving the physical health and wellbeing of the population and reducing health inequalities	Seek (4)	**To be discussed**
Provide the best care and support to people	Open (3)	**Open (3)**
Strengthen care and support in local communities	Seek (4)	**Seek (4)**
Respond well to complex needs	Seek (4)	**Seek (4)**
Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	Seek (4)	**Significant (5)**
Live within our means and use our resources wisely	Financial Management - Open (3) Commercial – Seek (4)	**Financial Management - Open (3)** **Commercial – Seek (4)**
Deliver the vision of the Trust by transforming our services through innovation, research and digital transformation	Seek (4)	**To be discussed**

Board Discussion

NHS Somerset NHS Foundation Trust

- To receive and discuss recommendations from the Board Sub-Committees on the proposed risk appetite level for strategic aims 2-6

- To discuss and agree on the risk appetite level for strategic aims 1 & 7 which are under the remit of the Board

- To discuss and review the risk appetite levels across all of the strategic aims to ensure there is a joined-up approach to the Trust's risk appetite

NHS
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Seabrooke,David
25/06/2025 15:10:21

Kindness, Respect, Teamwork
Everyone, Every day

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee held on 4 June 2025
SPONSORING EXEC:	Isobel Clements, Chief People Officer
REPORT BY:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Graham Hughes, Chair of the People Committee
DATE:	1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	The Committee has discussed a range of matters across the People agenda. It has been agreed that meetings will be quarterly going forward.
Recommendation	That the report be noted.

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

- ☐ Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
- ☐ Aim 2 Provide the best care and support to people
- ☐ Aim 3 Strengthen care and support in local communities
- ☐ Aim 4 Respond well to complex needs
- ☐ **Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture**
- ☐ Aim 6 Live within our means and use our resources wisely
- ☐ Aim 7 Deliver the vision of the Trust by transforming our services through, innovation, research and digital transformation

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

Equality and Inclusion

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

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

The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Staff involvement takes place through the regular service group and topic updates.

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

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE MEETING HELD ON 4 JUNE 2025

1. PURPOSE

To advise the Board on the decisions arrived at and principal areas reviewed by the People Committee.

2. ASSURANCE RECEIVED

2.1. **Southwest temporary staffing collaboration:** the committee discussed this, which aims to align bank arrangements across the region. They highlighted the importance of engaging bank colleagues and ensuring that they are valued and fairly compensated to reduce reliance on agency staff.

2.2. Substantial assurance that the Integrated People Report is heading a positive direction.

2.3. Excellent data collection. Further review required on how best to use the leavers data.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. **Job planning** The Committee noted that the latest report shows compliance at 10% from the previous 7%. The ambition to reach 80% sign off by August, acknowledging that this might be too ambitious given the current progress. The situation will continue to be monitored by the Job Planning Steering Group and any further concerns will be escalated to this committee and Melanie Iles.

3.2. **Employee relations service** the committee noted increased pressure on the central service and a need to ensure that issues were handled appropriately locally at an earlier stage.

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

4.1. It was noted that there are 24 corporate risks, with seven scoring 25 or 20. Two risks related to the People Committee were reduced in the last quarter, consultant vacancies reduced from 20 to 16 and retention and turnover of staff and this has significantly reduced due to the work done by the people services team.

4.2. A new risk around well-being was identified.

5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1. The Committee has completed its review of the BAF and will report to the Audit Committee thereon. The areas of focus are all on plan, including the Learning, Education and Training Improvement Programme, the Employee Relation Improvement Programme, the transformation of people service.

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Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Integrated Performance Exception Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Lee Cornell, Associate Director – Planning and Performance Ian Clift, Senior Performance Manager Isobel Clements, Chief of People and Organisational Development Xanthe Whittaker, Director of Elective Care Stacy Barron-Fitzsimons, Director for Medical Services Group Sally Bryant, Director of Midwifery Leanne Ashmead, Director of Children, Young People and Families Neil Jackson, Deputy Service Director, Mental Health and Learning Disabilities Abbie Furnival, Service Group Director – Neighbourhoods and Communities Kerry White, Managing Director – Symphony Healthcare Services Emma Davey, Director of Patient Experience and Engagement
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	Our Integrated 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. In respect of the NHS England National priorities and success measures for 2025/26, the areas in which performance has been sustained or has notably improved include: • improving the percentage of patients waiting no longer than 18 weeks for treatment • improving the percentage of patients waiting no longer than 18 weeks for a first appointment

	Other areas in which performance has been sustained or has notably improved include: • Access to our perinatal service was significantly above the 10% national standard • the number of patients waiting 18 weeks or more from referral to be seen by our community services reduced. • Patient satisfaction levels across our Symphony Healthcare practices remained high. National priority areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • performance against the headline 62-day cancer standard. • compliance in respect of Cancer 28 Day Faster Diagnosis. • the numbers of patients waiting 52 weeks or more for treatment. • The percentage of patients admitted,discharged and transferred from A&E within four hours, and within 12 hours. • The average length of stay in our adult mental health wards.
Recommendation	The Board is asked to discuss and note the report.

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

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

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

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

Seabrooke,David
25/06/2025 15:10:21

SOMERSET NHS FOUNDATION TRUST

INTEGRATED PERFORMANCE EXCEPTION REPORT: MAY 2025

TABLE OF CONTENTS

Each of the scorecards includes thumbnail trend charts for the key measures, and also uses the summary Variation and Assurance icons below, drawn from the NHS England publication 'Making Data Count'.

In respect of the variation icons, the Orange icon indicates a concerning special cause variation requiring action, the Blue icon indicates where there appears to be improvement, the Purple arrows indicate that there has been special cause variation, but not necessarily indicating either improvement or deterioration, and the Grey icon indicates no significant change.

In respect of the assurance icons, the Blue icon indicates that the target is consistently achieved, the Orange icon indicates that the target is consistently missed, and the Grey icon indicates that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would vary between red, amber and green.

Each measure within the scorecards is also linked to one or more of our strategic aims, which are listed below:

1. Contribute to Improving the health and wellbeing of the population and reducing health inequalities.
2. Provide the best care and support to people.
3. Strengthen care and support in local communities.
4. Respond well to complex needs.
5. Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture.
6. Live within our means and use our resources wisely.
7. Deliver the vision of the Trust by transforming our services through innovation, research and digital transformation.

The sources of each of the measures contained within the scorecards are also specified, as follows:

- CQIM NHS England Clinical Quality Improvement Metric
- HDS NHS Hospital Discharge Service: Policy and Operating Model
- ICB Locally agreed measure from the NHS Contract with Somerset Integrated Commissioning Board
- LTP The NHS Long Term Plan, 2019
- NHSC: National measure from the NHS Contract
- NSG Measures derived from a range of guidance documents for Stroke services
- OPG NHS England Priorities and Operational Planning Guidance

- PAF NHS England Performance Assessment Framework for 2025/26
- SFT Somerset NHS Foundation Trust internal target / monitoring
- SHS Symphony Healthcare Services internal target / monitoring
- VWOF NHS England Virtual Wards Operational Framework

CHIEF FINANCE OFFICER

NARRATIVE REPORT

NHS ENGLAND NATIONAL PRIORITIES AND SUCCESS MEASURES FOR 2025/26

The key points of note in respect of the NHS England national priorities and success measures for 2025/26 are as follows:

NHS England's 2025/26 priorities and operational planning guidance lists 18 national priorities and success measures for 2025/26, of which 12 apply to Somerset NHS Foundation Trust as a provider. Of these, we are performing well in respect of:

- improving the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement against the November 2024 baseline
- improving the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement against the November 2024 baseline

For both of these measures, our performance in May 2025 remained better than our target trajectory.

Areas in respect of which we were underperforming against planned levels included the requirement to reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026. As at 31 May 2025, 2.8% of patients on our elective waiting list had waited 52 weeks or more, against a target of 2.2% or less. The increase in the percentage of patients waiting over 52 weeks is partly due to an increase in long waiters, but also to a reduction in the total waiting list size. A range of actions is in place to manage this position, including waiting list validation, and specialty-level planning and reporting arrangements, but it is acknowledged that the delivery of this standard will be a significant challenge, and one which we are likely not to achieve.

As at 30 April 2025 – the latest data available – we were below the compliance standard for the headline 62-day cancer standard, for which the national requirement is to improve performance to 75% by March 2026. Our performance during April 2025 was 70.2%, against a planning trajectory target of 72.8%. The main breaches were in urology (34% of breaches), lower gastrointestinal (15%) and breast (10%). The main cause of the breaches for urology and colorectal continues to be high demand, mainly for the diagnostic phase of the pathways, which cannot be accommodated within available capacity. A cancer 'front door' is in place for most tumour sites, which is creating a single-entry point for cancer referrals across Somerset helping to smooth demand across the two hospital sites; it includes nurse-led triage and management of the early diagnostic phase of pathways. Additional consultant urology posts are being appointed on substantive and fixed-term contracts, in recognition of the ongoing high demand, and pathway redesign work is also ongoing.

Also as at 30 April 2025, the percentage of patients diagnosed with a cancer or given a benign diagnosis within 28 days of referral was 72.6%, below the April 2025 planning trajectory of 79%. The highest volumes of breaches were in breast (32% of breaches; 57% performance), colorectal (23% of breaches; 52% performance), and urology (14% of breaches; 53% performance). The breast service will be attempting to recruit an additional member of the team, who can also provide breast radiology capacity. Additional CT colon capacity will come online with the opening of the Yeovil Community Diagnostic Centre, and in the meantime, extra lists are being put in place, where possible. The endoscopy washers at Bridgwater Community Hospital have now been repaired, and colonoscopy weekend insourcing lists have now resumed.

Trust-wide A&E 4-hour performance across our Emergency Departments and Urgent Treatment Centres was 73.0% in May 2025, the highest rate since February 2025 but still below the 76% national standard. We are also required to achieve an improvement in respect of the percentage of patients sending less than 12 hours in the departments, compared to the 2024/25 outturn. Between 1 April and 31 May 2025, 93.7% of patients spent less than 12 hours in the departments, which was below the 95.2% achieved in 2024/25. Actions being undertaken to improve performance include:

- the recruitment of a new consultant at YDH.
- An Operational Support Manager is now in post at YDH, holding daily 1:1s with the progress chaser to agree a plan of action for the day and a consistent focus on four-hour performance. Three additional progress chasers, and two receptionists have been recruited at YDH.
- A phased approach to converting Acute Assessment Unit spaces to ambulatory majors is planned to commence during the week commencing 16 June 2025, to reduce risk or corridor care in Minor Injury assessment, and support flow.

During 2025/26, there is a requirement to reduce the average length of stay in our adult acute mental health beds. As at 31 May 2025, the rolling three-month average length of stay within our adult mental health wards was 61.3 days, above the planning trajectory level of 57.1 days. New Multi-Disciplinary Team handover meetings are being trialled across the wards, discussing the purpose of admission, any barriers to discharge, and assigning actions to the responsible colleagues, with a view to making improvements to the average length of stay. Plans are being made to meet with housing officers from Somerset Council around housing challenges, and improvements are also being made to our interface meetings so that they are purposeful and promote collaboration between inpatient and community teams for easier transition of people from wards to the community and vice versa.

Responsive

Referral to Treatment Time (RTT): National priorities in 2025/26 are to: Improve the percentage of patients waiting no longer than 18 weeks for treatment, improve the percentage of patients waiting no longer than 18 weeks for a first appointment, and reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026.

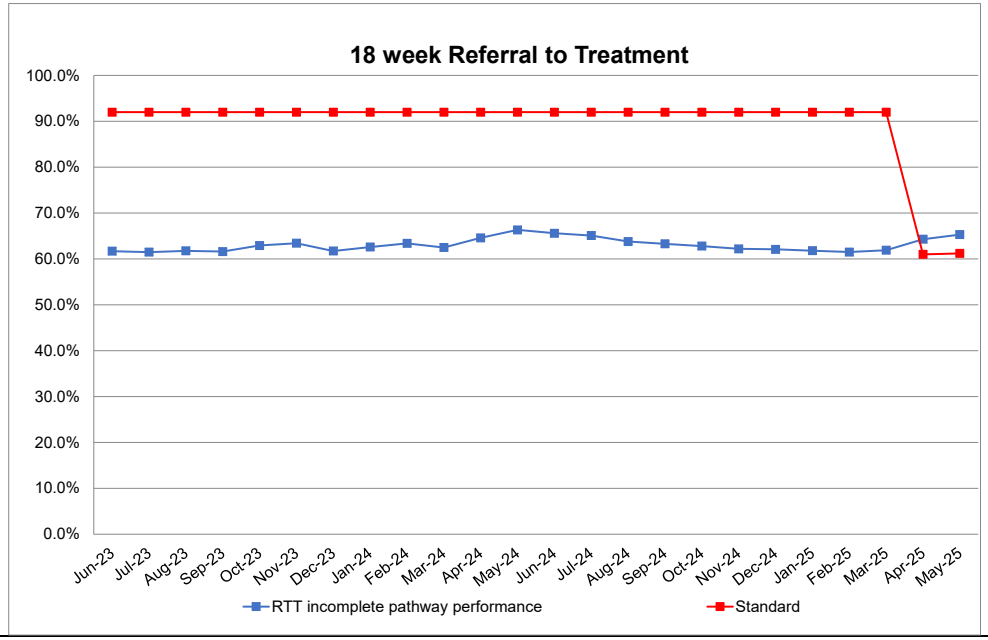
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 65.3% (combined acutes + community) in May 2025, up by 1.0% from the April 2025 position.
- The total waiting list size decreased by 1,401 pathways, and was 2,306 lower (i.e. better) than the planning trajectory (57,069 actual vs. 59,375 plan).
- The number of patients waiting over 52 weeks increased by 134 in May 2025 to 1,572 pathways; this represents 2.8% of the waiting list against a target for May 2025 of 2.2% or less. The increase in the percentage of patients waiting over 52 weeks is partly due to an increase in long waiters, but also a reduction in the total waiting list size.
- The number of patients waiting over 65 weeks increased by 26 to 112 at the month-end, against a trajectory of zero.
- Seven patients had waited over 78 weeks RTT.

Focus of improvement work

- A specialty-level RTT planning model has been developed for 2025/26, which takes account of the impact of productivity opportunities and quantifies the level of activity needed to meet the two new national targets of a 5% improvement in performance against the 18-week RTT and first appointment within 18 weeks standards. Delivery plans have been developed alongside this model, for the high-volume lower performing specialties.
- The Trust is taking part in the national RTT Validation Sprint (please also see the Elective Care narrative); this administrative validation of the RTT pathways has so far reduced total RTT waiting list size from 61,366 on 6 April 2025 to 57,473 on 8 June 2025.
- Monitoring reports for the new RTT standards are in place, along with reports to monitor the delivery against the core productivity measures, such as Advice & Guidance, Patient Initiated Follow-ups (PIFU), Did Not Attend (DNA rates) and capped theatre utilisation.

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 59.7% in April 2025, the latest data available; our performance was 64.3%. National performance decreased by 0.1% between March and April 2025; our performance improved by 2.4%. The number of patients waiting over 52 weeks across the country increased by 9,826 to 190,068 (2.6% of the national waiting list compared with 2.8% for the Trust). The number of patients waiting over 78 weeks nationally increased by 197 to 1,361.

Performance trajectory: 18-week, first OP within 18 weeks and 52-week wait performance

Area	Dec	Jan	Feb	Mar	Apr	May
18-week trajectory	N/A	N/A	N/A	N/A	61.0%	61.2%
18-week actual	62.1%	61.8%	61.5%	61.9%	64.3%	65.3%
First OPA 18 weeks trajct.	N/A	N/A	N/A	N/A	72.5%	72.4%
First OPA 18 weeks plan	N/A	N/A	N/A	N/A	75.2%	75.4%
52-week trajectory	N/A	N/A	N/A	N/A	2.2%	2.2%
52-week actual	2.3%	2.4%	2.4%	2.1%	2.5%	2.8%

Responsive

62-day Cancer is a measure of the length of wait from referral from a GP, screening programme or consultant, through to the start of first definitive treatment. The target is that by March 2026 at least 75.1% of patients are treated within 62 days of referral. The 28-day Faster Diagnosis is the first part of the 62-day pathway.

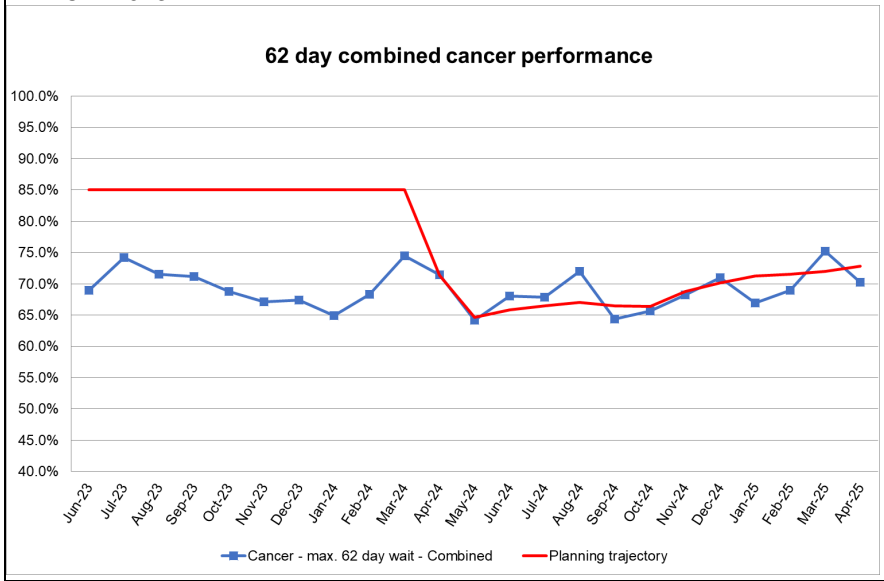
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 70.2% in April 2025, which is above the current national standard of 70% and national average performance, but below the planning trajectory.
- The main breaches of the 62-day combined cancer standard were in urology (34% of breaches), lower gastrointestinal (15%) and breast (10%).
- The main cause of the breaches for urology and colorectal continues to be high demand which cannot be accommodated within available capacity. This is mainly for the diagnostic phase of cancer pathways, when tests are still being undertaken to confirm whether a patient has a cancer or a benign condition. Please also see the 28-day faster Diagnosis Standard exception report.
- Thirty-three GP referred patients were treated in April 2025, on or after day 104 (the national 'backstop').

Focus of improvement work

- A cancer 'front door' is in place for most tumour sites; this is creating a single-entry point for cancer referrals across Somerset helping to smooth demand across the two hospital sites; it includes nurse-led triage and management of the early diagnostic phase of pathways.
- Additional consultant urology posts are being appointed on substantive and fixed-term contracts, in recognition of the ongoing high demand; pathway redesign work is also ongoing.
- Self-referral services are being piloted for patients with symptoms of cancer, to encourage patients to come forward sooner to get checked out; this will also help to smooth demand.
- Please also see the 28-day Faster Diagnosis Standard exception report, which provides details of the breast capacity actions and also the endoscopy.

Line Chart



How do we compare

National average performance for providers was 69.9% in April 2025, the latest data available. Our performance was 70.2%. We were ranked 91 out of 145 trusts.

Although the national standard remains 85%, the operating plan guidance for 2024/25 sets the improvement target as 70% for March 2025.

Recent performance

62-day GP cancer performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
% Compliance	68.2%	71.0%	66.9%	68.9%	75.2%	70.2%
Trajectory	68.8%	70.2%	71.3%	71.5%	72.0%	72.8%

Responsive

28 Day Faster Diagnosis Cancer Standard (FDS) is a measure of the length of wait from referral through to diagnosis (benign or cancer). The target is for at least 80% of patients to be diagnosed within 28 days of referral by March 2026. The first step in a 62-day cancer pathway.

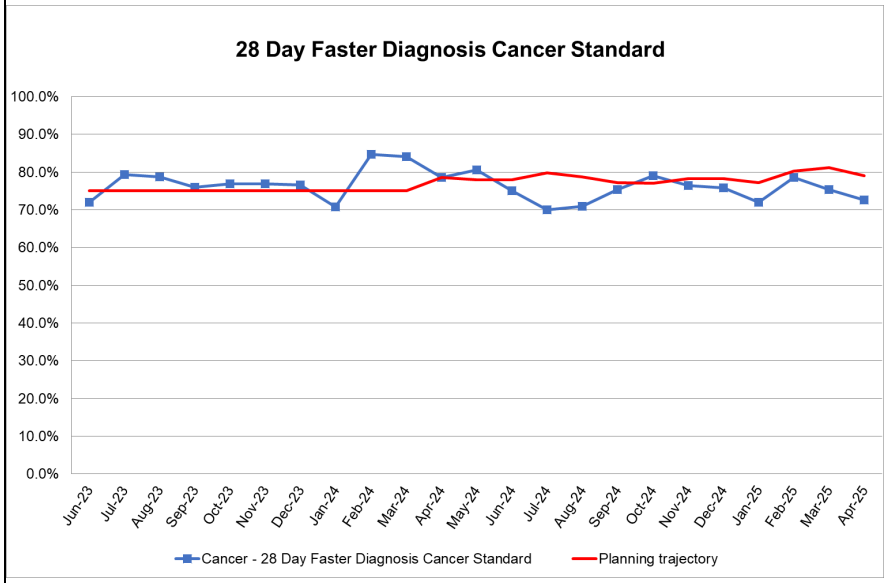
Current performance (including factors affecting this)

- The percentage of patients diagnosed with a cancer or given a benign diagnosis within 28 days of referral was 72.6% in April 2025, below the new March 2025 target of 77% and national average performance.
- The highest volumes of breaches of the FDS were in breast (32% of breaches; 57% performance), colorectal (23% of breaches; 52% performance), and urology (14% of breaches; 53% performance).
- The deterioration in the breast performance relates to sickness and a vacancy within the breast radiology element of the service.
- The lower performance in colorectal has been in part due to sickness within the colorectal Faster Diagnosis Team, which has resulted in delays in letters going out to patients advising them of a benign diagnosis; waiting times for CT colons and colonoscopies have also increased, due to high demand and reduced service capacity because of an equipment failure, sickness and a reduction in insourcing.
- In urology in particular, the service continues to experience very high levels of demand following the heightened awareness of symptoms of prostate cancer following recent high-profile cases in the media; the service also currently has two consultants on maternity leave, for whom there is insufficient cover, and one on long-term sick leave.

