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 4 November 2025** at **9.30am** at John Meikle Room, Deane House, Belvedere Road, Taunton, TA1 1HE

If you are unable to attend, would you please notify Ben Edgar-Attwell, Deputy Director of Corporate Services at Somerset NHS Foundation Trust by email on companysecretary@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 2 September 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.	**Questions from Members of the Public and Governors**	Receive	Chair	09:35	Verbal
6.	**Chair's remarks**	Note	Chair	09:50	Verbal
7.	**Chief Executive and Executive Directors' Report** • National and Regional Developments / Policy updates • Corporate Updates • Provider Capability Assessment • Anti-Racism Board Statement • Procurement Thresholds for Competition • Green Plan 2025-2028	 Approve Approve	Peter Lewis	10:00	Enclosure 04

- Guardian of Safe Working Report
- GMC National Training Survey and Resident Doctors 10-Point Plan
- Freedom to Speak Up Guardian Report
- Use of the Corporate Seal

8.	**Update on Paediatric and Maternity Services at Yeovil District Hospital**	Receive	Peter Lewis/ Mel Iles	10:20	Enclosure 05
9.	**Update on Community Hospitals**	Receive	Andy Heron	10:35	Enclosure 06
10.	**Q2 Board Assurance Framework and Corporate Risk Management Report**	Receive	Jade Renville Peter Lewis	10:45	Enclosure 07

Break 11:00-11:10

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

11.	**Six Monthly Safe Staffing Establishment Report**	Approve	Jo Poole	11:10	Enclosure 08
12.	**Assurance report of the People Committee meeting held on 26 September 2025**	Receive	Graham Hughes	11:25	Enclosure 09
13.	**Wellbeing Guardian Report**	Receive	Graham Hughes	11:30	Enclosure 10

Aim 2 – Provide the best care and support to people

14.	**Integrated Performance Report**	Receive	Pippa Moger	11:35	Enclosure 11
15.	**No Criteria to Reside update**	Receive	Peter Lewis	11:55	Verbal
16.	**Assurance report of the Quality and Governance Assurance Committee meetings held on 24 September 2025 and 3 October 2025**	Receive	Inga Kennedy	12:05	Enclosure 12 Enclosure 13
17.	**Maternity Services Quarterly Report**	Receive	Deirdre Fowler	12:10	Enclosure 14
18.	**Assurance report of the Mental Health Legislation Committee held on 17 September 2025**	Receive	Paul Mapson	12:25	Enclosure 15

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

19.	**Finance report (M6)**	Receive	Pippa Moger	12:30	Enclosure 16

20.	**Assurance report of the Audit Committee held on 15 October 2025**	Receive	Paul Mapson	12:40	Enclosure 17
21.	**Assurance report of the Charitable Funds Committee held on 23 October 2025**	Receive	Graham Hughes	12:45	Enclosure 18

For Information

22.	**Follow-up questions from the public and governors**	Chair	12:50	Verbal
23.	**Any other business**	All		Verbal
24.	**Risks identified**	All		Verbal
25.	**Evaluation of the effectiveness of the Meeting**	Chair	12-55-13:00	Verbal

26. Items to be discussed at the confidential Board Meeting

Investigation and Disciplinary Procedure Review
Healthset – Full Business Case
Minutes of the Finance Committee meeting
Fuller Inquiry update – Phase 2

27. Withdrawal of Press and Public

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

28. Dates of Next Public Meetings

13 January 2026
10 March 2026

Somerset NHS Foundation Trust

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 2 SEPTEMBER 2025 AT FROME COMMUNITY HOSPITAL, ENOS WAY, FROME

PRESENT

Rima Makarem	Chair
Graham Hughes	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Inga Kennedy	Non-Executive Director
Paul Mapson	Non-Executive Director
Olena Doran	Non-Executive Director
Darshan Chandarana	Non-Executive Director
Rosie Benneyworth	Non-Executive Director
Alexander Priest	Non-Executive Director
Tom Frederick	Associate 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 & Digital Development
Kirstie Lords	Deputy Chief People Officer (for Isobel Clements)
Dave Thomas	Interim Chief Nurse
Jade Renville	Director of Corporate Services

IN ATTENDANCE

Ben Edgar Attwell	Deputy Director of Corporate Services
David Seabrooke	Interim Trust Secretary
Mandy Carney and Stacy Baron-Fitzsimons	Service Group Directors - for update on Winter Planning
Sally Bryant and Amy Stubbs	Director of Maternity - for Maternity Services Report National Maternity Improvement Advisor

1. WELCOME AND APOLOGIES FOR ABSENCE

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

1.2. Apologies had been received from Isobel Clements.

2. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 1 JULY 2025

2.1. The Board approved the updated minutes of the Somerset NHS Foundation Trust Public Board meeting held on 1 July 2025 as a true and accurate record.

3. ACTION LOGS AND MATTERS ARISING

3.1. The Board noted the action log.

3.2. There were no matters arising from the minutes.

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

4.1. The Board received the updated Register of Directors' interests; Graham Hughes advised that he was no longer a member of Babcary Parish Council.

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

5. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

5.1. The Chair noted that a set of public questions had been received about the future of Crewkerne Hospital – the Trust's formal response to these is appended to the minutes. The Chair called on the Chief Executive and Chief Operating Officer to respond additionally to these as part of their updates to the Board.

6. UPDATE ON PAEDIATRIC AND MATERNITY SERVICES AT YEOVIL DISTRICT HOSPITAL AND COMMUNITY HOSPITALS

Maternity at YDH

6.1. The Chair called on the CEO and COO to provide these updates and invited Board members to ask questions. The three-month formal review of the maternity, SCBU and paeds closure had taken place with the ICB. Births that would have been at Yeovil had been moved, mainly to Musgrove Park or Dorset County, with some going to RUH Bath and Salisbury. The rate of home births was unchanged. Service user outcomes had been reviewed and there was nothing that could be attributed to the change.

6.2. Many colleagues had taken well to working in other locations, although there was extra travel time. Twelve midwives were working at Dorchester. The CEO reminded the Board that the closure of maternity at YDH was not due to any failing within the maternity service. The Trust was seeking to appoint paediatricians this month and seven candidates had been shortlisted. The additional cost was not significant. The Executive continued to work towards re-opening the service, setting milestones and criteria – the appointment of paediatricians to form a county-wide service was a key step from which further plans could be made.

6.3. Communication with staff had been improved with three workshops run about progress and regular staff briefings. There was also dedicated OD support from HR.

Community Hospitals

6.4. The COO reported that the Trust had attended the Somerset CC Health Overview & Scrutiny Committee in August with a lengthy and positive discussion with metrics shared. The great affection for the community hospitals continued to be recognised. The COO was clear that the Trust's plans were positive and that community hospitals remained part of the Trust's future model of care.

6.5. The transformation of intermediate care had seen £17m invested over seven years in new services to help more people get home and to live independently; inpatient beds remained important, but we need fewer of them. Around 100 colleagues were impacted by the change process and 19 were more directly impacted. There was a process of redeployment in place where an employee could try a new role for up to 12 weeks.

6.6. At Burnham and Crewkerne conversations would continue this month with local people about what was important to them. The ICB continued to lead on the services provided at Wellington and we continued to look at what services could be provided from other locations. It was acknowledged that the community hospitals were not located evenly across the county and its centres of population.

6.7. The COO emphasised that Crewkerne Hospital was very relevant to the future provision of services. The Trust continued to seek to respond to the stories on social media in this area.

7. CHAIR'S REMARKS

7.1. The CEOs of the NHS Confederation and NHS Providers were visiting Somerset to discuss neighbourhood health.

7.2. Rob Whiteman from Dorset ICB has been confirmed as the Chair of the new ICB cluster for Somerset, Dorset and BNSSG.

7.3. The Chair had visited University of West England with Olena Doran and was considering establishing a local Research & Innovation Committee to bring together research leads from partner organisations.

7.4. The Chair confirmed that she had completed the appraisals for the non-executive directors and met with the executive directors individually.

7.5. She reminded everyone of the AGM on 30 September at Somerset Cricket Club being held in conjunction with Somerset ICB.

7.6. Finally, Board members joined the Chair in marking with sadness the recent passing of a colleague, Fiona Higginson, Matron in the emergency department at Yeovil District Hospital.

8. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT

8.1. The Chief Executive presented the report, which was received by the Board. The report was produced in line with changes agreed earlier in the year. As noted, several items that had previously been presented to Board in full were now summarised in the report and were available to Board members for reference.

8.2. The report summarised matters considered by the Executive Committee and two matters for Board approval today: the Quality Account and the Annual Medical Appraisal / Revalidation report. The report also included as appendices a record of the use of the Trust seal and the Board Business Planner for 2025/26.

8.3. The Chief Executive confirmed that following the recruitment process, Diedre Fowler was due to start with the Trust as Chief Nurse at the end of September.

8.4. The Trust had been shortlisted in the Health Service Journal awards 2025 under three categories.

8.5. In support of the NHS Oversight Framework 2025/26, Boards were required to undertake a self-assessment of Capability for submission to NHS England in October. Inga Kennedy commented that the Trust should take an open and honest approach and continue its work around risk management. The Trust was ranked along with acute and community providers and the ratings were due to be published this month.

8.6. He gave an update on the Ten Year Plan (10YP) published in July, including the eight workstreams that had been established by NHS England to take matters forward. The recommendations of the Dash Review into patient safety would be taken forward via the work on the 10YP.

8.7. The Quality Account had been recommended for approval by the Quality & Governance Assurance Committee (QGAC). It was acknowledged that there were some gaps in assurance for the evidence to confirm delivery of some of the objectives.

8.8. The Q1 Learning from Deaths report was addressed by the Chief Medical Officer and it was noted that mortality rates were within the expected range. There were three Coroners active locally at the moment tackling a backlog of inquests, which in turn had raised the Trust's activity levels in supporting these and providing the required witnesses. Learning from Deaths was an important theme for the Board, and it was requested that Prevention of Future Deaths be reported to QGAC. A central tracker of Prevention of Future Deaths actions was being introduced.

8.9. It was noted that a report on the outcomes and actions arising from the David Fuller inquiry would be made to the November Board.

8.10. NHS England has approved a £17.8 million investment to construct a new diagnostic centre adjacent to Bridgwater community Hospital. The facility will offer CT, MRI, echocardiography, ultrasound, and outpatient services, supporting cardiac and

cancer diagnostics. The centre is expected to deliver up to 25,000 additional scans annually from summer 2026.

8.11. On medical appraisal, the L2P system continued to be used and there was good progress on appraisals although some deferred revalidations for example where 360-degree feedback was required every five years affecting 16 people this year. Appraisal was peer led, appraiser training was provided and there was independent quality assurance. The need to ensure that appraisals were of good quality was emphasised. The People Committee would continue to review this.

8.12. On the Guardian of Safe Working report, it was noted that there was more escalation of missed education exceptions to the Director of Medical Education and Medical Staffing team. Doctors were also able to self-roster as one of the improvements delivered by a new IT system The Board supported the recommendations in the report to support expansion of resident doctors in Cardiology/Respiratory, the implementation of the electronic exception reporting system and revision of the procedure for short term sick leave for Resident Doctors.

The Board approved the Quality Account and the Annual Medical Appraisal and Revalidation report.

9. 2025/26 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER REPORT

9.1. The Board received the report setting out the latest updates.

The report set out the highest areas of risk for the organisation as:

- insufficient capacity to meet demand, deliver against
- referral to treatment times and reduce waiting lists
- workforce recruitment and retention
- financial position
- ageing estates – acute and community
- pressures in social care; intermediate care; and primary care
- delivery of digital transformation

The compound risks to the organisation:

- capacity and flow constraints across services
- maternity and neonatal service pressures
- infrastructure and estate failures
- Infection Prevention Control failures
- workforce shortages and burnout
- IT and digital system failures
- financial pressures and strategic delivery risks

9.2. Three risks were rated 25, having been increased since the last report:

- Risk of patient harm due to backlog and delays with remote monitoring of cardiac devices due to reductions in staffing capacity
- Risk to the delivery of the service provision due to the inability to recruit substantive Orthodontic consultant
- Risk to the continuation of providing the Somerset Hub coordinating care service due to move from Wells to Taunton which has led to vacancies of 75% of the service establishment

9.3. There were fourteen new / emerging risks that had been put forward, of which five were from Symphony Health Care. There were 25 risks on the Corporate Risk Register on 15 August 2025.

9.4. There was some more to do in reflecting strategic risks in the corporate risk register. Some areas were outside of risk appetite. Strategy would be reviewed in the light of the Ten Year Plan.

9.5. The BAF presented today was structured around the 2025/26 strategic aims. It was acknowledged that while some BAF risks could not be expected to change rapidly, there should be deep dives into risks scored 20+. Risks were scored 1-5 in line with NHS practice. There also needed to be a better understanding of risk appetite vs risk tolerance. Each board committee had reviewed its allocated risks and the risk appetite had been set by the Board in March. There was also a need to ensure that the "if/then" way of describing risks was adhered to.

10. INCLUSION PROGRESS REPORT

10.1. Following on from development day discussions the Board received a report proposing a formal statement on What Inclusion Means to us at SFT and giving an update on the Trans Inclusive Healthcare project. The CEO reflected that there was enthusiasm for the health care project. The Chair commended the work led by Harriet Smith and Mike Walburn to get us to this point and called upon everyone to take ownership. It was noted too that work in the estates area was being actively pursued.

10.2. Next steps were around the Patient Experience and Engagement team building a network of Trans and non-binary experts by experience and developing communications and metrics. Work was going on around improving how we record gender and sex, and with the Safeguarding team to understand risks that our Trans and Non-binary patients are exposed to and seek to mitigate these.

10.3. The Board approved the following statement:

At SFT, we believe inclusion is essential.
For the people we care for, for our colleagues, and for better care.
We listen to every voice, and we work to remove every barrier for those in our communities.

11. WINTER PLAN 2025/26

11.1. The Chair welcomed Mandy Carney and Stacy Barron-Fitzsimons to address this item. The Chief Operating Officer advised that the planning process for winter

2025/26 had started in June and that there was a Board Assurance Statement template required by NHS England at the end of September.

11.2. In discussion, the following principal points were made:

- Morning discharges had a good effect on patient flow
- Priority areas for winter included reducing ambulance handover times, improving 4 hour waits in ED and reducing 12 hour waits;
- the Trust should avoid transferring risk back to the ambulance service – there was executive level working with SWAST
- the Trust had engaged with the Emergency Care Intensive Support Team (ECIST) on understanding who was using A&E
- There was limited funding at this stage, although bids around urgent treatment centres had been made
- No criteria to reside was at 19% and the target was to get this to 13%
- Performance data was shared was shared internally and it was possible to see other agencies' activity

11.3. It was agreed because of the timings that QGAC would finalise the Board Assurance Statements required by NHS England on the Board's behalf.

12. INTEGRATED PERFORMANCE REPORT

12.1. The Chief Finance Officer presented the report which was received by the Board. In general, community health, mental health and mandatory training were performing well. Work on improving productivity in community dental continued. There was sustained improvement in improving the percentage of patients waiting no longer than 18 weeks for treatment and the percentage of patients admitted discharged and transferred from A&E within four hours, and within 12 hours.

12.2. Mental health length of stay was too long and a multi-disciplinary team approach was being trialled. Ligature incidents related to a small number of patients.

12.3. There were variances in elective acute care and twelve specialties were submitting 18-week recovery plans. The position had been affected by the resident doctors' industrial action. There was a temporary variance on children's due to a mis-application of the 18 week rules now corrected.

12.4. The Trust had been escalated to Category 2 on cancer. Three specialties were affected.

13. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETINGS HELD ON 25 JUNE AND 30 JULY 2025

13.1. The Chair welcomed Amy Stubbs, National Maternity Improvement Advisor, NHS England for this and the Maternity Services item. The QGAC report included the executive summary of the Maternity & Neonatal safety & quality quarterly report Q1 2025/2026 presented to the Committee.

14. MATERNITY SERVICES QUARTERLY REPORT

14.1. The full report was available to Board members for reference. The Chair welcomed Sally Bryant to the meeting. The following principal points were made:

- The CQC action plan was 94% complete
- Safeguarding training had reached a good level
- Maintaining a safe service remained a challenge although bringing teams together had accelerated the improvement work
- There were workforce challenges at Musgrove Park in some areas and an uptick in sickness with autumn demand about to arise
- Work to improve the patient pathway to Dorchester County Hospital was continuing and we were assessing and treating the risks around fragmentary care through the Neo-natal Network
- Options to develop older estate at Musgrove Park in 2026 were being reviewed
- There was a challenging, but much improved relationship with Bristol around perinatal pathways

Amy Stubbs acknowledged SFT's commitment in this area along with the stretch on its resources

The Board noted the report.

15. ASSURANCE REPORT OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 17 JUNE 2025

15.1. The Board received the report and the Chairman of the Committee highlighted a positive CQC inspection report in relation to Rydon 2 and that out of area placements continued to be addressed.

16. FINANCE REPORT

16.1. The Chief Finance Officer presented the financial report which was received by the Board. She particularly highlighted that there was an in-month deficit of £700k. The resident doctors' industrial action was thought to have cost around £250k – there was no national financial support.

16.2. CIP was £1.1m ahead of plan this month but a 2025/26 CIP savings requirement of £11.4m with no savings schemes against it remained a significant gap. The use of medical locums was being reviewed.

16.3. The Strategic Estates Group was discussing progress with schemes that were behind plan. There was £52m at bank.

16.4. There was concern about the Trust's run rate, which had been mitigated by the use of non-recurrent resources. A Financial Recovery Board had been established to close the CIP gap and reduce the run rate. There needed to be a focus on rosters, job planning and all areas of discretionary spend.

17. ASSURANCE REPORT OF THE AUDIT COMMITTEE MEETING HELD ON 23 JULY 2025

17.1. The Board received the report of the Chairman of the Committee who highlighted the work around overseas medical recruitment in conjunction with the People Committee and that we was discussing risk management with committee chairs.

18. ASSURANCE REPORT OF THE CHARITY COMMITTEE – 22 JULY 2025

18.1. The Chairman of the Committee acknowledged the continuing work around fundraising and referred to the £10k legacy to Holford.

18.2. It was agreed that Paul Mapson and Darshan Chandarana would join the Committee to fill vacancies.

19. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

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

20. ANY OTHER BUSINESS

20.1. There was no further other business.

21. RISKS IDENTIFIED

There had been a good discussion of risk but there was now concern about the Trust's ability to control its rate spend in the months ahead.

22. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

22.1. The Board agreed that the meeting had been productive with a large number of items covered effectively.

23. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

23.1. 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.

24. WITHDRAWAL OF PRESS AND PUBLIC

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

25. DATE FOR NEXT PUBLIC BOARD MEETING

25.1. 4 November 2025

APPENDIX

Response to public questions about Crewkerne Hospital (minute 5)

Thank you for your questions and for sharing your concerns regarding Crewkerne Community Hospital.

There are no plans to close Crewkerne Community Hospital. In fact, we want to adapt it and expand the range of services offered from the hospital to benefit more local people.

Our community hospitals are vital assets for the future delivery of healthcare services for local communities. We think there are exciting opportunities to make greater use of Crewkerne Community Hospital with an expanded range of diagnostic services and treatments which could benefit many more local people, meaning that fewer local residents need to travel to one of our acute hospitals.

We have begun work with our Leagues of Friends, and with colleagues, discussing potentially reducing bedded capacity at Crewkerne Community Hospital in order to create more physical space for additional services such as additional outpatients, chemotherapy, cardiology, urology, and community midwifery.

Our trust's patient engagement and involvement team is reaching out to local people in the Crewkerne area to understand how they access healthcare services. The team wants to hear from all voices, including those who are often less heard, about what's working, what's missing, and what would make the biggest difference to local people. The information that people share with us will help us to understand what additional local services they would benefit from.

If any changes are made they will be on a temporary test and learn basis. No decisions have been made to permanently close community hospital beds.

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON 2 SEPTEMBER 2025

Minute	Action	By whom	Due date	Progress
8.8 Learning from Deaths (in CEO report)	Report on Prevention of Future Deaths reports to QGAC	Melanie Iles	4 November 2025	Complete - Learning from Deaths and Prevention of Future Deaths reports and processes were discussed at the QGAC meeting in September.
8.9 David Fuller Inquiry (in CEO report)	Report on the Trust's response to 4 November Board	Andy Heron	4 November 2025	Update scheduled for the Board meeting on 4 November 2025
11 Winter Plan	Report to September QGAC and submit final copy	Andy Heron	24 September 2025	Completed
18 Assurance report of the Charity Committee	Advise the two new NED appointments to the Committee	David Seabrooke	22 September 2025	Completed

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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:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Rima Makarem, Chair
DATE:	4 November 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 27 October 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 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?**
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

REGISTER OF DIRECTORS' INTERESTS

NON-EXECUTIVE DIRECTORS	
Rima Makarem Chair	• 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
Paul Mapson Non-Executive Director	• Nothing to declare.
Inga Kennedy Non-Executive Director	• Director - IJKennedy Healthcare Consultancy (however this Ltd Company is registered as not trading at this time.) • Trustee of the White Ensign Association
Dr Rosie Bennyworth Non-Executive Director	• Interim CEO - Health Services Safety Investigations Body • Member of the Royal College of GPs
Darshan Chandara Non-Executive Director	• Managing Director - NeoPath Ltd
Prof Olena Doran Non-Executive Director	• Professor and Dean for Research and Enterprise at University of West England

Tom Frederick Associate Non-Executive Director	• Director - Oliver Wyman

EXECUTIVE DIRECTORS	
Peter Lewis Chief Executive (CEO)	• Management Board Member, Somerset Estates Partnership (SEP) Board • Director, Somerset Estates Partnership Project Co Limited
Jade Renville Director of Corporate Services	• 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 Musgrove Park Hospital • Nephew works as a physio assistant within Musgrove Park Hospital. • 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 subcontract for liaison and diversion services) • Director of the Shepton Mallet Health Partnership • Director of Symphony Healthcare Services
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 • Director of Symphony Healthcare Services • Wife works within the Neighbourhood's Directorate. • Management Board Member, Somerset Estates Partnership (SEP) Board • Director Predictive Health Intelligence Ltd • Shareholder Director of Simply Serve Limited

Melanie Iles Chief Medical Officer	• None to declare
Deirdre Fowler Chief Nurse	• None to declare

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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive and 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:	4 November 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 any key legal or statutory changes affecting the work of the Trust. The following items require Board approval: • Procurement Thresholds for Competition • Green Plan 2025-2028
Recommendation	The Board is asked to note the report and approve the above listed items.

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 – e.g. 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:

- Procurement Thresholds for Competition
- Green Plan 2025-2028

2 NATIONAL AND REGIONAL DEVELOPMENTS / POLICY UPDATES

NHS Medium-Term Planning Framework (2026–2029)

2.1 NHS England has published its Medium-Term Planning Framework for 2026-2029, setting out expectations for NHS organisations to deliver sustainable improvements in care, access, and financial performance over the next three years.

2.2 Key points include:

- Integrated planning: Trusts are expected to align operational, workforce, financial, and capital plans with system-wide objectives. Plans must be realistic, risk-assessed, and reflect local population needs.
- Efficiency and productivity: A renewed focus on delivering value for money, with expectations for trusts to demonstrate measurable improvements in productivity and service redesign.
- Workforce transformation: Emphasis on new roles, flexible staffing models, and improved retention. Plans must include actions to address workforce gaps and support staff wellbeing.
- Digital and data: Trusts must embed digital transformation into service planning, including use of shared care records, population health tools, and AI-enabled diagnostics.
- Financial discipline: Organisations are expected to deliver balanced plans, with clear trajectories for cost improvement and reduced reliance on non-recurrent funding.

2.3 The framework also introduces a new assurance model, with NHS England assessing plans against delivery risk, capability, and alignment with national priorities.

2.4 From October to December, providers should develop their first submissions, to be sent to NHSE 'before Christmas':

- 3-year revenue and 4-year capital plan return
- 3-year workforce return
- 3-year operational performance and activity return
- integrated planning template showing triangulation and alignment of plans
- board assurance statements confirming oversight of process

2.5 Plans are expected to be finalised in early February. Full plan submissions will include updated versions of those listed above plus the five-year narrative plan. System plans are no longer required, however providers' integrated plans should be developed in collaboration with their NHS partners and in discussion with NHSE regional teams.

2.6 The Trust will incorporate these requirements into its planning cycle and continue to engage with system partners.

Sir Julian Hartley steps down as Chief Executive of CQC

2.7 Sir Julian Hartley has stepped down as Chief Executive of the Care Quality Commission (CQC) with immediate effect. His decision follows concerns about public confidence due to his previous role at Leeds Teaching Hospitals NHS Trust, which is subject to ongoing maternity service investigations.

2.8 Dr Arun Chopra, Chief Inspector of Mental Health, has been appointed as Interim Chief Executive. The Trust will monitor any changes to regulatory engagement or inspection processes arising from this leadership transition.

Resident Doctors Industrial Action

2.9 The British Medical Association (BMA) has announced a five-day strike by resident doctors (formerly junior doctors) across England, scheduled to take place from 7am on 14 November to 7am on 19 November 2025. This marks the 13th round of industrial action since March 2023.

2.10 The Trust is working closely with system partners to prepare for the impact of the strike, particularly in light of ongoing winter pressures. Contingency planning is underway to maintain safe staffing levels and minimise disruption to patient care.

Record Summer of NHS Activity

2.11 NHS England has reported record levels of activity across elective, cancer, and urgent care services during summer 2025. Between June and August:

- 4.6 million elective cases were managed – up 138,000 on the previous year.
- 7.5 million tests and checks were delivered – 250,000 more than summer 2024.
- 654,640 patients received a cancer diagnosis or had cancer ruled out within 28 days – a record high.

2.12 Despite five days of industrial action and peak annual leave, NHS staff increased treatments per working day by 4.4% compared to August 2024.

2.13 Urgent and emergency care also saw record demand:

- 2.31 million A&E attendances in September – a 4% rise year-on-year.
- 761,433 ambulance incidents – up 6% from September 2024.

2.14 GP practices have expanded use of online consultation tools to ease pressure on urgent care services ahead of winter.

2.15 This performance reflects the impact of national reforms, including expanded surgical hubs, extended hours for diagnostics, and increased use of Advice and Guidance to reduce unnecessary referrals.