Focus of improvement work

- The breast service will be attempting to recruit an additional member of the team, who can also provide breast radiology capacity.
- Additional CT colon and endoscopy capacity will come online with the opening of the Yeovil Community Diagnostic Centre; in the meantime, extra lists are being put in place whenever possible.
- The endoscopy washers at Bridgwater Community Hospital have now been repaired; colonoscopy weekend insourcing lists have now resumed.

Line Chart



How do we compare

National average performance for providers was 76.7% in April 2025, the latest data available. Our performance was 72.6%. We ranked 114 out of 137 providers.

Recent performance

Performance in recent months was as follows:

28-day Faster Diagnosis performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
Trajectory	78.3%	78.3%	77.1%	80.3%	81.2%	79.0%
Compliance	76.5%	75.8%	72.0%	78.6%	75.4%	72.6%

Responsive

The Accident & Emergency (A&E) 4-hour standard is a measure of the length of wait from arrival in an Emergency Department (ED) to the time the patient is discharged, admitted or transferred to another provider. The target is that at least 76% of patients will wait less than four hours in the Emergency Department, rising to 78% by March 2026.

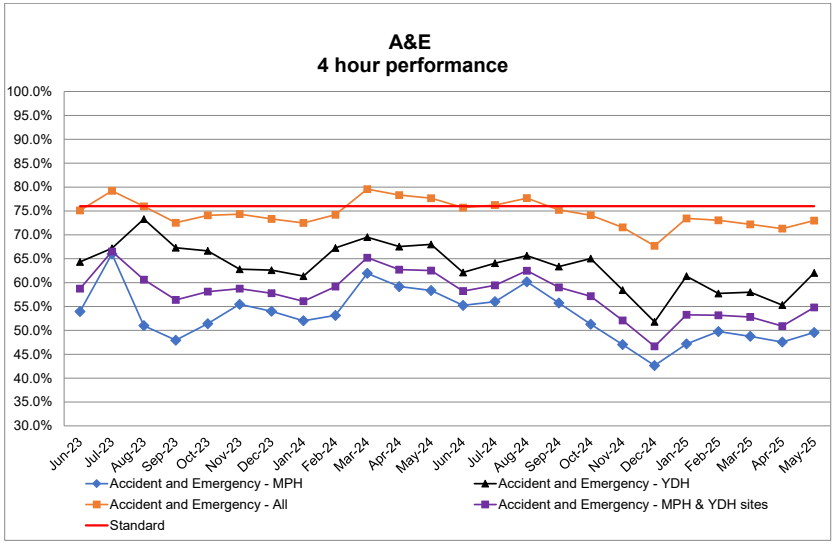
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 54.8% during May 2025, up from 50.9% in April 2025. With Urgent Treatment Centres (UTCs) compliance included at 97.5%, overall compliance was 73.0%, the highest rate since February 2025 but still below the 76% national standard.
- Compliance in respect of our two A&E departments was:
    - Musgrove Park Hospital (MPH): 49.6%.
    - Yeovil District Hospital (YDH): 62.0%.
- Combined rolling 12-month A&E attendances at MPH and YDH, for the period from 1 June 2024 to 31 May 2025, were 0.2% lower than the same months of 2023/24.
- We are required to achieve an improvement in respect of the percentage of patients sending less than 12 hours in the departments, compared to the 2024/25 outturn. Between 1 April and 31 May 2025, 93.7% of patients spent less than 12 hours in the departments, which was below the 95.4% achieved for the 12 months ending 31 March 2025.

Focus of improvement work

- An updated four-hour improvement plan has been developed in conjunction with senior teams.
- MPH – room changes are planned, to provide additional space for ambulatory majors / Integrated Front Door (IFD) patients, including the development of paediatric dedicated staffing, and movement of the eye room. New workstations have been installed at MPH for the IFD to tackle constraints due to space limitations.
- One new consultant at YDH has now started; pre-employment checks are underway for a further consultant, and two further interviews are planned. There continues a reduction in Specialty and Associate Specialist doctors (SAS) vacancies with support from the recruitment team; further interviews are planned.
- An Operational Support Manager is now in post at YDH, holding daily 1:1s with the progress chaser to agree a plan of action for the day and a consistent focus on four-hour performance. Three additional progress chasers, and two receptionists have been recruited at YDH.
- Acute Assessment Unit (AAU) – a phased approach to converting AAU spaces to ambulatory majors is planned to commence during the week commencing 16 June 2025, to reduce risk or corridor care in Minor Injury assessment, and support flow.

Line Chart



How do we compare

In May 2025, the national average performance for Trusts with a major Emergency Department was 61.2%. Our performance was 54.8%. We were ranked 88 out of 121 trusts. With Urgent Treatment Centre attendances included, we were ranked 56, with performance of 73.0%. National average performance was 72.8%.

Recent performance

Area	Dec	Jan	Feb	Mar	Apr	May
A&E only	46.6%	53.3%	53.2%	52.8%	50.9%	54.8%
Including UTC	67.7%	73.4%	73.0%	72.2%	71.3%	73.0%

Responsive

Reduce average length of stay in adult acute mental health beds. We aim to reduce length of stay by eliminating delays in discharge and promote care in a less restrictive setting, that is, to discharge patients safely to their place of residence with ongoing care from community teams, with benefits to quality of care.

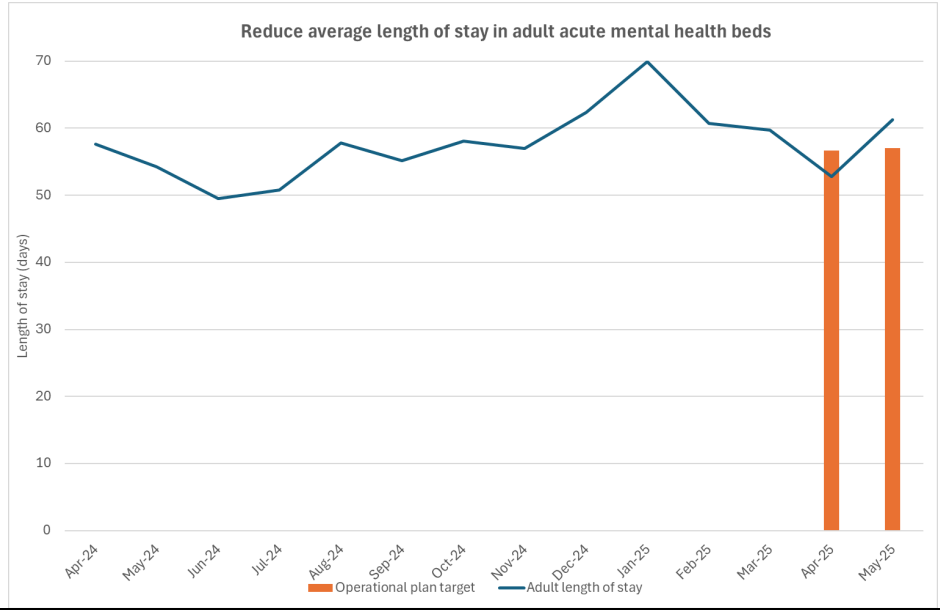
Current performance (including factors affecting this)

- During May 2025 the rolling three-month average length of stay within our adult mental health wards was 61.3 days, above the trajectory agreed with the Somerset Integrated Care Board to reduce our average length of stay from a baseline level of 57.0 days for the three months ending 30 November 2024, to an average of 53.1 days for the three months ending 31 March 2026.
- During May 2025 discharges totalled 26; during the previous three months discharges averaged 36.

Focus of improvement work

- Rydon wards 1 & 2 are trailing the new way of Multi-Disciplinary Team handover meetings (MDT), discussing the purpose of admission, any barriers to discharge, and assigning actions to the responsible colleagues.
- Rowan wards 1 & 2 have introduced their new MDT meeting, to be held every Thursday, and running for around two and half hours. These meetings are in addition to their daily MDT handover. The meeting similarly helps to identify any barriers, with identified actions being assigned to colleagues.
- Pyrland wards 1 & 2 are finding challenges around the number of choices available to patients on placement options, the expectations from patients and families, and the use of the reluctant discharge policy within mental health. The action for Pyrland is to meet separately and review the options, the expectations and the use of reluctant discharge policy in mental health so that all teams have a consistent approach.
- The Social Work manager is reviewing the staff allocation for each ward and levels of cover during periods of annual leave and sickness.
- We are planning to meet with housing officers from Somerset Council around housing challenges. Some of the concerns relate to delayed responses to referrals from external agencies.
- We are also improving our interface meetings so that they are purposeful and promote collaboration between inpatient and community teams for easier transition of people from wards to the community and vice versa.

Line Chart



How do we compare

The average length of stay increased when compared to April 2025.

Performance over the last six months

Area	Dec	Jan	Feb	Mar	Apr	May
Average length of stay	62.4	70.0	60.7	59.7	52.8	61.3
Operational plan	N/A	N/A	N/A	N/A	56.6	57.1

SOMERSET NHS FOUNDATION TRUST

NHS ENGLAND 2025/26 PRIORITIES AND OPERATIONAL PLANNING GUIDANCE: NATIONAL PRIORITIES AND SUCCESS MEASURES FOR 2025/26

No.	Priority	Success Measure	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
NP1	Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline	1,2	65.6%	65.1%	63.8%	63.3%	62.8%	62.2%	62.1%	61.8%	61.5%	61.9%	64.3%	65.3%	Per the planning trajectory, culminating in 67.3% in March 2026.		
NP2		Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline	1,2	77.6%	75.5%	75.6%	73.9%	74.3%	74.7%	73.7%	74.7%	73.8%	73.9%	74.7%	75.4%	Per the planning trajectory, culminating in 80.3% in March 2026.		
NP3		Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	1,2	3.3%	3.2%	3.1%	2.6%	2.5%	2.3%	2.3%	2.4%	2.4%	2.1%	2.5%	2.8%	Per the planning trajectory, culminating in 1.5% in March 2026.		
NP4		Improve performance against the headline 62-day cancer standard to 75% by March 2026	1,2	68.0%	67.8%	72.0%	64.4%	65.6%	68.2%	71.0%	66.9%	68.9%	75.2%	70.2%	Data not yet due	From March 2025 at or above trajectory =Green and below trajectory =Red		
NP5		Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	1,2	75.0%	70.0%	70.9%	75.4%	79.0%	76.5%	75.8%	72.0%	78.6%	75.4%	72.6%	Data not yet due	From March 2025 at or above trajectory =Green and below trajectory =Red		
NP6	Improve A&E waiting times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026: **Trust-wide performance**	2	75.7%	76.2%	77.7%	75.2%	74.1%	71.6%	67.7%	73.4%	73.0%	72.2%	71.3%	73.0%	From April 2025 >=76%= Green >=66% - <76% =Amber <66% =Red (the standard will rise to 78% in March 2026)		
NP7		Improve A&E waiting times, with a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25 - **Trust-wide performance**	2	97.8%	97.4%	97.3%	97.2%	97.0%	96.7%	96.0%	95.4%	95.1%	95.2%	92.8%	93.7%	From April 2025 >=95.4% = Green <95.4% = Red		
NP8	Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds	2,6	49.5	50.8	57.8	55.2	58.1	57.0	62.4	70.0	60.7	59.7	52.8	61.3	Per the planning trajectory, culminating in 53.1 days in March 2026.		
NP9	Live within the budget allocated, reducing waste and improving productivity	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	6	£8,096K	£10,459K	£13,055K	£15,165K	£17,862K	£20,290K	£22,460K	£24,679K	£26,790K	£28,921K	£1,827K	£3,489K	>=30% reduction= Green >=25% - <30% reduction =Amber <25% reduction =Red		
NP10		Close the activity / WTE gap against pre-Covid levels (adjusted for case mix)	6	To be included in the six-monthly Productivity report.												To be confirmed.		
NP11	Maintain focus on quality and safety of services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'	1,2	Clarification sought from NHS England as to how this is to be monitored and assessed.												To be confirmed.		
NP12	Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people	1	Clarification sought from NHS England as to how this is to be monitored and assessed.												To be confirmed.		

Sector-Based Performance Summaries

NARRATIVE REPORT

URGENT AND EMERGENCY CARE SERVICES

The key points of note in respect of Urgent and Emergency Care services are as follows:

Ambulance handovers - During May 2025, performance for the handover within 30 minutes of patient arrivals by ambulance improved across both acute sites when compared to April 2025. Compliance in May 2025 improved by 1.1% at MPH and by 11.2% at YDH.

Flow from our acute sites improved during May and subsequent benefits in ambulance handover time reductions have been seen.

Focus of improvement work:

- SWAST are attending site team bed meetings to improve communications and understanding of factors affecting flow, particularly the evening meeting with on-call teams to ensure overnight flow is maintained.
- "Call before convey" work is due to start in June 2025 to support in reducing attendances where there may be alternatives to attendance, in the community.
- The YDH Urgent Treatment Centre (UTC) has unfortunately been delayed due to water damage in the diagnostics centre, delaying the movements of departments. However, a soft launch of UTC operations at YDH has been in place to support the availability of capacity within the department.

No criteria to reside - During May 2025, the percentage of occupied bed days lost due to patients not meeting the criteria to reside increased at MPH by 3%, compared to the previous month, to 26.7% and increased at YDH by 7% to 25.1%.

Focus of improvement work:

- A continued drive to improve hospital-related delays as well as continued focused work on board rounds and criteria-led discharge.

Stroke

Stroke indicators for May 2025 on the MPH site are provisional and require some further validation due to a SSNAP co-ordinator hiatus; it is anticipated that the data will be validated during the next month. Patients directly admitted to a stroke ward, and time on a stroke unit on the YDH site continue to be affected by an increase in patients who do not meet the criteria to reside. The two units continue to support one another throughout the month, to maximise available stroke beds.

Focus of improvement work:

- A Stroke Improvement Group has been established to focus on scanning, stroke consultant assessment and length of stay.
- Supported work to reduce the number of patients on the stroke wards who do not meet the criteria to reside, to ensure that patients are therefore able to access a stroke ward in a timely way.

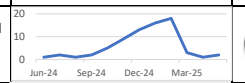
SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
UEC1	Ambulance handovers waiting less than 30 minutes	MPH	NHSC	2	76.6%	75.5%	82.4%	74.4%	67.9%	62.1%	47.3%	56.8%	62.4%	71.8%	64.6%	65.7%	>=95%= Green >=85% - <95% =Amber <85% =Red		F
UEC2		YDH			66.0%	59.8%	66.0%	63.0%	64.8%	62.3%	47.4%	52.8%	57.1%	62.3%	51.0%	62.2%			F
UEC3	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	SFT	2,6	6.2	6.3	6.4	6.6	6.4	6.9	6.9	7.2	7.0	6.9	6.9	7.0	Monitored using Special Cause Variation Rules. Report by exception.		
UEC4		YDH			9.0	8.1	9.3	8.7	9.1	8.4	8.9	10.0	9.7	9.8	9.0	8.7			
UEC5	Patients not meeting the criteria to reside: percentage of occupied bed days lost	MPH	SFT	2,6	19.4%	23.2%	22.4%	19.6%	19.0%	22.7%	20.0%	19.5%	26.4%	26.0%	23.7%	26.7%	<=9.8%= Green >15% =Red		F
UEC6		YDH			23.0%	21.0%	19.9%	26.4%	21.3%	20.8%	20.2%	20.9%	26.2%	24.4%	18.1%	25.1%			F
UEC7	Percentage of Stroke Patients directly admitted to a stroke ward within four hours	MPH	NSG	1,2,4	50.0%	52.4%	54.3%	34.9%	58.6%	46.8%	60.4%	67.3%	53.3%	72.7%	86.7%	52.9%	>=90%= Green >=75% - <90% =Amber <75% =Red		F
UEC8		YDH			27.6%	35.6%	40.0%	41.2%	30.0%	36.6%	28.6%	23.3%	16.3%	32.5%	32.4%	41.9%			F
UEC9	Percentage of patients spending >90% of time in stroke unit - acute services	MPH	NSG	1,2,4	88.5%	94.1%	94.0%	98.2%	76.7%	70.3%	82.0%	78.8%	89.4%	89.4%	90.9%	71.4%	>=80%= Green >=70% - <80% =Amber <70% =Red		F
UEC10		YDH			67.7%	70.3%	56.3%	74.2%	63.0%	63.0%	65.0%	64.0%	76.2%	63.6%	71.4%	57.8%			F
UEC11	Percentage of patients scanned within 20 minutes of clock start	MPH	NSG	1,2,4					48.6%	52.4%	50.9%	37.5%	50.0%	47.8%	73.3%	22.2%	>=32%= Green >=27% - <32% =Amber <27% =Red		F
UEC12		YDH			18.8%	19.4%	44.0%	36.4%	19.4%	14.3%	5.7%	12.9%	17.6%	16.7%	18.9%	13.5%			F
UEC13	Percentage of patients assessed by a Stroke Specialist Consultant within 14 hours of clock start	MPH	NSG	1,2,4					48.6%	52.4%	50.9%	37.5%	50.0%	39.1%	46.7%	44.4%	>=70%= Green >=60% - <70% =Amber <60% =Red		F
UEC14		YDH			50.0%	38.7%	56.0%	57.6%	64.5%	54.7%	40.0%	45.2%	64.7%	42.9%	56.8%	44.2%			F
UEC15	Stroke: Median number of minutes of total therapy received per inpatient day	MPH	NSG	1,2,4					33	34	26	26	No Data	34	No Data	No Data	>=42= Green >=32 - <42 =Amber <32 =Red		F
UEC16	Stroke: Median number of minutes of total therapy received per inpatient day	YDH	NSG	1,2,4					33	34	26	25	24	21	42	53	>=42= Green >=32 - <42 =Amber <32 =Red		?
UEC17	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the patient	MPH, YDH, Community Hospitals and Mental Health wards	NHSC	1,2,4	75.6%		79.2%		63.0%		Work still being undertaken to improve robustness of recording and to ensure all required data captured. The first inpatient NEWS audit report is planned for early July 2025								F

SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
UEC18	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	NHSC	1,2,4	83.3%	100.0%	90.9%	87.1%	92.3%	90.6%	90.6%	90.0%	84.2%	82.9%	96.9%	84.8%	>=90%= Green >=80% - <90% =Amber <80% =Red		
UEC19	Percentage of emergency patients screened for sepsis - Emergency Departments				90.9%	77.8%	91.0%	90.7%	92.8%	94.2%	93.9%	94.9%	100.0%	88.9%	88.2%	90.0%			
UEC20	Percentage of patients admitted as an emergency within 30 days of discharge		PAF	2,3	10.2%	10.2%	10.1%	9.6%	9.8%	8.6%	9.6%	7.6%	8.3%	9.0%	8.9%	8.6%	To be confirmed.		
UEC21	Average number of days between planned and actual discharge date		PAF	2,3	2.3	2.6	2.9	2.6	2.6	2.6	2.7	2.9	2.8	3.0	2.7	2.6	To be confirmed.		
UEC22	Monthly number of inpatients to suffer a new hip fracture		PAF	2	2	3	2	3	1	1	2	4	2	0	0	1	To be confirmed.		
UEC23	Number of mental health patients spending under 12 hours in A&E		PAF	2,3	91.0%	91.9%	89.9%	90.8%	91.6%	91.6%	91.3%	91.5%	91.2%	90.7%	87.8%	93.2%	From April 2025 >=90.7% = Green <90.7% = Red		
UEC24	Percentage of over 65s attending emergency departments to be admitted		PAF	2,3	46.8%	47.1%	45.9%	47.5%	47.9%	48.4%	49.9%	49.9%	47.6%	47.0%	46.1%	45.7%	To be confirmed.		
UEC25	Percentage of under 18s attending emergency departments to be admitted		PAF	2,3	12.7%	12.1%	12.1%	16.1%	15.2%	16.1%	14.6%	14.7%	14.8%	13.4%	12.9%	11.3%	To be confirmed.		
UEC26	Percentage of inpatients referred to stop smoking services		PAF	1,2	Report awaited from topic lead who is liaising with our Data Analytics team to resolve some identifed data quaiity issues.												To be confirmed.		
UEC27	Average daily number of medical and surgical outliers in acute wards during the month	MPH	NHSC	2	1	2	1	2	5	9	13	16	18	3	1	2	Monitored using Special Cause Variation Rules. Report by exception.		
UEC28		YDH	NHSC	2	9	18	13	13	13	10	13	14	13	12	14	13	Monitored using Special Cause Variation Rules. Report by exception.		
UEC29	Number of patients transferred between acute wards after 10pm	MPH	NHSC	2	57	59	66	81	104	85	152	146	117	99	85	96	Monitored using Special Cause Variation Rules. Report by exception.		
UEC30		YDH	NHSC	2	48	84	98	123	130	132	176	152	92	149	126	85	Monitored using Special Cause Variation Rules. Report by exception.		
UEC31	Summary Hospital-level Mortality Indicator (SHMI)		NHSC	2	99.52	99.05	97.76	102.63	99.59	102.73	95.93	103.75	104.97	Data not yet due - March 2025 to be reported after June 2025			Monitored using Special Cause Variation Rules. Report by exception.		
UEC32	Total number of patient falls - acute services		NHSC	2	147	146	150	149	162	171	164	189	174	138	167	154	Monitored using Special Cause Variation Rules. Report by exception.		
UEC33	Rate of falls per 1,000 occupied bed days - acute services		NHSC	2	5.21	5.01	5.16	5.13	5.38	5.80	5.26	5.22	6.05	4.46	5.56	5.14	Monitored using Special Cause Variation Rules. Report by exception.		
UEC34	Number of pressure ulcers	MPH	NHSC	2	27	24	14	17	25	31	19	33	27	17	17	Data not yet due	Monitored using Special Cause Variation Rules. Report by exception.		