NHS Online Hospital Launch

2.16 NHS England has announced the development of a new NHS Online Hospital, a virtual care platform designed to give patients greater control over their healthcare. Launching in 2027, the service will connect patients to specialist clinicians across England via the NHS App, without the need for physical hospital visits.

2.17 Key features include:

- Direct booking of specialist appointments, scans, and procedures at Community Diagnostic Centres.
- Remote consultations and monitoring, with access to national clinical expertise.
- Prescription tracking and condition management tools from home.

2.18 The platform is expected to deliver up to 8.5 million appointments and assessments in its first three years, four times more than an average trust, helping to reduce waiting times and improve access regardless of postcode.

2.19 Initial rollout will focus on planned treatment areas with the longest waits, expanding as clinically safe. The programme builds on proven digital models already in use, such as virtual triage and remote follow-up pathways.

2.20 NHS England has committed to co-designing the service with patients, ensuring accessibility and addressing digital exclusion risks. The Trust will monitor developments and assess opportunities to align local services with this national initiative.

3 CORPORATE UPDATES

3.1 Critical Incident Update

3.2 The Trust recently declared an internal Critical Incident due to significant pressures on services, driven by high attendances at our emergency departments and a large number of patients in hospital who no longer require acute care. This step enabled us to prioritise patient safety and mobilise additional support across the wider system.

3.3 Thanks to the exceptional efforts of colleagues and teams, the position has improved, and we have now stepped down to a Business Continuity Incident (BCI). While this marks positive progress, demand for services remains high and is expected to increase as we move into the winter months. We continue to monitor the situation closely and maintain enhanced operational oversight to ensure safe and effective care for patients.

Plans to reopen Special Care Baby Unit and inpatient maternity service at Yeovil District Hospital

3.4 Subject to meeting essential safety criteria, the Trust is planning to reopen the Special Care Baby Unit (SCBU) and inpatient maternity services at Yeovil District Hospital (YDH) on 21 April 2026.

3.5 This follows a period of temporary closure that began on 19 May 2025 due to concerns about the safety, quality, and fragility of the paediatric service at YDH. Consultant paediatricians from Musgrove Park Hospital have supported inpatient and outpatient paediatric services at YDH during this time, but it was not possible to maintain SCBU operations, which in turn impacted the ability to safely provide inpatient maternity care.

3.6 Since the closure (as of 20 October 2025):

- 393 babies who would have been born at YDH were delivered elsewhere:
  - 153 at Musgrove Park Hospital
  - 189 at Dorset County Hospital
  - 14 at Royal United Hospital, Bath
  - 9 at other hospitals
  - 28 at home

3.7 In August, the Trust undertook a three-month review, shared with NHS Somerset, and continues to work closely with Dorset County Hospital NHS Foundation Trust and the Somerset Maternity and Neonatal Voices Partnership to support service users and colleagues.

3.8 The reopening plan is part of a broader transformation to establish a Somerset-wide paediatric service, with equitable provision across the county.

3.9 Key steps include:

- Recruitment of new paediatric consultants (joining between November 2025 and March 2026)
- Continued support from maternity colleagues currently working at Musgrove Park and Dorset County Hospitals
- Detailed planning to ensure safety criteria are met without destabilising existing services.

3.10 The Trust has also welcomed the inclusion of YDH in the national investigation into maternity and neonatal services, announced by the Department of Health and Social Care on 15 September. This presents an

opportunity to contribute to national learning and drive further improvements locally.

Update on Stroke Services Reconfiguration

3.11 Implementation of the reconfigured stroke service model continues following the statutory consultation in 2023 and NHS Somerset ICB's decision in January 2024. The model includes a Hyper Acute Stroke Unit (HASU) at Musgrove Park Hospital, additional HASU capacity at Dorset County Hospital, and Acute Stroke Units (ASUs) at both Musgrove and Yeovil District Hospitals. A seven-day TIA service is being established at Musgrove, with a five-day service at Yeovil.

3.12 Estates work is progressing:

- Refurbishment of the stroke unit at Musgrove is to begin in the near future.
- At Yeovil, building work to expand rehabilitation facilities, including a larger physio gym and ADL kitchen, are subject to Building Safety Regulator approval and have therefore not yet begun. A start date for building work on the ASU at Yeovil District Hospital is not yet confirmed. This is due to the complexity of new regulations that were introduced as part of the Building Safety Act following the Grenfell tragedy. These new regulations mean that any work in tower blocks has to be approved by the Building Safety Regulator before building work can be carried out. Due to the complexity and scale of the requirements, it is taking is longer than expected to submit our plans to the Building Safety Regulator. Work will start as soon as approval is received from the regulator.
- Dorset County Hospital commenced building works in August to expand HASU capacity.

3.13 Recruitment to new roles across Somerset and Dorset is underway, alongside pathway development with SWASFT and community partners. The Stroke Stakeholder Reference Group remains active, supporting communications, transport planning, and patient engagement.

3.14 These changes aim to improve outcomes by increasing access to specialist stroke care while maintaining local provision for ongoing treatment and rehabilitation.

Work begins on £17.8 million NHS diagnostic centre in Bridgwater

3.15 On 21 October 2025, construction officially began on the new £17.8 million Bridgwater Diagnostic Centre, marking a significant milestone in the Trust's commitment to expanding community-based diagnostic services.

3.16 The centre, located adjacent to Bridgwater Community Hospital, will be operated by Somerset NHS Foundation Trust, with medical equipment managed by Ergéa UK. Conditional planning permission was granted earlier this month, and the facility is expected to open to patients in early summer 2026.

3.17 The state-of-the-art centre will offer:

- Two CT scanners
- Two MRI scanners
- Four outpatient rooms
- Two echocardiography/ultrasound rooms

3.18 These services will support routine and specialist cardiac and cancer diagnostics, delivered in a one-stop model that enhances patient experience and streamlines care pathways.

3.19 The centre will:

- Increase diagnostic capacity across Somerset, relieving pressure on scanners at Musgrove Park and Yeovil hospitals.
- Improve access for patients in Bridgwater and surrounding areas, with good transport links and extended operating hours.
- Support earlier diagnosis and reduce waiting times, contributing to national efforts to tackle backlogs.

3.20 This development builds on the success of previous diagnostic centres in Taunton (opened in 2020) and Yeovil (opening shortly) and aligns with the NHS 10-Year Plan's ambition to shift care closer to home.

3.21 The project is being delivered in partnership with Actiform Ltd, using modern construction methods to create a high-quality, purpose-built healthcare environment.

4 REPORTS AND ASSURANCE UPDATES (INCLUDING UPDATES FROM EXECUTIVE COMMITTEE)

Assurance Report from the Executive Committee meetings held on 1 September 2025 and 6 October 2025

4.1 At the Executive Committee meetings held on 1 September 2025 and 6 October 2025, the Committee focused on key strategic and operational priorities, beginning with updates on system reconfiguration.

4.2 Operational discussions centred on winter planning, with emphasis on patient flow improvements and a proactive approach to addressing pathway blockages. Plans for early November include senior leaders spending time on wards to identify and resolve operational challenges, supported by weekly winter reviews and regional coordination.

4.3 Financial performance was reviewed in detail, noting a month 5 deficit and reliance on non-recurrent resources to maintain a break-even position. Risks from industrial action costs, agency expenditure, and a significant gap in recurrent CIP delivery were highlighted. The Committee agreed on the need for increased scrutiny of transformational savings plans and Service Group engagement in financial recovery.

4.4 The meeting also considered the Trust's Green Plan 2025–2028, which sets out six strategic aims to embed sustainability across workforce, estates, transport, supply chain, digital transformation, and climate resilience.

4.5 Updates were received on workforce engagement initiatives, including Pulse survey results and the Listening Report, as well as GMC training survey findings, which showed strong performance at Musgrove Park Hospital and improvements at Yeovil District Hospital, though further work is needed in specific specialties.

4.6 Additional reports covered quality and performance exceptions, patient safety priorities, and data assurance. The Committee reviewed progress on the Digital, Data and Technology Strategy, which will support unified electronic health records and organisational transformation. Finally, the Committee considered safety criteria for the planned relaunch of YDH maternity services, ensuring robust governance and workforce readiness.

Provider Capability Assessment

4.7 The Trust's Provider Capability Assessment was formally submitted to NHS England on 22 October 2025, in line with national requirements. The assessment evaluates organisational capability across six domains and forms part of the NHS Oversight Framework. It was developed using internal performance data, national benchmarking, and Board-level discussion at the Development Day held on 7 October.

1.1. The Trust submitted the following assessment across the six domains:

Domain	Assessment
1. Strategy and leadership	Confirmed
2. Quality of care	Partially Confirmed
3. People and culture	Confirmed
4. Access and delivery of services	Partially Confirmed
5. Productivity and value for money	Confirmed
6. Financial performance and oversight	Confirmed

4.8 The two domains, Quality of Care and Access and Delivery of Services, were assessed as Partially Confirmed, reflecting ongoing improvement work in paediatric and maternity services and the challenges faced around performance against the national measures.

4.9 The full Provider Capability Assessment report (as circulated to Board members on 21 October 2025 via electronic means) is available in the Reading Room.

Anti-Racism Board Statement

4.10 Two new guidance documents to support managers in responding to racist behaviour, whether from colleagues or from patients and visitors, have been developed and signed off by the Violence and Aggression Group. These resources aim to strengthen the Trust's response to racism and provide clear, practical support for managers handling such incidents.

4.11 Each document includes a Board-level statement affirming the Trust's commitment to anti-racism and the importance of supporting colleagues who experience discrimination. The statement has been reviewed and is proposed to be signed off on behalf of the Board, with final formatting to be completed by the Communications team.

"At Somerset NHS Foundation Trust, we are united in our commitment to uphold the dignity and safety of every colleague. Racism, discrimination, or abuse of any kind has no place in our trust—whether it's from patients, visitors, or colleagues.

We are proud of the diversity that strengthens our teams and the compassionate care we deliver together. This guidance reaffirms our duty to protect our people and challenges us all to act with kindness, respect, and courage.

Creating an inclusive, safe environment is not optional—it is essential. We expect every leader and team member to stand against racism and support those who are impacted.

Integrity in the NHS means upholding the highest ethical standards and acting with honesty, transparency, and accountability in all actions. If you witness racism or inequality, you must act—report it, challenge it, and support those affected. Silence is not neutrality."

4.12 Once finalised, the guidance will be shared widely and will form part of the Trust's broader work on inclusion, safety, and staff wellbeing.

Procurement Thresholds for Competition

4.13 Approval is being sought from the Trust Board for changes to be made to the Procurement thresholds for competition as stated in the SFT Standing Financial Instructions.

4.14 The current thresholds have remained unchanged for several years and are no longer aligned with national procurement legislation or best practice.

4.15 The proposed changes aim to:

- Enable greater focus on higher-value contracts where greater benefit can be achieved.
- Reduce administrative burden for lower-value procurements.
- Encourage participation from SMEs and local suppliers.
- Align thresholds with the Procurement Act 2023 and the Provider Selection Regime.

4.16 Key amendments include:

- Updating terminology to reflect current legislation.
- Revising financial limits for goods, services, and works to reflect national thresholds.
- Introducing a specific category for healthcare services with no fixed threshold.

- Streamlining references in Standing Orders to ensure future updates require changes in only one location.

4.17 The full detail is included within Appendix A to this paper.

4.18 The proposals were reviewed and supported by the Audit Committee on 15 October 2025. The Board are asked to **approve** these proposals.

Approval of the Green Plan 2025-2028

4.19 Following discussion at the Board Development Day on 7 October 2025, the updated Green Plan 2025-2028 was presented and supported. The revised plan reflects national guidance and a strategic shift in approach, focusing on fewer, larger-scale initiatives to maximise impact, rather than numerous smaller schemes.

4.20 Key updates include:

- A target to increase staff engagement in sustainability by 25% by 2028, measured through participation in the Green Clinical Action Group, training completion, and award nominations.
- Strengthened focus on travel and transport, with site-specific plans and a car-sharing portal under development.
- Integration of sustainability into procurement, digital transformation, and estate planning.
- Improved alignment with regional and national sustainability networks and funding opportunities.

4.21 The Board welcomed the involvement of clinicians in shaping the plan and emphasised the importance of transparency, impact measurement, and continuous engagement.

4.22 The Board is asked to formally **approve** the Green Plan 2025–2028, following its endorsement at the Board Development Day.

Guardian of Safe Working for Post Graduate Doctors Report

4.23 The quarterly Guardian of Safe Working report for August to October 2025 highlights exception reporting activity across Somerset NHS Foundation Trust. A total of 278 exception reports were submitted, with General Surgery and Urology at Musgrove Park Hospital (MPH) and General Surgery at Yeovil District Hospital (YDH) showing notable increases. These areas will be monitored into the next quarter.

4.24 Key points:

- Immediate Safety Concerns (ISCs): Seven ISCs were reported, though most were submitted in error. One valid concern related to lack of support in gastroenterology at YDH.
- No fines or work schedule reviews were issued this quarter.
- Weekend and out-of-hours exception reporting remains low, with short-term sickness continuing to impact cover.

- The Trust awaits implementation of new rota management and exception reporting software, expected to improve data accuracy and responsiveness to rota gaps.

4.25 The report also includes a breakdown of exception reports by specialty and trainee grade, and outlines agency and locum spend to cover training posts.

4.26 The full report is available in the Reading Room for Board members.

GMC National Training Survey and Resident Doctors 10-Point Plan

4.27 An update was presented to the People Committee on the General Medical Council (GMC) National Training Survey (NTS) and the National Education and Training Survey (NETS), alongside progress against the Trust's 10-Point Plan to improve resident doctors' working lives.

4.28 GMC and NETS Survey Findings:

- Musgrove Park Hospital (MPH) achieved high overall satisfaction, outperforming Bath for the first time and ranking among the best training environments in the South West.
- Yeovil District Hospital (YDH) showed improvement, moving out of the lowest quartile and into the interquartile range.
- Areas of strength included Radiology at MPH, which demonstrated best practice in departmental education and feedback mechanisms.
- Areas requiring improvement include Cardiology, Clinical Oncology, Ophthalmology, and General Psychiatry at MPH, and Acute Internal Medicine, Cardiology, Respiratory Medicine, Obstetrics and Gynaecology, and Paediatrics at YDH.
- Concerns were raised about clinical supervision and patient safety, particularly in YDH, with action plans in place.
- The Southwest region was identified as a negative outlier for sexual safety, with one in six colleagues reporting they do not feel able to raise concerns. Further work is underway to strengthen leadership visibility and assurance in this area.

4.29 Resident Doctors – 10-Point Plan: This highlighted a number of areas which required further review. Key issues include:

- Sickness absence management, with 61 doctors reporting five or more episodes between August 2024 and September 2025. A proposal has been made to use tariff funding to support a named individual to manage sickness tracking and support.
- Workplace wellbeing concerns persist, including access to rest areas, lockers, on-call parking, and unprotected breaks.
- Annual leave restrictions due to rota compliance remain a challenge, though self-rostering in Emergency Medicine has improved feedback. The rollout of Patchwork aims to support this Trust-wide.
- Payroll errors have increased, and further work is needed to improve accuracy.
- Study leave reimbursement is now processed post-expenditure, and mandatory training duplication has been reduced through pre-arrival evidence collection—an approach recognised by NHSE as best practice.

4.30 The Committee acknowledged the hard work to maintain high standards at MPH and the improvements underway at YDH. Further action is being taken to improve data collection for locally employed doctors and to strengthen the culture of feedback and inclusion.

Six-Monthly Freedom to Speak Up Guardian Report

4.31 The six-monthly Freedom to Speak Up (FTSU) Guardian report was presented to the Executive Committee on 3 November 2025.

4.32 During this period, 185 concerns were raised – a 14% decrease compared to the previous six months. Key themes included worker safety and wellbeing (64%), inappropriate behaviours (41%), and bullying and harassment (16%). Concerns about patient safety declined, while sexual safety concerns rose slightly.

4.33 Notable developments:

- Expansion of the FTSU Ambassador Programme, with 12 ambassadors now in place.
- Delivery of targeted training and launch of new resources and videos.
- Strengthened governance, including involvement in policy assurance, mock inspections, and walkabouts.
- Development of an internal assurance framework and improvements to the RADAR dashboard.

4.34 Feedback remains positive, with average scores of 7.98/9 from staff and 4.9/5 from managers. While no formal detriment cases were reported, fear of detriment remains a barrier, and national guidance has been promoted to address this.

4.35 The report also notes the planned closure of the National Guardian's Office in March 2026, with functions transitioning to NHS England.

4.36 The full FTSU Guardian report is available in the Reading Room for Board members.

Use of the Corporate Seal

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

4.38 The seal register entries over the period 1 April 2025 to 27 October 2025 are set out in the attached Appendix B.

Appendix A

SOMERSET NHS FOUNDATION TRUST

Proposed amendments to the Procurement thresholds for competition as stated in the SFT Standing Financial Instructions

1. BACKGROUND AND PURPOSE

This paper has been prepared to request approval from the Trust Board for changes to be made to the Procurement thresholds for competition as stated in the SFT Standing Financial Instructions.

The existing thresholds have been unchanged for several years and prevent colleagues from focusing time and resource on higher spend contracts where there is potentially greater benefit to be obtained. In addition, the current tendering thresholds do not encourage SMEs and local suppliers to bid as submitting proposals is administratively heavy.

2. AMENDMENTS PROPOSED TO STANDING FINANCIAL INSTRUCTIONS

2.1. Point 12.6.1 Duties of officers (page 30), first bullet point, final sentence should be amended to read 'Contracts above specified thresholds are advertised and awarded in accordance with public procurement law'.

This amendment removes reference to previous EU public procurement rules.

2.2 Appendix 1: Financial limits

Table 3 within Annex 1 of the Standing Financial Instructions, 'Procurement thresholds for competition' should be amended from a to b below. For completeness, Healthcare Service contracts have been added to the table for which there is currently no threshold at which the Provider Selection Regime applies.

a)

3) Procurement thresholds for competition	**Authorisation Level £ (excluding VAT)**
Request for quotation	10,000
Request for tender	50,000
Competition in accordance with Public Contracts Regulations and Provider Selection Regime	Current limit *

*The levels are amended at a national level and set pre–VAT. Advice should be sought from the Procurement Department as to the correct limit to apply in each situation

b)

Type of Expenditure	Process	Procurement threshold for competition excluding VAT
Goods and Services	Request for Quotation (minimum 3 quotations sought)	£10,000
	Procurement Act 2023 above threshold tender or competition against compliant framework agreement	£116,407*
Works	Request for Quotation (minimum 3 quotations sought)	£10,000
	Below Threshold Tender (minimum 4 tenders sought) or competition against compliant framework agreement	£250,000
	Procurement Act 2023 above threshold tender or competition against compliant framework agreement	£4,477,174*
Healthcare Services	Process in accordance with Provider Selection Regime	No threshold

*The levels are amended every 2 years at national level and set pre–VAT. Advice should be sought from the Procurement Department as to the correct limit to apply in each situation.

3. AMENDMENTS PROPOSED TO STANDING ORDERS

3.1 Annex 3 (Standing Orders Tendering and Contract Procedure), point 1.3.2.1 amend *'the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 exc VAT (this figure to be reviewed annually)'* to read *'the estimated expenditure or income does not, or is not reasonably excepted to exceed thresholds stated in Appendix 1, table 3 of the Trust Standing Financial Instructions'.*

This amendment references the proposed new thresholds table b of 2.2 above. This means that only the table in the Standing Financial Instructions needs to be amended should there be any future changes required.

4. RECOMMENDATION

The Trust Board is asked to discuss and approve the proposed changes to the existing Procurement thresholds for competition as recommended following a discussion at Audit Committee.

Somerset NHS Foundation Trust

Appendix B

SOMERSET NHS FOUNDATION TRUST - SEAL REGISTER

1 April 2025 – 27 October 2025

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
02/04/2025	17	Lease Agreement – 9 Artillery Road, Yeovil	David Shannon	Peter Lewis
29/04/2025	18	Lease – Supply Connection – Convamore – Southern Electric Power	Pippa Moger	David Shannon
30/05/2025	19	Clearchannel Agreement – Bauer Media Group	David Shannon	Peter Lewis
30/05/2025	20	License for works – 27a Vicarage Walk, Quedam, Yeovil	David Shannon	Peter Lewis
04/06/2025	21	Licence to Underlet, Lease of garage 38, Cheddon Mews, Taunton	David Shannon	Isobel Clements
13/06/2025	22	JCT – Refurbishment of Phoenix and St Andrews Wards, Wells Priory	Peter Lewis	David Shannon
18/06/2025	23	Lease with Bauer Media Outdoor UK Limited	David Shannon	
25/06/2025	24	Deed documents for Ryalls Park and Oaklands Surgery (x6)	Pippa Moger	Andy Heron
16/07/2025	25	Deed of Variation of Contract between SFT and Ergea UK and Ireland Ltd	David Shannon	Isobel Clements
18/07/2025	26	Yeovil JCT Minor Works Building Contract	David Shannon	Peter Lewis
19/08/2025	27	Licence to Occupy, Rooms G15-G20, Fore Street, Bridgwater	Isobel Clements	Andy Heron
16/10/2025	28	Contract documents for alterations to form Aseptic Pharmacy - JHC Surveying Limited	David Shannon	Isobel Clements
24/10/2025	29	Renewal lease at The Exchange, Bridgwater	David Shannon	Pippa Moger

NHS
Somerset
NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST	
REPORT TO:	Trust Board of Directors
REPORT TITLE:	Yeovil District Hospital Special Care Baby Unit and Inpatient Maternity Services: Criteria for safe re-launching of services
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Melanie Iles, Chief Medical Officer
PRESENTED BY:	Melanie Iles, Chief Medical Officer
DATE:	4 November 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 paper seeks formal ratification of the framework for the safe re-launch of the Special Care Baby Unit (SCBU) and inpatient maternity services at Yeovil District Hospital, following approval in principle at the Board Development Day on 7 October 2025. The framework sets out safety criteria grouped under four themes: Workforce, Training, Leadership & Culture, and Governance. Criteria are colour-coded: red (must be met before re-launch) and amber (should be progressed but not required pre-opening). The framework has been co-developed with clinical teams, system partners, and service user representatives, and includes a post-launch safety monitoring model to ensure ongoing oversight.
Recommendation	The Board is asked to: • Ratify the approval given at the Board Development Day for the framework as the basis for decision-making on the safe re-launch of services at YDH.

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

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

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

Equality and Inclusion

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

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

The framework has been developed with input from service users, including those with protected characteristics, through the Somerset Maternity and Neonatal Voices Partnership. It aims to improve access to safe, high-quality care for all families and supports an inclusive culture for staff. No adverse impacts have been identified, and the re-launch is expected to enhance equity and experience across the service.

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 Somerset Maternity and Neonatal Voices Partnership (MNVP) has played an integral role throughout this work, ensuring that the voice of service users remains central to managing the impact of the temporary closures and the safe reopening of services. This has included active participation in the formal Somerset ICB review meeting on the three-month temporary closure, held on 14 August 2025. Colleagues have also been invited to participate in this work, through a series of engagement workshops held to develop criteria for safe re-opening of services.

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 Framework has previously been considered by the Executive Committee and by the Board at the Board Development Day in October 2025.

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

CRITERIA FOR SAFE RE-LAUNCHING OF SPECIAL CARE BABY UNIT AND INPATIENT MATERNITY SERVICES AT YEOVIL DISTRICT HOSPITAL

1. INTRODUCTION

1.1. This report provides an overview of the detailed framework developed to support the safe and sustainable re-launch of the Special Care Baby Unit (SCBU) and inpatient maternity services at Yeovil District Hospital (YDH), following their temporary closure in May 2025. The closure was prompted by significant concerns regarding paediatric safety, including staffing gaps and service resilience, as identified in a CQC inspection which led to a Section 29A warning notice.

1.2. This paper also seeks formal ratification of approval the framework for the safe re-launch of services at the Board Development Day on 7 October 2025.

2. FRAMEWORK FOR THE SAFE RELAUNCHING OF SERVICES

2.1. The framework has been co-produced with clinical teams, system partners including Somerset Integrated Care Board (ICB) and South Western Ambulance Service NHS Foundation Trust (SWAST), and service user representatives via the Somerset Maternity and Neonatal Voices Partnership (MNVP). It reflects a safety-first approach, aligned with national standards and regulatory expectations, and is designed to ensure that services are re-launched in a way that is clinically safe, operationally resilient, and responsive to the needs of families.

2.2. The framework is structured around four key components:

1. **Workforce Sustainability**
   Ensuring safe staffing levels across paediatrics, neonates, obstetrics, and midwifery, including compliant rotas, consultant presence at peak times, and qualified neonatal nursing cover.
2. **Training and Skills Development**
   Meeting essential training standards such as Neonatal Life Support, airway management competencies, and regular simulation training.
3. **Leadership and Culture**
   Establishing cross-county leadership structures and fostering a culture of learning, collaboration, and continuous improvement.
4. **Governance**
   Strengthening governance through updated policies, safety monitoring frameworks, and active participation in national audits and programmes.

2.3. Each criterion within the framework is colour-coded:

- Red criteria are mandatory and must be fully met prior to re-launch.
- Amber criteria are important areas for improvement that should be actively progressed but do not need to be fully achieved before reopening.

2.4. The framework also includes a post-launch safety monitoring model based on the *Health Foundation's Framework for Measuring and Monitoring Safety*, which will provide ongoing oversight and assurance following the re-launch.

2.5. The temporary closure has had a notable impact on neighbouring maternity units, particularly Musgrove Park Hospital and Dorset County Hospital, which have absorbed increased activity. The re-launch must therefore be carefully managed to avoid destabilising services elsewhere in the system.

3. RECOMMENDATION

3.1. The framework was presented and received approval in principle at the Board Development Day on 7 October 2025. The Trust Board is now asked to formally ratify this decision, approving the framework as the basis for decision-making regarding the safe re-launch of SCBU and inpatient maternity services at Yeovil District Hospital.

3.2. This ratification will confirm the Board's support for the safety criteria and operational planning outlined in the framework, enabling the Trust to proceed with preparations for reopening the services in a safe, sustainable, and coordinated manner.