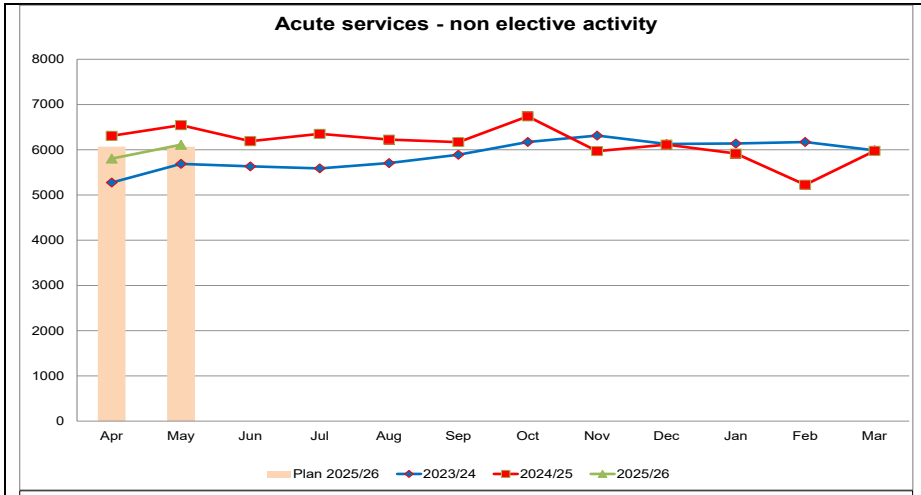
SOMERSET NHS FOUNDATION TRUST

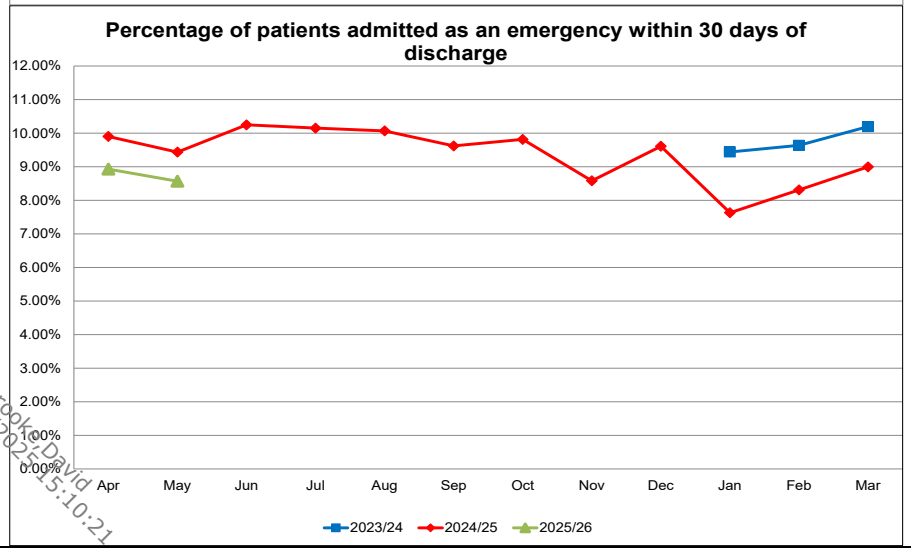
URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
UEC35	Rate of pressure ulcer damage per 1,000 occupied bed days	MPH	NHSC	2	1.49	1.30	0.77	0.92	1.30	1.64	0.96	1.34	1.48	0.87	0.88	Data not yet due	Monitored using Special Cause Variation Rules. Report by exception.		
UEC36	Number of pressure ulcers	YDH	NHSC	2	10	11	21	12	18	21	26	26	14	19	21	Data not yet due	Monitored using Special Cause Variation Rules. Report by exception.		
UEC37	Rate of pressure ulcer damage per 1,000 occupied bed days	YDH	NHSC	2	0.99	1.03	1.94	1.13	1.65	1.97	2.26	2.24	1.34	1.68	2.02	Data not yet due	Monitored using Special Cause Variation Rules. Report by exception.		
UEC38	No. ward-based cardiac arrests - acute wards	MPH	NHSC	2	7	2	4	3	4	1	5	4	6	3	4	2	Monitored using Special Cause Variation Rules. Report by exception.		
UEC39	No. ward-based cardiac arrests - acute wards	YDH	NHSC	2	3	2	2	3	1	1	0	4	4	5	0	2	Monitored using Special Cause Variation Rules. Report by exception.		
UEC40	Total number of medication incidents	MPH	NHSC	2	92	100	91	86	85	91	73	98	76	82	92	71	Monitored using Special Cause Variation Rules. Report by exception.		
UEC41	Total number of medication incidents	YDH	NHSC	2	41	42	28	25	40	17	32	43	22	24	30	22	Monitored using Special Cause Variation Rules. Report by exception.		

Operational context

Acute services: This section of the report provides a summary of the levels of non-elective activity, emergency readmissions within 30 days, and non-elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- Between 1 April and 31 May 2025 non-elective admissions decreased by 7.3% compared to the same months of 2024 but increased by 8.7% compared to the same months of 2023. Activity for 1 April to 31 May 2025 was 1.8% below the plan.
- Between 1 April and 31 May 2025, emergency readmissions elective admissions totalled 2,200, 16.1% lower than the same period in 2024, when there were 2,621 admissions.
- We aim to include data showing the Trust-wide monthly average non-elective length of stay in the next version of the report.

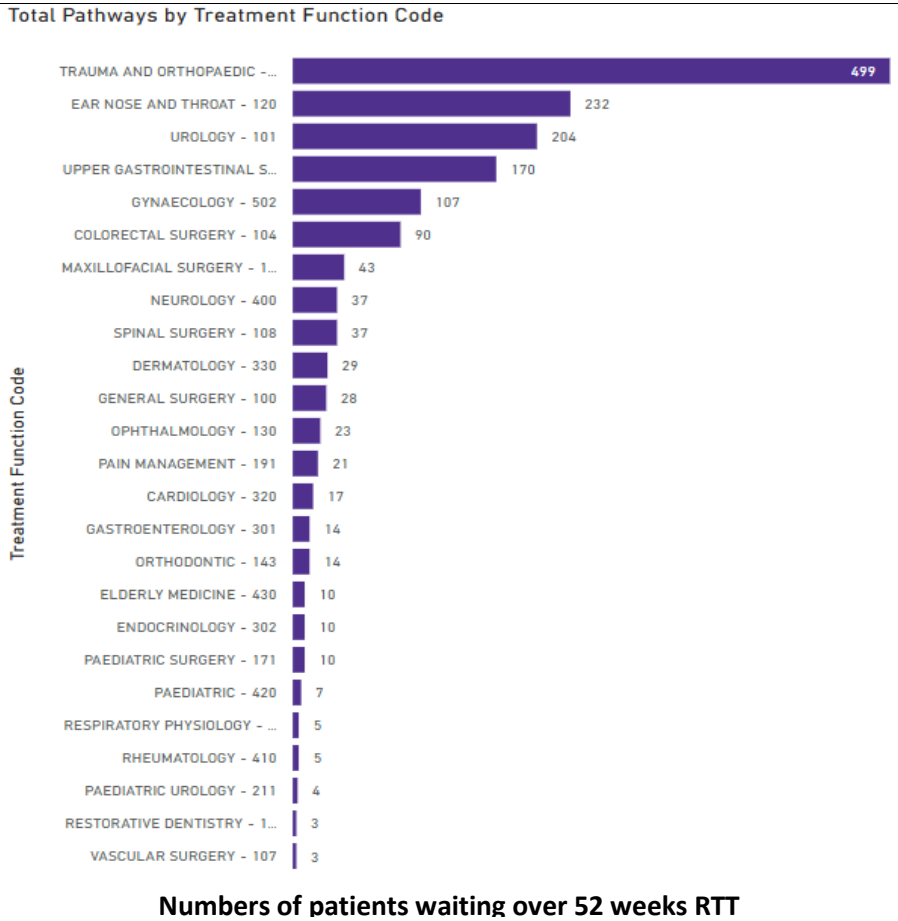
NARRATIVE REPORT

ELECTIVE CARE SERVICES

The key points of note in respect of Elective Care services are as follows:

1) The number patients waiting over 52 weeks and over 65 weeks continued to increase in May 2025. This is due to several factors including a reduction in capacity due to bank holiday weekends, a reduction in weekend working because of a re-setting of pay rates, an increase in trauma, and an increase in emergency bed pressures, the latter in particular impacting on orthopaedic elective admissions. There has also been a change of focus to reducing waiting times for the front end of the pathway, which in time will also reduce the number of longer waiting RTT patients. The main specialties making up the increase in the 52-week waiters are as shown to the right, with Trauma & Orthopaedics (T&O), ENT and Urology making-up 57% of all current over 52-week waiters. The following actions are being taken to try to reduce waiting times in these specialties:

    - Two additional orthopaedic consultants have been appointed and will start in post in September 2025.
    - Four additional physiotherapy-led T&O clinics will be run each week (one has already started, increasing to four per week by September 2025).
    - Increasing the use of pooled surgeon orthopaedic waiting lists, to be used for patients that can be operated on by several different surgeons; this should smooth waiting times across surgeons.



Numbers of patients waiting over 52 weeks RTT

- Standardisation of clinic templates (T&O, ENT, Urology and other high-volume specialties), which for some consultants will lead to an increase in the number of patients seen per clinic.
- Weekend Super clinics in Orthopaedics, including Yeovil consultants who have shorter waiting times for first appointments, seeing patients currently on Musgrove lists.
- Increasing the number of arthroplasty (i.e. joint replacements) undertaken on a theatre list in Musgrove to five from four, by September 2025.
- Recruitment of two ENT middle grade doctors (one has commenced, the other will come into post in July 2025).
- Job plan reviews (T&O, ENT and Urology).
- Validation through contacting patients, to check the need for a follow-up, to free-up outpatient capacity.
- Implementation of Advice & Refer (including Advice & Guidance as part of an enhanced triage), using the Cinapsis system for ENT; this should reduce outpatient referrals and will thereby help to reduce 52-week waiters in 2026/27.
- Appointment of three additional urologists (one on a substantive contract, and two on fixed term contracts); two consultants also return in September 2025, following maternity leave.

Delivery against the above actions is being overseen by the three-weekly RTT Oversight meetings, chaired by the Director of Elective Care. Most of these actions will also support the delivery of the 18-week RTT, and first outpatient appointments within 18 weeks targets, for which the Trust is currently performing substantially better than plan.

2) The number of patients waiting over six weeks for a diagnostic test has increased in the period from 3,388 at the end of April 2025 to 3,415 at the end of May 2025. The overall percentage of patients waiting under six weeks for a diagnostic test has reduced from 75.7% in April to 74.5% in May. This decline is also through a reduction in the total waiting list size by just over 500 patients, which means less demand needs to be met in future months. The number of over six-week waiters has reduced for echo, CT and MRI scans but has increased for ultrasound scans and gastrointestinal endoscopies. The reasons for this rise are multi-factorial and include vacancies, sickness, equipment failure and high demand. Additional ultrasound lists are being scheduled at Musgrove, with additional ultrasound capacity also being provided at Yeovil by a locum insourcing contract. The endoscopy scope washers have now been successfully repaired and are fully operational again. Insourcing contracts for endoscopy lists at the weekend are back in place. Substantive appointments continue to be made where vacancies exist. CT and MRI scanning vans also continue to be used to provide capacity which would have been provided by the Yeovil Community Diagnostic Centre, until it opens later in the year. A capital business case has been submitted for the expansion of diagnostic capacity in Bridgwater, which includes provision for two

high specification CT and two high specification MRI scanners, which will help provide additional scanning capacity for the more complex scans, such as whole body and cardiac scans. Long waiting patients on RTT pathways continue to have their diagnostic tests prioritised whenever possible, without compromising the waiting times for urgent and cancer patients.

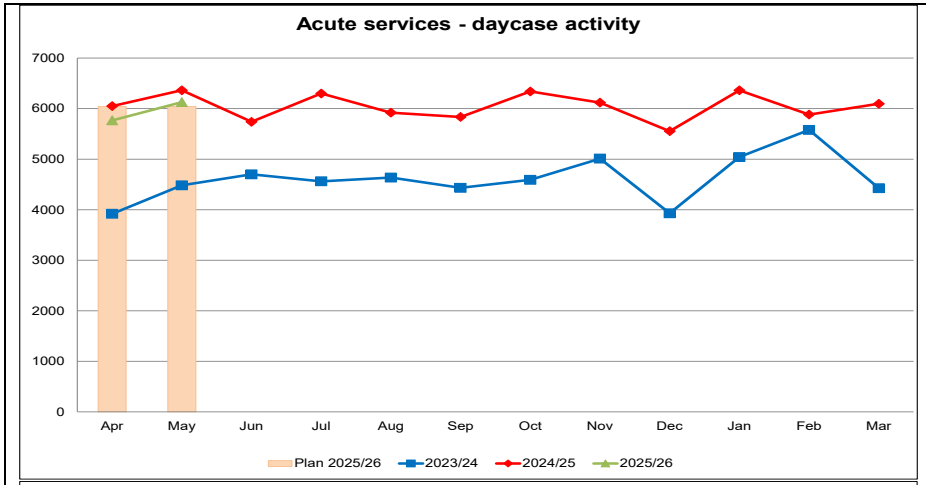
SOMERSET NHS FOUNDATION TRUST

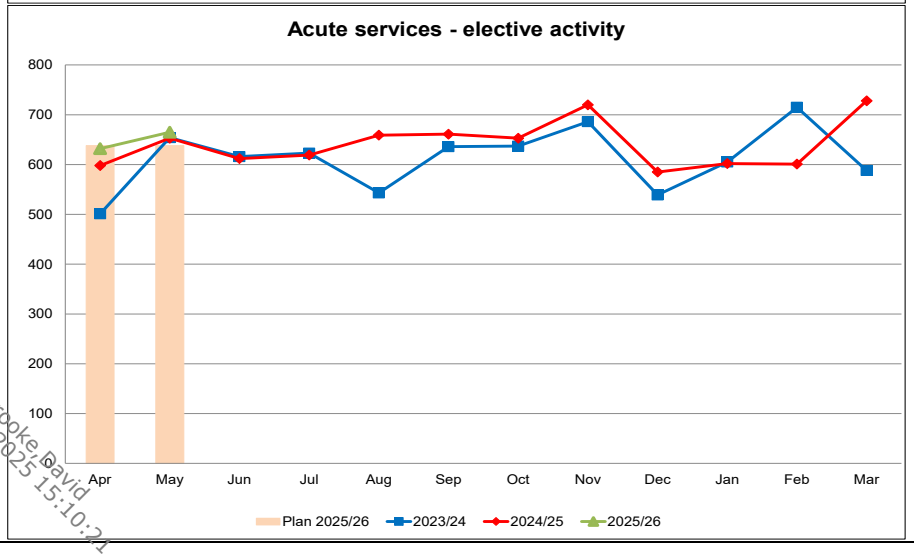
ELECTIVE CARE

No.	Description		Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
EC1	Diagnostic 6-week wait - acute services	MPH	NHSC	1,2	84.0%	78.9%	76.3%	83.5%	87.4%	85.2%	72.9%	72.2%	77.4%	79.0%	79.7%	81.4%	From March 2024 At or above regional ambition 85% = Green Above trajectory = Amber Below trajectory = Red		
EC2		YDH			69.2%	67.3%	69.9%	70.6%	77.6%	79.3%	77.0%	65.7%	77.6%	73.6%	65.5%	64.3%			
EC3		Combined			78.3%	74.8%	74.0%	79.8%	84.7%	83.8%	74.1%	70.4%	77.4%	77.6%	75.7%	74.5%			
EC4	52 week RTT breaches - Patients of all ages		OPG	1,2	1,873	1,842	1,769	1,536	1,445	1,371	1,364	1,388	1,406	1,257	1,438	1,572	From April 2023 At or below trajectory = Green Above trajectory = Red		
EC5	65 week RTT breaches - Patients of all ages		NHSC		493	426	370	247	198	144	142	146	117	81	86	112			
EC6	Referral to Treatment (RTT) incomplete pathway waiting list size		NHSC		56,599	57,442	57,619	58,112	58,725	59,585	60,076	59,061	59,310	59,621	58,470	57,069			
EC7	Rate of annual growth in under 18s elective activity - Rolling 12 months comparison of previous 12 months		PAF		25.2%	22.8%	25.5%	23.2%	19.9%	13.3%	11.0%	7.0%	5.3%	28.1%	-4.7%	-3.1%	To be confirmed		
EC8	Elective Care: Estimated time it would take to clear the waiting list if no new patients were added		PAF	1,2	Report being developed and should be available from May 2025 reporting.												To be confirmed		
EC9	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	SFT	2,6	3.1	2.7	3.0	2.5	2.3	2.4	3.9	2.5	3.0	2.7	3.0	3.5	Monitored using Special Cause Variation Rules. Report by exception.		
EC10		YDH			1.9	1.5	1.9	1.5	1.7	1.6	1.4	1.4	2.0	1.4	1.9	1.7			

Operational context

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





Summary:

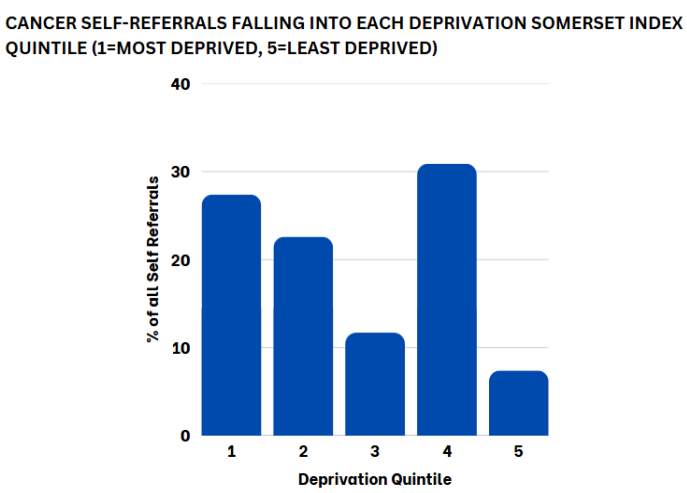
- The number of day cases undertaken by our acute services between 1 April and 31 May 2025 decreased by 4.2% compared to the same months of 2024 and by 41.6% compared to the same months of 2023. Activity for the year to date was 2.2% below the current year plan.
- Over the same period, elective admissions were 4.7% higher than the corresponding months of 2024 and 10.7% higher compared to the same months of 2023. Activity for the year to date was 5.9% above the current year plan.
- We aim to include data showing the Trust-wide monthly average elective length of stay in the next version of the report.

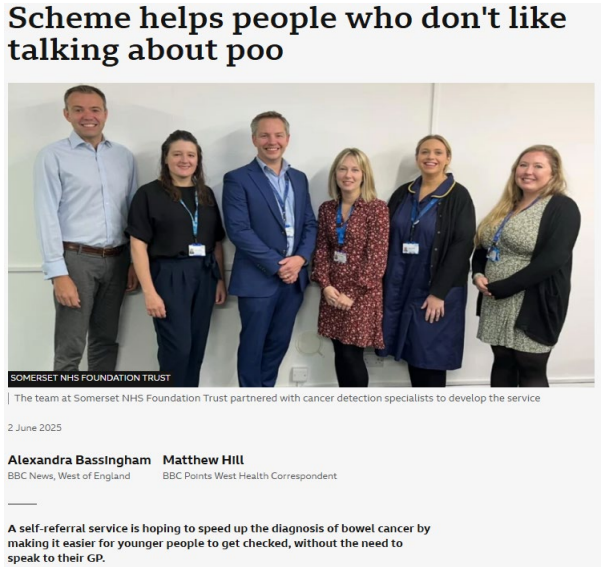
NARRATIVE REPORT

CANCER SERVICES

The key points of note in respect of Cancer services are as follows:

- Last month the Trust's Somerset Bowel Service was highlighted by BBC Points West (photo below). Following the initial pilot in the Bridgwater area, the service continues to be rolled-out as part of an ongoing programme of work to provide self-referral options for people with potential symptoms of cancer. This includes self-referral for patients with bleeding in menopause, bowel, lung and breast cancer symptoms. These services are in various stages of being piloted and rolled out. For some, such as the Somerset Bowel Service, we have been focusing first on those areas of Somerset where we see the highest rates of late-stage cancers, with the aim of giving patients another, convenient way in which they can get their symptoms checked out. These areas are often the most socially deprived. For the bleeding in menopause service, we have taken a different approach and have set-up clinics across a range of sites across Somerset, to try to improve access for patients. Across the full range of self-referral services, we have so far seen a high proportion of patients referred from the most deprived parts of the county (i.e. quintiles 1 and 2) as shown in the graph (right).





Scheme helps people who don't like talking about poo

SOMERSET NHS FOUNDATION TRUST

The team at Somerset NHS Foundation Trust partnered with cancer detection specialists to develop the service

2 June 2025

Alexandra Bassingham, BBC News, West of England
Matthew Hill, BBC Points West Health Correspondent

A self-referral service is hoping to speed up the diagnosis of bowel cancer by making it easier for younger people to get checked, without the need to speak to their GP.