Mel Iles
CHIEF MEDICAL OFFICER

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Community Hospital Transformation Update
SPONSORING EXEC:	Andy Heron, Chief Operating Officer
REPORT BY:	Andy Heron, Chief Operating Officer Abbie Furnival, Service Group Director Neighbourhoods & Community Services
PRESENTED BY:	Andy Heron, Chief Operating Officer
DATE:	4 November 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	To provide an update to the board of directors around Phase 1 and Phase 2 of SFT's Community Hospital Transformation Programme.
Recommendation	To receive the update

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

☐ Aim 1 Contribute to improve health and wellbeing of 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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

Equality and Inclusion

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

How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?
The Community Hospital Transformation Programme aims to realise the full potential of the community hospitals in delivering the 10 Year Health Plan for England. The 10 Year Health Plan was published in July and sets out how it will reinvent the NHS through three radical shifts. One of those shifts is a shift of services from hospital to community. The 10 Year Health Plan sets out how the shift from hospital to community will be realised through the Neighbourhood Health Service that will bring care into local communities, convene professionals into patient-centred teams and end fragmentation. At its core, the Neighbourhood Health Service will embody our new preventative principle that care should happen: • as locally as it can • digitally by default • in a patient's home if possible • in a neighbourhood health centre (NHC) when needed • in a hospital if necessary. Our trust and NHS Somerset are working together on a programme designed to deliver that shift. We are running two test and learn processes and NHS Somerset is inviting local people to shape how the NHS in Somerset shifts care to neighbourhoods to achieve better health outcomes and less pressure on acute hospitals.

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.
N/A

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.
Yes

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]
No

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

COMMUNITY HOSPITAL TRANSFORMATION PROGRAMME UPDATE

1. BACKGROUND AND PURPOSE

1.1 The purpose of this report is to provide an update on the Community Hospital (CH) Transformation Programme.

1.2 Moving care from hospitals to communities is among the three key shifts at the centre of the 10 Year Health Plan. We want to retain the essence of community hospitals and to care for people locally, but modernise the way we do this, that is fit for purpose. This is about using community resources, including Community Hospitals, in a way that enables the best possible local delivery of care. This could include local access to chemotherapy, or more x-rays or more outpatient clinics in community settings. We want to get better outcomes with the resources, which are available to our community.

1.3 Phase 1 involves a test and learn of the Intermediate Care development as part of what has now been a long-standing partnership programme between the NHS and Adult Social Care in the county. This test and learn is designed to support more people to live independently for longer with a reduced reliance on bed-based care in Community Hospitals as additional investment is put into community alternatives. The design of this programme includes temporary bed reductions at Frome, West Mendip and Bridgwater Community Hospitals.

1.4 Phase 2 involves exploratory engagement with Burnham-on-Sea and Crewkerne Hospital League of Friends over potentially reducing bedded capacity at those hospitals to create more physical space for additional services such as outpatients, chemotherapy, cardiology, urology, community midwifery etc as part of a test and learn.

2 PHASE 1 UPDATE

2.1 The increase in reablement at home and the temporary bed reductions were fully operational by 29th September 2025. From this date onward the impacts are measured, with the first evaluation point (evaluation will be continuous) taking place from week commencing 22nd December.

2.2 The phase 1 test and learn involves:

- Expanding our Pathway 1 service to care for more people in their own homes, extending this service to care for 83 (from 67) new people per week.
- Spot purchasing 28 beds in care homes in Somerset so that people whose needs have changed can move directly from an acute hospital into a care home and will no longer need to move twice. In addition, there are some changes to the commissioning of care home beds so

that it can move to a spot purchase model and the Council are leading on this element.

- Temporarily reducing the number of community hospital beds in three of our community hospitals:
    - Bridgwater Community Hospital – 30 beds to 24 beds
    - West Mendip Hospital in Glastonbury – 30 beds to 16 beds
    - Frome Community Hospital – 24 beds to 16 beds.

  These temporary changes enable patients in Somerset to receive intermediate care at home, or in a community hospital, or move directly to a long-term care placement if their needs have changed.

2.3 The measures which will be used to assess the test and learn pilots are as follows:

- The number of patients whose discharge from Yeovil Hospital or Musgrove Park Hospital is delayed.
- How long a patients' discharge from an acute hospital is delayed
- The length of time that patients wait to access intermediate care at home (Pathway 1).
- Delays leaving either an acute or community hospital bed.
- Patients' length of stay in a community hospital bed.
- The proportion of patients who need to be readmitted from the Pathway 1 service.
- Qualitative feedback from patients and colleagues.
- Patient outcomes including the proportion who are discharged home, able to remain at home, and what proportion require care packages

2.4 For colleagues effected, 23 colleagues (10 HCAs, 9 RNs) were redeployed, with six still on trial periods of their redeployment. Four individuals have raised concerns around suitability of the role and have HR support, and some have extended trial periods. 9 individuals took MARS (mutually agree resignation scheme), across both Frome and Bridgwater; all have left with MARS agreements in place.

3 PHASE 2 UPDATE

3.1 Discussions with Staff and League of Friends for Burnham-on-Sea and Crewkerne community hospitals commenced in May 2025 with a full engagement programme implemented by our Patient Experience team in August – October 2025. As part of this engagement programme, 520 people across 5 community hospitals have completed a survey link. Of the 520 survey responses were received: 31% (162) related to Burnham-on-Sea (BoS) and 21% (111) to Crewkerne. The team conducted 12 community visits to Crewkerne and 7 to BoS. In the last 2–3 weeks, targeted engagement activities reached men, children, young people, and families—groups previously underrepresented in survey responses.

3.2 The aim is to meet with Town Council representatives in November with a recommendation for a test and learn to be shared by the first week in December 2025. Any recommendations for a test and learn will be informed by our understanding of local people's experience of health services, what's working, what's missing, and what would make the biggest difference to local people.

4. RECOMMENDATION

4.1 The Board is asked to note the progress.

ABBIE FURNIVAL
SERVICE GROUP DIRECTOR NEIGHBOURHOODS & COMMUNITY SERVICES

ANDY HERON
CHIEF OPERATING OFFICER

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2025/26 Q2 Board Assurance Framework
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Jade Renville, Director of Corporate Services
DATE:	4 November 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	Somerset NHS Foundation Trust (SFT) continues to embed its refreshed Board Assurance Framework (BAF), aligning strategic risks with the Trust's updated aims and objectives. The Q2 2025/26 iteration builds on the initial framework presented in Q1, incorporating further refinement of KPIs, enhanced risk articulation, and strengthened assurance mechanisms. Key updates in this Q2 report include: • Expanded narrative and performance data across all seven strategic aims. • Updated risk scores and appetite assessments, with several risks remaining above appetite. • Inclusion of new risks and mitigations, particularly in relation to maternity services, paediatric care, and workforce challenges. • Enhanced reporting on digital transformation, including progress on the Electronic Health Record (EHR) business case and ambient voice technology. • Continued development of controls and assurance processes, with clearer governance oversight. The BAF remains a dynamic tool, evolving in response to operational learning and feedback. It is presented quarterly to the Board and aligned with the Corporate Risk Register. Discussions took place at the Board Development Day in October regarding the refresh of the Trust's Strategy which will be reflected in future iterations of the BAF.

Recommendation	The Board is asked to: • Note the Q2 2025/26 Board Assurance Framework. • Review Aim 7, which remains under the direct oversight of the Board. • Note the strategic risks and mitigating actions across all aims. • Provide feedback to inform future iterations of the BAF.

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

☒ Aim 1 Contribute to improve health and wellbeing of 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 Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies

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

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

Details: N/A

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

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

The needs and impacts on people with protected characteristics have not been considered as part of this report but are considered as part of the mitigating actions taken at service group level.

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 the Board on a quarterly basis.

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

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

SOMERSET NHS FOUNDATION TRUST

2025/26 Q2 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1. This report presents the Q2 2025/26 iteration of the Board Assurance Framework (BAF), following further refinement and development since the initial refresh in Q1. The BAF continues to provide a structured and detailed view of strategic risks, associated programmes, and assurance mechanisms aligned to the Trust's seven strategic aims.

1.2. It is designed to support the Board in its oversight of risk exposure, programme delivery, and governance effectiveness.

2. OVERVIEW OF STRATEGIC AIMS AND OBJECTIVES

2.1. The Trust's strategic risk profile remains broadly consistent with Q1, with several aims continuing to operate above their stated risk appetite. Risks associated with urgent care access, workforce capacity, and financial sustainability remain among the highest rated. The BAF reflects these challenges while also capturing areas of progress and improvement. The Q2 iteration includes updated KPIs, expanded narrative detail, and a more nuanced distinction between strategic and operational risks.

Corporate Aim	Risk Appetite		Highest Risk to Aim
1. Contribute to improving the health and wellbeing of the population and reducing health inequalities	Within Appetite	Seek 15-16	9
2. Provide the best care and support to people	Above Appetite	Open 12	25
3. Strengthen care and support in local communities	Within Appetite	Seek 15-16	16
4. Respond well to complex needs	Within Appetite	Seek 15-16	16
5. Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	Within Appetite	Seek 15-16	16
6. Live within our means and use our resources wisely	Above Appetite	Financial Manag – Open 12	20
	Within Appetite	Commercial – Seek 15-16	
7. Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies	Above Appetite	Seek 15-16	20

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

2.2. The Trust continues to deliver a programme of work aimed at improving population health outcomes and reducing inequalities. A Consultant in Public Health has been appointed to lead the development of a population health strategy, which will be overseen by a newly established Population Health Group. The “Stolen Years” programme remains a key initiative, addressing the physical health disparities experienced by people with severe mental illness (SMI). The programme has made progress in both inpatient and community settings, with improved monitoring systems and digital dashboards supporting compliance with physical health standards.

Early cancer diagnosis pathways have expanded, with self-referral services now live across multiple PCNs. These services have demonstrated positive diagnostic conversion rates and strong patient satisfaction. The ADHD service model piloted in Central Mendip PCN has proven effective and is now subject to a business case for wider rollout. Risks under this aim remain within appetite, although concerns persist around data visibility and the coordination of population health efforts.

Aim 2: Provide the best care and support to people

2.3. The Trust remains committed to delivering high-quality care aligned with national priorities, though performance continues to be mixed. Challenges persist in urgent care, discharge processes, and elective recovery. The percentage of patients with no criteria to reside in acute beds remains significantly above target, despite ongoing interventions such as Criteria-Led Discharge. The Trust continues to operate above its stated risk appetite, with high-rated risks including access to primary care, social care capacity, and workforce shortages.

2.4. The temporary closure of the Yeovil Maternity Unit due to rota challenges and the findings of the CQC report into paediatric services in the east of the county have introduced new risks. Actions are underway to address these issues, including recruitment of paediatric consultants and development of safe staffing models.

2.5. Despite operational pressures, the Trust has sustained performance in areas such as cancer diagnosis timelines and continues to demonstrate resilience and commitment to improvement.

Aim 3: Strengthen care and support in local communities

2.6. This aim reflects the Trust’s ambition to deliver more care closer to home. Programmes include urgent community response, integration of primary and community services in South Somerset West, and decentralisation of acute services. The Hospital at Home service has shown improvement, with record caseloads and referrals in September, although it remains below target

capacity. Embedded in reach services have recently commenced at acute hospitals, with early feedback suggesting positive impact.

2.7. Integration efforts with Symphony in South Somerset West are ongoing, though progress is behind schedule due to resource constraints. Public engagement activities have taken place across several localities, with further conversations planned to support service transformation. Risks under this aim remain within appetite but highlight challenges in sustaining change within a financially constrained environment and in influencing professional cultures.

Aim 4: Respond well to complex needs

2.8. Efforts under this aim focus on reducing Tier 4 CAMHS admissions, improving transitions from children's to adult services, and rolling out digital Treatment Escalation Plans (eSTEPs). The RAFT+ programme, developed in partnership with the South West Provider Collaborative, is progressing well, though its scope has been expanded to include eating disorders. Transition pathways for young people with complex needs require further development following the departure of the Transition Lead. While mental health transitions are generally well established, transitions for young people with complex physical health needs remain a concern.

2.9. The rollout of eSTEPs continues successfully, with over 11,000 plans now completed and widespread adoption across GP practices. Risks under this aim remain within appetite, though intermediate care capacity and personalised care delivery are areas requiring continued attention.

2.10. **Aim 5: Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture**

2.11. The Trust is delivering its Year 3 People Strategy, with programmes focused on learning and education, employee relations, and transformation of the people services function. The Learning, Education and Training (LET) programme is improving governance and visibility of development funding, while the Employee Relations Improvement Programme is shifting the culture towards early resolution and compassionate leadership.

2.12. The transformation of the people services function is progressing, with a focus on digital solutions and cost reduction. The Inclusive Board governance framework has been implemented and is being monitored through agreed actions. Risks previously assessed as above appetite have reduced following mitigation actions, although appraisal compliance remains a concern. A deep dive by the People Committee into this risk is recommended to ensure appropriate assurance and leadership support.

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

2.13. The Trust has submitted a breakeven financial plan for 2025/26, supported by a £50 million cost improvement programme. Extensive work is underway across

service groups to develop and deliver cost improvement plans. While productivity initiatives and digital transformation are progressing, the delivery of recurrent savings remains behind schedule.

2.14. The rollout of ambient voice technology has demonstrated significant productivity improvements in several specialties and is being expanded.

2.15. Risks under financial management remain above appetite, with concerns around CIP delivery, system-wide pace of change, and elective activity targets. Assurance mechanisms are in place, but further mitigation is needed to ensure financial sustainability.

Aim 7: Deliver the vision of the Trust by transforming our services through research, innovation and digital technologies

2.16. Digital transformation continues to be a key enabler of strategic delivery. The Electronic Health Record (EHR) Outline Business Case has received approval, and the procurement process is underway. The timeline for full business case approval and contract award remains tight, with capital funding contingent on timely progress. Digital medicines management and electronic documentation are being rolled out across services, with positive impact on efficiency and patient experience.

2.17. The Somerset Research Partnership with Exeter University has been formally launched, supporting medical education and research.

2.18. Risks under this aim remain above appetite, particularly around infrastructure safety and EHR implementation, but progress remains on track across all objectives.

3. CONCLUSION

3.1. The Trust continues to carry a number of high strategic risks that exceed their associated risk appetite, particularly in areas such as urgent care access, workforce capacity, and financial sustainability. Despite these challenges, there is progress across several strategic aims. Some of the highest-rated risks relate to broader system factors, including social care capacity and the resilience of primary care. While these may not be wholly within the Trust's control, opportunities remain to influence and collaborate across the system to mitigate their impact.

3.2. The revised BAF structure offers a clearer and more integrated view of strategic risks, objectives, and performance. It continues to evolve in response to feedback and operational learning, supporting more effective governance and alignment with the Trust's strategic direction. Delivering the Trust's Aims remains complex, particularly in the context of sustained operational pressures, workforce constraints, and financial limitations. Continued Board oversight,

focused action, and system-wide engagement will be essential to maintain momentum and ensure risks are managed effectively.

4. RECOMMENDATION

4.1. The Board is asked to review the Q2 2025/26 Board Assurance Framework, note the strategic risks and mitigating actions, and provide feedback to inform future iterations.

DEPUTY DIRECTOR OF CORPORATE SERVICES

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26 – Q2 Summary

Ref	Exec Owner	Corporate Aim & Objectives/Programmes	Overseeing Committee	Risk Appetite
1	MI	**Contribute to Improving the health and wellbeing of the population and reducing health inequalities** 1. Improve the physical health of mental health inpatients and community MH patients with SMI 2. Increase opportunities for self-referral/early diagnosis with a focus on areas with current lower access rates 3. Develop an innovative service for assessment, treatment and monitoring of adults with ADHD	Board	⇔
2	DT	**Provide the best care and support to people** 1. Delivery of 2025/26 national priorities and success measures 2. Reduce the number of patients who no longer have a reason to reside in an acute bed to no more than 15% of the bed base	QGAC	⇔
3	AH	**Strengthen care and support in local communities** 1. Community response including care-co, virtual ward and Call before Convey 2. Fully implement the model of care between Somerset FT and Symphony in South Somerset West; test the outcomes and spread to other services in the county 3. Make a range of currently acute-based services available within more accessible neighbourhood settings	QGAC	⇔
4	MI	**Respond well to complex needs** 1. Develop pathway for C&YP with complex health and care needs to avoid CAMHS tier 4 admission and minimise paediatric in-patient LOS 2. Improve transition from children's to adult services 3. Convert all TEPS to digital format and make them available across all information systems via SIDER	QGAC	⇔
5	IC	**Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture** 1. Year 3 People Strategy priority: Learning, Education and Training (LET) Programme 2. Year 3 People Strategy Priority: Employee Relations Improvement Programme 3. Implement new model for people services function, including cost reduction 4. Implement Inclusive Board governance framework (embed all aspects of EDI into board decision making) and ensure the board has the skills and experience to understand and address the needs of diverse communities	People	⇔
6	PM	**Live within our means and use our resources wisely** 1. Deliver the 2025/26 financial plan and deliver the financial strategy and reduction in recurrent deficit 2. Drive up productivity across all six service groups via the productive care programme, including transformation and the deployment of new digital/AI based technologies	Finance	⇔

Ref	Exec Owner	Corporate Aim & Objectives/Programmes	Overseeing Committee	Risk Appetite
		3. Estates strategy review to ensure capital funds are prioritised and national funding sources utilised where applicable in the context of the changed operating environment		
7	DS	**Deliver the vision of the Trust by transforming our services through innovation, research and digital transformation** 1. Level up digital offer across our services – Digital medicines management and electronic documentation Objective/Programme 2. Conclude Full Business case for Electronic Health Record and appoint the preferred provider. 3. Develop our relationships with Medical Schools specifically the Biomedical Research Centre with Exeter University	**Board**	⇔

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

1	**Aim:**	Contribute to improving the health and wellbeing of the population and reducing health inequalities
	Executive Owner:	Melanie Iles, Chief Medical Officer
	Overseeing Committee:	Board of Directors

Narrative Overview

SFT has employed a Consultant in Public Health to help develop and lead a population health strategy. The strategy will be owned by a Population Health Group chaired jointly by the Chief Medical Officer and the Director of Strategy & Digital Development.

A diverse programme of work has been established that aims to improve the health and wellbeing of the population of Somerset and reduce health inequalities.

The SFT stolen years programme continues to support people with severe mental illness (SMI) who struggle to live independently, are at greater risk of developing health problems and are less equipped to recognise when and how to respond to worsening health signs. It is well documented that people living with SMI often have poor physical health and on average die 15 – 20 years earlier than other people. It is estimated two out of three people, with a diagnosis of SMI, die from physical illnesses that can be prevented. The main causes of death being circulatory disease, diabetes, and obesity.

Early diagnosis of cancer is known to have a major influence on outcomes and cancer tends to be diagnosed later (stage 3 and 4) in deprived areas. A programme targeting multiple tumour sites is seeking to address this by establishing self-referral pathways. Pilots and the initial rollout of new pathways has targeted populations with the greatest inequalities.

The development of a new model of care for the assessment, treatment and monitoring of adults with ADHD is progressing well. A new service based within a Primary Care Network, has been tested successfully in Central Mendip and will be rolled out trustwide subject to approval of a business case.

SFT Objectives / Programmes

1	**Improve the physical health of mental health inpatients and community MH patients with SMI**	**On Plan**
	Community: 1. Wellbeing and Depot Clinics – delivery of services reviewed and standardised, emphasising the need for monitoring and interventions around physical health and communication between different health care providers - GPs etc. Also currently working on improving capacity and using digital dashboard to improve patient checks. 2. Physical and Wellbeing Clinics SOP updated 3. Digital dashboard set up that allows compliance with monitoring standards to be checked and provides individual patient information. Covers wellbeing, depot and clozapine clinics and allows for follow ups and reminders. 4. Audit of SOP implementation and further barriers to improving compliance	

	Inpatients: 5. System in place for inpatient physical health monitoring to ensure monitoring is completed on time with weekly reports 6. Auditing physical health monitoring (Cardio-metabolic monitoring) for patients on inpatients wards in Taunton, to assess compliance with cardio metabolic screening. This will then be replicated on other sites. 7. Engagement with on call resident doctors to improve knowledge; 8. Induction handbook for resident doctors updated to reflect the importance of physical health monitoring 9. Physical Health Monitoring SOP for Inpatients – completed and awaiting ratification.	
2	**Increase opportunities for self-referral/early diagnosis with a focus on areas with current lower access rates**	**On Plan**
	Bleeding after menopause service – 873 referrals received into the service with 38 cancers diagnosed. On average patients are seen within 7 days of completing the referral form and patient feedback highlights that 97% of patients are very satisfied with the service. Somerset Bowel Service – The team are in the process of rolling out the service across somerset and is now live in Bridgewater, Yeovil and CLIC PCNs. 466 patients have referred themselves with 10% of patient having a FIT positive and of those 40% of patients are being identified as having high risk factors to developing colorectal cancer. Breast 111 Online Pathway – 367 patients have accessed the 111 online form since launching in Feb 2025 of which 7% of patients have been diagnosed with cancer, this is a higher conversion rate than the Urgent Suspected Cancer Pathway, reassuring the team that the correct people are being triaged through to secondary care appointments. Somerset Chest x-ray Service – The team are also in the process of rolling out across Somerset and is so far live in Bridgwater and CLIC PCN. Referral rates are lower but engagement is ongoing with community pharmacy etc and 30 patients have so far completed a referral form for the service with 3 patients being diagnosed with cancer. Overall, the engagement from primary care has been very positive and the team continue to raise awareness and ensure all services are rolled out across Somerset. To date the team have received just over 1,700 referrals equating to 57 days saved of GP time. Patient feedback continues to be collected and is very positive with further deep dives planned with patient groups. A business case is being prepared, seeking longer term funding for these initiatives (see risk below).	
3	**Develop an innovative service for assessment, treatment and monitoring of adults with ADHD**	**On Plan**
	A draft model for delivering care for adults with ADHD has been developed, working alongside Central Mendip PCN and people with lived experience. The model proposes delivering care at a PCN footprint level by a specialist practitioner, most likely an NMP. Following triage, referrals are stratified and diverted to the most appropriate practitioner, who carries out an ADHD assessment. The assessment is shorter than that recommended by NICE but results have been validated as part of a pilot. The pilot in Central Mendip PCN has demonstrated that the model of care can diagnose and manage ADHD in adults. A business case has been developed to extend the service to the rest of the Trust.	

Risks - Scoring and Appetite

Risk Appetite over Time – Aim

Significant 20-25				
July 2024	**October 2024**	**January 2025**	**April 2025**	**July 2025**
Within appetite	Within appetite	Within appetite	Within appetite	Within appetite

Risks to Aim

		Radar Ref.	Score
1	Population Health may not get the focus required	**R1613**	**9**
2	Approach to Population Health may be uncoordinated	**R1615**	**8**
3	Lack of analytic support and visibility of data	**R1616**	**9**

Risks to Objectives

		Radar Ref.	Score
Obj1	Data collected does not provide an accurate reflection of care provided		
	Primary care capacity/resilience constraints across Somerset	**R0673**	**16**
	GP collective action may stop physical health monitoring for patients on antipsychotic/ADHD meds/eating disorders	**R2884**	**12**
Obj2	Funding for earlier cancer diagnosis is withdrawn		
	Diagnostic waiting times performance	**R0009**	**16**
	Demand growth outpacing capacity (demographic trends)	**R0004**	**15**
Obj3	Divergence from NICE Guidance result in challenge and complaints		
	Fail to secure funding through business case		
	Unable to recruit sufficient clinicians		

Controls and Assurance

Controls	Assurance
Risk Controls • Digital Strategy Board • Weekly / fortnightly reviews of Patient Tracking Lists for tumour sites	**Risk Controls** • Reports to the Board • Cancer Governance involvement in System Performance Group, Cancer Performance Steering Group, SFT and System Cancer Board
Oversight Arrangements for Governance and Engagement • ICS Population Health Transformation Board • ICS Data Development Group • Trust Information and Data Group • Quality Assurance Group	**Oversight Arrangements for Governance and Engagement** • Progress on KPIs presented to Board on regular basis • Overview of Programme to Board Development Sessions • Oversight of flagship priorities and clinical strategy presented to Quality and Governance Assurance Committee • Oversight of topic assurance via Quality Assurance Group

NHS Somerset NHS Foundation Trust

Measures and KPIs – Aim 1 – Contribute to improving the health and wellbeing of the population and reducing health inequalities

	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Peri-op anaemia: pats receiving intravenous iron	Green: 5=< Red: <7	8	7	6	5	12	6						
Diabetes: pats on hybrid closed loops	192 in Year 1	237											
Smoking status: acute inpatients	Green: >=60% Red: <55%	41.1%	43.4%	44.2%	41.1%	40.2%	36.8%						
Smoking quit rates: Mental health inpatients	Green: >=55% Red: <50%			45%			57%	42%					
Percentage of cancers diagnosed that are diagnosed at stage 1 or 2	Green: >=60.1% Red: <55.1%	58.1%	60.0%	62.7%	62.4%	59.2%							
Suicide/Self harm prevention: MH Staff	Green: >=365 Red: <350	385	392	392	378	378	377	375	369				
Suicide/Self harm prev: non-MH	Green: >=165 Red: <150	222	219	219	214	214	212	209	202				
Years in good health (females)	Green: National best quartile: 64.3 years Red: National worst quartile: 58.1 years	63.2	63.2	63.2	63.2	63.2	63.2	63.2					
Years in good health (males)	Green: National best quartile: 63.8 years Red: National worst quartile: 57.6 years	63.2	63.2	63.2	63.2	63.2	63.2	63.2					

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

2	**Aim:**	Provide the best care and support to people
	Executive Owner:	Deirdre Fowler, Chief Nurse and Midwife
	Overseeing Committee:	Quality and Governance Assurance Committee

Narrative Overview

The Trust remains committed to its overarching aim of delivering the best possible care and support to people, guided by its strategic objectives and national priorities. While progress has been made across several domains, challenges persist that require continued focus.

The Trust is making steady progress in delivering the 2025/26 national priorities, as outlined in its annual operating plan. However, performance remains mixed. Reducing the number of patients who no longer meet the criteria to reside in an acute bed remains a significant challenge. The Trust continues to operate in a high-risk environment, with several critical risks exceeding the defined risk appetite.

While the Trust faces ongoing challenges it continues to demonstrate resilience and commitment to improvement. Targeted interventions, strong governance, and a focus on national priorities are central to driving progress toward the aim of providing the best care and support to all individuals.