- There continue to be challenges with achieving the new March 2025 Faster Diagnosis Standard (FDS) target of 77% of patients receiving a diagnosis within 28 days of referral. Breast has a one-stop service, where patients have any scans and tests they need, as well as seeing a specialist, in a single visit. This usually allows over 90% of patients to receive a diagnosis within 28 days, but

recently the breast service performance against the 28-day standard has dipped. One of the reasons for the deterioration in performance in recent months has been a reduction in the breast service capacity. This has been a result of sickness and also a vacancy within the radiology team which provides breast radiology capacity for the one-stop clinics. The member of the team who was off sick is now back on a staged return. We continue to look at ways of managing demand across the two hospital sites. But we are also recruiting to an additional post within the Breast team to expand service capacity.

- Whilst performance against the 62-day referral to treatment standard is currently meeting the 70% national improvement target set for March 2025, we are currently performing below our planned trajectory. The highest number of breaches of the standard are in urology, lower gastrointestinal (GI) and breast. Performance in these three tumour sites is being affected by waiting times against the diagnostic phase of these pathways (i.e. the 28-day Faster Diagnosis Standard). For breast, the issues are as described in the previous section. As covered in the Elective Care (RTT) section of the Board Report, consultant appointments are due to be made shortly in urology, one of which will be providing leadership and capacity to the cancer element of the urology service. This will include the risk stratification of patients on suspected bladder or prostate cancer pathways, to ensure the patients needing timely investigations and interventions are prioritised, but also so patients not requiring these steps in the standard pathway do not have unnecessary attendances at hospital. For lower GI pathway patients, the greatest gains in waiting times will be in reducing waits for colonoscopies and CT colon scans. Additional capacity will be available once the Yeovil Community Diagnostic Centre (CDC) opens. But in the meantime, to reduce waiting times, additional capacity is being provided via waiting list initiatives and insourcing. The Trust will be taking part in the regional and national Get It Right First Time (GIRFT) improvement workstreams for urology and lower GI ‘Days Matter’, which commence the week commencing 23 June 2025.

SOMERSET NHS FOUNDATION TRUST

CANCER SERVICES

No.	Description	Source	Links to strategic aims	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Thresholds	Trend	Variation / Assurance
C1	31 day wait - from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment	NHSC	1,2	91.9%	91.2%	96.4%	94.8%	93.7%	94.1%	90.1%	93.7%	93.7%	97.1%	96.7%	95.4%	>=96%= Green <96% =Red		
C2	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104	OPG	1,2	20	23	21	19	22	33	23	13	17	28	25	32	0= Green >0 = Red		
C3	Cancer: 62-day wait from referral to treatment for urgent referrals – Breast	OPG	1,2	72.0%	77.1%	89.2%	88.6%	89.7%	88.9%	82.9%	82.4%	77.8%	80.0%	87.5%	78.7%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C4	Cancer: 62-day wait from referral to treatment for urgent referrals – Colorectal	OPG	1,2	55.0%	53.1%	53.3%	49.2%	51.1%	59.5%	57.1%	45.2%	50.0%	46.2%	58.1%	55.2%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C5	Cancer: 62-day wait from referral to treatment for urgent referrals – Gynaecology	OPG	1,2	71.4%	71.0%	77.8%	75.0%	69.2%	74.2%	82.4%	72.2%	80.0%	75.0%	77.8%	78.9%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C6	Cancer: 62-day wait from referral to treatment for urgent referrals – Haematology	OPG	1,2	100.0%	63.6%	63.6%	64.7%	53.8%	66.7%	100.0%	76.9%	77.8%	93.8%	78.9%	78.6%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C7	Cancer: 62-day wait from referral to treatment for urgent referrals – Head and Neck	OPG	1,2	83.3%	63.6%	86.7%	42.9%	81.8%	58.8%	47.1%	62.5%	69.0%	34.6%	77.8%	68.8%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C8	Cancer: 62-day wait from referral to treatment for urgent referrals – Lung	OPG	1,2	50.0%	50.0%	59.2%	61.0%	64.3%	53.1%	53.7%	70.8%	54.2%	71.2%	73.1%	69.8%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C9	Cancer: 62-day wait from referral to treatment for urgent referrals – Other	OPG	1,2	75.0%	75.0%	66.7%	80.0%	100.0%	72.2%	80.0%	100.0%	83.3%	33.3%	88.9%	92.9%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C10	Cancer: 62-day wait from referral to treatment for urgent referrals – Skin	OPG	1,2	77.6%	80.2%	65.3%	87.6%	68.8%	65.5%	75.5%	72.9%	75.0%	85.9%	92.8%	98.7%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C11	Cancer: 62-day wait from referral to treatment for urgent referrals – Upper GI	OPG	1,2	68.8%	61.5%	71.2%	73.7%	97.3%	78.9%	80.0%	83.7%	72.6%	80.8%	91.1%	63.2%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C12	Cancer: 62-day wait from referral to treatment for urgent referrals – Urology	OPG	1,2	50.0%	60.0%	62.2%	55.9%	33.9%	53.5%	51.6%	68.7%	56.2%	51.5%	52.8%	36.5%	From March 2025 at or above trajectory =Amber and below trajectory =Red		
C13	Cancer: Percentage of all cancers diagnosed that are diagnosed at stage 1 or 2 (75% to be achieved by 2028)	PAF	1,2	Report being developed by our Data Analytics Team.												>=60.1%= Green >=55.1% to <60.1% = Amber <55.1% =Red		

NARRATIVE REPORT

MATERNITY SERVICES

The key points of note in respect of Maternity services are as follows:

The trust made the very difficult decision to temporarily close the Special Care Baby Unit on the Yeovil District Hospital site from 5pm on Monday 19 May 2025, for an initial period of six months. This means that Yeovil Hospital is also unable to safely provide inpatient maternity care, including care during labour and birth and emergency triage, during the period of closure. Women and birthing people booked to have their babies at Yeovil Hospital can continue to receive antenatal outpatient care and ultrasound scans at the hospital but will be supported to birth and receive emergency and/or inpatient care at Musgrove Park Hospital, Dorset County Hospital or Royal United Hospitals Bath.

Following the temporary closure, the service continues to work closely with Somerset Maternity and Neonatal Voices Partnership colleagues, neighbouring NHS trusts, Integrated Care Boards, and NHS England to ensure pregnant women, birthing people and newborn babies have access to the care they need and to monitor and track activity, outcomes and experience for the affected cohort of service users.

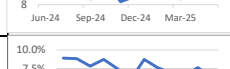
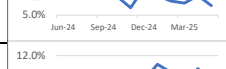
SFT Maternity services on the MPH site have seen a significant increase in activity across all maternity service areas. Demand and capacity have been successfully managed by the increased accommodation space and service reconfiguration.

Neighbouring trusts have also seen an increase in activity from the YDH displaced cohort with neighbouring Dorset County Hospital (DCH) seeing the largest increase. SFT meets weekly with the DCH team to understand any challenges relating to the increase and develop enhanced care pathways and support to manage the impact.

The service has focused support on the most vulnerable service users affected by the temporary closure and developed enhanced communication and care pathways to support all those most likely to experience poor outcomes.

SOMERSET NHS FOUNDATION TRUST

MATERNITY SERVICES

No.	Description	Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
M1	Babies readmitted to hospital who were under 30 days	CQIM	2	8	0	5	5	4	5	5	9	4	3	7	4	Monitored using Special Cause Variation Rules. Report by exception.		
M2	Babies who were born preterm - less than 37 weeks gestation	CQIM	2	23	29	36	34	24	22	22	25	22	31	17	29	Monitored using Special Cause Variation Rules. Report by exception.		
M3	Percentage of babies where breast feeding was initiated	CQIM	1,2	87%	87%	89%	85%	86%	89%	88%	85%	91%	80%	80%	87%	>=80%= Green >=75% - <80% =Amber <75% =Red		
M4	Percentage of babies with an APGAR score between 0 and 6	CQIM	1,2	1.4%	1.6%	2.0%	1.5%	2.8%	1.4%	3.0%	2.3%	1.2%	1.8%	1.2%	0.4%	=<1%= Green >1% - =<2% =Amber >2% =Red		
M5	Women who had a 3rd or 4th degree tear at delivery	CQIM	2	8	15	7	9	7	7	9	9	7	3	4	5	To be confirmed, following benchmarking against regional performance.		
M6	Women who had a postpartum haemorrhage (PPH) of 1,500ml or more	CQIM	2	16	18	12	10	16	9	11	11	15	10	14	13	To be confirmed, following benchmarking against regional performance.		
M7	Women who were current smokers at booking appointment	CQIM	1,2	8.9%	8.8%	7.8%	8.7%	7.5%	6.0%	8.7%	7.6%	6.9%	6.6%	7.6%	6.3%	No target level.		
M8	Women who were current smokers at delivery	CQIM	1,2	8.3%	5.5%	7.4%	4.4%	7.1%	7.1%	6.8%	10.1%	8.4%	6.1%	9.2%	5.9%	=<10%= Green >10% - =<12% =Amber >12% =Red		
M9	No. of still births	CQIM	2	0	2	0	2	1	1	2	0	0	0	0	0	Monitored using Special Cause Variation Rules. Report by exception.		
M10	No. of babies with Hypoxic Ischaemic Encephalopathy Diagnosis (rate per 1,000 births)	CQIM	2	3.0	0.0	0.0	0.0	0.0	0.0	3.1	0.0	0.0	0.0	0.0	0.0	Monitored using Special Cause Variation Rules. Report by exception.		

NARRATIVE REPORT

CHILDREN AND YOUNG PEOPLE'S SERVICES

The key points of note in respect of Children and Young People's services are as follows:

Children and Young People's Eating disorders service

Our Children and Young People's services are performing well against a wide range of measures. As at 28 February 2025, the latest validated data available, our Children and Young People's eating disorder service had seen all urgent referrals within one week of referral, and 96.2% of routine referrals within four weeks, above the 95% compliance standard in both cases.

Children and Young People's Community Mental Health service

As at 30 April 2025, the latest data available, we were also performing better than plan for the number of young people accessing our mental health services. As at 31 May 2025, all young people on the waiting list had waited under six weeks to be seen.

Primary care dental service

Community Dental Services in Dorset and Somerset continue to face operational challenges, particularly around recruitment and sufficiency of cover for maternity leave. However, recent progress, especially in Somerset, marks a positive shift. The Somerset team is nearing full establishment, with maternity returners expected by end of June 2025 and a new Consultant in Special Care Dentistry joining in July 2025. The service has recently welcomed a new Clinical Director, who will support the teams in both Somerset and Dorset.

In Dorset, despite the retirement of two full time equivalent (FTE) senior dentists and an upcoming maternity leave, recruitment mainly of junior dentists has been successful and adverts remain to try to fill all remaining vacancies. Further resilience is expected with a Specialist returning from career break in early Spring 2026 and a new Consultant starting post-maternity in June 2026.

This month, the service launched its 2025/26 Productive Care Initiatives, supported by the Data Science Team, to improve appointment allocation and reduce waiting lists in Somerset.

On the general wait list 2,532 patients had waited over 18 weeks, a slight increase on the previous month. 70% of these are Somerset patients, being addressed directly through phased dentist capacity and productive care improvements.

The GA waiting list for young people waiting 18 weeks or more has continued to reduce over the last five months to 552, and though still above the target of 463 or fewer, it is steadily reducing. A business case approved by Dorset ICB provides additional theatre slots through to August 2025, supporting further GA list reductions. However, GA pool dentist constraints limit full utilisation. In Somerset, the upcoming surgical building opening will double Paediatric GA capacity.

Despite ongoing pressures, the outlook is improving through strategic recruitment, data-driven planning, and system-wide collaboration.

Acute Paediatric service

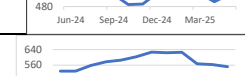
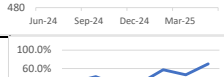
The data for the national paediatric early warning system (PEWS) has recently become available, and we will be linking with colleagues to review compliance levels and identify any themes and actions to be taken. There is difference in outcomes of these reports between the YDH and MPH sites, with YDH demonstrating excellent results and MPH showing less favourable outcomes. These differences are currently being investigated in order to determine next steps.

CYP Neurodevelopmental Partnership (CYPNP) service

Waiting lists continue to grow within the CYPNP cohort of children; overall numbers waiting increased from 3,564 patients as at 30 April 2025 to 3,676 as at 31 May 2025. CYP waiting 104 weeks or more increased from 356 to 425. CYP waiting 52 weeks or more were 63 above the trajectory agreed with NHSE. The team has developed a ‘one stop shop’ service model to improve the efficiency of the pathway, resulting in 35 additional appointments per month and improving the service user experience. This model is currently being piloted and clinic space to deliver it in the long term is being explored.

SOMERSET NHS FOUNDATION TRUST

CHILDREN AND YOUNG PEOPLE'S SERVICES

No.	Description		Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
CYP1	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		NHSC	1,2,3,4	100.0%	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Data has been validated and presented to the servce lead for sign-off. Reporting is expected to recommence from June 2025.			>=95%= Green >=85% - <95% =Amber <85% =Red		P
CYP2	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)			1,2,3,4	97.1%	96.6%	100.0%	95.7%	95.7%	95.5%	95.5%	96.4%	96.2%				>=95%= Green >=85% - <95% =Amber <85% =Red		P
CYP3	Increase the number of CYP accessing mental health services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019		OPG	1,2	4,418	4,501	4,500	4,595	4,730	4,795	4,900	4,970	5,010	5,216	5,246	Data not yet due	From April 2025 >=4,075 = Green <4,075 = Red		P
CYP4	Mental health referrals offered first appointments within 6 weeks	Children and young people's mental health services	ICB	1,2,3	95.3%	98.5%	97.8%	98.8%	97.8%	96.3%	97.5%	97.3%	98.8%	99.0%	95.6%	100.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
CYP5	Improve A&E waiting times, with a minimum of 76% of patients admitted, discharged and transferred from ED within 4 hours in March 2026: Trust-wide performance - Under 18 years old		PAF	2	77.8%	80.5%	84.0%	79.0%	79.8%	71.3%	69.0%	78.4%	74.4%	70.3%	74.0%	76.8%	From April 2025 >=76%= Green >=66% - <76% =Amber <66% =Red (the standard will rise to 78% in March 2026)		?
CYP6	52 week RTT breaches - Patients aged 18 or under		OPG	1,2	168	165	162	115	91	86	87	104	108	116	122	134	Per the planning trajectory.		F
CYP7	Community dental services - General, Domiciliary or Minor Oral surgery waiting 18 weeks or more		SFT	1,2,3	2,428	2,452	2,436	2,394	2,394	2,543	2,688	2,631	2,629	2,544	2,516	2,532	From April 2024 <1,979 = Green >=1,979 = Red		F
CYP8	Community dental services - General, Domiciliary or Minor Oral surgery waiting 52 weeks or more				620	600	538	533	489	491	540	559	571	538	502	535	From April 2024 <574 = Green >=574 = Red		P
CYP9	Community dental services - Child GA waiters waiting 18 weeks or more		SFT	1,2,3	529	529	558	577	586	603	627	624	626	567	563	552	From April 2023 <463 = Green >=463 = Red		F
CYP10	National paediatric early warning system (PEWS) - Medium risk: percentage reviewed by the nurse in charge	MPH	SFT	1,2,4	Reporting moved from a paper method to a digital solution to improve the robustness of recording. Reporting recommenced from October 2024				30.0%	42.1%	23.8%	28.6%	57.1%	46.2%	70.0%	43.8%	>=90%= Green >=80% - <90% =Amber <80% =Red		F
CYP11		YDH	SFT	1,2,4	Reporting solution adopted at MPH implemented at YDH from January 2025							85.7%	66.7%	76.9%	-	100.0%			?

NARRATIVE REPORT

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

The key points of note in respect of Mental Health and Learning Disabilities services are as follows:

What is going well

The mental health and learning disabilities dashboard remains positive, maintaining good performance in most areas.

The number of inpatient falls reduced from 13 in April 2025 to three in May 2025. This reduction related to Pyrland Ward 2, which had two patients who were falling on a regular basis (one was suffering with a delirium post-Covid, which had a significant impact both physically and mentally and they had a number of falls, another was a 90-year-old patient who was very physically frail, with minimal diet/fluid intake and who fell a number of times during their admission) both have now been discharged.

There was a reduction in restrictive interventions, prone restraints, violence and aggression from patient to staff and seclusion, which is closely monitored by the Mental Health Lead for Proactive Care and Reducing Restrictive Interventions.

What is going less well

Two patients remain placed out of area. The Urgent Care Hub is working closely with the wards and placement team to ensure patients placed out of area are kept under review and returned at the earliest opportunity. Our numbers of inappropriate out of area placements remain amongst the lowest nationally.

The number of medication incidents rose from 11 in April 2025 to 14 in May 2025. Although only a slight increase, a review of the data will be undertaken to identify any issues that may support targeted work to reduce incidents.

The number of ligature incidents rose again, from 130 in April 2025 to 192 in May 2025. A more in-depth review of the incidents will be undertaken. There was no serious harm reported as a result of these incidents. Initial data suggests that this relates to a small number of patients, where the risk is being managed by the wards.

Talking Therapies waiting times compliance is measured on the discharge of the patient, and current performance reflects an issue affecting the service around 12 months ago, when there were no assessment workers and the service was struggling to recruit. The six-week measure continues to show undercompliance, which is expected before an improvement is seen over the next few months.

Focus of improvement work

To support the work around length of stay, the Service Group is planning 'breaking the cycle' week style events, using 'breaking the cycle' principles, for the acute and older persons mental health wards, to enable a detailed review of all patients currently on the wards and to provide additional scrutiny and support, and identify options to support discharge decisions.

No.	Description		Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
MH1	Mental health referrals offered first appointments within 6 weeks	Adult mental health services	ICB	1,2,3	92.5%	94.2%	91.5%	90.4%	90.3%	92.5%	89.6%	92.9%	96.4%	91.0%	94.0%	92.6%	>=90%= Green >=80% - <90% =Amber <80% =Red		
MH2		Learning disabilities service	ICB		100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			
MH3	Percentage of women accessing specialist community Perinatal MH service - 12 month rolling reporting		LTP	1,2	13.1%	13.1%	13.2%	13.1%	13.2%	13.0%	13.1%	12.9%	12.9%	13.0%	12.6%	12.6%	>=10%= Green >=7.5% - <10% =Amber <7.5% =Red		
MH4	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		NHSC	1,2,3	77.8%	70.6%	84.6%	87.5%	100.0%	100.0%	91.7%	94.4%	93.8%	88.2%	81.3%	80.0%	>=60%= Green <60% =Red		
MH5	Talking Therapies RTT : percentage of people waiting under 6 weeks		NHSC	1,2,3	85.4%	82.7%	88.0%	86.5%	86.9%	85.6%	79.4%	81.5%	73.6%	69.6%	66.0%	58.8%	>=75%= Green <75% =Red		
MH6	Talking Therapies RTT: percentage of people waiting under 18 weeks		NHSC	1,2,3	98.7%	98.2%	99.6%	98.9%	98.3%	97.8%	98.4%	99.0%	98.4%	99.3%	98.7%	98.5%	>=95%= Green <95% =Red		
MH7	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		NHSC	1,2,3	59.6%	58.9%	61.2%	54.8%	53.0%	56.9%	56.3%	56.3%	55.9%	58.4%	58.0%	59.3%	>=50%= Green <50% =Red		
MH8	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Improvement		NHSC	1,2,3	72.5%	74.0%	77.8%	76.6%	73.6%	75.9%	71.0%	75.1%	72.4%	70.5%	74.7%	76.6%	>=67%= Green <67% =Red		
MH9	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Recovery		NHSC	1,2,3	56.0%	55.1%	58.7%	53.1%	52.6%	52.6%	50.1%	53.9%	51.4%	54.2%	54.1%	57.9%	>=48%= Green <48% =Red		
MH10	Adult mental health inpatients receiving a follow up within 72 hours of discharge		NHSC	1,2	90.5%	100.0%	96.2%	97.4%	96.9%	100.0%	97.1%	100.0%	94.6%	97.5%	96.7%	96.2%	>=80%= Green <80% =Red		
MH11	Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end		LTP	1,2	3	3	3	3	4	2	1	1	6	3	2	2	1= Green >1 = Red		
MH12	Percentage of adult inpatients discharged with a length of stay exceeding 60 days		PAF	2,3	17.1%	28.3%	36.8%	29.5%	25.0%	36.1%	23.1%	21.2%	40.9%	20.5%	17.4%	45.7%	To be confirmed		
MH13	Percentage of inpatients referred to stop smoking services		PAF	1,2	Reporting was planned to commence from May 2025. However, data anomalies have been identified. The topic lead is working with our Data Analytics team to investigate these and the issue is anticipated to be resolved before June 2025 reporting.												To be confirmed		
MH14	Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours		PAF	1,2,3	86.3%	85.4%	87.3%	87.8%	89.9%	90.7%	91.6%	93.0%	92.8%	90.0%	92.3%	91.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
MH15	Number of people accessing community mental health services with serious mental illness - rolling 12 month number.		PAF	1,2,3,4	9,716	9,852	9,892	9,968	10,048	10,035	10,071	9,974	9,965	9,916	9,805	Data not yet due	To be confirmed		
MH16	Percentage of people with suspected autism awaiting contact for over 13 weeks (aged 18 or over)		PAF	2,3,4	87.5%	91.3%	86.1%	85.4%	86.7%	91.4%	90.3%	93.0%	97.0%	98.2%	97.0%	98.7%	To be confirmed		