Whilst the ongoing work to deliver the national priorities continues, it must be noted that there are risks to delivery of the possible best care to support people. The closure of Yeovil Maternity Unit, due to the inability to run a Neonatal Paediatric doctor rota, is impacting local delivery of maternity care in the Yeovil area. Ongoing actions to re-open the unit with clear criteria to safely staff the unit are underway.

It must be noted that the CQC report into Paediatric care in the east of the county, is requiring actions to enable a better level of care delivery at Yeovil District Hospital going forwards. Increasing the cadre of Paediatric Consultants is well underway to support improved and modern ways of working.

SFT Objectives / Programmes

1	**Delivery of 2025/26 national priorities and success measures**	**Behind Schedule**
	The Trust continues to make steady progress towards the delivery of the 2025/26 national priorities and success measures, in line with its operating plan for the year. There are some areas where performance remains challenged due to increased demand and backlog waiting lists. Our Integrated Performance Report sets out the key exceptions across the range of measures. An area in which performance has been sustained or has notably improved include compliance in respective of Cancer 28 Day Faster Diagnosis. Performance against the Referral to Treatment (RTT), headline 62-day cancer standard, and A&E performance remains below the national targets.	
2	**Reduce the number of patients who no longer have a reason to reside in an acute bed to no more than 15% of the bed base**	**Behind Schedule**
	The percentage of bed days lost due to patients not meeting the criteria to reside remains above our target of no more than 15%. On 31 March 2025, our performance was 23.8% of beds, ranking SFT	

	as 114 out of 118 trusts nationally. In July our performance was 21.4% of beds. We were ranked 102nd out of 118 Trusts nationally. The national best quartile performance was that 10% of Adult General and Acute Beds did not meet the criteria to reside (slipping form 9.5%). A range of actions continue to be undertaken to improve patient flow, care for people at home where appropriate, facilitate timeline and appropriate discharge and address the difficulties in the domiciliary care market. Actions include expansion of Criteria-Led Discharge, to discharge patients when they meet pre-agreed clinical criteria for discharge, as identified by the lead clinician. This reduces delays in discharge processes and ensures that discharges are appropriate and timely. The conclusion of the first 100 day sprint will baseline further development needs.

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Open - 12				
July 2024	**October 2024**	**January 2025**	**April 2025**	**July 2025**
Above	**Above**	**Above**	**Above**	**Above**

Risks to Aim

		Radar Ref.	Score
1	Inability to deliver local maternity services equitably across the county		20
2	Inadequately rated CQC paediatric services in the east of the county	R3110	25
3	Access to primary care / increasing ED demand	R0673	16
4	Shortfalls in system capacity to enable timely discharge	R2773	16
5	Age of acute and community estates	R1789	20
6	Workforce shortages	R2044	16

Risks to Objectives

		Radar Ref.	Score
Obj1	Waiting times capacity risk (cross-cutting)	R0012	20
	Failure to deliver elective activity trajectory	R3060	16
	Insufficient capacity/resources for non-admitted/admitted care	R0007	16
Obj2	Insufficient intermediate care capacity	R2273	16
	Ambulance handover delays	R2620	12
	Reliance on escalation beds across SFT	R0862	15

Controls and Assurance

Controls	Assurance
Risk Controls • Service Group Workforce Plans • Risk assessed capital and backlog maintenance programmes • LMNC system dashboards	**Risk Controls** • People Committee reports and oversight • Internal Audit programme and reports feedback
Oversight Arrangements for Governance and Engagement • Operational Leadership Team (Transformation) – delivery of Clinical Strategy • Strategic Estates Group	**Oversight Arrangements for Governance and Engagement** • Delivery of Transformation – Trust Board • Oversight of Clinical Strategy – Quality and Governance Assurance Committee • Governance Assurance Reports incl. MSSP, MIS, CQC action plan and LMNC • Integrated Performance Reports to Board

NHS Somerset NHS Foundation Trust

Measures and KPIs – Aim 2 – Provide the best care and support to People

		Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Patient Initiated follow up (PIFU)		Green: >=5% Red: <4%	7.6%	8.9%	7.9%	8.1%	7.9%	8.3%	8.0%					
Clostridium difficile cases in inpatient settings: YTD		Green: <91 annually Red: >96 annually	84	86	90	12	16	20	32	45				
Falls per 1000 bed days: YTD			5.59	5.66	5.58	5.38	5.20	5.00	5.10	5.24				
Pressure ulcers per 1000 bed days: YTD			1.27	1.28	1.26	1.31	1.20	1.15	1.08					
Acute Home Treatment caseload		Green: >=134 Red: <120	72	84	89	92	77	77	74	85				
No criteria to reside: % of acute beds (month end position)		Green: =< 9.8% Red: >15%	24.2 %	27.5%	23.8%	25.6%	21.3 %	19.8 %	21.4%	21.6 %				
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		6.7	7.1	6.4	6.5	6.6	6.3	5.9	6.1				
	YDH		8.1	7.2	7.2	6.9	6.7	6.6	7.2	6.5				
Patients not meeting the criteria to reside: percentage of occupied bed days lost	MPH	Green: =< 9.8% Red: >15%	19.5%	26.4%	26.0 %	23.7 %	26.7%	22.5%	22.3%	22.1%				
	YDH	Green: =< 9.8% Red: >15%	20.9%	26.2%	24.4 %	18.1 %	25.2%	22.8%	20.7%	21.3%				
Percentage of Stroke Patients directly admitted to a stroke ward within four hours	MPH	Green: >=90% Red: <75%	67.3%	53.3%	72.7 %	75.0 %	62.3%	71.7%	75.5%					
	YDH	Green: >=90% Red: <75%	23.3%	16.3%	32.5 %	32.4 %	41.9%	48.4%	27.0%					
Percentage of patients spending >90% of time in stroke unit – acute services	MPH	Green: >=80% Red: <70%	78.8%	89.4%	89.4%	70.0%	81.7%	73.1%	78.3%					
	YDH	Green: >=80% Red: <70%	64.0%	76.2%	63.6 %	67.5 %	57.8%	63.8%	42.5%					

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	Trajectory: Green: >=67.3% by March 2026 Red: <67.3% by March 2026	61.8 %	61.5%	61.9%	64.3%	65.3%	65.8%	63.9%					
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	Trajectory: Green: >=80.3% by March 2026 Red: <80.3% by March 2026	74.7 %	73.8%	73.9%	74.7%	75.4%	74.1%	72.3%	70.2%				
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	Trajectory: Green: =<1% by March 2026 Red: >1% by March 2026	2.4%	2.4%	2.1%	2.5%	2.8%	2.8%	3.0%					
Improve performance against the headline 62-day cancer standard to 75% by March 2026	Trajectory: Green: >=75% by March 2026 Red: <75% by March 2026	66.9%	68.9 %	75.2 %	70.2 %	69.2%	68.1%	68.4%					
Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	Trajectory: Green: >=80% by March 2026 Red: <80% by March 2026	72.0%	78.6%	75.4%	72.6 %	65.2%	73.0%	75.5%					
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	Green: >=76% Red: <66%	73.4%	73.0%	72.2%	71.3%	73.0%	75.7%	77.5%	73.5%				
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 – Trustwide	Green: >=95.3% Red: <95.3%	95.4%	95.1%	95.2%	92.9%	93.9%	94.9%	95.5%	95.6%				
Reduce average length of stay in adult acute mental health beds	Trajectory: Green: =<53.1 days by March 2026 Red: >58.1 days by March 2026	70.0	60.7	59.7	52.8	61.3	61.1	67.8	64.7				
Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'		Clarification sought from NHS England as to how this is to be monitored and assessed											
Deteriorating Patient Care measure													

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

3	**Aim:**	Strengthen care and support in local communities
	Executive Owner:	Andy Heron, Chief Operating Officer
	Overseeing Committee:	Quality and Governance Assurance Committee

Narrative Overview

This objective encapsulates an area of key priority for the Trust and also some of the aspirations that underpinned two mergers to create Somerset Foundation Trust. These objectives closely align with national NHS strategy to deliver more care closer to home for the populations we serve within the context of local communities and partnership-based neighbourhoods. For the delivery of community based urgent and emergency care services there is a comprehensive and well-developed set of metrics with Executive oversight. Similarly, the experimental integration of Primary Care and Community Services in South Somerset West is underpinned by a number of key performance metrics. With regard to making more of what are currently acute based services available in local communities the key measures here will be related to progress from the current baseline range of services and an increase in the locations where services are available as the Trust seeks to maximise and transform the use of its building assets across the county.

SFT Objectives / Programmes

1	**Community response including care-coordination, virtual ward and Call before Convey**	**Behind Schedule**
	The Hospital at Home average caseload level in September so far is 100 (50 Frailty, 50 Respiratory), up from 85 in August and 74 in July. The plan is to consistently achieve 80% capacity of 167 (in line with national recommendations) in the winter months. H@H in reach for the acute frailty units are planned to commence from 1st October for a 6 month pilot. Whilst the caseload for the service still remains below the current plan (134), the service is showing signs of significant improvement at the present time with caseload numbers growing. September brought record highs in terms of monthly average caseload levels, monthly numbers of referrals received and monthly numbers of admissions to the virtual beds. On 6 October the service commenced embedded inreach services at two acute hospitals designed to pull additional patients from the hospital onto the service caseload. Whilst this new development has not yet fed through to data sets, early anecdotal reports are encouraging.	
2	**Fully implement the model of care between Somerset FT and Symphony in South Somerset West; test the outcomes and spread to other services in the county**	**Behind Schedule**
	Demonstrate improvements and benefit across the range of metrics developed to underpin the programme. Further work underway in the Performance and Improvement Teams to refine the available metrics for this objective.	
3	**Make a range of currently acute-based services available within more accessible neighbourhood settings**	**On Plan**

	We are on schedule in terms of increasing acute service availability in community settings. Programmes are in place to make further progress e.g. BOS and Crewkerne with extensive planning currently underway for this being led by the service group director for neighbourhoods. Further work will shortly be undertaken with senior members of Somerset Children's Social Care to improve collaboration in supporting pre-school children and their families in the county. Public engagement across West Mendip, Frome, Bridgwater, BOS and Crewkerne has been in progress over August and September with plans for more engagement conversations with local groups in October. In November there will be conversations with staff and town councils about possible test and learn proposals to allow greater access to services in BOS and Crewkerne from April 2026.

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Seek – 15-16				
July 2024	**October 2024**	**January 2025**	**April 2025**	**July 2025**
Within appetite	Within appetite	Within appetite	Within appetite	Within appetite

Risks to Aim

		Radar Ref.	Score
1	Failure to sufficiently influence longstanding professional cultures and working practices	**TBC**	**16**
2	Failure to sufficiently communicate with the public of the value of new models of care	**TBC**	**12**
3	Mobilising and maintaining sufficient resource to deliver new care models within a financially challenged operating environment	**TBC**	**12**

Risks to Objectives

		Radar Ref.	Score
Obj1	Intermediate care capacity limits home-first/virtual ward flow	**R2273**	**16**
	Primary care capacity/resilience	**R0673**	**16**
	Increased stress from acuity/volume at UTCs affecting responsiveness	**R3080**	**9**
Obj2	Symphony patient record update backlog	**R2683**	**15**
	Symphony not becoming self-sustaining	**R2192**	**20**
Obj3	Poor condition of Shepton Mallet CH portakabins	**R0534**	**20**

Controls and Assurance

Controls	Assurance
Risk Controls • Reports to Operational Leadership Team (OLT) • Reports to Quality, Outcomes, Finance and Performance meetings • Hospital at Home Programme Board • Reports to South Somerset West Programme Board	**Risk Controls** • Board Development Programme • Operational Leadership Team meetings • Regional oversight of implementation and performance of Hospital at Home
Oversight Arrangements for Governance and Engagement	**Oversight Arrangements for Governance and Engagement** • Trust Integrated Performance Report

• Reports to Quality and Governance Assurance Committee • Integrated Neighbourhood Working Steering Group • Urgent Emergency Care Delivery Group	• Intermediate Care performance report (weekly)

NHS Somerset NHS Foundation Trust

Measures and KPIs – Aim 3 – Strengthen care and support in local communities

	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Admissions prevented by Rapid Response/AHT	Green: >=500 Red: <450	573	478	481	501	572	516	577	557	609			
Patients admitted to Acute Home Treatment	Green: >=419 Red: <350	305	227	237	265	258	242	289	288	308			
Increase Open Mental Health attendances (12 month rolling)	Green: >=20,018 Red: <20,018	21,695	21,376	21,485	21,520	21,224	21,328	21,278	21,184	21,431			
Increase numbers of self-referrals – cumulative year to date	Green: >=30,181 annually Red: <28,672	25,370	27,791	30,181	2,553	5,014	7,504	10,136	12,558	15,123			
Urgent Community response <2hrs	Green: >=70% Red: <60%	92.6%	92.7%	90.9%	91.9%	93.0%	92.6%	93.5%	92.0%	93.0%			
Treatment Escalation Plans – patient/family involvement	Green: >=90% Red: <80%	62.0%	62.0%	63.0%	62.0%	68.0%							

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

4	**Aim:**	Respond well to complex needs
	Executive Owner:	Melanie Iles, Chief Medical Officer
	Overseeing Committee:	Quality and Governance Assurance Committee

Narrative Overview

SFT has now served notice on Wessex House, to the SW Provider Collaborative. The absence of a tier 4 facility in Somerset increases reliance on paediatric wards and length of stay may increase until RAFT+ is in place. The development of RAFT+ is on schedule but risks to progress remain.

Whilst there are some good transition pathways for young people, especially between CAMHS and adult mental health services, not all young people with complex needs receive the support they need when transitioning from services for young people to those for adults. Work to design more effective transition pathways for this group has stalled following the departure of the Transition Lead at the end of her fixed term contract.

The number of completed eSTEPS on SIDeR+ has reached 11,200. Work continues to transcribe paper TEPs onto SIDeR+ but the majority of new TEPS are now input directly onto the system.

Positive progress has been made to strengthen the Paediatric Team in Yeovil. Following recent interviews, a number of offers have been made to Consultant Paediatricians.

SFT Objectives / Programmes

1	**Develop pathway for C&YP with complex health and care needs to avoid CAMHS tier 4 admission and minimise paediatric in-patient LOS**	**On Plan**
	A business case for the two-phase programme developed with the SW Provider Collaborative (SWPC), based on an enhanced community offer (RAFT+) and multi-agency community hubs, has been submitted to SWPC. The SWPC has requested the scope of the proposal is extended to include Eating Disorders. The programme is on schedule but could be delayed by this change in scope.	
2	**Improve transition from children's to adult services**	**Signficantly Behind Schedule**
	Work to define a programme of support for young people with complex physical health needs transitioning to adult services has stalled, due in part to the end of a fixed term Transition Lead role leading the work. For mental health transition arrangements are generally well established, with CAMHS and adult mental health services co-operating well, although resource constraints, including in adult social care, can impact on transition.	
3	**Convert all TEPS to digital format and make them available across all information systems via SIDER**	**On Plan**
	The age group with the greatest number of eSTEPS is 85+, followed by 75-84. Every GP practice in Somerset has added at least 1 eSTEP to SIDeR+.	

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Seek – 15-16				
July 2024	**October 2024**	**January 2025**	**April 2025**	**July 2025**
Within Appetite	Within Appetite	Within Appetite	Within Appetite	Within Appetite

Risks to Aim

		Radar Ref.	Score
1	Sub-optimal links between primary care and SFT services	**TBC**	**12**
2	Personalised care doesn't get required focus	**R1952**	**8**
3	LOS > 21 days due to insufficient intermediate care capacity	**R2273**	**16**

Risks to Objectives

		Radar Ref.	Score
Obj1	Potential for delay in the delivery of alternatives to tier 4 admission resulting from the extension of scope to include eating disorders	**TBC**	
	Care is compromised for young people requiring a tier 4 admission.	**R2623**	**10**
	YDH Paediatric Acute quality/safety concerns	**R2839**	**16**
Obj2	The management of transitions for young people with complex physical health needs to not improve without a Transition Lead	**R2905**	**15**
	No unified transition service post-funding; risk of harm/gaps in care	**R2838**	**16**
	Inability to meet paediatric transition service requirements	**R2905**	**15**
Obj3	SIDeR+ is not checked when patient care is transferred - Private ambulance providers do not have access to e-STEP	STEP Hazard log	
	Patient wishes not recorded on e-STEP – not all clinical areas currently using e-STEP	STEP Hazard log	
	Countywide IT outage risk	**R3107**	**16**

Controls and Assurance

Controls	Assurance
Risk Controls • Clinical priority programme. e.g. high service use, homeless, eating disorders • Support to ICS Personalised care strategy planning • Primary Care / SFT Interface Group	**Risk Controls** • Compliance with national and regional programmes • Internal monitoring and audits • Reporting to GP Provider Support Unit and Operational Leadership Team (OLT) Transformation Group
Oversight Arrangements for Governance and Engagement • Quality and Governance Assurance Committee Assurance Reports/Reporting • Symphony Board • Complex Care Board	**Oversight Arrangements for Governance and Engagement** • Reports to Quality and Governance Assurance Committee • Oversight Reports for ICB, Primary Care Board etc. • Progress on KPIs presented to Board on a regular basis

NHS Somerset NHS Foundation Trust

Measures and KPIs – Aim 4 - Respond well to complex needs

	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CYP Eating Disorders - Routine	Green: >=95% Red: <85%	79.5%	86.5%	71.7%	72.7%	73.8%	93.2%						
Reduce time in ED: intensity users	Green: =< 75,081 Red: >78,835	83,844	84,134	84,356	84,464	85,507	86,124						
Time to assessment in CYPNP	Green: =<16 weeks Red: >20 weeks	81.9	95.5	88.3	71.0	90.4	95.6	98.6	78.7				
Av wait for assessment: adults w/ASD	TBC	71	74	77	79	81	83	84	86				
Homeless service: annual referrals	Green: >696 Red: <696	789	802	798	802	788	817	774	761				
Dementia diagnosis rate - Symphony	Green: >=66.7% Red: <61.7%	52.6%	52.3%	51.9%	52.5%	53.1%	54.0%	53.8%					
No criteria to reside: % of acute beds	Green: =< 9.8% Red: >15%	24.2%	27.5%	23.8%	25.6%	21.3%	19.8%	21.4%	21.6%				
Personalised care planning tbc													

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

5	**Aim:**	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
	Executive Owner:	Isobel Clements, Chief People Officer
	Overseeing Committee:	People Committee

Narrative Overview

Following the June 2025 People Committee a review of the risks relating to this aim has been undertaken. This has resulted in new risks being added to the risk register which better describe the challenges which led to the four objectives to support achievement of this aim. Due to the actions which have been in place throughout Q1, the risks are scoring lower than they would have been had they been assessed at the beginning of the year. The risk assessment process has evidenced strong controls in place to mitigate the risks, however, measures to demonstrate improvement and provide assurance are still outstanding and are the focus of Q2.

Alongside the four areas established to support this aim is the ongoing deliverables from the People Strategy. Recent review of the Board scorecard and People Committee measures identified an additional risk of low compliance of appraisals, while this is improving, the rate of improvement is very slow and significantly below the target level. A year 2 People Strategy deliverable has been focused on the quality of appraisals, which is important, however, equal focus needs to be on achieving compliance. A risk assessment is in development and will be added once this has been through relevant approval and moderation processes. It is recommended the People Committee seek a deep dive into this risk to provide assurance on actions and seek support through leadership challenge.

SFT Objectives / Programmes

1	**Year 3 People Strategy priority: Learning, Education and Training Programme**	**On Plan**
	A Learning, Education and Training programme (LET) has been developed to address a gap in understanding how the funding used for colleagues' development is measured, to improve associated governance processes and ensure full integration of our offering across the Trust to all colleagues. The programme will measure the delivery of a productive and financially efficient plan to improve visibility, inclusivity and return on investment of learning. The programme will establish standards, benchmarking and toolkits through improvement programmes to tackle inefficiency, identify processes for learning and develop the learning strategy and charter.	
2	**Year 3 People Strategy priority: Employee Relations improvement programme**	**On Plan**
	An Employee Relations Improvement programme will be implemented to improve the approach when responding to complex employee relations issues where managers often lack the confidence or capability to address issues proactively and at an early stage, often causing harm to colleagues as an unintended consequence. The ambition is to create a fairer, more positive workplace culture by transforming the approach to employee relations. This will:	

	• Empower leaders to take early, appropriate action when people issues arise, handling concerns with clarity, consistency and compassion. • Shift the culture from over-reliance on formal processes towards open dialogue, early resolution and shared accountability. • Ensure colleagues have a more positive and supportive experience when raising or being involved in workplace concerns. • Refocus the HR Advisory service to become a specialist team providing expert support to complex and high-risk issues, equipping leaders to manage everyday issues with confidence and compassion. The programme has been expanded to focus on strategies to improve support to colleagues and reduce absence levels.	
3	**Implement new model for people services function**	**On Plan**
	The transformation of the people services function is required to address the increasing demand on a service which is fragmented, labour intensive and not designed to meet the changing expectations and demographics. The People Services function is key in creating compassionate and inclusive cultures, supporting leaders and ensuring a learning culture. Following the mergers, there remains opportunities to rationalise the service and redesign the focus as a core specialist enabling service. To achieve this the service needs to transform through the adoption of digital solutions which are automated or self-service. This will contribute toward reducing cost while improving the delivery of services which are designed around the diverse needs of the organisation.	
4	**Implement Inclusive Board governance framework (embed all aspects of EDI into board decision making) and ensure the board has the skills and experience to understand and address the needs of diverse communities**	**On Plan**
	Implement an Inclusive Board governance framework in recognition inclusion needs to be led from the top to have an impact, the framework will be designed to ensure data led decision making and role modelling. Every Trust should be led by an effective and diverse board that is innovative and flexible, the board is responsible for ensuring the vision, value and culture are aligned, act with integrity and lead by example. The inclusion governance framework has been designed to support this objective, designed around 4 key areas; Vision, Leading by Example, Accountability and Assurance, the framework sets out how the Board take impactful actions to achieve an inclusive culture. The framework was socialised with the Board in a development day in April 2025, following which actions have been agreed and progress monitored by the Board.	

Risks – Scoring and Appetite

Risk Appetite over Time - Aim

Significant – 20-25				
July 2024	**October 2024**	**January 2025**	**April 2025**	**July 2025**
Above appetite	Above appetite	Above appetite	Above appetite	Within appetite

Risks to Aim

		Radar Ref.	**Score**

1	Burnout resulting in challenging behaviours and instability in the working environment	**R1944**	**12**
2	Systemic Discrimination: The inability to become the equitable and inclusive organisation we aspire to be for our communities and colleagues if we do not design systems, policies and processes to be inclusive, if we do not use data to understand impact and if we do not develop the knowledge and capability to support governance processes that are fully inclusive.	**R2770**	**16**
3	Inconsistent provision of rest spaces for colleagues.	**R3222**	**16**

Risks to Objectives

		Radar Ref.	Score
Obj1	Increasing time being required for colleagues to complete role essential training due to increasing courses being added	**R3397**	**15**
Obj2	Harm caused to colleagues through approach when responding to complex employee relations issues	**R3394**	**15**
Obj3	Failure to rationalise People Services through digital transformation	**R3393**	**12**
Obj4	Discriminatory behaviour: Inability to create a compassionate and inclusive culture where all colleagues can thrive due to the lack of knowledge and understanding of inclusive behaviour and how to address systemic discrimination.	**R2821**	**12**

Controls and Assurance

Controls	Assurance
Risk Controls • People Services Transformation Board • Productive People Services • Engagement with National TOM for People Services • Process mapping priority • Employee relations improvement programme • Workforce Inclusion Improvement Plan • Inclusive Board Action Plan • People Strategy Year 3 Plan	**Risk Controls** • People Services Finance and Performance meeting • People Committee Performance Report • Board Performance Report • Corporate benchmarking reported through Model Health System • Board Development
Oversight Arrangements for Governance and Engagement • Reports to Exec Committee • Chief of People report to People Committee • People Committee • People Services Governance Committee	**Oversight Arrangements for Governance and Engagement** • Quality Assurance Group Topic Reporting

NHS Somerset NHS Foundation Trust

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

	Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Retention: to retain at least 88.3% of colleagues over a rolling 12-month period.	Green: >=88.3% Red: <83.3%	88.8%	89.0%	89.1%	89.1%	89.4%	89.5%						
National Quarterly Pulse Survey Engagement Score: To be within the top 10% of Trusts for the engagement score. This means achieving a score of 7.1 or higher.	Green: >=7.1 Red: <6.1	6.79											
National Quarterly Pulse Survey Advocacy Score: To be within the top 10% of Trusts for the advocacy score. This means achieving a score of 7.3 or higher.	Green: >=7.3 Red: <6.3	6.77											
Inclusion: % of colleagues in a senior role (Band 8a+ and consultants) who are female. The ambition is to represent the overall Trust position by 2028 with a trajectory for March 2026 of 69.8%.	Trajectory: Green: >=69.8% by March 2026 Red: <64.8% by March 2026	58.1%											
Learning Education and Training (LET): A reduction in the cost of mandatory and role essential training.													
Disciplinary Investigations to take no more than 4 weeks.	Gree<4 weeks Red: >6 weeks	New reporting		13	12								
Appraisal Compliance: To achieve 90% of colleagues with a completed appraisal in a 12-month period.	Green: >90% Red: <80%	77.0%	77.0%	76.4 %	77.4%								
Board inclusion (Under development)													
Sickness absence: over rolling 12 months maintain levels within the upper control limit of 5.2%		5.2%	5.2%	5.2%	5.2%	5.2%	5.2%						

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

6	**Aim:**	Live within our means and use our resources wisely
	Executive Owner:	Pippa Moger, Chief Finance Officer
	Overseeing Committee:	Finance Committee

Narrative Overview

The financial plan for 2025/26 has been submitted to NHS England with a breakeven position. Extensive work is underway across service group and corporate areas to develop the cost improvement plans that will be required to achieve £50m cost reduction to enable the breakeven position to be achieved.

SFT Objectives / Programmes

1	**Deliver the 2025/26 financial plan and deliver the financial strategy and reduction in recurrent deficit**	**Behind Schedule**
	Cost improvement plans being developed for 2025/26 across the Group. A medium-term financial plan will be developed in September – December to achieve the reduction in recurrent deficit.	
2	**Drive up productivity across all 6 service groups via the productive care programme, including transformation and the deployment of new digital/AI based technologies**	**On Plan**
	Productivity opportunities being identified as part of service group efficiency plans. Following a successful pilot programme AI capability is now available across the Trust Microsoft CoPilot. The trail of ambient voice technology is complete and has shown significant productivity improvements across a number of specialties including adult ADHD, Dental and MSK services. A roll out of voice to text and ambient voice will be undertaken over the autumn.	
3	**Estates strategy review to ensure capital funds are prioritised and national funding sources utilised where applicable in the context of the changed operating environment**	**On Plan**
	Core funding prioritised and programme is deliverable within available resources in 2025/26. Additional national funding available to support additional diagnostics, UEC and elective schemes. Business cases have been developed for the diagnostics and mental health Schemes. Approval has been received for the development of a Community Diagnostics Centre in Bridgwater.	

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Financial Management - Open - 12				
Commercial – 15-16				
July 2024	**October 2024**	**January 2025**	**April 2025**	**July 2025**
FinMan - above	FinMan – above	FinMan – above	FinMan – above	FinMan – above

Comm - within	Comm – within	Comm – within	Comm – within	Comm - within

Risks to Aim

		Radar Ref.	Score
1	Failure to identify and deliver sufficient recurrent CIP	TBC	20
2	Lack of pace of system-wide changes to address deficit	TBC	16
3	The Trust fails to deliver the elective activity trajectory	R3060	16

Risks to Objectives

		Radar Ref.	Score
Obj1	CIP Plans not being delivered in full	R3058	20
	Unplanned cost pressure from operational activities and activity levels not being delivered	R3059	20
Obj2	Failure to deliver elective activity trajectory	R3060	16
	Inability to fund new EHR	R1840	20
Obj3	Insufficient investment to reduce backlog maintenance	R0003	16
	Failure to secure necessary infrastructure/capital funding	R1611	20

Controls and Assurance

Controls	Assurance
Risk Controls • System wide discussions to manage available resources • Finance Committee oversight • System Triple Lock Process	**Risk Controls** • Reports to Finance Committee • Reports to System Finance Assurance Group and System Assurance Forum (SAF)
Oversight Arrangements for Governance and Engagement • Control and oversight of Cost Improvement Programmes (CIP) through Accountability Frameworks • System Finance Assurance Group • Finance Committee	**Oversight Arrangements for Governance and Engagement** • Financial Oversight Reports to Finance Committee • Key Financial Systems Internal Audit Report • Reports to Board

Somerset NHS Foundation Trust

Measures and KPIs – Aim 6 – Live within our means and use our resources wisely

	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Financial position v plan (YTD)	Green: >=plan Red: <plan	B/E	B/E	B/E	B/E	B/E	B/E	B/E	B/E				
% of CIP identified as recurrent	Green: >=70% Red: <40%	47.0%	47.0%	56.0%	8%	12%	17%	23%	31%				
Agency v plan (YTD)	Green: >=plan Red: <plan	£6,969k fav	£8,060k fav	£4,685k fav	£110k adv	£61k adv	£34k adv	£34k adv	£51K fav				
No criteria to reside: % of acute beds	Green: =< 9.8% Red: >15%	24.2%	27.5%	23.8%	25.6%	21.3%	19.8%	21.4%	21.6%				
Performance v workplan trajectory	Trajectory: Green: =<12,505 by March 2026 Red: >12,505		12,535	12,531	13,076	12,981	12,964						
Capital Expenditure v plan													

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

7	**Aim:**	Deliver the vision of the Trust by transforming our services through research, innovation and digital technologies
	Executive Owner:	David Shannon, Director of Strategy and Digital Development
	Overseeing Committee:	Board of Directors

Narrative Overview

The first quarter of the year has shown good progress with our digital strategy and providing improvements to the efficiency and safety within our services whilst progressing the long-term strategy. The Outline Business case for the Electronic Health record has received approval which will allow for the procurement process to commence over the Summer 2025. The implementation of electronic prescribing has continued and will continue over the rest of the year alongside continued developments in the implementation of digital records and Artificial intelligence tools, specifically through the deployment in voice technology.

April 2025 saw the official launch of the Somerset Research Partnership. This represents the Trust collaboration and partnership with Exeter University Biomedical Research Centre. The next quarter will continue the development of the local offer for medical students as part of the expansion in medical school placements within the South West.

SFT Objectives / Programmes

1	**Level up digital offer across our services – Digital medicines management and electronic documentation**	**On Plan**
	Digital medicines are now live across both acute hospitals and within community hospitals. Community services and mental health services will be live by December 2025. The Electronic Prescription service, which is a first of type in the NHS, allows the transfer of prescriptions to community pharmacists directly without the need for separate prescriptions. The initial phase commenced in Hospital at Home, CAMHS, Adult ADHD and number of other community services. This will be expanded to district nursing, OPMH, MIU, homeless service and community mental health services over the next few months. Since the number of items have increased on a monthly basis saving both colleague time and improved timeliness for patients are carers. Electronic documentation – The upgrade of Epro in June 2025 has included speech to text capability, and will enable electronic outpatient documentation to be undertaken in YDH and the reduction in the need to scan paper records in MPH. Following the pilot of ambient voice technology, a delivery plan for the wider adoption of voice technology is in deployment.	
2	**Conclude Full Business case for Electronic Health Record and appoint the preferred provider**	**On Plan**
	Approval of the Outline Business Case has been received, with the procurement process currently underway. The programme is on track for approval of the full business case in November. The timeline for approval and contract award remains very constrained to ensure the allocated capital funding can be utilised within the financial year.	

3	**Develop our relationships with Medical Schools specifically the Biomedical Research Centre with Exeter University**	**On Plan**
	April 2025 saw the official launch of the Somerset Research Partnership. This represents the Trust collaboration and partnership with Exeter University Biomedical Research Centre. The next quarter will continue the development of the local offer for medical students as part of the expansion in medical school placements within the South West. A Memorandum of Understanding is in the final stages of agreement with University of Exeter to formalise the collaboration.	

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Seek 15-16				
July 2024	**October 2024**	**January 2025**	**April 2025**	**July 2025**
Above Appetite	**Above Appetite**	**Above Appetite**	**Above Appetite**	**Above Appetite**

Risks to Aim

		Radar Ref.	Score
1	Risk EHR business case is not approved or delays to process	**R1840**	**20**
2	Failure to secure/implement necessary digital/data/technology	**R1611**	**20**
3	Unsafe premises and environment/fire compartmentalisation	**R1789**	**20**

Risks to Objectives

		Radar Ref.	Score
Obj1	Imaging systems ↔ TrakCare/NHS Spine interoperability gap	**R2485**	**12**
	Lack of access to records across multiple systems (safety/data quality)	**R2542**	**12**
Obj2	EHR funding shortfall	**R1840**	**20**
	Risk EHR business case is not approved or delays to process	**R1840**	**20**
Obj3			

Controls and Assurance

Controls	Assurance
Risk Controls • Joint Electronic Health Record Programme Board across Somerset and Dorset – Healthset • Somerset ICS Digital Strategy Implementation Group • Data Security and Protection Toolkit • AI Governance Group	**Risk Controls** • External Review of programme governance and Full Business Case readiness • NHS England Digital Maturity Assessment • Data Security and Protection Toolkit internal audit report (annually)
Oversight Arrangements for Governance and Engagement • Digital Strategy Board, Data Strategy Group • Research Strategy Oversight Group	**Oversight Arrangements for Governance and Engagement** • Reports to Finance Committee and Executive Committee

NHS
Somerset
NHS Foundation Trust

Measures and KPIs – Aim 7 - Deliver the vision of the Trust by transforming our services through research, innovation and digital technologies

	Threshold	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Research: active trials / studies open	Green: >=240 Red: <220	223	224	224	228	230	233						
Quality Improvement: training packages	Trajectory: Green: >=750 annually Red: <700	561	588	658		105			271				
Data Delivery Strategy on track		Behind plan	Behind plan	Behind plan	On plan	On plan	On plan						
Patient interactions via Patient Hub	Green: >=17,500 per month Red: <15,000	5,925	5,039	5,269	5,609	6,181	5,654						
Electronic Health Record on track		Behind plan	Behind plan	Behind plan	On plan	On plan	On plan						
WTEs freed up: Robotic Process Automation	Green: >=107 Red: <95	79	82	89	84	70	71						
Number of Services Live with Ambient Voice Technology													
Number of Prescriptions processed through EPS Service													

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Sam Hann, Head of Health & Safety and Risk - Acting Director of Governance
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	4 November 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 (CRR) 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 The compound risks to the organisation are: • Demand, capacity and flow constraints across services • Clinical safety and continuity of services • Workforce sustainability and wellbeing • Maternity and neonatal service pressures • Infrastructure and estate failures • Infection Prevention Control • Digital and information governance

	• Financial sustainability and strategic delivery If the compound risks were realised at the same time, the combined impact could be severe because these would interact and amplify each other. These risks are not isolated and if they materialise together, they can cascade into system wide failures. The potential consequences for the Trust from the compound risks are: • Increased patient safety and quality of care concerns • Reduced service resilience and ability to continue to deliver services • Reduced workforce wellbeing and ability to retain colleagues and recruit • Financial pressures and inability to achieve strategic aims • Increased regulatory interest and reputational concerns The combined effect can lead to loss of public confidence, regulatory intervention and strategic derailment.
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust Corporate Risk Register on 17 October 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.

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 17 OCTOBER 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 17 October 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, 3315, 3318, 3375, 3381).

3. CORPORATE RISK REGISTER

3.1 There are currently twenty-five risks on the Corporate Risk Register detailed within the circle heat map, eight of which score 20 or 25. The headline titles for the top eight risks are:

- Risk 3110 Inability to deliver safe, effective and sustainable neonatal service (YDH) (25)
- Risk 0012 Waiting times (20)
- 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 (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 3058 Delivery of CIP 2025/26 (20)
- Risk 3059 Failure to deliver financial plans 2025/26 (20)

New Risks

3.2 There has been one new risk added to the Corporate Risk Register since the last report to the Board on 16 June 2025:

Risk No	Risk Description	Current Risk Score
3222	Inconsistent provision of rest/wellbeing spaces across SFT impacting on colleague health and wellbeing	16

Increased Risks

3.3 There has been one risk which have increased since the last report to the Board on 16 June 2025:

Risk No	Risk Description	Previous Risk Score	Current Risk Score
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	15	20

Risks which have Reduced

3.4 There have been three risks which have reduced since the last report to the Board on 16 June 2025:

Risk No	Risk Description	Previous Risk Score	Current Risk Score
2923	Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas	20	16
0004	If demand for services continues to increase inline with demographic trends, then the Trust will not have sufficient capacity to keep pace and the quality of services will be affected which could result in poor outcomes, increase the risk of the number of medical outliers and impact on achievement of key targets, leading to regulatory action	20	15
3016	Risk of suicide or self-harm by ligature by patients during community hospital inpatient admissions	15	5

Risks which have been Archived

3.5 There have been no risks which have been archived since the last report to the Board on 16 June 2025.

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.

Compound Risks

3.9 Compound risks refer to the situation where two or more risks or hazards interact with each other, resulting in amplified or unexpected negative impacts. These risks can be different types of hazards occurring simultaneously or sequentially, or they can be interactions between hazards and existing vulnerabilities and can influence each other's impacts.

3.10 The key characteristic of compound risks is that their combined effect is greater than if each risk occurred in isolation. This amplification can lead to more severe consequences for individuals, communities, organisations and systems.

3.11 Understanding compound risks is crucial for effective risk management because it highlights the interconnectedness of different hazards and vulnerabilities, requiring a more holistic approach to mitigation and adaptation.

3.12 The compound risks the Trust should be aware of are:

- Demand, capacity and flow constraints across services
- Clinical safety and continuity of services
- Workforce sustainability and wellbeing
- Maternity and neonatal service pressures
- Infrastructure and estate failures
- Infection Prevention Control
- Digital and information governance
- Financial sustainability and strategic delivery

3.13 If the compound risks were realised at the same time, the combined impact could be severe because these would interact and amplify each other. The potential consequences for the Trust are:

- Increased patient safety and quality of care concerns
- Reduced service resilience and ability to continue to deliver services
- Reduced workforce wellbeing and ability to retain colleagues and recruit
- Financial pressures and inability to achieve strategic aims
- Increased regulatory interest and reputational concerns

3.14 The combined effect can lead to loss of public confidence, regulatory intervention and strategic derailment.

Emerging Risks

3.15 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.

3.16 It is a responsibility of the Board to horizon scan and identify external risks that may impact on the delivery of its strategy. The Head of Health & Safety and Risk 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 17 October 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	
16	R3222	Inconsistent provision of rest/wellbeing spaces across SFT impacting on colleague health and wellbeing
NEW	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	

Quality & Governance Committee

25	R3110	Inability to deliver safe, effective and sustainable neonatal service (YDH)
⇔	SA2	
20	R0012	Waiting Times
⇔	SA2	
20	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	
20	R1789	Unsafe premises and environment
⇔	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
⇔	SA4	
16	R2923	Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas
↓	SA2	
15	R0004	Demand
↓	SA2	
15	R0862	Use of escalation beds across SFT
⇔	SA2	
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	

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

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 aims in accordance with the Board's strategy and risk appetite. It is the application of risk appetite to specific aims 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 aims and refers to the acceptable level of variation relative to achievement of a specific aim.

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 aims.

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 aim (*figure 1*) for the organisation 2025/26, including for SSL where relevant (*figure 2*) for 2025/26. 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 risk the risk has been assigned to.

Figure 1

Somerset NHS Foundation Trust Strategic Aims 2025/26		Risk Appetite
1	Contribute to improving the physical health and wellbeing of the population and reducing health inequalities	**Significant (5)**
2	Provide the best care and support to people	**Open (3)**
3	Strengthen care and support in local communities	**Seek (4)**
4	Respond well to complex needs	**Seek (4)**
5	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	**Significant (5)**
6	Live within our means and use our resources wisely	**Financial Management - Open (3)** **Commercial – Seek (4)**
7	Deliver the vision of the Trust by transforming our services through innovation, research and digital transformation	**Seek (4)**

Figure 2

Simply Serve Limited Strategic Objectives 2025/26		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	**Significant (5)**
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)**

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board of Directors
REPORT TITLE:	Six Monthly Safe Staffing Establishment Report
SPONSORING EXEC:	Professor Deirdre Fowler, Chief Nurse & Midwife
REPORT BY:	Jo Poole, Interim Deputy Chief Nurse, SFT (Development of report informed by Associate Directors of Patient Care in Service Groups)
PRESENTED BY:	Deirdre Fowler, Chief Nurse & Midwife Jo Poole, Interim Deputy Chief Nurse
DATE:	4 November 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 a six-monthly update, Jan 25 – June 25, In accordance with National Quality Board (NQB) safe staffing guidance and workforce standards for all Somerset NHS Foundation Trust (SFT) inpatient wards, critical care, emergency departments and neighbourhoods. The paper provides an overview on associated safer staffing risks for the nursing. midwifery and AHP workforce and the controls and mitigations in place for these risks. This report offers a description of staffing across the organisation and highlights how safe staffing is reviewed holistically considering a variety of metrics, data, and professional opinion although SNCT has not been utilised since Jan 2025 apart from neighbourhoods when a census was completed in June 25 however we are unable to utilise this data as the full set of tools were not available to the team hence leaving the data inaccurate. We aim to reinstate the SNCT across all appropriate areas in SFT in 2026. Over the last six months we have experienced continued pressures from: • Delays to discharge with high numbers of patients with no criteria to reside (NCTR) • High pressures on urgent and emergency care. • On going use of unfunded escalation beds

- 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 and increased levels of staff sickness.
- Increased levels of sickness seen in neighbourhood teams thought to be related to an ongoing consultation and reconfiguration.

The Board are asked to note the following:

- Staffing levels have been reviewed by budgeted establishments and fill rate as detailed in this report however with the absence of SNCT we are unable to provide full assurance to the board for this time period. Implementation of a variety of acuity tools ie SNCT, MHOST and CNSST is a key priority for the chief nurse team over the next 6-month period.
- The current rostering policy requires an urgent review which will complement the work that is already underway from staffing solutions.
- The temporary staffing authorisation framework is in the process of being reviewed, supported by the implementation of a monthly non-medical agency and staffing assurance group which will be chaired by the DCNO or CNMO.
- Review and management of daily staffing is under review as currently the leadership is inconsistent and weekends in the acutes are not routinely supported by senior nurses.
- One potential risk is the delay between vacancy identification, approval, and recruitment, which may lead to prolonged gaps in staffing, particularly where redeployment processes are required. Additionally, there is a risk that continued high levels of HCA vacancies especially where posts are held for redeployment is affecting day-to-day service delivery and patient care.
- There are pockets of over established areas within the medical service group however, throughout the organisation there is increased sickness and high numbers of staff on maternity leave leading to increased use of bank and agency.
- There is currently no national acuity tool in place for the AHP workforce.

Further work is required to offer robust assurance to the Board regarding compliance with NQB safe staffing and workforce standards.

Recommendation	• The Board is asked to consider the report and note the above points. • The Board are asked to approve this report for publication on the public website as per requirements

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)

Senior nursing and service group level leadership teams have been involved in the preparation of this report.

Previous Consideration

(Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – e.g. in Part B]
The six-monthly review was last presented to the Board in May 2025 covering the period of July to December 2024.

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
SIX MONTHLY STAFFING ESTABLISHMENT REPORT

1. CONTEXT

1.1. Following publication of the Francis Report 2013[1] and the subsequent "Hard Truths" (2014)[2] document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels. These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift on the Trust website.
- Provide a 6-month report on nurse staffing to the Board of Directors.

For Nurses, AHPs and HCAs

1.2. There are eight specific strategic nursing, AHP and HCA staffing risks graded as high risk held on the corporate risk register as below. The risks have remained unchanged due to the continued favorable vacancy and turnover positions sustained over the past 6 months however in light of recent workforce changes in the chief nurse team these risks require a review which will be carried out within the next 6 months.

Nursing, HCA & AHP Risks 15+

Extract taken from Corporate Risk Register Report September 2025

NHS Somerset NHS Foundation Trust

R2621	20	⇔	Unsafe staffing levels in oncology/haematology day unit due to absence within the service which is compromising patient safety
R2643	20	↑	Inadequate staffing to safely maintain a comprehensive, fully functioning Acute Haematology and Oncology Service due to vacancies and absences (nursing)
R2302	16	⇔	Inability to provide comprehensive and equitable vascular access service due to insufficient staffing for the service and escalation pathways causing delays in patient care
R3355	16	⇔	Risk to service provision with patients being cancelled on the day of their operations due to shortfall within staffing and skill mix of colleagues (Ophthalmology MPH)
R3374	16	NEW	Unable to recruit experienced practice nurses due to lack of available experienced practice nurses within the Somerset area and nationally impacting on current workforce; increased costs and increased complaints
R2374	15	⇔	Insufficient staffing to meet national guidelines in Stroke
R2803	15	⇔	Reduced ability to deliver the nurse advice line at MPH for patients on biologic drugs due to insufficient staffing within the rheumatology nursing team
R2892	15	⇔	Reduced ability to meet national service delivery targets due to staff shortages (Acute Occupational Therapy service)

Key: Risk Score = 15-25 R = Risk 01 = Unique Risk Reference * = Risk Awaiting Approval on Radar
Service Group / Corporate Functions - Children, Young People & Families; Clinical Support and Cancer; Medical; Mental Health & Learning Disabilities; Neighbourhoods; Surgical; Corporate Functions; SFT Trustwide Corporate Risk: SSL Risk SHS Risk
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

External Risks – Risks which are predominately outside of the control of the organisation to mitigate

Internal Risks – Risks which are predominately within the control of the organisation to mitigate

[1] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK (www.gov.uk)
[2] NHS England » Guidance issued on Hard Truths commitments regarding the publishing of staffing data

For Midwives

1.3. One risk (risk 3354) that is a service level risk that is mapped into the risk on the corporate risk register covering the neonatal service and the closure of maternity services (risk 3110). Extract from the risk register below. The asterisk on the risk 3354 is because this risk still awaited approval by the service group however the score has been reduced to 9

R3110	25		Inability to deliver safe, effective and sustainable neonatal inpatient service (YDH)
SA2			

R2839	16		Quality and safety concerns associated with Paediatric Acute service at YDH impacting on patients, wellbeing of clinical staff and ability to recruit
R3139	16		Delays to the SWASFT provision due to the increased number of maternal and neonatal transfers and case complexity
R3207	16		Risk of inconsistent care coordination with partner trusts and delays for patients due to incomplete care pathways for displaced YDH maternity service users
R3255	16		Following the temporary closure of full obstetric services at YDH, antenatal clinics continue to operate without immediate access to on-site obstetric support including triage and labour ward which could result in clinical risks to service users and their babies
R3354*	16		Risks to patient and colleague staffing and the ability to continue to provide services due to maternity demand surge at MPH

2. NURSING REPORT

Trust Metrics Overview

2.1. The previous 6 months Trust level staffing metrics are contained within Table 1, the service group summary tables can be found in the appendices.

2.2. Key points to note: -

- Over the past 6 months, the registered nurse fill rates have dipped month on month and are sitting at 90% with the highest number of low staffing incidents, **855**, being reported from the medical service group.
- All in-patient area fill rates are based on funded beds and do not include the additional boarding beds within a ward and escalation beds, when in use these beds are an additional workload for staff or a cost pressure as temporary staffing utilised.
- Overall, the RN WTE establishment position shows – **Budget 3590** of which there are **3491** in post, with **3314** actual (worked WTE) leaving a vacancy gap of 99 with an incoming pipeline of 259.
- Overall, the HCA WTE establishment position shows – **Budget 2082** of which there are **1936** in post with **1886** actual (worked WTE) leaving a vacancy gap of 146 with an incoming pipeline of 135.
- Overall, turnover on average sits around 10% for this period however there are hotspots of higher turnover in the MH Service Group and Neighbourhoods Service Group. Work is taking place within these service groups to understand and address this.
- Care hours per patient day (CHPPD) is a measure of actual nursing resource deployment and the registered nurse (RN) CHPPD and total CHPPD are included in the metric tables. Trust wide RN CHPPD has remained within the range 5.6 – 4.4.
- There does not appear to be a strong culture of red flag reporting, however going forward this data will be captured and reported on a monthly basis.
- NICE Midwifery red flags are now included in the midwifery section and are reported each month through the Safe Staffing Report as per the CQC Improvement recommendations.

- Agency usage remains within trajectory however bank usage is high and above target. Work required to look at moving staff from over recruited areas to areas with vacancy where appropriate.
- Work required to benchmark all relevant staffing against national standards such as acute stroke, critical care.
- Internal auditors were commissioned to undertake a review of Agency ID checks over June 25 to Oct 25 which found the design to be moderate however limited operational effectiveness over the controls in place for agency ID checks. Several recommendations have been made and an action plan has been agreed. The report is due to be presented at audit committee in October.
- Internal Auditors were commissioned to review Observation and Support in June 25 which concluded that the control design was moderate due to there being a clear policy, decision making tool and training programme in place, however the control effectiveness was limited as the auditors identified evidence of non-compliance with key procedures such as:
  a) Evidencing approval of agency cover
  b) Reviewing the need for observation and support once provided
  c) Documenting supervision appropriately in the patients notes
  d) Time periods spent continually providing observation and support cover
  e) Completing the decision-making tool appropriately
  f) Evidencing appropriate training had been completed by those providing observation and support care.

Table 1 - Trust Metrics

Overall	SFT

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	94%	92%	92%	93%	93%	90%	
Unregistered Nursing Fill Rate	101%	100%	98%	99%	99%	96%	
All Staff Fill Rate - Day	94%	92%	91%	93%	93%	91%	
All Staff Fill Rate - Night	103%	101%	100%	100%	101%	98%	
All Staff Fill Rate - Overall	98%	96%	95%	96%	96%	94%	
Care Hours per Patient Day	8.8	10.5	8.2	8.2	8.6	8.3	
Registered Hours per Patient Day	4.7	5.6	4.5	4.4	4.6	4.5	
Completing Safer Staffing Measures	47%	44%	50%	50%	54%	53%	
Sickness	6.7%	6.3%	6.1%	6.1%	5.8%	6.0%	
Labour Turnover Rate	10.9%	10.6%	10.1%	9.8%	9.5%	9.2%	
Registered Nurse Vacancy Rate	6.5%	6.6%	7.3%	7.0%	9.2%	10.0%	
Unregistered Nurse Vacancy Rate	8.3%	7.8%	8.4%	6.7%	7.5%	7.2%	
All Clinical Staff Vacancy Rate	6.7%	#N/A	7.5%	7.1%	9.3%	#N/A	

Table 2 – Low staffing incidents

2.3. For the period April 2025 to September 2025, the estimate is 10% of events relating to staffing issues by service group is as follows.

Service Group	Number Staffing Events
Medical Services Group	855
Surgical Services Group	224
Neighbourhoods Services Group	220

Children, Young People and Families Services Group	120
Mental Health & Learning Disabilities Services Group	80
Corporate Services	68
Clinical Support and Cancer Services Group	62

2.4. This is based on:

- use of the new safety challenge Staffing / workload / capacity or capability of services
- where reporters have indicated people's availability involvement in the event was 'There were people absent who were required' or 'The wrong skill mix was involved'
- A small number of staffing related terms present in the description field. (""short staff", "short of staff", "numbers", "staffing", "no PLT cover")

2.5. As a result, this may include some non-staffing related events and may miss others. These incidents will include events that have occurred where staffing was a factor (e.g. a fall occurred), and occasions where staffing was a risk to safety, but an event did not occur, but reporter was concerned enough to report it.

Safer Nursing Care Tool (SNCT) 2023*

2.6. Due to workforce changes and constraints within the Chief Nurse team, the SNCT assessment has not been completed since Jan 25 apart from within the neighbourhoods service group.

2.7. Community Hospitals (CH) are now part of the SFT SNCT audit cycle. There have been 3 completed audit cycles to date. There is a consistency across the audit reports but a lack of matron level confidence that the tool adequately reflects the individual layout and acuity challenges of each CH. Broadly speaking completed audits show that establishments matched acuity with individual complex cases requiring 1:1 observation/support requiring additional agency/bank. A focus on dementia training and targeted support from the dementia and delirium and Intensive Dementia and delirium (IDDS) service has helped hugely in this space and the impact of the commissioning changes for P3 patients mentioned above remains to be seen. The above transformation will obviously render previous SNCT results obsolete for the 3 hospitals where bed and staffing numbers have changed significantly so the next audit cycle will involve a re-set.