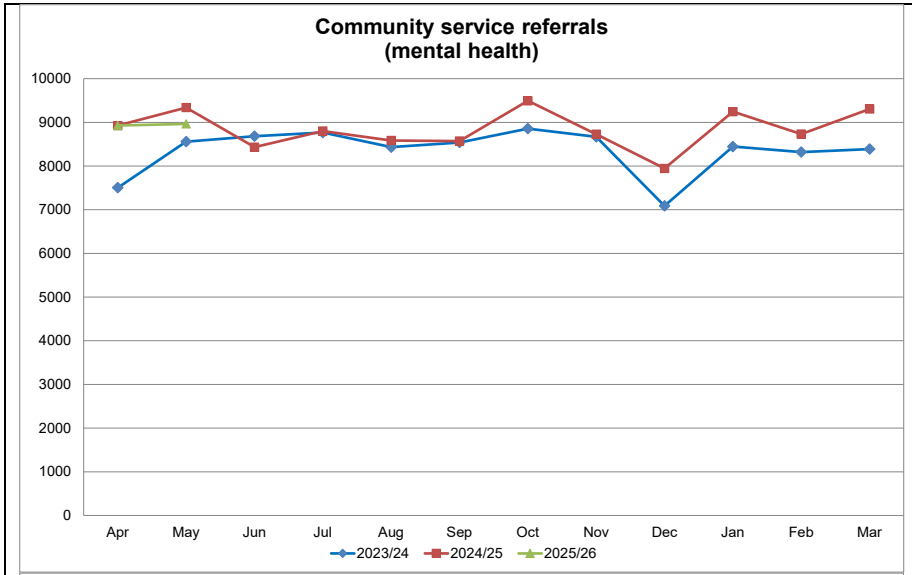
SOMERSET NHS FOUNDATION TRUST

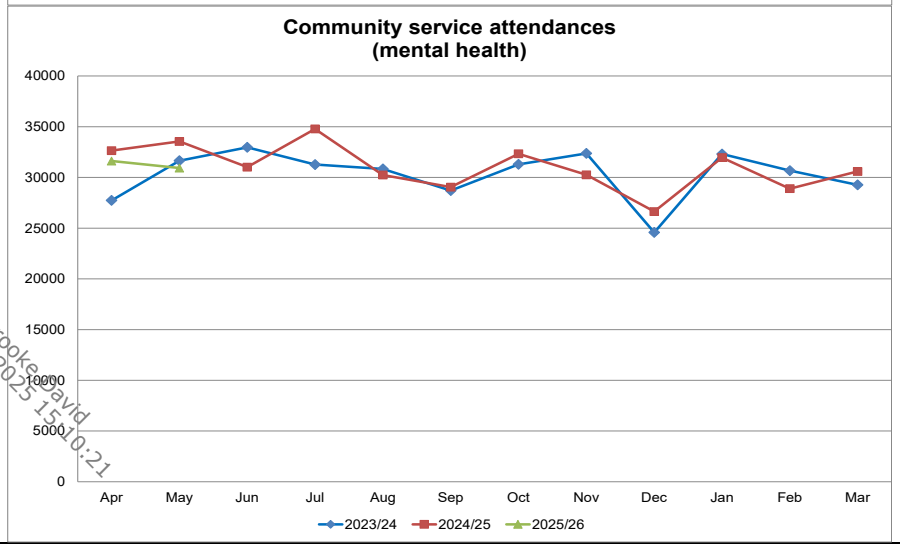
MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
MH17	Percentage of adults over the age of 65 with a length of stay beyond 90 days at discharge	PAF	2,3	0.0%	8.7%	15.8%	0.0%	2.3%	16.7%	5.1%	3.0%	11.4%	6.8%	4.3%	14.3%	To be confirmed		
MH18	Total number of patient falls - mental health inpatient wards	NHSC	2	13	19	12	20	13	16	21	16	16	27	13	3	Monitored using Special Cause Variation Rules. Report by exception.		
MH19	Rate of falls per 1,000 occupied bed days	NHSC	2	3.9	5.5	3.4	6.1	3.8	5.0	6.4	4.6	5.2	7.9	3.9	0.9	Monitored using Special Cause Variation Rules. Report by exception.		
MH20	Restrictive Interventions - total number of incidents	NHSC	2	36	50	53	34	63	98	45	77	90	119	114	72	Monitored using Special Cause Variation Rules. Report by exception.		
MH21	Restrictive Interventions per 1,000 occupied bed days	NHSC	2	10.8	14.4	15.2	10.4	18.5	30.4	13.7	22.0	29.2	34.7	34.3	20.9	Monitored using Special Cause Variation Rules. Report by exception.		
MH22	Number of prone restraints	NHSC	2	4	8	5	3	22	16	5	21	14	6	15	9	Monitored using Special Cause Variation Rules. Report by exception.		
MH23	Prone restraints per 1,000 occupied bed days	NHSC	2	1.2	2.3	1.4	0.9	6.5	5.0	1.5	6.0	4.5	1.7	4.5	2.6	Monitored using Special Cause Variation Rules. Report by exception.		
MH24	Total number of medication incidents in a mental health setting	NHSC	2	9	18	17	20	20	21	15	9	11	5	11	14	Monitored using Special Cause Variation Rules. Report by exception.		
MH25	Ligatures: Total number of incidents	NHSC	2	54	65	50	33	34	42	40	41	64	65	130	192	Monitored using Special Cause Variation Rules. Report by exception.		
MH26	Number of ligature point incidents	NHSC	2	1	1	3	1	0	1	1	0	0	1	0	0	Monitored using Special Cause Variation Rules. Report by exception.		
MH27	Violence and Aggression: Number of incidents patient on patient (inpatients only)	NHSC	2	23	15	5	6	18	10	6	6	6	3	2	2	Monitored using Special Cause Variation Rules. Report by exception.		
MH28	Violence and Aggression: Number of incidents patient on staff	NHSC	2	53	72	41	34	79	79	51	99	24	12	23	14	Monitored using Special Cause Variation Rules. Report by exception.		
MH29	Number of Type 1 -Traditional Seclusion	NHSC	2	17	18	11	10	24	27	7	21	10	13	20	11	Monitored using Special Cause Variation Rules. Report by exception.		
MH30	Number of Type 2 -Short term Segregation	NHSC	2	2	2	3	1	0	5	0	2	0	2	1	0	Monitored using Special Cause Variation Rules. Report by exception.		

Operational context

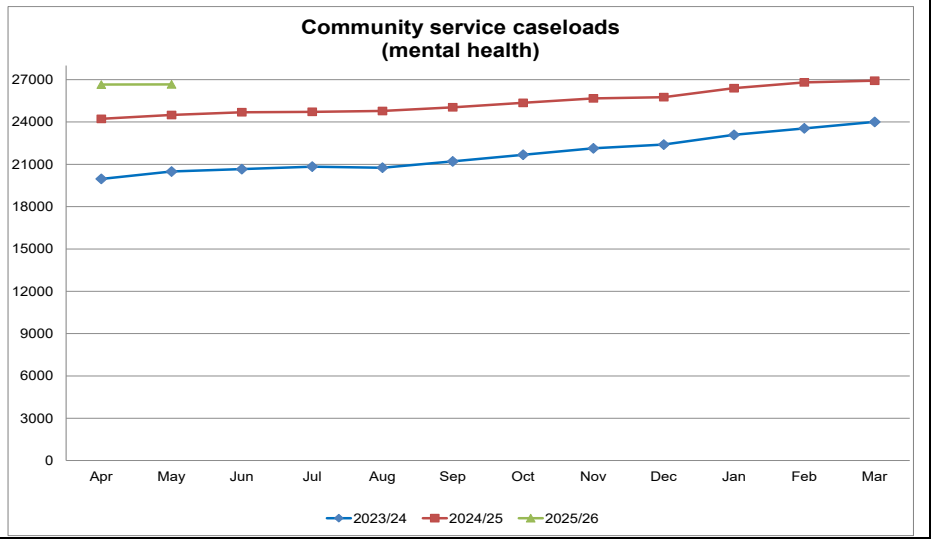
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





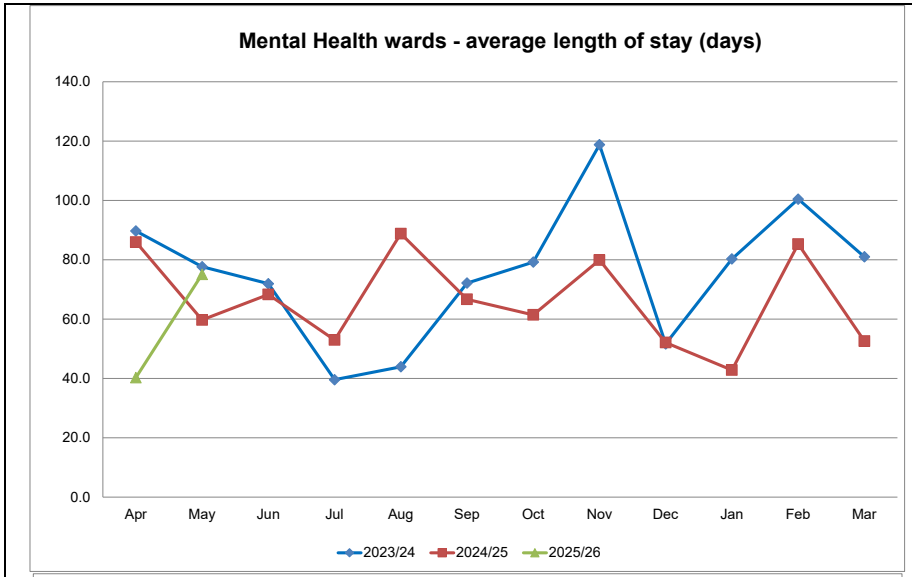
Summary:

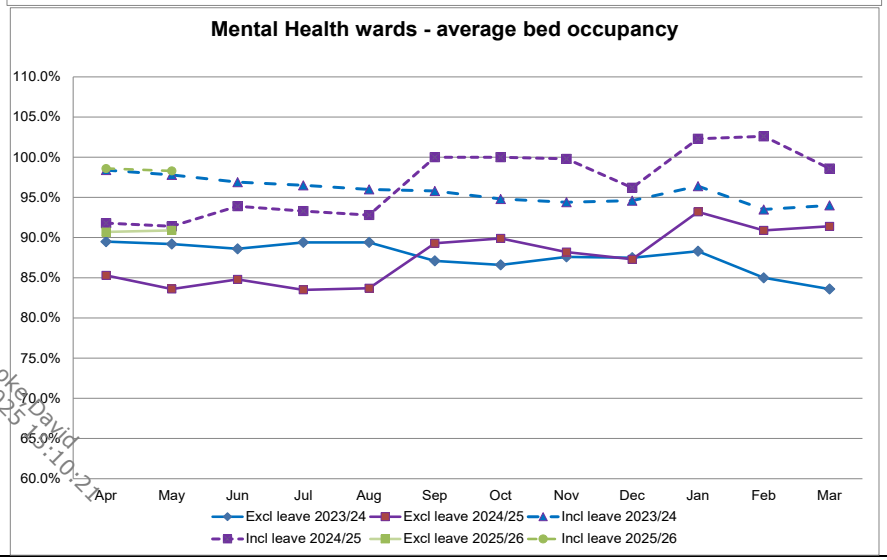
- Direct referrals to our community mental health services between 1 April and 31 May 2025 were 2.0% lower than the same months of 2024 and 11.4% higher than the same months of 2023.
- Attendances for the same reporting period were 5.5% lower than the same months of 2024 and 5.3% higher than the same months of 2023. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services.
- Community mental health service caseloads as at 31 May 2025 increased by 8.9% when compared to 31 May 2024 and were 30.2% higher than as at 31 May 2023. It should be noted that investment has facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

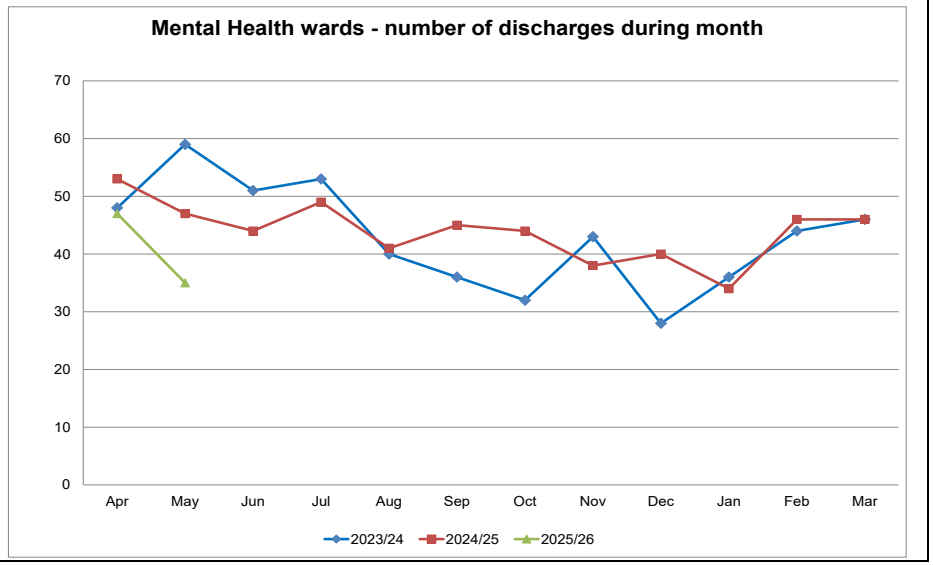
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay across all of our mental health wards in May 2025 was 75.1 days, up from 40.3 days April 2025. During May 2025, 10 patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Pyrland ward one, one of our older persons wards, who had a length of stay of 336 days. The rolling 12-month average length of stay for the period ending 31 May 2025 was 63.6 days, compared to 73.1 days for the period ending 31 May 2024.
- The mental health bed occupancy rates excluding leave increased in May 2025 compared to April 2025 but decreased when including leave. A total of 35 patients were discharged in May 2025, down from 47 discharged in April 2025.



NARRATIVE REPORT

NEIGHBOURHOODS AND COMMUNITY SERVICES

The key points of note in respect of Neighbourhoods and Community services are as follows:

Achievements

- Community Inpatient Provision Redesign: An extensive programme is underway, involving engagement with League of Friends teams, local ward managers, and staff. The formal consultation period commenced on 12 June 2025, alongside engagement with members of parliament. This transformation relies on an increase in Discharge to Assess (D2A) capacity, with starts in the first two weeks of June reaching 81 and 91 respectively.
- Hospital at Home: In May 2025, we received 268 referrals, the second-highest monthly number since the programme began. The team had 258 admissions (158 Frailty, 100 Respiratory), the third-highest monthly number since the programme began.
- Older Persons Mental Health (OPMH): As at 31 May 2025, 98% of OPMH patients referred by their GP had waited six weeks or less, the highest percentage since June 2024.
- Somerset Fatigue Service: Continued improved performance with 95.7% of patients starting treatment within 18 weeks.
- The number of people waiting over 18 weeks to be seen by our community physical health services has halved in the last six months.
- Our Urgent Community Response service saw 93.1% of patients within two hours in May 2025, against a national target of at least 70%.

Challenges

- Hospital at Home Caseload: Reduced due to the same number of referrals but a shorter length of stay. Somerset was placed fifth out of seven counties within the region.
- RTT Performance: Underperforming in Care of the Older Persons and Pain Management. Admitted Pain Management has 62 patients in the backlog, and Care of the Older Persons has a backlog of two patients. Non-admitted backlogs include 254 patients in Pain Management and 150 in Care of Older Persons. Risks around 65 weeks have been managed so far.

Actions to Address Underperformance:

- Hospital at Home: Centralised nursing team recruitment is underway, with arrivals progressing over the next six weeks. Efforts with GP surgeries showing low levels of referrals are going well, with signposting to the Care Co-ordination Hub. Collaboration with SPL colleagues to adopt an “accept first” approach with hospital at home referrals is in motion. Medical leaders are adopting a “DOT Positive” approach (outlined below) on AMU, ED, and the wards to further identify patients for transfer to Hospital at Home.

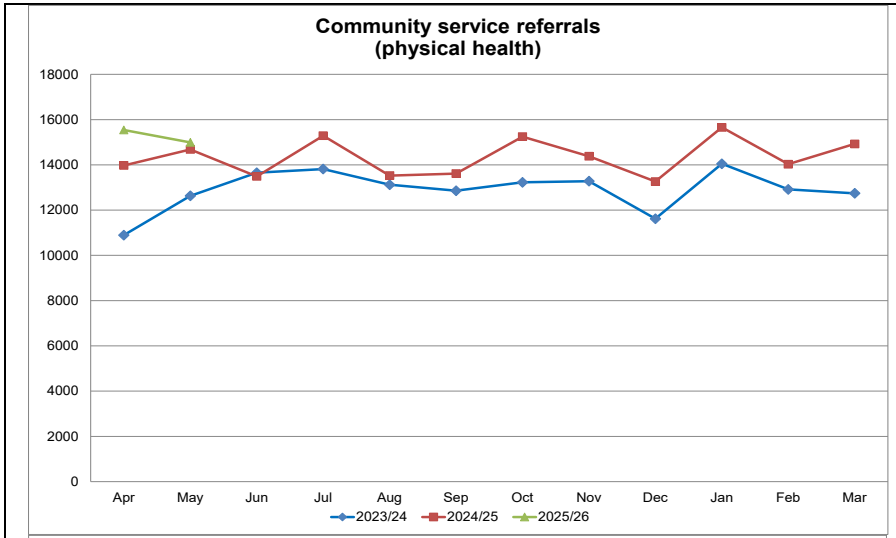
  DOT Positive
  - **Drink** – can they get a drink on their own, or do they have someone who can get it for them?
  - **Once a day** – can they cope with a visit from the team only once a day?
  - **Toilet** – can they get to the toilet on their own, or do they have someone who can help them?

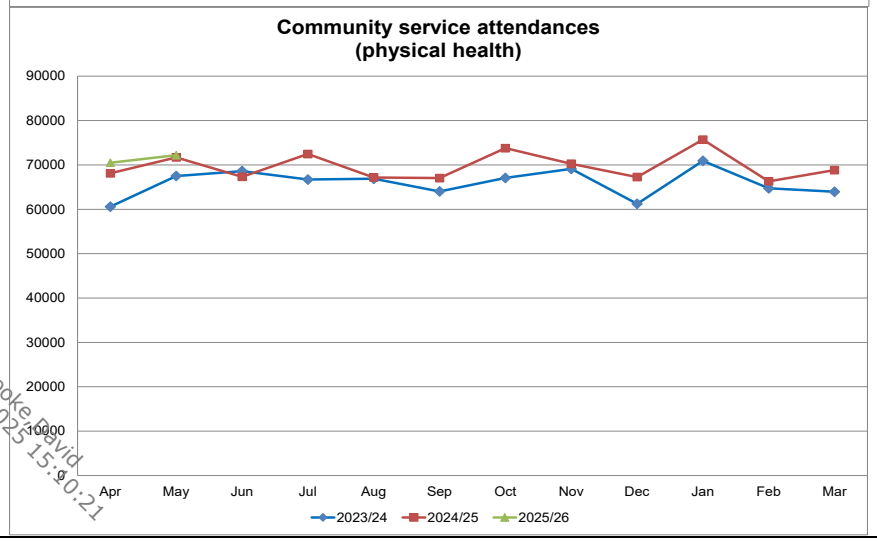
- RTT: The team is embarking on a full patient tracking list (PTL) validation exercise, along with scoping extra clinics and outsourcing opportunities for admitted patients in Pain Management.

No.	Description	Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
NC1	Mental health referrals offered first appointments within 6 weeks Older Persons mental health services	ICB	1,2,3	100.0%	97.2%	93.8%	93.4%	97.8%	94.7%	97.7%	91.1%	96.2%	96.2%	97.5%	98.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
NC2	Community service waiting times: number of people waiting over 18 weeks from referral to first appointment (excluding dental)	SFT	1,2,3	1,870	1,944	1,937	1,736	1,426	1,061	768	592	576	589	554	536	From June 2024 At or below planning trajectory = Green Above trajectory = Red		P
NC3	Community service waiting times: number of people waiting over 52 weeks from referral to first appointment (excluding dental)	PAF	1,2,3	280	277	277	263	240	95	26	9	5	4	2	1			P
NC4	Community service waiting times: percentage of people waiting over 52 weeks from referral to first appointment (excluding dental)	PAF	1,2,3	2.85%	2.91%	2.97%	3.03%	2.82%	1.10%	0.29%	0.10%	0.05%	0.04%	0.02%	0.01%			P
NC5	Community service waiting times: number of people waiting over 104 weeks from referral to first appointment (excluding dental)	SFT	1,2,3	57	73	88	93	86	25	7	1	0	0	0	0			P
NC6	Intermediate Care - Patients aged 65+ discharged home from acute hospital beds on pathway 0 or 1	HDS	1,2,3	94.3%	94.6%	93.8%	94.9%	94.8%	94.8%	93.2%	94.5%	94.4%	94.5%	93.9%	94.5%	>=95%= Green >=85% - <95% =Amber <85% =Red		F
NC7	Urgent Community Response: percentage of patients seen within two hours	NHSC	1,2,3	87.5%	87.4%	89.5%	85.8%	87.4%	87.1%	93.4%	92.6%	92.7%	90.9%	91.9%	93.1%	>=70%= Green >=60% - <70% =Amber <60% =Red		P
NC8	Hospital at Home - Caseload Size	VWOF	1,2,3	48	48	48	54	70	66	68	72	84	89	92	77	>167 = Green >134 - <167 =Amber <134 =Red		F
NC9	Hospital at Home - Admissions	VWOF	1,2,3	174	161	154	252	248	220	255	305	227	237	266	258	>419 = Green >377 - <419 =Amber <377 =Red		F
NC10	Total number of patient falls - community hospitals	NHSC	2	36	48	43	27	41	36	29	41	46	33	27	37	Monitored using Special Cause Variation Rules. Report by exception.		
NC11	Rate of falls per 1,000 occupied bed days - community hospitals	NHSC	2	6.79	8.90	8.02	5.30	7.81	7.08	5.10	6.76	8.82	5.78	4.75	6.65	Monitored using Special Cause Variation Rules. Report by exception.		
NC12	Community hospitals - number of pressure ulcers	NHSC	2	12	6	6	4	5	7	8	9	5	3	10	Data not yet due	Monitored using Special Cause Variation Rules. Report by exception.		
NC13	Rate of pressure ulcer damage per 1,000 occupied bed days	NHSC	2	2.26	1.11	1.12	0.78	0.95	1.38	1.41	1.48	0.96	0.53	1.83	Data not yet due	Monitored using Special Cause Variation Rules. Report by exception.		
NC14	District nursing - number of pressure ulcers	NHSC	2	79	74	51	61	62	56	76	100	83	62	72	Data not yet due	Monitored using Special Cause Variation Rules. Report by exception.		
NC15	Rate of pressure ulcer damage per 1,000 district nursing contacts	NHSC	2	2.66	2.36	1.70	2.05	1.95	1.81	2.41	3.04	2.84	1.98	2.27	Data not yet due	Monitored using Special Cause Variation Rules. Report by exception.		
NC16	Total number of medication incidents in a community setting	NHSC	2	41	42	28	25	40	17	32	43	22	24	30	22	Monitored using Special Cause Variation Rules. Report by exception.		