SNCT Community

2.8. District nursing had piloted the community nursing safer staffing tool (CNSST). This was paused nationally due to data collection discrepancies and relaunched in January, with a longer data collection period of two weeks completed in June. However, discrepancies continued, and a new resource pack was circulated enabling analysis of data that was collected in June with the aid of a professional judgement calculator (which was not originally included). Hopefully this will address current discrepancies.

2.9. The national team recommend that 2 data collections should be taken before the data can be considered reliable. SFT has a provisional date for the second collection of the 2nd week in November.

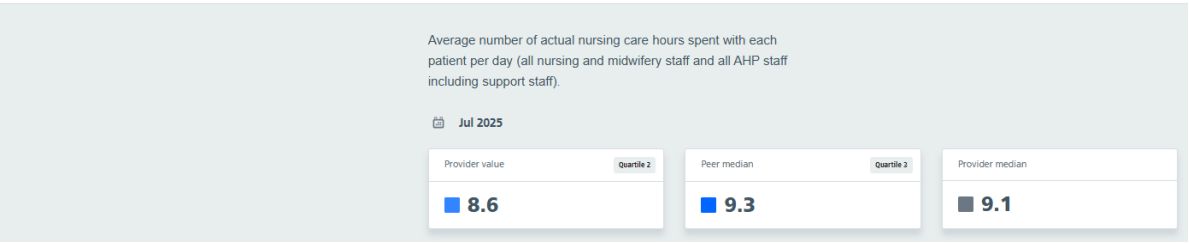
MODEL HOSPITALS

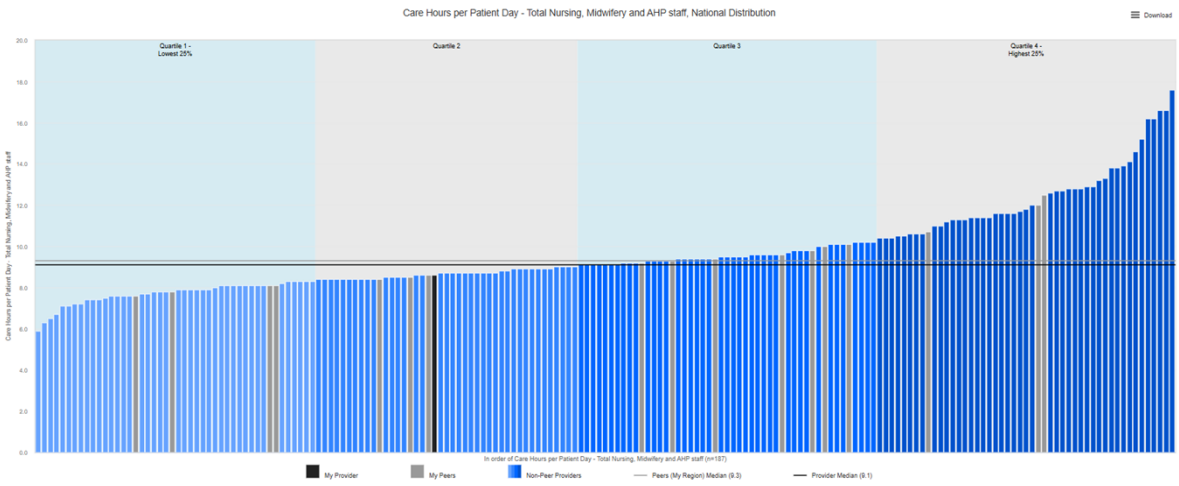
2.10. Data of care hours per patient day are submitted nationally and uploaded for comparison via the model hospital system. The high-level data also combines nursing and midwifery which is not the same as our local data, but the charts below are provided as a benchmark. They include Mental Health, Community and Acute ward figures.

2.11. Review of the model hospital data continues to indicate that our total staffing level is below but close to our region and national averages but that our skill mix is more weighted towards unregistered colleagues than in other areas which is attributed to community hospitals and MH given the acuity of patients in those beds.

2.12. In the last update in Model Health (Jul 25) our overall position has improved to 8.5. National average has remained the same at 9.0, as has our regional peers (9.0). Registered Nurses and Midwives improved from 4.3 to 4.4 but is still lower than regional peers at 4.8 and national position of 4.9. Care provided by healthcare support workers remains higher than national average at 3.8 hours (National average 3.6), regional peers average is the same as SFT at 3.8.

Care Hours per Patient Day - Total Nursing, Midwifery and AHP staff



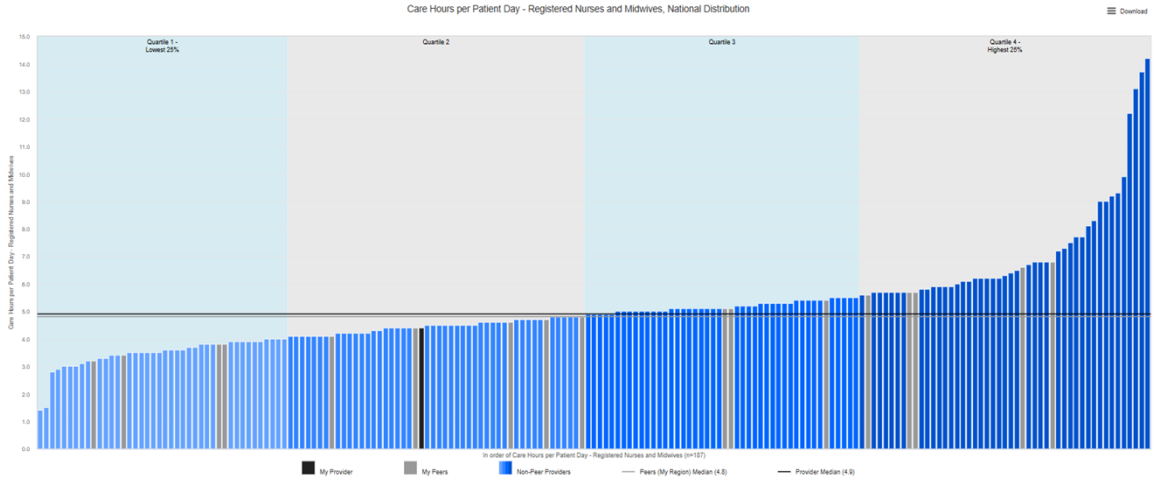


Care Hours per Patient Day - Registered Nurses and Midwives

Average number of actual registered nursing care hours spent with each patient per day.

Jul 2025

Provider value	Peer median	Provider median
Quartile 2	Quartile 2	
4.4	4.8	4.9



Six Monthly Review of Safe Staffing

2.13. Due to workforce changes and constraints within the Chief Nurse Team a six-monthly review of safe staffing has not been completed however below you will see a helpful narrative from each service group which include risks, challenges and successes.

Bi-Annual Midwifery, Maternity and Neonatal Staffing Report

2.14. There are two consultant-led units at SFT, on the acute sites at Yeovil and Taunton hospitals. Since May 19th 2025, the YDH site has been temporarily closed to all inpatient maternity care.

2.15. The Clinical Negligence Scheme for Trusts (CNST) Maternity (and perinatal) Incentive Scheme (MIS) supports the delivery of safer maternity and neonatal care by evidencing compliance with 10 safety standards. Safety Action 5 relates specifically to the midwifery workforce and details 5 elements to the required standard:

Safety Action 5 a): A systematic evidence-based process to calculated midwifery staffing establishment has been completed within the last three years.

2.16. Birthrate Plus® is the only nationally validated workforce evaluation tool to calculate required midwifery and maternity support worker workforce requirements. Following the Ockenden report (2020) Birthrate Plus® have revised the tool to take into account the additional staffing needs identified by the Ockenden review plus an increase in headroom and percentage of specialist midwives required to deliver safe and effective modern maternity services.

2.17. A formal Birth rate Plus assessment was completed for SFT in November 2024 which reviewed the acuity of women who used maternity services at SFT across both YDH and MPH settings.

2.18. This review recommended a total Midwifery WTE of 239.57, as per tables below. This was an increase to the funded establishment of 15.62WTE.

Safety Action 5 b): Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

The tables below represent the 2024/5 Birthrate Plus® recommendations for each site.

	RMs Bands 5 to 7	Specialist contribution	PN MSWs	Total Clinical wte
Taunton Clinical Staff	124.24	2.60	15.05	141.89
Yeovil Clinical Staff	59.88	1.71	0.00	61.59
Specialist Midwives additional				15.59
Senior Managers				4.88
Total Current Funded wte				223.95

Current funded establishment

	Current Total Funded wte	Birthrate Plus Recommended wte	Variance wte
Taunton	141.89	148.30	-6.41
Yeovil	61.59	60.02	1.57
Additional Specialist Midwives	15.59	31.25	-10.78
Senior Managers	4.88		
TOTAL WTE	223.95	239.57	-15.62

Comparison of clinical, specialist and management WTE

2.19. NICE (2017) recommend that an assessment is carried out every three years and that the midwifery staffing budget is reflective of the establishment as calculated by Birth Rate Plus (or equivalent) and evidence of this reflected in Trust Board minutes.

2.20. SFT Maternity services presented a successful business case via the triple Lock process in March 2025 outlining the response to the Birth rate Plus recommendations and has subsequently successfully recruited to the identified shortfall.

2.21. The SFT Birth rate Plus review was conducted during a time of transition for SFT maternity services prior to several workforce related improvements were made to help align care delivery to improve equity of care in Somerset and before several specialist roles had been reviewed to identify areas for potential merging.

2.22. Following robust workforce review using the Birth Rate Plus methodology and in consideration of current team performance, caseload distribution, service delivery requirements and efficiency of staffing levels, SFT senior maternity leads identified a number of opportunities for improvement for more effective use of existing resources resulting in a reduction in the staffing shortfall recommended by Birth Rate Plus of 5.61 WTE from 15.62WTE to 10.01WTE:

- 3.91 WTE clinical midwives
- 6.10 WTE specialist midwives

Establishment:

2.23. SFT Maternity has increased budgeted establishment in line with the amended Birth rate Plus calculations.

2.24. The service has a total funded establishment of 296.15WTE with 274.51WTE In Post as at end Sept 2025 and a total of 14.22WTE on Maternity leave. This leaves a vacancy of 7.42 WTE. The service has recently recruited NQRM's into posts who are all due to start work imminently and is actively recruiting to the remaining shortfall.

Band	Funded Establishment	Funded (LMNS/MIS/ Other)	In Post	On Mat Leave	Variance
B3	59.43	0.00	58.11	0.61	0.71
B4	4.14	0.00	4.32	0.00	-0.18
B5	0.00	0.00	9.48	0.80	-10.28
B6	185.79	2.80	157.02	12.81	18.76
B7	34.19	2.80	38.70	0.00	-1.71
B8a	5.00	0.00	4.88	0.00	0.12
B8b	0.00	1.00	1.00	0.00	0.00
B8c	0.00	1.00	1.00	0.00	0.00

Specialist Midwives

2.25. Birth Rate Plus recommends that 11-13% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 15% for multi-sited Trusts. This includes management positions and specialist midwives.

RM's	WTE	% of total
Spec	34.84	
Managers	5.00	
Total establishment	296.15	13%

2.26. The current percentage for 296.15 is calculated to be 13%. SFT Maternity continue to develop long term workforce plans that addresses the shortfall and creates a cross county specialist team.

Safety action 5 c & d): The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.
All women in active labour receive one-to-one midwifery care.

Midwifery services in each acute site capture maternity Red Flag data via the Birthrate Plus® acuity app. Midwifery coordinator in charge and 1:1 care in labour are routinely collected via the app along with other (non- staffing related) red flag data.

*YDH Inpatient services have been suspended since 19th May 2025

	Site	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Midwifery coordinator	MPH	100%	100%	100%	100%	100%	100%	100%	100%	100%

supernumerary at start of shift	YDH	100%	100%	100%	100%					
Women in active labour receiving 1:1 care	MPH	100%	100%	100%	100%	100%	100%	100%	100%	100%
	YDH	100%	100%	100%	100%					

2.27. SFT maternity services have in place an escalation policy which provides clear instruction to mitigate risk and actions to take in the event that a substitute co-ordinator is required where there is no co-ordinator available at the start of a shift.

2.28. In line with the escalation guideline, the maternity service regularly review staffing levels and skill mix to ensure adequate and safe cover at all times. In times of high acuity and activity, there is a requirement to fill shifts by mobilising non-clinical staff such as specialist midwives to work clinically or to use bank or agency staff to ensure safe care delivery. SFT bank staff are almost exclusively substantive contract holders and as such any additional shifts worked must be considered to ensure support for effective work life balance to maintain resilience within the team. Where this is not possible, the service will move to fill shifts using agency. Historically, this predominantly occurs on the YDH acute site where the pool of available staff is much smaller which impacts on the ability to flex staff across the service.

Neonatal Nursing:

2.29. The Neonatal service has a total funded establishment of 59.75WTE with 53.03WTE In Post as at end Sept 2025 and a total of 6.72WTE on Maternity leave. This leaves a vacancy of 4.8WTE WTE.

Band	Funded Establishment	In Post	On Mat Leave	Variance
B3	11.69	11.54	0.00	0.15
B4	7.14	5.14	0.00	2.00
B5	14.23	16.83	1.00	-3.60
B6	19.10	13.59	0.92	4.59
B7	7.59	5.93	0.00	1.66

3. SERVICE GROUP AND INPATIENT LEVEL DATA

(Minus numbers in red indicate over recruitment; numbers in black are vacancy levels)

Clinical Support & Cancer Services, narrative from the Associate Director of Patient Care Shona Turnbull-Kirk

CSCS	MPH

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	97.5%	96.7%	99.9%	97.0%	100.0%	101.8%	
Unregistered Nursing Fill Rate	89.0%	98.8%	100.6%	93.4%	104.2%	107.1%	
All Staff Fill Rate - Day	91.4%	95.4%	99.6%	93.4%	98.8%	99.3%	
All Staff Fill Rate - Night	100.0%	101.2%	101.1%	100.0%	106.5%	111.7%	
All Staff Fill Rate - Overall	94.5%	97.4%	100.1%	95.7%	101.5%	103.6%	
Care Hours per Patient Day	6.8	13.3	8.7	6.8	7.2	7.5	
Registered Hours per Patient Day	4.5	8.6	5.6	4.5	4.6	4.7	
Completing Safer Staffing Measures	54%	38%	38%	39%	51%	49%	
Sickness	8.6%	3.3%	3.4%	6.7%	3.4%	5.6%	
Labour Turnover Rate	3.9%	3.8%	3.9%	3.9%	3.9%	3.9%	
Registered Nurse Vacancy Rate	5.6%	-1.2%	-1.2%	-1.5%	1.5%	1.8%	
Unregistered Nurse Vacancy Rate	5.6%	-0.3%	-0.3%	0.6%	0.6%	0.6%	
All Clinical Staff Vacancy Rate	5.6%	-1.2%	-1.2%	-1.5%	1.5%	1.8%	

3.1. Sickness absence is a significant concern for Ward 9. HR actively working with ward manager to address this. During this reporting period absence is related to short term sickness and appropriate measures are in place to support.

3.2. Ward 9 nursing establishment has been increased and substantiated to facilitate ambulatory care.

3.3. High scoring risk recently added to the corporate risk register to articulate senior

3.4. Both ward rosters are scheduled to be reviewed by the eroster team, ward manager and matron. With the impact of long-term sickness in the leadership teams this is exposing areas where we can make improvements.

3.5. Review of leadership model and how the two wards can better work to support each other will take place over the next few months.

3.6. We hold numerous risks and vulnerabilities relating to AHP and Clinical Scientist staffing levels across multiple professions and services. Many of these will be impacting on patient care (inpatient and outpatient) and resulting in pathway delays and suboptimal care.

Risks relating to CSCS:

Nursing, HCA & AHP Risks

Extract taken from Radar – Early October 2025 – **Clinical Support and Cancer Services**

Reference	DoT	Current score	Service Group	Description
RSK002724	↓	12	Clinical Support & Cancer Services	Due to a number of factors, the Radiology service is facing significant and unexpected staffing challenges. this will result in a reduction in the level of established service that we provide.
RSK002621	↔	12	Clinical Support & Cancer Services	Risk of unsafe staffing level in the day unit due to repeated episodes of sickness This impacts on ability to book to chair capacity and curtails service development. Places stress burden on colleagues at work who are required to absorb an increased and risk's compromising patient safety
RSK002317	↔	12	Clinical Support & Cancer Services	From May 2024, the Cardiology Department at YDH will only be covered by 2 part time Cardiac Physiologists who can ensure patients with MR conditional cardiac devices are put into appropriate mode for MRI pre/post scan. In addition, only 1 part time CP member of staff is trained to put defibrillators into the appropriate mode.
RSK001463	↔	12	Clinical Support & Cancer Services	Winter pressure/staff sickness risk a) Increased numbers of deaths in both the acute hospital, community hospitals and within the community over winter period b) Maintaining flow within both acute settings and across the community c) Staffing levels d) No viewing facilities in the mortuary e) Festive bank holidays impacting paperwork due to the unavailability of doctors f) as a specialist service we cannot use bank unless specifically trained and we have no administrator to assist with admin tasks, if someone goes off sick this can significantly impact the service.
RSK001345	↔	12	Clinical Support & Cancer Services	Sustainability of Pharmacy workforce. There are significant challenges in recruiting pharmacists and pharmacy technicians which reflected nationwide
RSK001911	↔	9	Clinical Support & Cancer Services	Pathologist availability to carry out PM's is particularly tight with capacity for up to 5 per week with possible additional support (9 per week) from Exeter based pathologist. This capacity will be too short for winter demands.

Mark Roughan Oct 2025

Nursing, HCA & AHP Risks

Extract taken from Radar – Early October 2025 – **Clinical Support and Cancer Services**

Reference	DoT	Current score	Service Group	Description
RSK-001856	↔	9	Clinical Support & Cancer Services	Anticipated staffing challenges within the Interventional radiology nursing team and subsequent effect on O/C rota.
RSK-001449	↔	8	Clinical Support & Cancer Services	Radiology MSK service,
RSK-000530	↔	8	Clinical Support & Cancer Services	If the Somerset Lipid Service is not adequately developed and resourced
RSK-002286	↔	2	Clinical Support & Cancer Services	Risk of: cancellation of pacing list Due to: YDH - lack of radiology nursing cover

Children, Young People & Family Services, narrative from the Associate Director of Patient Care Suki Norris

CYP & Families Services	MPH

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	91.9%	93.1%	93.2%	96.3%	94.5%	94.2%	
Unregistered Nursing Fill Rate	67.4%	66.0%	65.6%	93.1%	87.3%	79.2%	
All Staff Fill Rate - Day	91.5%	92.8%	92.2%	97.7%	97.3%	96.7%	
All Staff Fill Rate - Night	90.0%	90.9%	90.3%	99.0%	95.6%	92.8%	
All Staff Fill Rate - Overall	90.8%	91.9%	91.4%	98.3%	96.5%	94.9%	
Care Hours per Patient Day	9.7	9.3	8.9	10.0	11.0	10.2	
Registered Hours per Patient Day	8.4	8.0	7.8	8.4	9.3	8.8	
Completing Safer Staffing Measures	56%	44%	51%	48%	57%	56%	
Sickness	5.8%	7.3%	4.2%	5.3%	3.3%	4.3%	
Labour Turnover Rate	10.0%	9.9%	10.1%	11.4%	10.4%	10.6%	
Registered Nurse Vacancy Rate	0.5%	2.1%	1.7%	7.6%	8.3%	2.4%	
Unregistered Nurse Vacancy Rate	14.8%	17.4%	18.7%	11.2%	8.3%	3.7%	
All Clinical Staff Vacancy Rate	0.5%	#N/A	1.7%	7.5%	8.2%	#N/A	

CYP & Families Services	YDH

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	87.6%	84.8%	85.6%	87.6%	87.9%	55.5%	
Unregistered Nursing Fill Rate	87.1%	84.8%	81.1%	83.1%	98.7%	57.7%	
All Staff Fill Rate - Day	83.2%	80.1%	79.7%	81.9%	87.2%	58.4%	
All Staff Fill Rate - Night	97.1%	95.4%	95.4%	97.1%	96.6%	51.7%	
All Staff Fill Rate - Overall	87.5%	84.8%	84.6%	86.6%	90.3%	56.3%	
Care Hours per Patient Day	29.4	24.1	22.6	32.4	194.0	31.7	
Registered Hours per Patient Day	22.8	18.7	17.8	25.4	147.0	24.3	
Completing Safer Staffing Measures							
Sickness	6.7%	7.8%	7.7%	7.5%	7.2%	5.4%	
Labour Turnover Rate	14.9%	13.8%	10.1%	10.9%	11.4%	10.9%	
Registered Nurse Vacancy Rate	-0.5%	1.4%	5.4%	5.6%	6.8%	20.0%	
Unregistered Nurse Vacancy Rate	-0.3%	-6.6%	-3.0%	-8.1%	-8.1%	-1.1%	
All Clinical Staff Vacancy Rate	-0.5%	1.4%	5.4%	5.6%	6.8%	20.0%	

3.7. The data for the CYP and Families service group encompasses the children's wards and the neonatal units at both sites both of which experience fluctuating occupancy levels around the clock. We strive to adjust staffing ratios based on occupied beds rather than funded beds. Therefore, although the fill rate figures may not always appear optimal, they are aligned with actual occupancy. A weekly review of data on patient acuity and bed occupancy rates is ongoing. The closure of inpatient maternity at YDH will also be having an impact on fill rates.

3.8. The staffing levels on the children's ward at YDH does not meet the recommended guidelines for safe staff-to-bed ratios when the ward is at full capacity and patient acuity is high. Long-term efforts to improve staffing have been successful and we are now recruiting to a small bank team; we are also attempting to promote cross-county working particularly at times of short notice sickness which so far has been successful.

3.9. Preceptee nurses are joining the teams at both sites following the completion of their training. This is a testament to both teams' support throughout their

colleagues' training, leading these nurses to choose to join the teams permanently. We anticipate that the two paediatric teams will achieve a fully established staffing team by November 2025.

3.10. A bespoke team to support CAMHS patients has been recruited on both sites which has supported challenges around skill mix. This team provides therapeutic support alongside nursing support to vulnerable patients when they need hospitalisation due to a deterioration in their physical health. The team receives training and supervision from our CAMHS colleagues and offers educational bite-size training to nursing colleagues during their daily shifts. Feedback from our CAMHS patients and the CQC team following the recent inspection has been positive.

3.11. The extension of the Paediatric Assessment Unit (PAU) to a seven-day service at MPH has been very positively received by the paediatric teams, with encouraging feedback from families. This service plays a key role in admission avoidance ensuring that all admissions are appropriate and has played a fundamental role in reducing length of stay overall.

3.12. At YDH, the PAU operates differently, currently situated within the Emergency Department (ED). Paediatricians are called to assess and review patients from the ward, which can result in delays. We are actively working towards aligning the model with MPH by establishing a dedicated paediatric presence within the PAU at YDH. Planning is underway, including the development of joint patient pathways to support the proposed model led by the Clinical Director for acute paediatrics. Progress is dependent on relocating the YDH Paediatric Outpatient Department to enable the creation of a suitably sized PAU adjacent to Ward 10 however there are challenges with this around access and fire constraints as well as no identified funding for nurse staffing and paediatric consultants.

3.13. At MPH, we have two designated High Dependency Unit (HDU) beds, supported by appropriate funding to ensure access to specialist nursing and medical care when required. In contrast, YDH does not currently have a commissioned HDU service. As a result, children requiring HDU-level care are managed within the general paediatric ward unless their condition deteriorates. In such cases, they may be transferred to the Adult Intensive Therapy Unit (ITU), where a paediatric nurse is redeployed to provide care, and in some instances, patients are transferred to tertiary centres such as Bristol or Southampton. This arrangement presents risks to patient safety, increases staffing costs, and places additional pressure on service delivery. It also contributes to heightened stress levels and impacts the overall wellbeing of staff. Whilst this poses a risk there are mitigations in place such as 70% of RNs on Ward 10 have completed the Paediatric HDU module.

Risks relating to CYP & Families:

Nursing, HCA & AHP Risks

Extract taken from Radar – Early October 2025 – **Children, Young People and Families**

Reference	DoT	Current score	Service Group	Description
RSK003110	↔	25	Children & Young People & Families Service Group	Linked to RSK002839 and RSK003099 A number of significant concerns have been identified which impact on the safety and quality of the SCBU service on the YDH site. January 2025 acute paediatric CQC inspection identified significant concerns relating to senior medical presence during hours of pe demand, an ineffective learning culture and weaknesses in the governance process Section 29A warning notice was issued by the CQC subsequent to this the service has faced a critical situation relating to medical staffing with over 50% of consultants off
RSK001894	↔	12	Children & Young People & Families Service Group	Significant shortages in sonographer workforce
RSK000266	↔	12	Children & Young People & Families Service Group	Nursing staffing numbers do not adhere to National standards (BAPM)
RSK000341	↔	9	Children & Young People & Families Service Group	TBC
RSK002873	↔	6	Children & Young People & Families Service Group	Increased workload within Adoption is noted but staffing as of 2025 will be reduced retirement, clarification of roles & responsibilities, & vacant caseloads within LA. Car planning around work allocation & hybrid model of working
RSK001324	↔	6	Children & Young People & Families Service Group	High levels of vacancies or absence/leave across community and urgent care teams is especially the case for key clinical psychology roles. In addition, some newer staff newly qualified or new into CAMHS.
RSK000360	↔	6	Children & Young People & Families Service Group	If we continue with inadequate staffing levels at Tier 2
RSK001740	↓	3	Children & Young People & Families Service Group	If equipment expenditure continues at current levels

Mark Roughan Oct 2025

Medical Services, narrative from the Associate Director of Patient Care Jacqueline Phillips

Medical Services	MPH

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	94.5%	93.4%	93.4%	94.2%	94.5%	93.6%	
Unregistered Nursing Fill Rate	98.7%	96.7%	98.5%	97.7%	98.5%	96.1%	
All Staff Fill Rate - Day	93.5%	91.3%	92.0%	93.9%	93.3%	93.6%	
All Staff Fill Rate - Night	103.9%	102.1%	103.4%	101.4%	103.5%	100.8%	
All Staff Fill Rate - Overall	98.1%	96.1%	97.1%	97.3%	97.9%	96.8%	
Care Hours per Patient Day	7.6	7.4	8.0	7.5	7.5	7.9	
Registered Hours per Patient Day	3.8	3.8	4.1	3.8	3.8	4.0	
Completing Safer Staffing Measures	57%	52%	58%	56%	58%	58%	
Sickness	6.8%	6.6%	6.4%	5.1%	5.3%	5.9%	
Labour Turnover Rate	10.3%	10.4%	10.3%	9.8%	9.8%	8.8%	
Registered Nurse Vacancy Rate	1.5%	1.8%	2.6%	3.5%	5.2%	6.9%	
Unregistered Nurse Vacancy Rate	9.6%	8.8%	8.9%	7.4%	6.7%	5.1%	
All Clinical Staff Vacancy Rate	1.5%	1.8%	2.6%	3.5%	5.2%	6.9%	

Medical Services	YDH

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	99.6%	97.3%	96.3%	91.6%	93.3%	94.0%	
Unregistered Nursing Fill Rate	92.0%	88.7%	94.6%	92.3%	93.2%	92.1%	
All Staff Fill Rate - Day	97.1%	94.8%	96.1%	91.4%	93.4%	93.6%	
All Staff Fill Rate - Night	100.1%	98.6%	100.1%	98.5%	99.6%	99.4%	
All Staff Fill Rate - Overall	98.4%	96.4%	97.8%	94.4%	96.0%	96.0%	
Care Hours per Patient Day	5.8	5.7	5.3	5.8	6.0	6.0	
Registered Hours per Patient Day	3.1	3.1	3.0	3.1	3.3	3.3	
Completing Safer Staffing Measures	13%	25%	30%	35%	41%	40%	
Sickness	5.8%	4.8%	6.1%	7.0%	8.0%	8.3%	
Labour Turnover Rate	8.6%	8.0%	8.1%	8.1%	7.6%	7.9%	
Registered Nurse Vacancy Rate	-8.3%	-6.0%	-2.2%	-4.9%	-2.8%	-2.3%	
Unregistered Nurse Vacancy Rate	1.7%	-1.6%	-2.7%	-4.5%	-4.0%	-3.0%	
All Clinical Staff Vacancy Rate	-8.3%	-6.0%	-2.2%	-4.9%	-2.8%	-2.3%	

3.14. Registered Nurses (RNs) Positive RN position - the service remains over-established across both acute sites. Any staffing gaps are backfilled from over-established areas; weekly vacancy control panel meetings provide consistent oversight. Internal promotion rates remain high, with OD and HR teams actively supporting retention and career development initiatives. Health Care Assistants (HCAs) Significant deficit: There are currently 76 WTE vacancies across acute sites, including 10 WTE at YDH. Recruitment was temporarily halted due to the PCN consultation; resumed in July 2025 with approval to recruit 35 WTE HCAs. The closure of Exmoor Ward and the reduction in beds at AMU Barrington have necessitated HCA reallocations therefore predicting to have 0 WTE HCA vacancy is anticipated by the end of October 2025.

3.15. Staffing Pressures & Absences Agency use increased driven by bed pressures, corridor nursing, and seasonal spikes in illness, musculoskeletal problems, pregnancy related sickness. Sickness rates have decreased from 6% in January to 5.7% in August; musculoskeletal pain remains the leading cause.

3.16. Bank fill rate: Maintains a strong 97% fill rate, with most requests due to late sickness or emergency leave.

3.17. Training & Development Observation & Support (O/S): 145 HCAs have completed training; the target is 250 by April 2026 which has seen a measurable reduction in incidents involving violence and aggression has been observed.

3.18. Skill mix: Continues to improve, supported by safer staffing tools and clinical oversight.

3.19. Leadership changes: Six ward manager transitions have occurred; recruitment is underway for three senior roles.

YDH

3.20. Operational Challenges Bed reconfiguration: Completed across both sites; AMU (6B) is experiencing skill mix challenges.

3.21. Escalation beds: All escalation beds are currently open, contributing to increased bank and agency expenditure.

3.22. ED corridor nursing: Persistent issue with six patients regularly accommodated; over 20 patients are often awaiting inpatient beds.

3.23. MIA patient delays: Extended waits in chairs are common; staff sickness due to stress and burnout is increasing.

3.24. ED staffing: Operating under financial pressure; additional funding was previously requested to support permanent 24/7 staffing increases. There is currently a workforce review taking place now we are opening our urgent treatment centre on the 29th of October 25 on the YDH site.

Challenges

3.25. Cost pressures: Risk of nursing overspend due to increased HCA ratios on Fielding and AFU where we are not currently funded for.

3.26. Cross-county review: Seven matrons are currently under review to assess efficiency and pathway alignment in relation to the cross-county working.

3.27. KPI concerns: A decline in ward KPIs and an increase in care concerns have been noted.

3.28. The national recommended staffing ratio for a Hyper Acute Stroke Unit (HASU) is 80:20 (**see table 2.5**). At SFT the current ratio is 66:34 split however the unit is a combined unit with neurology and general medicine which therefore makes it more challenging to staff appropriately.

3.29. Despite ongoing pressures, the Medical Service Group continues to demonstrate resilience and adaptability. Strategic recruitment, targeted training, and strong leadership oversight have helped maintain a positive RN position and mitigate HCA shortages. Continued focus on workforce wellbeing, skill mix, and operational efficiency will be essential to sustain safe staffing and high-quality care delivery across both acute sites.

Table 2.5 Recommended levels of staffing for hyperacute, acute and rehabilitation units

	Physio-therapy	Occupational therapy	Speech and language therapy	Clinical psychology / neuro-psychology	Dietetics	Nursing	Consultant stroke physician	Consultant-level practitioner-led ward rounds
Hyper-acute stroke unit	Whole-time equivalents (WTE) per 5 beds*					WTE per bed	24/7 availability; minimum 6.0 thrombolysis trained physicians on rota	Twice daily ward round
	1.02	0.95	0.48	0.28	0.21	2.9 (80:20 registered: unregis-tered)		
Acute stroke unit & stroke rehab-ilitation unit	1.18	1.13	0.56	0.28	0.21	1.35 (65:35 registered: unregis-tered)	Acute stroke unit: 7 day cover with adequate out of hours arrange-ments**	Acute stroke unit: daily ward round** Stroke rehabilit-ation unit: twice-weekly ward round**

Risks relating medical service group

Nursing, HCA & AHP Risks

Extract taken from Radar Early October 2025 – **Medical**

Reference	DoT	Current score	Service Group	Description
RSK001649	↑	16	Medical Service Group	Heart Failure Nurse Led Service Demand and capacity mismatch. Due to current staffing level unable to review all hea failure types criteria has been reviewed and reduced to support management of caseload. Referrals to service continues to increase creating limited time to review inpatients who are ther discharged without a HF management plan. 4 month waiting lis for new referrals and those discharged from hospital who have not been seen as an IP. The HF Service was commissioned in 2013 with 4 WTE Nurse yearly increase in referrals 10% to 14% increase in referrals and FU activity.
RSK001993	↓	12	Medical Service Group	The South West Asthma Network have identified significant service gaps and capacity issues in Somerset that impinge heavily upon the timeliness and adequacy of patient assess and subsequent access to treatment.
RSK001402	↔	12	Medical Service Group	IF we're unable to recruit cardiac physiologists within cardiolog

Mark Roughan Oct 2025

Nursing, HCA & AHP Risks

Extract taken from Radar Early October 2025 – **Medical**

Reference	DoT	Current score	Service Group	Description
RSK000953	↔	12	Medical Service Group	The bed capacity of AMU has been reduced in recent months allowing a reduction in double up rooms. However, there are still some double up rooms on AMU and there remains a risk that when ED holds ambulances due to ED overcrowding resulting from flow challenges there will be pressure to reopen closed A bedsie further double up rooms. Opening further double up rooms on AMU increases the risk o not identifying deteriorating patients in good time, increased ris of falls; increased workload and possible increase sickness of staffing. However these risks need to be balanced against the risk to patients of being held in ED, being held in ambulances having to wait longer for an ambulance because they remain queued outside ED with patients they cannot admit. The Trust recognises the risk of this escalation and the implications on safety, quality and experience of patients and colleagues is owned at a corporate level and the executives wi be kept informed of the use of these beds and any adverse incidents or concerns. We know that this practice will place extreme pressure on nursing colleagues in this area and the Tr will hold the vicarious liability and accountability for the compromised care that may be delivered as long as the registrants and colleagues who are on duty are undertaking be endeavours to prioritise the delivery of care that is required
RSK002825	↔	10	Medical Service Group	Risk of inadequate staffing for nursing, senior cover and decisi maker for appropriate SDEC activity Due to funding and increased demand

Mark Roughan Oct 2025

Nursing, HCA & AHP Risks

Extract taken from Radar Early October 2025 – **Medical**

Reference	DoT	Current score	Service Group	Description
RSK002765	↔	8	Medical Service Group	Clinics are running regularly in Wellington but all other peripheral clinics are currently stood down. Other peripheral clinic locatio will be reinstated in the coming months.
RSK001329	↔	8	Medical Service Group	Inability to staff within core numbers of junior and consultant medical workforce, reliance on bank and agency. Due to: Not meeting RCP recommendations for safe staffing; unprecedented surge in emergency medical activity, surge in respiratory patients; all of this on top of usual winter pressures; volume of staff absences due to increased respiratory illness; inability to move patients through the system so bed base in th acute keeps expanding; 170% bed base currently which excludes onboarding pts; establishment of additional escalatio wards does not cover increased medical workforce only increased nursing workforce; additional doctors needed on dut in peak hours to support strike action, bank holidays, weekend etc but pulling from same workforce; supervisory status of som of the junior workforce due to recognised gaps in competency levels; increased use of temporary medical workforce (locums) which adds additional pressures to the substantive workforce (clinical and non-clinical)
RSK002758	↔	6	Medical Service Group	Patients on NIV requiring Level 2 care are not receiving appropriate care and monitoring due to staffing level as these types of patients require 1:2 ratio.

Mark Roughan Oct 2025

Nursing, HCA & AHP Risks

Extract taken from Radar Early October 2025 – **Medical**

Reference	DoT	Current score	Service Group	Description
RSK001758	↔	6	Medical Service Group	Risk of: Delays in assessment and treatment of patients which could impact on patient outcomes and inability to cover requirements in all areas of the ED Due to: significant staffing vacancies in ED nursing and ENPs
RSK003028	↔	4	Medical Service Group	Annual reviews now required for all patients of child bearing age within the epilepsy service currently taking Topiramate. Howev the epilepsy service is unable to deliver this due our existing waiting patients likely having a greater clinical risk, which woul escalate if we prioritised topiramate reviews in patients with well controlled epilepsy, over these already waiting patients.

Mark Roughan Oct 2025

Mental Health and Learning Disabilities, narrative from the Associate Director of Patient Care Ali Van Laar

Mental Health and Learning Disabilities MH wards

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	101.1%	102.9%	101.1%	100.4%	99.2%	100.2%	
Unregistered Nursing Fill Rate	117.7%	123.4%	112.6%	113.6%	107.7%	108.0%	
All Staff Fill Rate - Day	96.4%	98.6%	93.0%	94.9%	92.2%	94.6%	
All Staff Fill Rate - Night	111.5%	116.9%	110.3%	107.0%	105.6%	106.9%	
All Staff Fill Rate - Overall	101.8%	105.2%	99.2%	99.2%	96.9%	98.9%	
Care Hours per Patient Day	14.1	#DIV/0!	12.8	12.5	12.0	11.6	
Registered Hours per Patient Day	5.3	#DIV/0!	4.9	4.8	4.8	4.6	
Completing Safer Staffing Measures	59%	53%	59%	58%	63%	60%	
Sickness	7.7%	6.1%	6.1%	6.4%	4.6%	4.4%	
Labour Turnover Rate	12.9%	12.3%	12.1%	11.0%	11.1%	11.2%	
Registered Nurse Vacancy Rate	19.2%	20.4%	19.9%	22.2%	23.3%	24.2%	
Unregistered Nurse Vacancy Rate	10.6%	9.9%	12.9%	12.7%	13.2%	15.6%	
All Clinical Staff Vacancy Rate	19.8%	21.4%	20.4%	22.0%	23.0%	23.1%	

3.30. We are in the process of conducting safer staffing surgeries across all the wards to give the ward managers the opportunity to review the required numbers of staff and the management of temporary staffing. We hope to have these completed by September 2025.

3.31. Staffing remains challenging on the mental health inpatient wards, with additional colleagues being required for managing vacancies, sickness, and complex high-risk individuals. Where additional observation and supervision is required for this complex patient group, this will sometimes artificially inflate the average fill rates for HCAs.

3.32. Wards, including Holford, Rydon and Rowan are areas where we frequently need to have additional staffing to support the acuity of their patient groups, including when they need to be seen in the Acute Hospitals. We are going to seek advice from our neighbouring trust, to see how they manage their staffing in PICU's across the South West for consistency and parity.

3.33. All the mental health inpatient wards have robust processes for managing and reviewing staffing levels for all shifts. This involves routine and regular core staffing level reviews taking account of patient presentation, acuity, dependency and needs, escalation processes to more senior clinical managers, moving colleagues across the wards to support, as well as ensuring temporary staffing is available, if this is indicated.

3.34. The nursing fill rates on the wards are monitored regularly through the operational management team meeting. During this meeting, the following areas have been identified:

3.35. The ward nursing fill rate levels fluctuate when managing complex and vulnerable patients requiring additional 1:1, 2:1 or 3:1 staffing, sometimes for lengthy periods. Especially on the Psychiatric Intensive Care Unit (PICU) when vulnerable females need to be supported on a mainly male ward or where is a significant risk to others identified.

3.36. In the absence of RNs to cover shifts, and to ensure the wards remain safe, the wards will undertake a risk assessment at the time and sometimes prefer and agree a nursing associate or an experienced HCA who is familiar with the ward to work alongside the registered nurse and other team members to ensure safety and stability of the ward, as an alternative to employing an unknown RN agency worker, who may not know the ward or patients.

3.37. The service group employ a number of Registered General Nurses (RGN) one of these may take charge of the Ward where they work, but they always work alongside a RMN as this is required for reasons relating to the Mental Health Act. Agency RGN are never booked to work in our mental health wards and staffing gaps are mitigated in other ways.

3.38. Wessex Ward has been temporarily closed since August 2024, due to staff shortages, with the remaining staff being redeployed across our other services whilst Tier 4 inpatient provision is reviewed with the Southwest Provider Collaborative.

3.39. RN vacancy rates have remained static over the last 6 months however are a concern given they are fluctuating around 20%. The figures shown below suggests more vacancies than there actually are due to the way ESR reports leavers and starters. There are also newly qualified B5 nurses employed throughout the year who have accepted substantive posts but haven't actually started yet. Slight improvement seen in turnover which is

Inpatient

	Band 3	Band 5	Band 6	Band 7
Vacancies	17.23	21.96	20.59	4.72
Pipeline	6.53	13.00	7.44	1.00
Total	10.70	8.96	13.15	3.72

Community

	Band 3	Band 5	Band 6	Band 7
Vacancies	8.38	8.80	8.76	7.90
Pipeline	4.40	0.00	5.55	4.00
Total	3.98	8.80	3.21	3.90

3.40. The ward teams aim to complete twice daily patient acuity and dependency scoring using the Mental Health Optimisation Staffing Tool (MHOST). Alongside professional judgment, this tool supports ward clinicians to assess staffing requirements based on the presenting levels of patient acuity and dependency.

MHOST incorporates a staffing multiplier to ensure that ward establishments are able to safely and effectively meet patient needs.

3.41. The wards continue to manage daily challenges through their capacity meetings and continue to strive to reduce reliance on temporary and agency staffing. This has resulted in a significant reduction in the use of agency.

3.42. We have three Trainee Advanced Nurse Practitioners who are working well across Rydon Wards, Rowan and Pyrland Wards, which enhances the clinical support available to the wards. Two trainees are due to complete their studies in summer 2025 and the other is on track to complete by summer 2026. Once the ANP's are qualified, we will look to support them to complete the MPAC (multiprofessional approved clinician) qualification to support the utilisation of the MHA across our wards.

3.43. All ward managers use the risk register to reflect where concerns are raised around staffing and recruitment to the service group, which are reviewed within the regular governance meeting and operational management meeting.

Sickness

3.44. During this period the rolling sickness rate has decreased slightly to between 6.5%- 6.6%, with the reason for absence attributed to stress/anxiety/depression. Some of these are due to bereavement however this cannot be captured with the current options within ESR.

Date	Turnover (Rolling)	Sickness (In Month)	Sickness (Rolling)	Top Absence Reason
January 2025	12.1%	7.8%	6.6%	S10
February 2025	11.2%	6.4%	6.5%	S10
March 2025	11.4%	6.7%	6.5%	S10
April 2025	10.3%	6.7%	6.6%	S10
May 2025	10.7%	5.5%	6.6%	S10
June 2025	11.4%	5.3%	6.6%	S10

S10 = Stress/Anxiety/Depression

Holford

3.45. Due to the acuity over the past few months, and management of a number of high-risk patients on a mixed sex PICU with only one extra care area, this has required additional staffing to support patients on 1:1, 2:1 and 3:1. This has been managed primarily using bank staff and using agency HCA staff where bank staff have not been available to maintain safety and due to the high level of observations. As part of the safer staffing surgeries, we are reviewing substantive staff. We continue to have discussions regarding sourcing female beds for our patients.

Rowan 1 & 2

3.46. The wards need to have staff available to cover the 2 health-based places of safety on site 24/7.

3.47. The 2 wards are now established, and staff have settled in well. Each ward takes responsibility for one of the health-based places of safety and use staff flexibly across the site, especially when there are challenging periods.

3.48. Staffing may need to be increased to support patients being nursed in the Extra Care Area, if and when required.

Risks relating to Mental Health and Learning Disabilities:

Nursing, HCA & AHP Risks

Extract taken from Radar Early October 2025 – **Mental Health & Learning Disabilities**

Reference	DoT	Current score	Service Group	Description
RSK002823	↔	12	Mental Health & Learni Disabilities Service Group	Due to 3.6 vacancies out of a total 7.6WTE we are struggling to provide regular cover YH at night. Despite spending £18000 on agency cover we are still unable to cover sc nights in their entirety.
RSK002593	↔	12	Mental Health & Learni Disabilities Service Group	Willow currently has no Psychologist with barriers to recruitment around finance.
RSK001780	↓	12	Mental Health & Learni Disabilities Service Group	Staff sickness, a vacant post and tCAP training in LD psychology impacting on ability offer a service in a timely manner and requiring the use of a waiting list for non urgent referrals
RSK002623	↔	10	Mental Health & Learni Disabilities Service Group	1. Impact on staff 2. Potential reduction of Tier 4 offer to Somerset young people
RSK001867	↔	10	Mental Health & Learni Disabilities Service Group	Staffing levels, vacancy freeze across the trust. Staff sickness within the LD nur combined with the requirement for existing staff to still take leave is resulting in minim LD nursing cover for significant periods. Clinical Lead has now gone on Maternity Lea August 2025 (Acting Post being advertise, JD currently being approved) Apprentices, who have been supporting, are now starting on placements and change within their OU pathway, therefore support to the team is limited.
RSK002553	↔	9	Mental Health & Learni Disabilities Service Group	Lack of resilience within staffing in a team working with high risk offenders, impacting on staffing, lone working, colleague safety and recruitment issues.
RSK003276	↔	8	Mental Health & Learni Disabilities Service Group	Recently identified that an internationally recruited nurse completed RN OSCE and w registered with NMC as RN in error, however is recruited into RMN post.
RSK003147	↓	8	Mental Health & Learni Disabilities Service Group	2 staff members going on maternity leave, both will be off for 12 months.

Mark Roughan Oct 2025

Nursing, HCA & AHP Risks

Extract taken from Radar Early October 2025 – **Mental Health & Learning Disabilities**

Reference	DoT	Current score	Service Group	Description
RSK-003146	↓	8	Mental Health & Learning Disabilities Service Group	2 staff members going on maternity leave and one staff member going on adoption leave. All of which, will be off between 8 and 12 months.
RSK-001510	↓	8	Mental Health & Learning Disabilities Service Group	High use of bank and agency staffing due to high acuity. Ward Manager and Clinical Service Manager discuss and review each day - high levels remain due, in part to long higher use of staffing.
RSK-003012	↔	6	Mental Health & Learning Disabilities Service Group	Covid provided opportunity for remote working but we still need to be able to provide F2F appointments to patients in Somerset
RSK-001695	↔	4	Mental Health & Learning Disabilities Service Group	Increases in requests for ADHD prescribing for people with childhood diagnosis have increased by around a 1/3. Over the quarter may to august 38% of new referrals to bridgwater CMHS were for ADHD prescribing
RSK-001026	↔	2	Mental Health & Learning Disabilities Service Group	Employment of Registered General Nurses

Neighbourhoods and Community Services, narrative from the Associate Director of Patient Care, Debra Nash.

Neighbourhood Services	Community

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	101.4%	99.3%	97.1%	100.8%	98.6%	100.2%	
Unregistered Nursing Fill Rate	111.2%	105.8%	98.9%	98.8%	100.9%	95.8%	
All Staff Fill Rate - Day	103.6%	99.8%	94.7%	98.0%	98.5%	95.7%	
All Staff Fill Rate - Night	113.7%	110.3%	104.9%	104.2%	104.7%	102.7%	
All Staff Fill Rate - Overall	107.6%	103.9%	98.7%	100.4%	101.0%	98.4%	
Care Hours per Patient Day	11.5	#DIV/0!	7.0	6.9	7.4	7.0	
Registered Hours per Patient Day	4.7	#DIV/0!	3.0	2.9	3.1	3.0	
Completing Safer Staffing Measures	59%	52%	57%	57%	60%	57%	
Sickness	8.7%	6.6%	6.7%	7.2%	7.6%	7.4%	
Labour Turnover Rate	12.5%	12.5%	12.6%	11.8%	10.4%	11.1%	
Registered Nurse Vacancy Rate	6.0%	6.8%	5.6%	8.1%	4.8%	5.0%	
Unregistered Nurse Vacancy Rate	5.8%	7.0%	8.6%	7.8%	10.4%	11.5%	
All Clinical Staff Vacancy Rate	6.0%	6.8%	5.6%	8.1%	4.8%	5.0%	

3.49. The overall landscape for community hospitals (CH) has changed and will continue to change significantly with the publication of the NHS 10-year plan.

3.50. Since the last board report recruitment drives have been successful with most CH achieving close to or up to full establishment.

3.51. A full roster review across all CH has been completed as part of the productive care programme to optimise staffing resource. This has eliminated the large variety of shift patterns and overlaps that had historically been in place, optimised staffing resource and brought community hospitals in line with the acute hospital shift patterns. The formal consultation relating to this completed at the end of summer with the new shift patterns live from 22nd September this year.

3.52. The Community Transformation Programme has seen investment into Discharge to assess (D2A) and Hospital at home teams as well as changes to the commissioning of P3 patients which now directs patients straight to nursing home places as opposed to via community hospital beds. This has enabled a trial period of bed reductions across 3 community Hospital sites (Bridgwater, Frome and West Mendip), which is currently being phased in. These changes are temporary whilst the collective investment “proof of concept” is tested and staffing requirements are also being incrementally reduced temporarily in line with the bed reduction. Vacancies were held in other community hospitals as well as across the wider trust for the significant redeployments now underway.

3.53. Discussion and pre-engagement is also underway for a similar transformation across Crewkerne and Burnham on Sea CH.

3.54. Although there had been a sustained downward trend in agency/bank need/ usage and also an improved sickness picture, the transformation has adversely impacted both and in particular staff well -being despite a significant planned well- being support offer.

3.55. Shadowing opportunities across the Trust have been supported/backfilled with bank/agency to allow those facing redeployment some experience of areas in

which there were vacancies. Hence the bank/agency impact which is being monitored.

3.56. CH have implemented CNSST and have completed 3 census audit cycles to date. There is a consistency across the audit reports but a lack of matron level confidence that the tool adequately reflects the individual layout and acuity challenges of each CH. Broadly speaking completed audits showed that establishments matched acuity with individual complex cases requiring 1:1 observation/support requiring additional agency/bank. A focus on dementia training and targeted support from the dementia and delirium and Intensive Dementia and delirium (IDDS) service has helped hugely in this space and the impact of the commissioning changes for P3 patients mentioned above remains to be seen.

3.57. The above transformation will obviously render previous STNT results obsolete for the 3 hospitals where bed and staffing numbers have changed significantly so the next audit cycle will involve a re-set.

3.58. Historically, recruitment to the more geographically isolated hospitals (Frome and Minehead) had been a challenge, but over- seas recruiting has successfully overcome this for now.

3.59. Prior to consultation and the redeployment process, sickness across the service group (which had been higher than Trust average throughout the last 6 months, with individual CH being hotspots) had been an improving picture. This was because of implementing sickness “surgeries” and focussed support from the HR team to support leaders plus offering flexible working to all colleagues to support wellbeing and retention. On-going/residual impact of the redeployment process remains to be seen.

3.60. There is also on-going work with HR colleagues re innovative ways to attract colleagues to community hospitals, including transfer windows, offering rotations, transferring any overrecruited colleagues from the acute sites, these initiatives have realised some success and will continue.

Safer Staffing Community

3.61. District nursing had piloted the community nursing safer staffing tool (CNSST). This was paused nationally due to data collection discrepancies and relaunched in January, with a longer data collection period of two weeks completed in June. However, discrepancies continued, and a new resource pack was circulated enabling analysis of data that was collected in June with the aid of a professional judgement calculator (which was not originally included). Hopefully this will address current discrepancies.

3.62. The national team recommend that 2 data collections should be taken before the data can be considered reliable. SFT has a provisional date for the second collection of the 2nd week in November. After which this can be included in board report.