Operational context

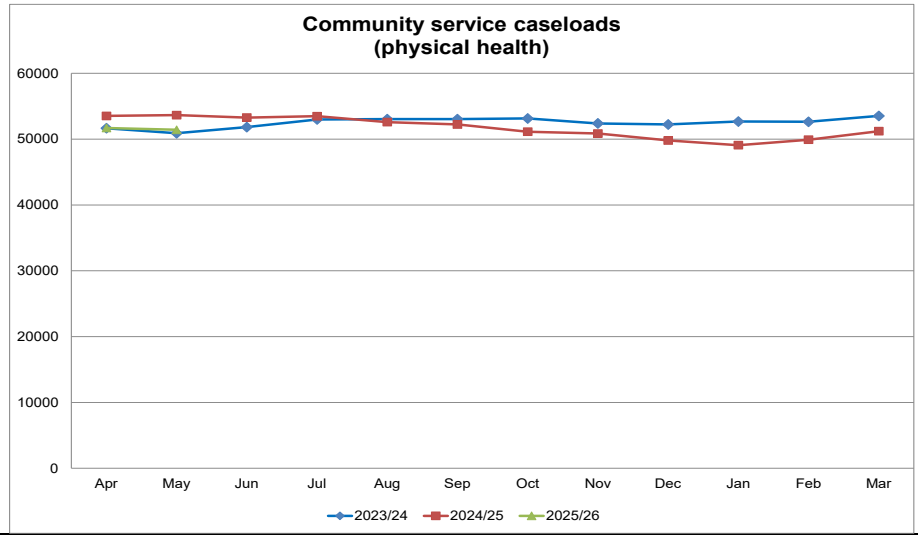
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





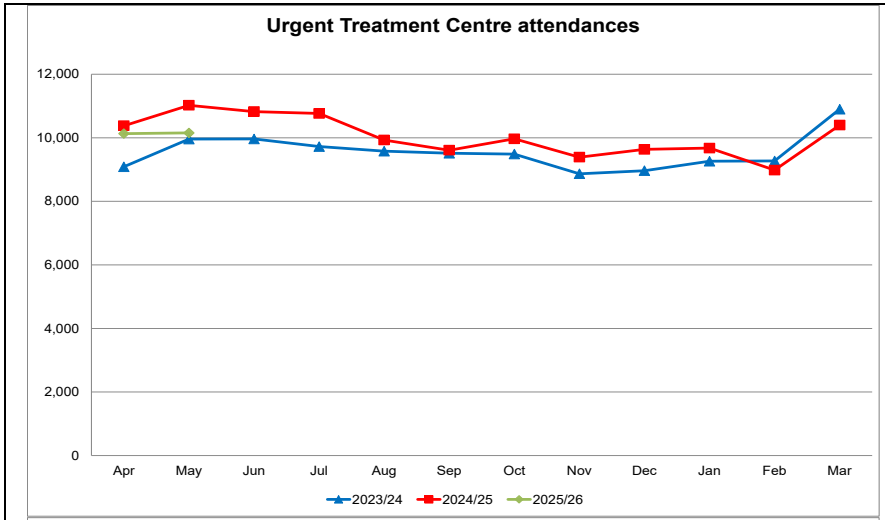
Summary:

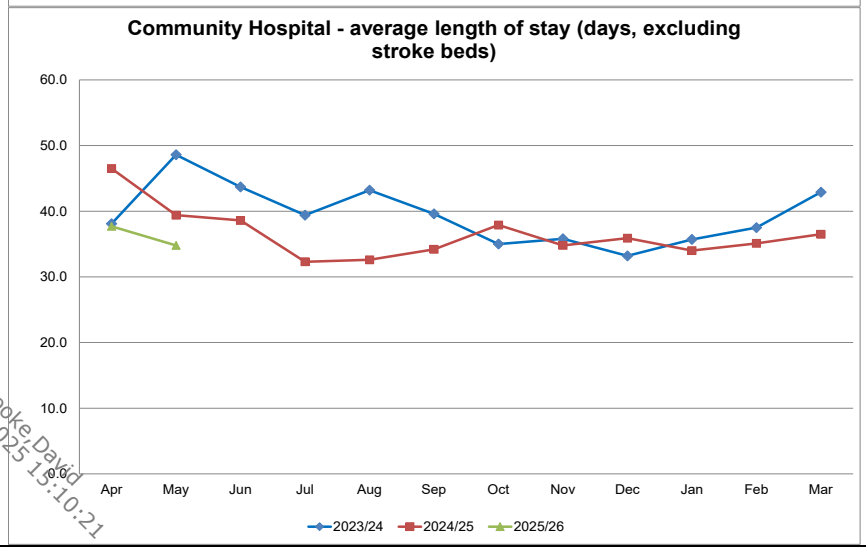
- Direct referrals to our community physical health services between 1 April and 31 May 2025 were 6.6% higher than the same months of 2024 and 29.8% higher than the same months of 2023. Services with the highest increases include Rapid Response, Diabetes Integrated Care and District Nursing.
- Attendances for the same reporting period were 2.1% higher the same months of 2024 and 11.4% higher than the same months of 2023.
- Community service caseload levels as at 31 May 2025 were 4.2% lower than as at 31 May 2024, but 1.0% higher than 31 May 2023 levels.



Operational context

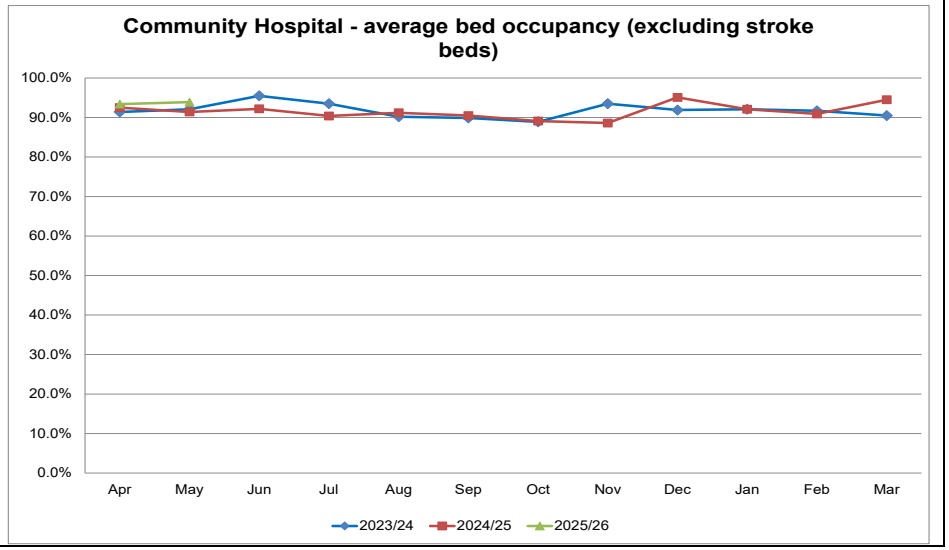
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





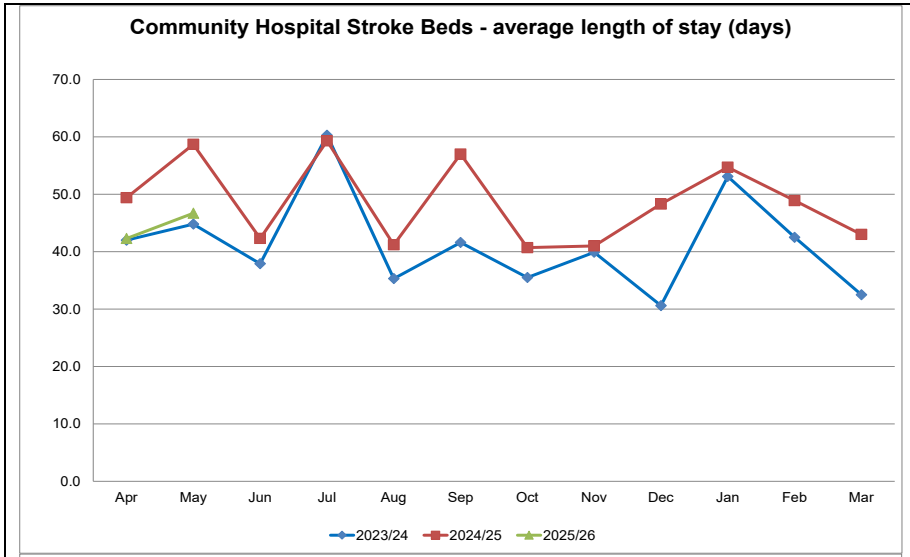
Summary:

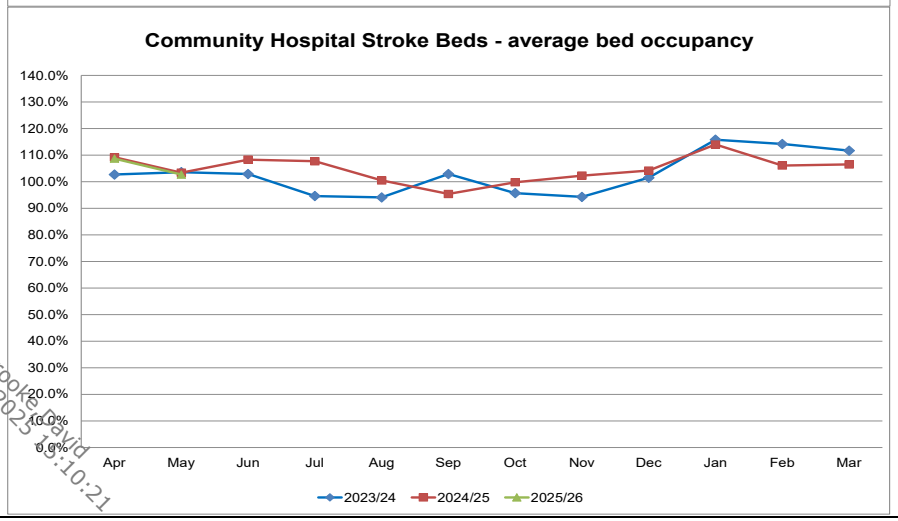
- Between 1 April and 31 May 2025, the number of Urgent Treatment Centre attendances was 5.2% lower than the same months of 2024 but 6.5% higher than the same months of 2023. During May 2025, 97.5% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%.
- The average length of stay for non-stroke patients in our community hospitals in May 2025 was 34.8 days, a decrease compared to April 2025. The rolling 12-month average length of stay for non-stroke patients for the period ending 31 May 2025 was 35.4 days, compared to 39.2 days for the period ending 31 May 2024. The community hospital bed occupancy rate for non-stroke patients in May 2025 increased to 93.9%, from 93.4% in April 2025.



Operational context

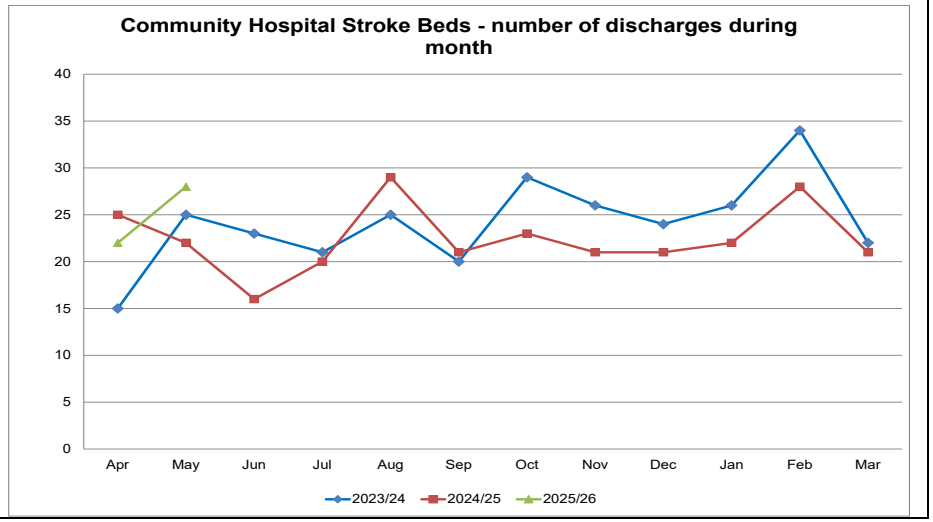
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay for stroke patients in our community hospitals in May 2025 increased to 46.7 days, from 42.3 days in April 2025. One Williton community hospital patient discharged during May 2025 had a length of stay exceeding 100 days, at 102 days. The rolling 12-month average length of stay in respect of stroke patients ending 31 May 2025 was 47.0 days, compared to 42.8 days for the period ending 31 May 2024.
- Stroke bed occupancy in May 2025 decreased compared to April 2025.
- During May 2025 there were 28 discharges of stroke patients, compared to 22 during April 2025.



NARRATIVE REPORT

SYMPHONY HEALTHCARE SERVICES

The key points of note in respect of Symphony Healthcare services are as follows:

What is Going Well

- **Progress Against NICE Linked Targets (S2 & S3):**
  Two key targets aligned with NICE guidelines are progressing positively toward the March 2026 goal. Cholesterol management (S3) is already performing above target. Hypertension management (S2) is tracking as expected over time.

- **Quality and Outcomes Framework (S5):**
  Progress is on track for the Quality and Outcomes Framework (QOF) target of 95% by March 2026. Notably, this benchmark was already achieved in March 2025, demonstrating strong performance.

- **Patient Satisfaction (S6):**
  Feedback from patients contacted after their appointments with Symphony practices remains consistently positive, indicating good patient experience and engagement.

- **Timely Access to Appointments (S9):**
  While not a formal national target, 90% of patients being seen within two weeks is an expectation. Urgent cases continue to be seen within 48 hours. Practices are proactively adapting by streamlining acute presentations from routine chronic care, which supports better two-week access. Given current system pressures, maintaining compliance just under 90% is viewed as strong performance.

What Requires Improvement and Planned Actions

- **Dementia Diagnosis Rates (S1):**
  Diagnosis rates remain below target. Exmoor Medical Centre, despite its 'Outstanding' CQC rating, is in the lowest quartile nationally. A data quality audit ruled out coding issues, confirming that the root cause is under-diagnosis. Current NICE guidance

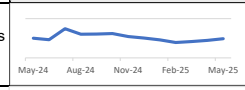
mandates diagnosis via specialist clinics due to the use of cholinesterase inhibitors. Many patients are reluctant to engage with secondary care pathways. A multi-stakeholder meeting has led to a proposed pilot enabling primary care diagnosis with support from secondary care to address this gap.

- **GP Vacancy Rate (S4):**
  The GP vacancy rate has deteriorated this month, in line with expectations following recent productivity and workforce reviews. While this has short-term impact on vacancy-related Cost Improvement Plan (CIP) delivery, active recruitment has resulted in some new appointments. The longer-term aim remains a more sustainable and resilient service model.

- **Call Waiting Times (S7):**
  The current average wait time is amber against Symphony's internal target. Contributing factors include elevated demand and staff sickness. There is also wide variation across practices. In response, contact hubs working across practices are being implemented to reduce variation and enhance resilience.

SOMERSET NHS FOUNDATION TRUST

SYMPHONY HEALTHCARE SERVICES

No.	Description	Source	Links to strategic aims	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
S1	Dementia diagnosis rates for patients aged 65 years plus	OPG	1,3,4	51.1%	53.5%	53.8%	53.8%	54.1%	53.9%	53.9%	53.5%	52.6%	52.3%	51.9%	52.5%	Data not yet due	>=66.7%= Green >=61.7% - <66.7% =Amber <61.7% =Red		
S2	Increase the % of patients with hypertension treated according to NICE guidance	OPG	1,2,3	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	70.0%	72.0%	Profiled target: 85% by year end		
S3	Increase the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance	OPG	1,2,3	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	65.0%	65.0%	Profiled target: 50% by year end		
S4	GP Vacancy rate	SHS	6	9.0%	8.0%	4.0%	5.0%	6.0%	8.0%	6.0%	7.0%	8.0%	1.0%	2.0%	4.0%	7.0%	=<5%= Green >5% - <10% =Amber >10% =Red		
S5	Percentage of total Quality and Outcomes Framework (QOF) points	SHS	1,2,3	80.0%	80.0%	82.0%	82.0%	83.0%	84.0%	86.0%	87.0%	89.0%	93.0%	95.0%	75.0%	75.0%	Profiled target: 95% by year end		
S6	Patient satisfaction rate	SHS	2,3	88.7%	89.8%	83.4%	91.5%	94.2%	93.4%	92.6%	90.3%	92.4%	94.3%	92.6%	92.1%	91.8%	>=85%= Green >=75% - <85% =Amber <75% =Red		
S7	Average time for calls in queue	SHS	2,3	06:02	05:34	08:55	07:13	07:16	07:27	06:30	06:05	05:29	04:42	05:01	05:20	05:52	=<4 minutes = Green >4 minutes - =<6 minutes = Amber >6 minutes = Red		
S8	Ask My GP/Klinik/AccuRX/Anima – percentage of requests raised online	SHS	2,3	54.7%	54.5%	56.2%	57.0%	56.8%	55.8%	54.7%	53.6%	53.6%	53.9%	54.5%	52.5%	52.9%	>=50%= Green >=40% - <50% =Amber <40% =Red		
S9	Percentage of patients seen within two weeks of request (acute team only)	SHS	2,3			New reporting									83.6%	86.8%	>=90%= Green >=80% - <90% =Amber <80% =Red		

NARRATIVE REPORT

PEOPLE

The key points of note in respect of People are as follows:

Areas of Success / Celebration

- The number of colleagues compliant with all their mandatory training requirements increased by 0.6% to 65.3% and there was improvement in the compliance rates for five resuscitation courses and for Safeguarding Adults level 3.
- The retention rate, demonstrating the percentage of colleagues who have remained in employment since commencing, is currently at its highest level over the course of the last 12 months.

Areas of Concern

- The career conversation figures remain static and far from the compliance threshold. A Silver Quality Improvement (QI) Project is being undertaken as part of the people strategy deliverables to understand and address the barriers, researching new ways of ensuring appraisals are fit for purpose in terms of the individual, the team and the Service Group/Trust, and focusing on the quality of the appraisal.
- The report shows a 0.1% drop in vacancy levels since last month, which is a near net zero position as required by the operational workforce plan, but it remains significantly outside of the target threshold. A review of the starter and leaver numbers indicates alterations in establishment levels have contributed to the vacancy figure remaining stable. The leaver figure is high, and starters are low compared to April 2025.
- Job plans signed off remains below the required threshold. NHSE are changing the job planning reporting criteria due to feedback on data quality and relevance. It is anticipated this could provide a small increase in compliance from next month. Engagement with the job planning steering group has been positive. The group provides a useful platform to align approaches and share learning across the organisation.
- Estates and Facilities staff turnover has seen a concerning upward trend of leavers, with an increase of 2.3% in leavers since November 2024. Further exploratory work needs to take place to understand this further.

Focus Areas

- Overall numbers of HR cases have increased in the month, with an increase in disciplinary cases, the employee relations improvement programme is designed to understand and improve the investigation process those involved.
- While absence levels remain stable, with long term absence reducing in month and a positive decrease in final formal sickness reviews in month, feedback on the length of time it can take to appropriately manage a colleague with persistent absence is a consistent theme from service groups, with absence levels from some colleagues having a detrimental impact on services. The employee relations improvement programme has been expanded to trial alternative methods of absence management, and to review the benefits and opportunities this could provide.
- The Retention Action Group will review mid-year turnover and identify any appropriate actions to take forward.
- New guidelines are expected on mandatory training to help rationalise and optimise mandatory training requirements. In the meantime, the team are working with NHSE to redesign mandatory training.

SOMERSET NHS FOUNDATION TRUST

PEOPLE

No.	Description		Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
P1	Mandatory training: percentage completed	Combined	SFT	5	93.1%	93.3%	93.7%	93.7%	93.7%	90.9%	92.2%	92.6%	92.8%	92.8%	93.0%	93.0%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber		
P2	Monthly percentage of days lost due to sickness absence		SFT	5	4.8%	5.2%	4.8%	5.0%	5.5%	5.6%	5.8%	5.7%	5.3%	4.8%	4.6%	4.7%	SPC (Upper Control Limit 5.4%)		
P3	Sickness absence levels - rolling 12 month average (Trust-wide)		SFT	5	5.2%	5.2%	5.1%	5.1%	5.1%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.1%	SPC (Upper Control Limit 5.2%)		
P4	Career conversations (12 months)		SFT	5	78.2%	78.9%	79.2%	80.0%	78.5%	79.8%	80.4%	78.5%	77.8%	78.2%	77.0%	77.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
P5	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		SFT	5	6.6%	7.1%	5.8%	7.0%	7.7%	7.7%	7.9%	8.0%	7.8%	7.8%	8.4%	8.3%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red		
P6	Retention rate – rolling 12 months percentage of colleagues in post		SFT	5	89.2%	89.0%	88.8%	88.7%	88.7%	88.7%	88.8%	88.8%	89.0%	89.1%	89.1%	89.4%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red		
P7	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	SFT	1,5	21.8%	21.0%			21.6%			22.5%			Quarterly reporting		>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red		
P8		Who are female	SFT	1,5	58.3%	58.0%			57.9%			58.2%							
P9		With a recorded disability	SFT	1,5	3.0%	3.4%			3.9%			4.0%							
P10	Job planning: Percentage of Consultant and SAS doctor job plans signed off		SFT	5	New measure - reported from March 2025.									21.5%	6.6%	10.2%	>=95%= Green >=85% to <95% =Amber <85% =Red		
P11	Percentage of patient-facing staff receiving a 'flu vaccination		PAF	1,5	Reporting to run from October 2025 to January 2026.												>=80%= Green >=70% to <80% =Amber <70% =Red		
P12	Number of formal HR case works (disciplinary, grievance and capability).		SFT	5	62	62	53	59	49	62	47	50	50	63	58	69	SPC (Upper Control Limit 78		

NARRATIVE REPORT

PATIENT EXPERIENCE AND INVOLVEMENT

The key points of note in respect of Patient Experience and Involvement are as follows:

What is going well

The number of Care Opinion stories has remained stable, although May 2025 saw a slight decline compared to expectations. Receiving patient stories continues to serve as a valuable source of insight, enabling us to identify areas for improvements, reinforcing our commitment to trust and transparency, and highlighting the impact of patient voices in shaping the quality of care. Notably, the percentage of stories responded to has consistently remained within the green performance threshold since December 2024.

Following the publication of the national KO41a (complaints) data, it was identified that the Trust is an outlier for upheld and partially upheld formal complaints. Specifically, the Trust had the lowest percentage of upheld complaints and the second highest percentage of partially upheld complaints nationally. Encouragingly, the percentage of upheld complaints has shown a steady increase over the past 12 months, and the percentage of partially upheld complaints has decreased. Comparative benchmarking against the national average will be reported later in the year.

The complaints team continues to analyse the rationale behind the requests for second response letters, which serve as a crucial indicator of the quality and effectiveness of initial complaint responses. This analysis will be utilised to identify areas within the complaint process that may impact on the success of initial resolution and inform process development.

What is going less well

The percentage of complaints responded to within the agreed time frame consistently does not meet the Trust target of 90%. Delays continue to occur due to a combination of reasons including:

- Ongoing operational and workforce challenges across all areas to be able to review, prioritise and respond to complaints.
- A change in process, resulting in clinicians not previously involved in handling complaints now taking on this responsibility.
- Continued complexity, with a large proportion of complaints overlapping teams and service groups, and challenges with service groups identifying a lead for the review and ongoing management of a complaint.

- The timely availability of paper medical notes when multiple teams are involved across service groups.

Focus of improvement work

- Targeted work with services that have not previously managed complaints, to identify the support required to ensure the process is efficient, timely and responses are compassionate.
- A weekly sitrep of service group positions regarding formal complaints is provided to the Director of Patient Experience and Engagement and the Chief Nurse. This report aims to provide senior leadership with oversight, particularly focusing on complaints that are 'at risk' (between 30 and 40 days old), to facilitate a more efficient escalation process.
- Escalation processes specific to individual Service Groups (Families, Neighbourhoods, Surgical) have been developed, including escalation to Associate Medical Directors and Associate Directors of Patient Care (ADPCs) prior to complaints breaching the time frame.
- Regular meetings between Associate Directors of Patient Care and the Head of Patient Experience to identify causes of delays and potential solutions.
- Regular tracker meetings between complaint co-ordinators and service groups to identify potential delays and escalate concerns.
- A review of targets to ensure alignment with national standards.
- A working group has been developed to perform an organisational diagnostic against NHS Complaint Standards. The first meetings took place between November 2024 and February 2025. The next meeting, scheduled for September 2025, will review progress against the NHS Complaint Standards action plan.
- Development of an interactive dashboard to increase visibility and timeframes of complaints is underway.
- Efforts are ongoing with the ADPCs and Care Opinion champions, to enhance the visibility of the platform. This initiative aims to ensure that wards and departments have designated active members who are responsible for responding to the stories shared with the Trust.
- Promotion of Care Opinion via social media platforms, engagement events and internal communications continues, to raise awareness among colleagues.

SOMERSET NHS FOUNDATION TRUST

PATIENT EXPERIENCE AND INVOLVEMENT

No.	Description	Source	Links to strategic aims	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Thresholds	Trend	Variation / Assurance
PE1	Care Opinion: Number of stories per month	SFT	2	30	41	44	42	60	56	42	39	46	48	48	38	Increase from 2024/25 baseline		
PE2	Care Opinion: Percentage of stories with responses	SFT	2	86.7%	90.2%	95.5%	97.6%	91.7%	85.7%	100.0%	94.9%	100.0%	100.0%	97.9%	100.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE3	Percentage of complaints responded to within the timescale agreed with the complainant	SFT	2	New reporting - to commence from September 2024			63.0%	39.1%	31.3%	47.8%	25.0%	47.6%	50.0%	39.3%	54.5%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE4	Number of complaints resulting in second letters	SFT	2	2	4	3	0	1	1	1	1	4	2	3	2	Monitored using Special Cause Variation Rules. Report by exception.		
PE5	Percentage of formal complaints fully upheld	SFT	2	11.0%	7.7%			9.0%			13.6%			14.8%		Compare to national average		
PE6	Percentage of formal complaints partially upheld	SFT	2	75.8%	78.8%			73.1%			75.8%			68.9%		Compare to national average		

Appendix 1 – Infection Control and Prevention – May 2025

MRSA bloodstream infections	Commentary on MRSA /MSSA BSIs
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Total year to date = 2**	There are no national thresholds assigned to MRSA or MSSA bloodstream infections (BSI). However, there is a zero tolerance of MRSA BSIs and as a Trust we assign an internal threshold for MSSA which will remain at 64 cases. Work is progressing on Fielding ward but will take time to complete. Trustwide improvement strategies have also begun, including the commencement of the joint monthly audit between Matrons and Infection Control. It is too early to identify trends, and more audits need to be completed.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 1 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0 **Internal Threshold = 64** **Total year to date = 10**	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 8 Yeovil District Hospital = 6 Community Hospitals / Mental Health = 0 **Predicted Threshold = 127** **Total year to date = 27**	The annual thresholds for 2025/26 have yet to be published nationally, thus we are using the same as 2024/25 until agreed. The most common sources to date for this financial year continue to mirror the previous year, urine and biliary / hepatobiliary. No new issues have emerged so far therefore work continues to focus on cases linked to urinary catheters. Initial work has begun with the Integrated Care Board looking at work that might prevent these infections earlier prior to the patients' requiring admission. This is very early days and may be affected by national changes to the ICB infection control teams.
Klebsiella bloodstream infections	
Musgrove Park Hospital = 3 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0 **Predicted Threshold = 51** **Total year to date = 9**	

Pseudomonas bloodstream infections	
Musgrove Park Hospital = 1 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Predicted Threshold = 17** **Total year to date = 4**	
C. difficile	**Commentary on C. difficile**
Musgrove Park Hospital = 4 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Predicted Threshold = 91** **Total year to date = 16**	Case numbers returned to a more usual level in May. No particular reason for the spike in April has been identified.
Respiratory Viral Infections - inpatients	**Commentary on Respiratory Viral Infections**
COVID (Trust Cases) = 14 Musgrove Park Hospital = 2 Yeovil District Hospital = 8 Community / Mental Health = 4 **Influenza = 11 (Inpatients)** Musgrove Park Hospital = 3 Yeovil District Hospital = 8 **Respiratory Syncytial Virus (RSV) = 3 (Inpatients)** Musgrove Park Hospital = 3 Yeovil District Hospital = 0	**Respiratory Viruses** Respiratory virus case numbers have reduced during May.
Outbreaks	**Commentary on outbreaks**
COVID = 4 Musgrove Park Hospital = 2 Yeovil District Hospital = 1 Community / Mental Health = 1	Outbreaks remain at low levels in May

Carbapenemase Producing Organism (CPO) • **YDH -** Since January 2022 there have been 89 cases of CPO identified on the YDH site.	**Carbapenemase Producing Organism (CPO) - YDH** This has been managed as a Trustwide outbreak which has spanned two key time periods, January 2022 to August 2023 and December 2023 to the current time. There are two different resistance mechanisms involved. The genes that encode for these resistance mechanisms can move between different species of bacteria which makes the linking of cases in the outbreak more challenging. This is the reason that more specialist testing has been required from UKHSA. A further external review was undertaken by a Microbiologist working for the New Hospitals Programme with a special interest in the impact of the hospital environment on infection risk. He was able to reassure us that we are focusing on appropriate actions to control the outbreak. More focus needs to be on management of wastewater and initial discussions have been undertaken with Estates colleagues.
Surgical Site Infections	**Commentary on Surgical Site Infections**
Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions. **Musgrove Park Hospital Site** Continuous surveillance for Total Hip Replacement (THR), Total Knee Replacement (TKR) and Spinal Surgery has been in place on the MPH site since 2009. **Yeovil District Hospital Site** Continuous surveillance on total hip replacement surgery has been in place on the YDH site since April 2022 and continuous surveillance was commenced on total knee replacement surgery from January 2024.	**Musgrove Park Hospital Site** • **Hip Replacement** Within the last year (May 2024 to April 2025) a total of 366 operations have been undertaken with no infections identified. • **Knee Replacement** Within the last year (May 2024 to April 2025) a total of 247 operations have been undertaken and 2 infections identified giving an infection rate of 0.81% which is slightly about the national benchmark of 0.4%. • **Spinal Surgery** Within the last year (May 2024 to April 2025) a total of 324 operations have been undertaken and 2 infections identified giving an infection rate of 0.62%. The infection rate has reduced and is below the national benchmark of 1.2%. **Yeovil District Hospital Site** • **Hip Replacement** Within the last year (May 2024 to April 2025) a total of 376 operations have been undertaken and 1 infection identified giving an infection rate of 0.27%. The infection rate has reduced and is below the national benchmark of 0.5%.

	• **Knee Replacement** Within the last year (May 2024 to April 2025) a total of 430 operations have been undertaken with no infections identified. The national rate is calculated over the period April 2019 to March 2024 and therefore not directly comparable to trust infection rates. However, as a trust the national benchmark is always used as a guide. A task group is in place, led by the Surgical Service Group but working with infection control to identify any areas for improvement that might reduce the risk of infections. Expansion of the surveillance programme to include C -sections has begun from April.

NHS
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NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee held on 30 April and 28 May 2025
SPONSORING EXEC:	Melanie Isles, Chief Medical Officer
REPORT BY:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Inga Kennedy, Chair of the Quality and Governance Assurance Committee
DATE:	1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	Sub-committees and reports are more aligned in their assessments of quality and safety. Combined efforts should now be focussed on delivering sustainable improvements. A unified approach to delivering assurance is to be developed in order to deliver enhanced assurance across the organisation.
Recommendation	That the report be noted.

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

- ☐ Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
- ☐ **Aim 2 Provide the best care and support to people**
- ☐ Aim 3 Strengthen care and support in local communities
- ☐ Aim 4 Respond well to complex needs
- ☐ Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☐ Aim 6 Live within our means and use our resources wisely
- ☐ Aim 7 Deliver the vision of the Trust by transforming our services through, innovation, research and digital transformation

Seabrooke,David
25/06/2025 15:10:21

10

Kindness, Respect, Teamwork
Everyone, Every day

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

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

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

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

ASSURANCE REPORT FROM THE QUALITY GOVERNANCE AND ASSURANCE COMMITTEE MEETINGS HELD ON 30 APRIL (FOCUS) AND 28 MAY (BUSINESS) 2025

1. PURPOSE

To advise the Board on the decisions arrived at and principal areas reviewed by the Quality Governance and Assurance Committee.

2. ASSURANCE RECEIVED

2.1. The committed noted that the Patient Safety Board had completed a full year of deep dives for each service group and will carry out a thematic review of patient safety to identify priorities arising from the investigations. Emerging themes include (i) transfers of care, (ii) patient identification and safety, (iii) missed appointments and (iv) gaps in care pathways between cancer, radiology and MH.

2.2. An update on virtual wards and Hospital at Home (H@H) was received: the right patients will benefit from being in the right setting; at a national level, it is anticipated that H@H would prevent two-thirds of admissions to acute settings with one-third being a facilitated discharge from acute settings into the community.

2.3. An presentation on the Maternity Safety Support Programme (MSSP) was given by senior representatives. The programme focused on leadership, governance, quality improvement, safety, culture, service user involvement and staff engagement.

2.4. It was noted that by the end of 2025 SFT will have standardised its existing three prescribing methods. It noted that under the Aseptic Pharmacy Consolidation, the service would be centralised at Musgrove Park (MPH). It was also planned to provide a 7-day pharmacy service at MPH.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. It was noted that primary care is stepping back from its traditional role of coordinating patient care, raising the question of who holds responsibility for complex patients receiving care from multiple services.

3.2. The Committee has been updated on the YDH neonatal and maternity closure, which is being discussed by the Board on 1 July.

3.3. Acute Frailty Peer Review & Modernising Services: an update on this confirmed that an improvement plan will be developed by July; the committee noted a re-audit of the service to measure improvement will be requested. The national Emergency Care Improvement Support Team (ECIST) will support along with the Urgent Emergency Care improvement group, a joint initiative with the ICB.

3.4. Assurance and triangulation – there is a need for clearer assurance measures and improved triangulation to link governance activity with patient and colleague experience. A review has commenced to refine topic scope, leadership and links to service group representation, the aim is to establish a unified assurance process across the Trust.

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

4.1. The Committee has reviewed the corporate risk register: there are currently 24 thematic and corporate high-level risks on the corporate risk register, including 7 risks scoring 20 or 25. A new risk has been added in relation to neonatal and maternity services at YDH. There are 44 risks scoring over 15 being held at service group level.

4.2. Job Planning – the Committee requests that future monitoring of this be carried out by the People Committee (this was picked up by People Committee on on 4 June) . It recommends that non-executive directors be invited GIRFT meetings. A GIRFT visit was imminent.

4.3. The committee has undertaken a review of its effectiveness, noting that it highlighted a predominance of amber ratings, largely because of shortfalls in areas of coverage in topic assurance – generally in community and mental health services but that there are inconsistencies of compliance across the Trust as a whole.

NHS
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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Group Finance report
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	The Finance report sets out the overall income and expenditure position for the Group. It includes commentary on the key issues, risks, and variances, which are affecting financial performance.
Recommendation	The Board is requested to discuss and note the report.

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

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

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

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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 People 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 People 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)
Not applicable

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

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

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

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT

1. SUMMARY

1.1 In May, the Trust recorded a deficit of £2.845m. This breakeven to plan for the month and cumulatively the Trust remains on plan.

1.2 The main May headlines are:-

- There were a number of operational pressures in May, these have been mitigated in month by the use of non-recurrent measures to ensure the Trust was able to deliver the planned position.
- Agency expenditure in month was £1.662m, this was £0.133m above the plan for the month but within the national target to reduce agency by spend by 30%. In month spend was £0.165m below that in April. On a comparable basis, the Trust spent £1.137m less than in May 2024, with medical agency reporting the largest reduction at £0.508m, nursing agency £0.301m less and other agency £0.329m less than in May 2024.
- CIP delivery of £2.374m was delivered in month, this was £0.407m above plan. May recurrent savings were £0.332m (14% of total). In total, recurrent savings of £19.634m are currently forecast to be delivered, representing 53% of the total forecast value of £36.777. There is significant work ongoing across service groups and corporate areas to improve the current CIP forecast.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 31 May 2025:

Table 1: Income and Expenditure Summary May

Statement of Comprehensive Income	Annual Budget	Current Month 2			Year to date		
	£000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	1,023,155	85,835	86,787	952	171,319	171,400	81
Other Operating Income	74,536	5,466	5,805	338	10,862	11,415	552
Total operating income	**1,097,691**	**91,302**	**92,591**	**1,290**	**182,181**	**182,814**	**633**
Operating expenses							
Employee Operating Expenses	(759,395)	(65,024)	(65,444)	(420)	(129,666)	(131,036)	(1,370)
Drugs Cost: Consumed/Purchased	(76,001)	(8,306)	(7,731)	575	(16,237)	(16,005)	232
Clinical Supp & Serv Exc-Drugs	(66,294)	(4,918)	(5,436)	(518)	(9,607)	(10,044)	(437)
Supplies & Services - General	(33,969)	(2,714)	(4,177)	(1,463)	(5,612)	(6,092)	(480)
Other Operating Expenses	(153,755)	(12,616)	(12,167)	449	(25,445)	(24,393)	1,052
Total operating expenses	**(1,089,414)**	**(93,578)**	**(94,955)**	**(1,377)**	**(186,566)**	**(187,570)**	**(1,004)**
Operating Surplus/Deficit	8,277	(2,276)	(2,363)	(87)	(4,386)	(4,756)	(370)
Finance Expense	(14,177)	(1,170)	(1,085)	85	(2,340)	(2,068)	271
Finance Income	3,518	285	269	(17)	664	577	(87)
Other	0	0	0	(0)	(1)	0	1
Overall Surplus/(Deficit)	(2,383)	(3,161)	(3,180)	(19)	(6,061)	(6,247)	(186)
Depr On Donated Assets	1,216	101	95	(6)	202	196	(6)
Donated Assets Income	(1,412)	0	(25)	(25)	0	(25)	(25)
Amortisation	0	0	6	6	0	6	6
IFRIC 12 UK GAPP Data	13,091	1,091	863	(228)	2,182	1,849	(333)
Revenue consequences of LIFT/PFI Schemes Under UK GAAP	(10,512)	(876)	(604)	272	(1,752)	(1,208)	544
Impairments	0	0	0	0	0	0	0
Adjustments to control total	2,383	316	335	19	632	818	186
Adjusted Financial Performance	(0)	(2,845)	(2,845)	0	(5,429)	(5,429)	0

2.2 The tables below set out pay expenditure and whole time equivalent (wte) information by month.

- In May, total staffing was 12,981 WTE, 200 WTE under the planned establishment for the month of 13,180 WTE with the following variances: -
  - Substantive staffing was 168 WTE under establishment plan
  - Bank 31 WTE over plan
  - Agency 7 WTE over &
    Locums 77 WTE under plan.

2.3 Overall temporary staffing numbers were over plan in month. Further information on May performance is set out in Tables 2 and 3 below:-

Table 2: Pay expenditure information

2025/26 Monthly Pay Expenditure analysis	Apr-25 £000	May-25 £000	2025/26 In Month Budget £000	F/(A) Variance £000	2025/26 Total £000	2025/26 YTD Plan £000	F/(A) Variance £000
Temporary staff							
Bank Staff	2,084	2,225	1,852	(373)	4,309	3,683	(626)
Medical Agency	1,251	1,178	1,084	(93)	2,429	2,152	(277)
Medical Locums	846	800	936	136	1,646	1,878	232
Nursing Agency	406	317	247	(69)	722	506	(217)
Other Agency	170	168	197	29	338	403	65
Total Temporary Staff	**4,757**	**4,688**	**4,317**	**(371)**	**9,444**	**8,622**	**(823)**
Nursing	16,525	16,473	17,380	907	32,998	34,797	1,799
Support to Nursing	6,368	6,342	5,978	(365)	12,710	11,698	(1,012)
Medical	13,858	13,752	12,916	(836)	27,610	25,757	(1,853)
AHP's	9,834	9,833	9,813	(20)	19,667	19,675	8
Infrastructure Support	10,548	10,483	10,771	288	21,031	21,582	552
Other	3,703	3,873	3,850	(24)	7,577	7,535	(42)
Substantive Staff	**60,835**	**60,756**	**60,707**	**(49)**	**121,592**	**121,045**	**(547)**
Total All Staff	**65,592**	**65,444**	**65,024**	**(420)**	**131,036**	**129,666**	**(1,370)**
% Temporary	7.25%	7.16%	6.64%		7.21%	6.65%	

Table 3: WTE information

2025/26 Monthly Workforce analysis	Apr-25 WTE	May-25 WTE	In Month WTE	In Month Plan WTE	F/(A) Variance WTE
Temporary staff					
Bank Staff	572.82	503.68	503.68	472.30	(31.38)
Medical Agency	57.89	54.97	54.97	56.46	1.49
Medical Locums	8.84	5.61	5.61	82.31	76.70
Nursing Agency	58.76	56.31	56.31	47.60	(8.71)
Other Agency	42.53	35.57	35.57	35.52	(0.05)
Total Temporary Staff	**740.84**	**656.14**	**656.14**	**694.19**	**38.05**
Nursing	3,515.03	3,503.44	3,503.44	3,467.94	(35.50)
Support to Nursing	2,008.96	1,990.93	1,990.93	1,893.25	(97.68)
Medical	1,215.27	1,216.97	1,216.97	1,269.23	52.26
AHP's	1,717.46	1,711.71	1,711.71	1,772.85	61.14
Infrastructure Support	2,743.25	2,761.69	2,761.69	2,805.89	44.20
Other	1,135.12	1,139.65	1,139.65	1,277.14	137.49
Substantive Staff	**12,335.09**	**12,324.38**	**12,324.38**	**12,486.30**	**161.92**
Total All Staff	**13,075.93**	**12,980.52**	**12,980.52**	**13,180.49**	**199.97**
% Temporary	5.67%	5.05%	5.05%	5.27%	

2.4 May's agency & locum expenditure was £2.462m, £1.370m lower than in the equivalent period in 2024/25 and £0.211m lower than April.

2.5 The national focus on agency continues in 2025/26 with an expectation that organisations reduce their spending by at least 30%. In addition, there is a requirement to reduce bank spend by 10%. The Board will be aware of the progress made on reducing our agency spend last year. Strong controls remain in place to authorise and review agency spend; however, these targets will be extremely challenging to deliver.

2.6 Total medical agency in May was £1.178m (£0.074m lower than April). Vacancies continue to be the largest driver of agency usage and accounted for £0.835m (71% of the total SFT agency spend in month).

2.7 The Trust continues to explore medical recruitment opportunities overseas and review alternative staffing models to mitigate the difficulty of recruiting into hard to fill vacancies.

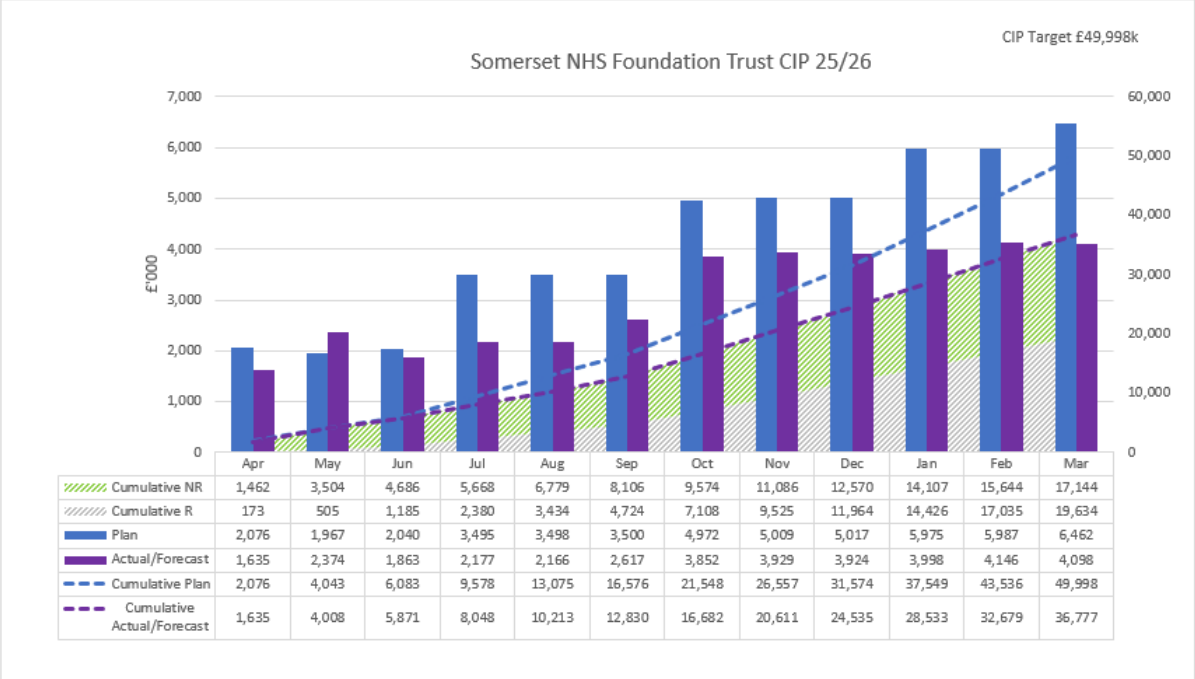
3. COST IMPROVEMENT PROGRAMME

3.1 The Trust has an agreed CIP plan of £49.998m for the year, this represents c4.6% of planned turnover. The target has been fully allocated to clinical service groups, SSL, SHS and corporate areas. There are no planned central schemes.

3.2 In May, savings of £2.374m were delivered. Total delivery was £0.407m favourable to plan for the month. Recurrent savings were £0.332m (14% of total). Cumulatively, the Trust is slightly behind of plan but of the savings delivered so far, only 12.5% are recurrent.

3.3 Further analysis is shown in the chart below: -

Chart 1: CIP Plan 2025/26



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative NR	1,462	3,504	4,686	5,668	6,779	8,106	9,574	11,086	12,570	14,107	15,644	17,144
Cumulative R	173	505	1,185	2,380	3,434	4,724	7,108	9,525	11,964	14,426	17,035	19,634
Plan	2,076	1,967	2,040	3,495	3,498	3,500	4,972	5,009	5,017	5,975	5,987	6,462
Actual/Forecast	1,635	2,374	1,863	2,177	2,166	2,617	3,852	3,929	3,924	3,998	4,146	4,098
Cumulative Plan	2,076	4,043	6,083	9,578	13,075	16,576	21,548	26,557	31,574	37,549	43,536	49,998
Cumulative Actual/Forecast	1,635	4,008	5,871	8,048	10,213	12,830	16,682	20,611	24,535	28,533	32,679	36,777

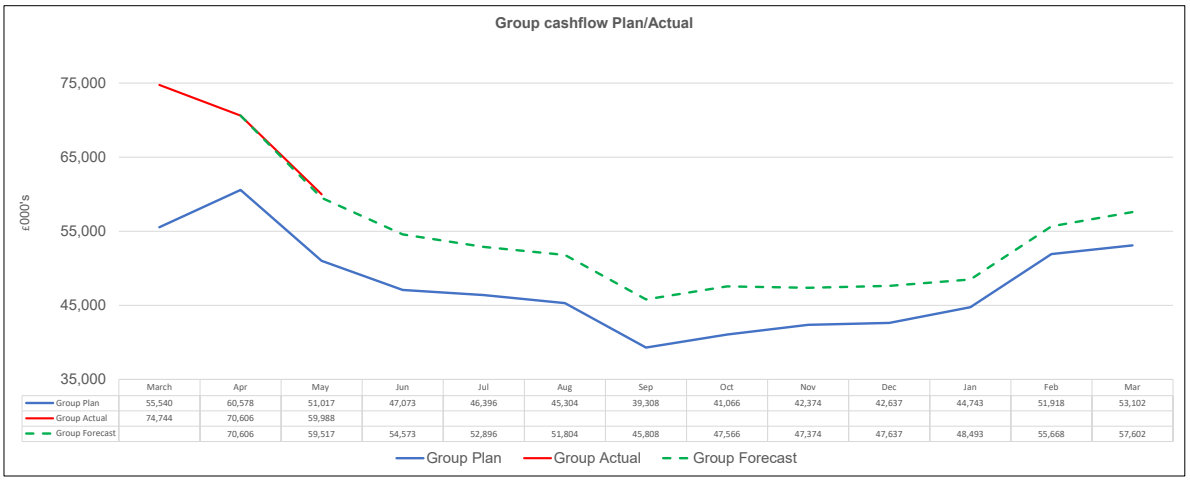
3.4 All services are being supported to improve their efficiency forecasts. There are a number of high risk schemes and schemes that are not fully matured and these need to be urgently progressed in addition to identifying additional savings to reduce the gap in existing plans.

4. CASH

4.1 Cash balances at 31 May were c£60m; c£9m higher than plan, this is primarily due to medical education income received in advance for Q1.

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

Chart 3: Cash flow Actual/Plan



	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Group Plan	55,540	60,578	51,017	47,073	46,396	45,304	39,308	41,066	42,374	42,637	44,743	51,918	53,102
Group Actual	74,744	70,606	59,988										
Group Forecast		70,606	59,517	54,573	52,896	51,804	45,808	47,566	47,374	47,637	48,493	55,668	57,602

Key headline:
The cashflow plan is based on the final 2025/26 plan that was submitted on 30 April. The forecast is based on an assessment of the impact of number of factors which drive cash utilisation, these include, I&E performance against budget, CIP delivery, capital expenditure being incurred in line with the agreed capital programme and normal movements in working capital.

5. STATEMENT OF FINANCIAL POSITION

Apr-25	May-25	Movement		Mar-25	May-25	Movement in Year
£000	£000	£'000		£000	£000	£000
46,598	46,389	(210)	Intangible Assets	35,549	46,389	10,840
396,494	398,963	2,468	Property, plant and equipment, other	409,854	398,963	(10,891)
29,141	28,786	(355)	On SoFP PFI assets	29,141	28,786	(355)
89,834	90,362	529	Right of use assets	89,834	90,362	528
14	14	0	Investments	14	14	(0)
14	14	0	Other investments/financial assets	14	14	0
3,115	3,241	127	Trade & other receivables >1yr	3,063	3,241	178
565,210	**567,770**	**2,560**	**Non-current assets**	**567,469**	**567,770**	**300**
11,594	11,707	113	Inventories	11,281	11,707	426
13,037	18,132	5,095	Trade and other receivables: NHS receivables	5,338	18,132	12,794
24,327	25,172	845	Trade and other receivables: non-NHS receivables	18,796	25,172	6,376
496	496	0	Non current assets held for sale	496	496	0
70,606	59,988	(10,618)	Cash	79,215	59,988	(19,227)
120,060	**115,495**	**(4,565)**	**Total current assets**	**115,126**	**115,495**	**369**
(104,988)	(116,429)	(11,440)	Trade and other payables: non-capital	(103,069)	(116,429)	(13,360)
(10,354)	(6,341)	4,013	Trade and other payables: capital	(18,183)	(6,341)	11,841
(30,435)	(23,835)	6,599	Other liabilities	(18,455)	(23,835)	(5,380)
(15,021)	(14,642)	379	Borrowings	(14,784)	(14,642)	142
(9,491)	(9,474)	17	Provisions <1yr	(9,522)	(9,474)	48
(170,288)	**(170,721)**	**(432)**	**Current liabilities**	**(164,012)**	**(170,721)**	**- 6,709**
(50,228)	**(55,226)**	**(4,997)**	**Net current assets**	**(48,886)**	**(55,226)**	**- 6,340**
(113,721)	(114,428)	(707)	Borrowings >1yr	(114,251)	(114,428)	(177)
(2,790)	(2,790)	0	Provisions >1yr	(2,790)	(2,790)	0
(1,402)	(1,380)	22	Other liabilities > 1Yr	(1,423)	(1,380)	43
(117,912)	**(118,598)**	**(685)**	**Total long-term liabilities**	**(118,464)**	**(118,598)**	**(134)**
397,069	**393,946**	**(3,123)**	**Net assets employed**	**400,120**	**393,946**	**(6,174)**
			Financed by:			
399,414	399,414	0	Public dividend capital	399,414	399,414	0
73,581	73,581	0	Revaluation reserve	73,581	73,581	0
219	202	(17)	Other reserves	(354)	202	556
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(73,800)	(76,980)	- 3,180	I&E reserve	(70,733)	(76,980)	(6,247)
			Other's equity			
126	201	74	Non-controlling Interest	683	201	(483)
397,069	**393,946**	**(3,123)**	**Total financed**	**400,120**	**393,946**	**(6,174)**

6. CAPITAL

6.1 Schemes are being progressed in accordance with the agreed programme for the year.

6.2 Year to date, capital expenditure is £5.7m compared with the plan of £10.6m, resulting in an underspend of £4.9m. A summary of the programme is shown below: -

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

Capital Programme 2025-2026	Plan £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000
Backlog Maintenance	**6,647**	**360**	**602**	**242**
Essential Facilities Improvement Works	**1,885**	**160**	**261**	**101**
Service Redesign Enabling Works	**4,243**	**1,518**	**364**	**(1,154)**
Service Redesign Enabling Works - Major	**13,400**	**5,767**	**1,513**	**(4,254)**
Infrastructure	**350**	**6**	**28**	**22**
Rolling IT & Digital Development	**7,230**	**583**	**578**	**(5)**
Equipment Replacement	**5,126**	**0**	**145**	**145**
Stroke CDEL Transfer	1,844	0	0	0
Transfers	**1,844**	**0**	**0**	**0**
Lease Additions	2,560	0	41	41
Lease Remeasurement	3,108	0	1,784	1,784
Leases	**5,668**	**0**	**1,825**	**1,825**
Total Internal Capital Envelope	**46,653**	**8,394**	**5,317**	**(3,077)**
Externally Funded Capital Schemes	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total Additional Schemes	**58,381**	**2,202**	**345**	**(1,857)**
TOTAL TRUST PROGRAMME	**105,034**	**10,596**	**5,661**	**(4,935)**

7. CONCLUSION & RECOMMENDATION

7.1 CIP performance improved in May and recovered the adverse performance in April so that our cumulative performance is broadly on plan. It is clear from the level of unidentified savings, risk profile and maturity of identified schemes that there is still a considerable amount of work required to identify efficiencies that will fulfil the full requirement of our programme. Services are being asked to identify all possible areas in scope, however difficult these are.

7.2 Agency expenditure is slightly above the 40% stretch plan we set ourselves but ahead of the national 30% reduction required. We need to ensure that the same focus is given to bank usage which is not currently meeting the requirement to reduce by 10%.

7.3 The Board are asked to note the financial performance in May.

Seabrooke,David
25/06/2025 15:10:47

CHIEF FINANCE OFFICER

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Audit Committee held on 18 June 2025
SPONSORING EXEC:	Pippa Moger Chief Financial Officer
REPORT BY:	David Seabrooke, Interim Trust Secretary
PRESENTED BY:	Paul Mapson, Chair of the Audit Committee
DATE:	1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	The Committee has completed the review of the internal audit programme 2024/25.
Recommendation	That the report be noted.

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

- ☐ Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
- ☐ Aim 2 Provide the best care and support to people
- ☐ Aim 3 Strengthen care and support in local communities
- ☐ Aim 4 Respond well to complex needs
- ☐ Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
- ☐ **Aim 6 Live within our means and use our resources wisely**
- ☐ Aim 7 Deliver the vision of the Trust by transforming our services through, innovation, research and digital transformation

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

Equality and Inclusion

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

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The needs and potential impacts on people with protected characteristics are considered by each individual service group as part of their update to the Committee. The Committee reviews data presented to the Committee and will raise any queries if required.
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Staff involvement takes place through the regular service group and topic updates.

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

ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETING HELD ON 18 JUNE 2025

1. PURPOSE

To advise the Board on the decisions arrived at and principal areas reviewed by the Audit Committee.

2. ASSURANCE RECEIVED

2.1. The Committee recommended to the Board the approval of the Annual Report and Accounts 2024/25 and associated reports. The Head of Internal Audit (HoIA) Opinion for the year was Moderate assurance; the Appointed Auditor has given an unqualified opinion of the annual accounts.

2.2. The completed annual report & accounts and audit opinion will be presented to the annual members' meeting on 30 September.

2.3. A positive assessment of the Digital Security Toolkit has been received.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The remaining internal audit reviews for 2024/25 were received, together with the final version of the HoIA's annual report.

Internal audit review	Design	Effectiveness
E-Rostering and Temporary Staffing	Moderate	Limited
Observation and Support	Moderate	Limited
Discharge Processes	Moderate	Moderate

3.2. The Limited Assurance reviews would be followed-up by the Executive and the Finance Committee will review the effectiveness of the improvements arising from the Rostering/Temporary Staffing review.

3.3. Reflecting on the year, Committee noted that there were more limited assurance findings in relation to operational effectiveness (7) than in Design (1) and will further discuss the underlying factors.

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

No matters to report.

5. BOARD ASSURANCE FRAMEWORK (BAF)

No matters to report.

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charity Committee meeting held on 23rd April 2025
SPONSORING EXEC:	Director of Strategy and Digital Development
REPORT BY:	Katie Fry, Executive PA
PRESENTED BY:	Graham Hughes, Chairman of the Charity Committee
DATE:	1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out the items discussed at the Charity Committee meeting held on 23rd April 2025. The Committee received assurance in relation to: • Updated Terms of Reference • Fundraising Report • Major Donation and Proposed Projects • Charitable Management Charge • Going Concern Review • Finance Report and Approvals The Committee will follow up progress on finalising the major donation allocation. The Committee did not identify any issues to be reported to the Board.
Recommendation	The Board is asked to note the assurance and areas for follow up identified by the Charity Committee. The Board is further asked to note the areas to be reported to the Board.

Links to Strategic Aims (Please select any which are impacted on / relevant to this paper)
☐ Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
☒ Aim 2 Provide the best care and support to people
☐ Aim 3 Strengthen care and support in local communities
☐ Aim 4 Respond well to complex needs

☒ Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ Aim 6 Live within our means and use our resources wisely
☐ Aim 7 Deliver the vision of the Trust by transforming our services through, innovation, research and digital transformation

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 People 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 People 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)

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]

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 23 APRIL 2025

1. BACKGROUND AND PURPOSE

1.1. The report sets out the items discussed at the meeting held on 23rd April 2025, along with the assurance received by the Committee and any areas for follow up identified. The meeting was conducted by MS Teams.

2. ASSURANCE RECEIVED

TERMS OF REFERNCE

2.1 David Shannon confirmed the terms of reference were confirmed in January's meeting subject to the agreed changes. The committee approved the terms of reference to be submitted to Board for approval.

FUNDRAISING REPORT

2.2 A significant donation of £20,000 for Musgrove Park Hospital and £10,000 for Yeovil District Hospital has been received.

2.3 James Kirton shared the success of the combined golf day at Cricket St. Thomas which showcased the charity.

2.4 James Kirton highlighted challenges in getting people to sign up to charity events due to economic factors.

2.5 David Shannon raised the closure of the Breast Appeal and highlighted legacy signage from the appeal still remains around the Yeovil site. James Kirton will look into replacing this signage.

MAJOR DONATION AND PROPOSED PROJECTS

2.6 James Kirton listed the projects funded by the major donation from Glastonbury Festival. These are:

- Development of the white space in the surgical centre for a urology "one-stop shop"
- The Surgical Centre garden
- The garden at West Mendip Community Hospital
- Improvements to Holford Garden
- Refurbishment of the St Andrews Building into a multi-disciplinary centre

2.7 James Kirton will work to identify ideas for future campaigns, focusing on popular causes and bring these to a future committee meeting.

CHARITABLE MANAGEMENT CHARGE

2.8 Chris Upham presented a paper on the charitable management charge and explained that this has not been revised for several years. The proposal was to increase the recharge from £54,000 per annum to £68,779 which covers staffing costs directly related to providing paymaster services to the charity. The committee approved the revised management charge.

GOING CONCERN REVIEW

2.9 Nick Boatwright presented a short paper on the Going Concern review which is a requirement for the Trustees to assess whether the charity is in a position to continue operating at the end of the year.

2.10 Nick Boatwright stated the charity is in a good position with significant cash influx last year and the committee agreed with the recommendation to prepare the accounts on a going concern basis.

FINANCE REPORT AND APPROVALS

2.11 Nick Boatwright presented the finance report and noted the charity had an excess of expenditure over income of £1.7million which was expected due to significant spending on approved projects including the Breast Care Centre.

2.12 Nick Boatwright stated the charity finished the year with reserves of £7.2million. This includes £1.3million from Glastonbury Festival which will be spent gradually.

2.13 Nick Boatwright proposed closing one of the higher interest deposit accounts which had a balance of £266,000 and moving the funds to another account for easier management. The committee approved this proposal.

2.14 Business cases 183 – 186 were ratified by the committee.

2.15 David Shannon updated on business case 186, the Armed Forces Welfare Officer post. Additional support had been secured through the Veterans Association, which offered £25,000 for two years, totalling £50,000. This funding, combined with the charity's contribution, ensures the programme's funding for three years

2.16 Nick Boatwright updated that the audit of the charity's accounts would commence on the 27th May and anticipates the accounts will be signed off around the same time as the Trust's accounts in July.

2.17 Nick Boatwright noted the charity's investment fund with CCLA had decreased by £125,000, leaving a balance of £2.393million. The charity does not rely heavily on investment income, with voluntary donations being the primary income stream.

3. AREAS OF CONCERN OR FOLLOW UP

3.1 There were no areas of concern or follow up.

4. BE REPORTED TO THE BOARD OR OTHER COMMITTEES

4.1 The updated Terms of Reference will be submitted to the Board for approval.

Graham Hughes
CHAIRMAN OF THE CHARITIES COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	2025/26 NHSE Board Assurance Statement
SPONSORING EXEC:	Pippa Moger – Chief Finance Officer
REPORT BY:	Pippa Moger – Chief Finance Officer
PRESENTED BY:	Pippa Moger – Chief Finance Officer
DATE:	1 July 2025

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

Executive Summary and Reason for presentation to Committee/Board	The Board reviewed and approved the Assurance Statement as part of the 2025/26 Plan submission. As part of the NHSE feedback to the System on the 2025/26 Plan submission the Trust has been requested to review the statements that were not positively responded to.
Recommendation	The Board is requested to review the updated document and approve.

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

☒ Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
☒ Aim 2 Provide the best care and support to people
☒ Aim 3 Strengthen care and support in local communities
☒ Aim 4 Respond well to complex needs
☒ Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ Aim 6 Live within our means and use our resources wisely
☒ Aim 7 Deliver the vision of the Trust by transforming our services through, innovation, research and digital transformation

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 People 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 People 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)

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]

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

Section B: Provider Assurance

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	Yes	The Trust Board considered the final version of the 2025/26 plan submission at its meeting held on 25 March 2025. The Board supported and approved the plan and the submission to be made on 27 March 2025. The Board has discussed the risks within the plan and recognises that they will need to be regularly reviewed, managed and mitigated during the year and that additional decisions and actions will need to be taken in year as and when risks materialise. The Board has taken assurance from formal and informal planning sessions led by the executives through the planning process and the work of the Board and its committees during the year and since the publication of the planning guidance. The latter in particular has enabled the Board to be assured that the correct processes are in place to ensure that the Trust can manage the delivery of operational, workforce and financial plans. This includes the organisation-wide productive care programme. The Board is also represented on the ICB finance committee, both by non-executive and executive members, where the overall system plan has been considered during the planning process.

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes	The Board noted that a clinical process was being set up to review the quality impact (QEIA) as the detailed savings plans are being taken forward
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes	
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	Yes	QEIA's have been completed for savings plans and are signed off by the Chief Medical Officer and Chief Nursing Officer.
The organisation's plan was developed with appropriate input from and engagement with system partners.	Yes	

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	Yes	
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.	Yes	
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.	Yes	
The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	Yes	