Risks relating to Neighbourhoods and Community Services:

Nursing, HCA & AHP Risks

Extract taken from Radar – Early October 2025 – **Neighbourhoods**

Reference	DoT	Current score	Service Group	Description
RSK003144	↔	12	Neighbourhoods Service Group	Wellington Hospital STAFFING (OPD & FACILITIES)
RSK003081	↔	10	Neighbourhoods Service Group	Generic Risk Due to the need to reduce agency spending by 40% in the coming financial year , The Trust has prohibited th using of off framework agencies to reduce costs. We currently sit as an outlier . To date agency, in the main on framework, h been used to manage the staffing short falls when there was a requirement to open additional beds due to the Trust being significantly challenged this winter. As pressure for beds continuewe need to be looking at more sustainable ways to manage staffing shortfall which are economically more sound and more financially viable.
RSK001736	↔	9	Neighbourhoods Service Group	There is no identified dietetic funding for any patients with mental health service. This includes adult patients in mental health units, children in Wessex House and for all patients with ARFID. This revised risk assessment incorporates risk 000799, now closed.
RSK003405	↔	9	Neighbourhoods Service Group	Inability to deliver a quality and safe Acute Adult Dietetic service at YDH (inpatient and outpatient) due to insufficient registered Dietitian staffing (due to vacancies) to meet demand, resulting in increased waiting times, reduced quality of patient care and a negative effect on staff wellbeing. Mark Roughan Oct 2025

Nursing, HCA & AHP Risks

Extract taken from Radar – Early October 2025 – **Neighbourhoods**

Reference	DoT	Current score	Service Group	Description
RSK003025	↔	6	Neighbourhoods Service Group	Insufficient Dietetic staffing to provide adequate service for children with diabetes. This is due to an increase in the Paediatric Diabetes caseload and the increase in complexity of the service i.e. more insulin pumps and advancing technology.
RSK002110	↔	6	Neighbourhoods Service Group	Update 14/05/25 There are 8 colleagues on long term sickness with one due to return tomorr which will take us down to 7. We are actively managing those that are off try support them to return to work where appropriate. Update 13/06/24 Number of Long term Sickness within team currently have 10 member of team long term sickness - majority are now over 12 month and high level being registered staff all supported via HR policy and some heading to formal stage impact now on team resilience Update 10/02/25 We have made some good progress with our sickness, currently we have 9 members of staff off on longer term sickness, 5 of which are registered mem of staff and 4 of which are Band 3. 3 of the 9 are significant long term sickness issues which are being manage other 6 should be resolvable and we are making progress with them to supp them to return to work. Mark Roughan Oct 2025

Nursing, HCA & AHP Risks

Extract taken from Radar – Early October 2025 – **Neighbourhoods**

Reference	DoT	Current score	Service Group	Description
RSK001647	⟷	6	Neighbourhoods Service Group	Non-concordance with national standard of patients being reviewed post within 30 minutes by a medic due to service provision not being 24/7. Potent for unidentified harm and escalation to acute hospitals
RSK000577	⟷	6	Neighbourhoods Service Group	Unable to recruit to the specialist Band 7 Learning Disabilities Dietitian

Mark Roughan Oct 2025

Surgical Care narrative, from the Associate Director of Patient Care, Kelly Hutchins.

Surgical	MPH

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	83.0%	81.3%	79.9%	82.6%	83.6%	82.7%	
Unregistered Nursing Fill Rate	94.3%	96.4%	95.7%	99.2%	96.9%	94.8%	
All Staff Fill Rate - Day	86.6%	84.4%	84.4%	87.0%	86.3%	85.6%	
All Staff Fill Rate - Night	95.7%	93.9%	91.7%	94.8%	95.9%	97.4%	
All Staff Fill Rate - Overall	90.6%	88.7%	87.7%	90.5%	90.6%	90.9%	
Care Hours per Patient Day	8.9	8.5	9.2	9.2	10.3	9.4	
Registered Hours per Patient Day	5.1	4.8	5.2	5.3	5.9	5.4	
Completing Safer Staffing Measures	57%	47%	53%	51%	54%	55%	
Sickness	6.1%	6.4%	6.2%	7.0%	7.2%	6.7%	
Labour Turnover Rate	11.5%	10.8%	9.5%	8.9%	8.7%	7.9%	
Registered Nurse Vacancy Rate	20.6%	17.7%	17.4%	8.2%	16.1%	17.0%	
Unregistered Nurse Vacancy Rate	10.7%	11.7%	9.4%	6.2%	9.1%	7.9%	
All Clinical Staff Vacancy Rate	20.3%	17.7%	17.4%	8.2%	15.9%	16.7%	

Surgical	YDH

Measure	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Trend
Registered Nursing Fill Rate	101.6%	94.7%	95.9%	95.5%	94.9%	88.6%	
Unregistered Nursing Fill Rate	106.1%	100.2%	98.5%	100.1%	95.9%	94.9%	
All Staff Fill Rate - Day	100.9%	95.3%	93.9%	96.3%	96.1%	91.6%	
All Staff Fill Rate - Night	109.2%	100.7%	103.6%	101.3%	98.5%	93.8%	
All Staff Fill Rate - Overall	104.6%	97.8%	98.1%	98.5%	97.2%	92.6%	
Care Hours per Patient Day	8.4	7.8	7.6	8.4	8.6	8.3	
Registered Hours per Patient Day	5.4	5.0	5.0	5.3	5.4	5.1	
Completing Safer Staffing Measures	0%	11%	25%	28%	33%	32%	
Sickness	5.7%	5.6%	5.5%	4.7%	3.0%	4.6%	
Labour Turnover Rate	10.0%	10.2%	8.9%	9.1%	8.1%	7.6%	
Registered Nurse Vacancy Rate	3.4%	3.2%	4.4%	10.4%	11.1%	12.5%	
Unregistered Nurse Vacancy Rate	4.9%	3.3%	6.2%	7.4%	10.0%	9.0%	
All Clinical Staff Vacancy Rate	3.4%	3.2%	4.4%	10.4%	11.1%	12.5%	

Vacancy Information

MPH

3.63. There are 4.39 RN vacancies and 22.88 HCA vacancies across various wards.

3.64. The highest number of HCA vacancies is in SDU (6.9), followed by Hestercombe North (4) and Gould (3).

3.65. Montacute North and SALs are the only wards with RN vacancies, at 1.5 and 2.89 respectively.

YDH

3.66. There are 7.68 RN and 9.25 HCA vacancies.

3.67. The ward with the most RN vacancies is 4A (4.41), followed by 7B (3.27).

3.68. 7B also has the highest HCA vacancies at 5, with KW and 4A having smaller numbers.

3.69. Overall Summary for surgical service group

- Total RN vacancies across both sites: 12.07
- Total HCA vacancies across both sites: 32.13

3.70. We are actively mapping our pipeline of Registered Nursing Degree Apprentices (RDNAs) and Student Nursing Associates (SNAs) into existing and projected Band 5 RN vacancies across the year. This approach has enabled us to consolidate staffing needs and support smooth progression for learners into substantive posts, reducing the need for external recruitment and improving workforce retention.

Healthcare Support Worker (HCA) Vacancies

3.71. There is currently a higher level of vacancies within our HCA workforce. These vacancies are being temporarily held to support the Trust-wide redeployment process taking place within the Neighbourhood Service Group. A review meeting is scheduled with the recruitment team to agree which posts can be released for recruitment now, and which should remain available for potential redeployees. This dual approach aims to balance local staffing needs with the broader organisational redeployment strategy.

Yeovil District Hospital (YDH) – RN Staffing and Vacancy Position

3.72. RN vacancies are currently higher at YDH. This is due to a recent staffing review using the Safer Nursing Care Tool (SNCT), which identified a need to increase RN numbers on some wards. These revised staffing levels were presented to and approved by the Chief Nurse and Deputy Chief Nurse in April 2025, with budgets aligned accordingly. The revised establishments were not recruited to until recently due to ward reconfigurations and redeployment taking place in Neighbourhoods.

3.73. The Budget for the YDH posts were reviewed and uplifted from April 2025, this agreed form Alison and Hayley in line with our SNCT data. Some of the vacancies for YDH are due to the increase of budget and the HR process, there was also a period in this where we were potentially being moved to a smaller ward and were asked to hold on putting them out.

3.74. The newly approved roles are currently being held and will go through the same recruitment and redeployment process as those at MPH. This ensures consistency of approach across both sites.

Critical Care

MPH

3.75. MPH are commissioned for 16 beds with 2 escalation beds; these are split 8 L3 and 8 L2. RN fill rates are low due to not being fully established, compounded currently by a high number of staff on maternity leave. We've currently got 4 new starters.

3.76. 34% of staff currently completed the ITU course. They also support 6-8 staff to complete the course on a rolling basis.

YDH

3.77. YDH are commissioned for 11 beds; these are split 5 L3 and 6 L2 beds.

3.78. 59% of staff have completed the ITU course with a further 3 members of staff to complete.

3.79. A full establishment review is currently underway for the Intensive Care Units at both MPH and YDH. This work is being guided by the Guidelines for the Provision of Intensive Care Services (GPICS) to ensure that both units are staffed safely, fairly, and consistently. The review will consider current staffing levels in relation to patient acuity and service activity, and it will also include aligning budgeted establishments to meet GPICS standards.

3.80. This is particularly important as we prepare for the transition into the new surgical build at Musgrove Park, where a robust staffing model will be essential. The aim is to ensure both sites have the appropriate level of critical care staff to deliver safe and effective care, with clear alignment to national standards. By taking this approach, we can ensure transparency and parity across the two sites and put in place a sustainable plan for the future needs of critical care.

Theatres Staffing and Over-Establishment Review

3.81. Separate work is underway within Theatres to review current staffing against demand. Initial findings suggest that some theatre areas may be over-established due to historical staffing patterns, such as additional weekend working requests that were not formally supported by updated budgets.

3.82. We have been undertaking a detailed demand and roster review to align templates more closely with operational requirements. This work is helping us identify where workforce can be more efficiently allocated and has already enabled the movement of theatre staff to cover other areas, removing the need for agency use in some departments.

3.83. Our first completed roster review for Day Theatres at YDH has demonstrated that the department is currently over-established. This finding has allowed us to release staff to support other clinical areas experiencing pressures, such as inpatient wards and endoscopy, where we have been able to prevent some elective list cancellations. This flexible workforce approach supports safer patient care and reduces reliance on temporary staffing.

Sickness Review and Management

3.84. We are also progressing a structured review of sickness levels across Surgery. Workforce data is being collected in collaboration with the central staffing and HR teams to identify trends in persistent or high sickness absence. The aim is to offer early support and guidance to both staff and managers, improving attendance and wellbeing.

3.85. As part of this, a new sickness support session has been launched by the HR team and is now being offered to all ward and department managers. These sessions are designed to equip leaders with tools to manage absence confidently and compassionately and ensure timely interventions.

3.86. The same structured approach to sickness and vacancy monitoring is being applied at YDH. We are working with workforce and HR teams to assess absence trends, support local teams, and ensure data accuracy. This includes a review of all open vacancies to remove duplicates and ensure alignment to actual establishment and budget.

Potential Risks

3.87. While our ongoing workforce reviews and improvement plans are making significant progress, there remain several potential risks that could impact our ability to maintain safe and sustainable staffing. One key risk is the delay between vacancy identification, approval, and recruitment, which may lead to prolonged gaps in staffing, particularly where redeployment processes are required. Additionally, there is a risk that continued high levels of HCA vacancies especially where posts are held for redeployment could affect day-to-day service delivery and patient experience.

3.88. The Budget for the YDH posts were reviewed and uplifted from April 2025, this agreed form Alison and Hayley in line with our SNCT data. Some of the vacancies for YDH are due to the increase of budget and the HR process, there was also a period in this where we were potentially being moved to a smaller ward and were asked to hold on putting them out.

3.89. Another emerging risk is linked to sickness absence levels. Although we are actively collecting and reviewing this data to support managers, persistent or rising sickness without timely intervention may challenge staffing resilience, particularly during peak periods such as winter.

3.90. Finally, as we uncover areas of over-establishment, such as in theatres, there is a need to sensitively manage this shift while maintaining morale, service quality, and ensuring that redeployed staff are appropriately matched to service need. Failure to do so may affect staff engagement or the ability to provide cover for areas under pressure.

Summary

3.91. Surgery is taking a proactive, data-driven approach to workforce management. With a healthy RN pipeline and a targeted focus on HCAs, sickness absence, and over-establishment, we are improving workforce sustainability and aligning staffing to actual service needs.

3.92. Key programmes include:

- Robust planning for ICU workforce based on national guidance.
- Continued roster reviews across theatres.
- Cross-site consistency on sickness and vacancy management.
- A focus on data integrity to ensure informed decision-making.

3.93. This joined-up approach helps safeguard patient care, promotes fairness across the workforce, and ensures we are making the best use of available resources as we move into a period of increased operational demand.

Risks relating to surgical service group

Nursing, HCA & AHP Risks

Extract taken from Radar Early October 2025 – **Surgical**

Reference	DoT	Current score	Service Group	Description
RSK002920	↔	12	Surgical Service Group	If we continue to run a service with our current nursing workforce establishment. Due to no previous service workforce review.
RSK001060	↔	12	Surgical Service Group	IF – The current level of capacity for bowel cancer screening is not maintained or increased to meet demand

Mark Roughan Oct 2025

NHS
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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee held on 26 September 2025
SPONSORING EXEC:	Isobel Clements, Chief People Officer
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Graham Hughes, Chair of the People Committee
DATE:	4 November 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 People Committee met on 26 September 2025 and reviewed the Quarter 2 BAF, People Performance Report, and Corporate Risk Register. Assurance was received on progress with job planning, rostering, and People Services transformation. However, concerns remain around appraisal compliance, sickness absence, time to hire, and wellbeing. This report provides assurance and highlights key risks for Board oversight.
Recommendation	The Board is asked to note the assurance provided and the key risks identified, including workforce sustainability, appraisal compliance, and wellbeing, and to support further work on inclusion, cultural change, and digital transformation.

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

SOMERSET NHS FOUNDATION TRUST
ASSURANCE REPORT FROM THE PEOPLE COMMITTEE MEETING HELD ON 4 JUNE 2025

1. PURPOSE

1.1. The People Committee met on 26 September 2025 to review workforce, culture, and organisational development priorities. This report provides assurance to the Board on matters discussed, highlights areas of concern, and identifies risks requiring escalation.

2. ASSURANCE RECEIVED

2.1. The Committee reviewed the Quarter 2 Board Assurance Framework for Strategic Aim 5, noting progress on the People Strategy deliverables, including the Learning, Education and Training (LET) Programme, Employee Relations Improvement Programme, and People Services transformation. While risks remain, controls and oversight arrangements were confirmed as robust.

2.2. The Chief People Officer report provided assurance on progress in job planning, with 60% sign-up achieved ahead of the October target, and on the implementation of the new e-rostering system to support flexibility and wellbeing. The Committee noted the successful delivery of the 2025/26 CIP target for People Services and progress on digital transformation initiatives, including process mapping and managed service pilots to improve recruitment.

2.3. The People Performance Report highlighted improvements in turnover and agency usage, alongside sustained mandatory training compliance. However, appraisal completion remains significantly below the 90% target, and sickness absence continues to exceed the 5.2% threshold. The Committee agreed that appraisal compliance requires a reset and a deep dive at a future meeting.

2.4. The Committee received updates on wellbeing initiatives, including the Compassionate Leadership Programme and findings from the Care Under Pressure 3 research. Data highlighted persistent challenges in colleague wellbeing, particularly among senior doctors, with high burnout rates and increasing stress-related absence. The Committee endorsed the need for a strategic approach to wellbeing, including improved rest spaces and access to hot food.

2.5. The GMC National Training Survey results provided assurance on strong performance at Musgrove Park Hospital and improvements at Yeovil District Hospital, though concerns remain in specific specialties. The Committee supported the 10-Point Plan to improve resident doctors' working lives, noting progress on rostering and exception reporting.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee identified several areas requiring further attention. Appraisal compliance remains a significant concern, with current improvement rates too slow to meet the target, and the issue continues to attract CQC scrutiny.

3.2. Sickness absence is on an upward trajectory, particularly in mental health and estates, and requires targeted intervention.

3.3. Time to hire remains above the Trust and NHSE targets, with delays in shortlisting and pre-employment checks contributing to the challenge.

3.4. The Committee also noted risks relating to inclusion, with gaps in data on locally employed doctors and concerns about equitable progression for BAME and disabled colleagues.

3.5. Finally, the Committee emphasised the need for visible improvements in wellbeing infrastructure, including rest spaces, and for sustained focus on cultural change to address stress and burnout.

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

4.1. The Committee agreed that Strategic Aim 5 remains above risk appetite, driven by challenges in appraisal compliance, sickness absence, and workforce sustainability. Compound risks across workforce, wellbeing, and digital transformation were noted, with potential to amplify operational pressures if not addressed.

4.2. The inconsistent provision of rest and wellbeing spaces has been added to the Corporate Risk Register, reflecting its impact on colleague health and retention.

4.3. The Committee also highlighted the need for improved assurance on inclusion and equality, particularly in relation to employment tribunals and sexual safety concerns raised in national surveys.

Graham Hughes
CHAIR OF THE PEOPLE COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board of Directors
REPORT TITLE:	Wellbeing Guardian Report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Dr Rosemary Novak, Head of Colleague Support
PRESENTED BY:	Graham Hughes, Non-Executive Director (Wellbeing Guardian)
DATE:	4 November 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	Focussed update on Compassionate Leadership, Enabling Improved Wellbeing.
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 improve health and wellbeing of 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 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?

Yes, this has been considered as part of this 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.
The data reported here is drawn from staff surveys, People Services data and research which included SFT colleagues as participants and stakeholders.
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 is considered on a regular basis by the Board.

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

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

SOMERSET NHS FOUNDATION TRUST

WELLBEING REPORT OCTOBER 2025

1. BACKGROUND AND PURPOSE

1.1. This report reflects a snapshot of one area of focus for the Wellbeing teams. Further information on the multilayered approaches for colleague wellbeing is available on request.

1.2. Wellbeing at work is systemic - shaped by individual experiences, the physical environment, a sense of belonging, the context of relationships and opportunities for fulfilment and meaning. The implementation of a cultural shift towards compassionate and inclusive leadership, will enhance the wellbeing of the workforce, and ultimately support the best outcomes for patient care. When colleagues feel like they belong, feel valued, supported, and cared for, they can take collective responsibility for their own and others wellbeing. This supports delivery of kind, compassionate, safe and effective care, that our population deserve and colleagues can feel fulfilled by and proud of.

2. LOCAL DATA AND RESEARCH – WHERE ARE WE NOW?

2.1. Results from a survey into hot food and rest spaces highlight significant variation across different trust sites. This evidence shows we are not getting the basics right for everyone, and the impact of this on colleague experience.

2.2. Staff Pulse Survey results show a decline in the perceived proactive support for wellbeing from the trust since between Jan 24 – July 25.

2.3. Data for Senior Dr Wellbeing shows the significant impact of organisational change on wellbeing scores. It echoes the disparity across service areas of perceived trust action on supporting wellbeing.

2.4. Colleague Support Service data indicates an increase in the percentage of colleagues who self report workplace stress as a referral reason. There is a rising trend of Burnout scores for Dr's between 2022 and 2025

2.5. Pulse survey data indicates the 'negative mood' of 45% of respondents, with 32% indicating relationships with colleagues a cause; reflecting current research that highlights the role of leadership in shaping colleague experiences.

2.6. The relational context of work stress is indicated across increased referrals to mediation, FSUG, OH and HR.

Local Data and Research - 'So What?'

2.7. S10 is the best organisational indicator of the impact of stress on the workforce. In July 2025, approximately 5000 FTE hours were lost to S10

sickness, this equates to an approximate cost of £768000. This is an underestimate and does not take into account exacerbations of long-term conditions, MSK or unknown sickness absence reporting, impact on service delivery, team functioning or the additional costs of resolution/support services.

2.8. National research (which involved our colleagues in the participant groups) makes recommendations for immediate and long-term improvements, which include systemic preventative action at practical, structural and policy levels:

- Prioritising improvements in working environments (inc. practical changes such as rotas, communication, rest spaces etc.)
- Increasing involvement of colleagues in creating solutions to improve their wellbeing (aspects of this necessarily sit outside the remit of a wellbeing team)
- Shifting expectations towards healthcare staff attending to their own physical and mental health too - being supported to prevent ill health and reducing barriers to accessing support – including stigma
- Emphasising relationships and belonging in intervention designs
- Reducing workplace trauma - e.g. Serious Incidents, Persistent Stressors (e.g. racism, discrimination, incivility and aggression) and Workforce Issues (availability of resources/ skillsets to meet acuity/demands of care needs).

3. CREATING A VISIBLE CULTURE OF COMPASSION TO ENABLE HEALTH AND WELLBEING

3.1. As we move through periods of high challenge, high demand and high change, we must operationalise our values of compassionate and inclusive leadership, trauma informed care, and just and learning cultures. The organisation must not only hold the values at its heart, but also build them into its foundations through its environment, policies, procedures, and the behaviours and relationships of it's people. This will support the wellbeing of the workforce now and through future challenges of transformation and changes in strategy – for example personalised care, which relies on good working relationships within and between teams, as well as good colleague-patient relationships to support meaningful shared decision making and choice for everyone.

Spotlight on 2 interventions: Developing New Leadership Approaches

New Medical Leadership Framework

3.2. A new model for medical leadership that is designed to ensure kindness and inclusion are central to our medical leadership roles and provides clarity around the responsibilities, skills and behaviours expected of our leaders while recognising the need to balance the very different demands and skillsets required for both clinical practice and leadership at a senior level.

3.3. The new framework:

- Enables all colleagues to have clarity in their roles.
- Clearly embeds kindness, compassion and inclusion as core responsibilities and accountabilities across all our leadership roles.
- Address barriers to medical leadership roles and ensure the diversity of our medical leaders reflects the diversity of all our clinicians.
- Ensures consistent, fair and transparent recruitment into and accountability of leadership roles.
- Provides guidance on development opportunities that build kind, compassionate and inclusive leadership skills.

Compassionate Leadership Development Programme

3.4. The Compassionate Leadership Programme aims to operationalise and embed Compassion as the foundation of the 3C's Leadership Framework (Compassion, Collaboration and Curiosity). The aim is to promote a measurable shift towards compassionate leadership which will underpin positive, inclusive and high-performing cultures in teams and services, and the whole organisation. Compassionate cultures foster greater confidence, resilience and wellbeing within teams, supporting them to respond effectively to current and future challenges, in order to thrive. The approach encompasses a 2-day Compassionate Leadership Training which is informed by theory and practice from Clinical, Organisational and Coaching Psychology, as well as Leadership and Organisational Development frameworks. The cultural shift is scaffolded by other compassion and inclusion orientated leadership activities, e.g. Cultural Competency training and reflective practice.

3.5. The Compassionate Leadership Development Training launches across the Trust this October – you are warmly invited to attend!

4. RECOMMENDATION

4.1. We are witnessing an increase in workplace stress and subsequent impacts on team relationships and patient care. The Board is asked to interweave wellbeing into decision-making when considering funding constraints, the development of physical estates, and service development. We recognise that the current climate of financial pressures, organisational change and focus on productivity is hugely challenging.

4.2. We are already witnessing a shift in the tone of conversations in leadership spaces, where difficult decisions must be made. Our ask is simply that the wellbeing of our colleagues (our teams and our organisation) is held with equal status to these pressing priorities; since the health and wellbeing of our workforce, underpins any potential success in meeting the rest of these ambitions.

NHS Somerset NHS Foundation Trust

Wellbeing Guardian Report May 25 : Appendix 1

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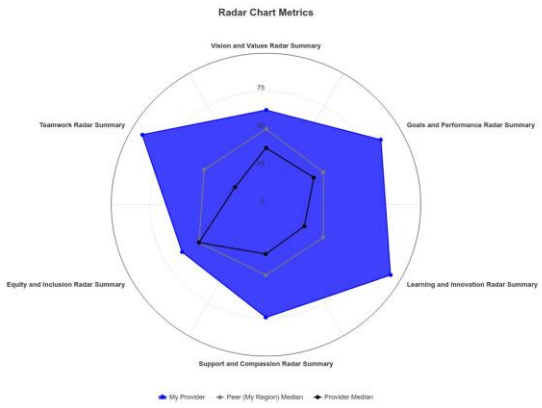
Model hospital data

How we currently compare nationally:

- Strong performance indicators across all metrics in relation to peers.
- No National Comparators with same level of integration as a provider: Somerset Foundation Trust (Mental Health, Acute & Community).

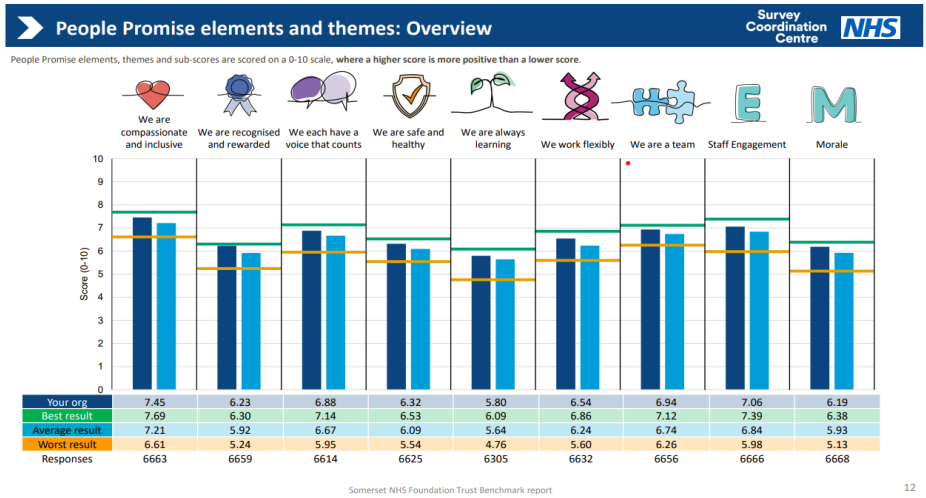


Staff Survey 2024

NHS Somerset NHS Foundation Trust

Overall Staff Survey results show above average scores for elements which impact directly on Colleague Wellbeing:

- We Are Safe And Healthy
- We are Compassionate and Inclusive
- Staff Morale



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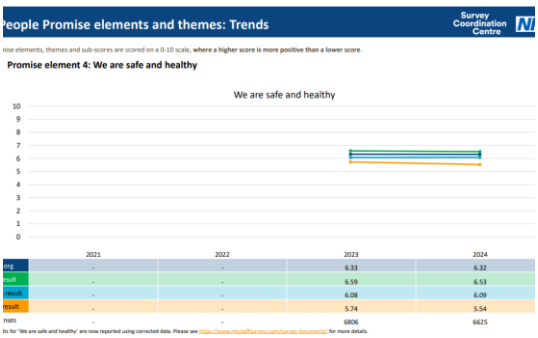
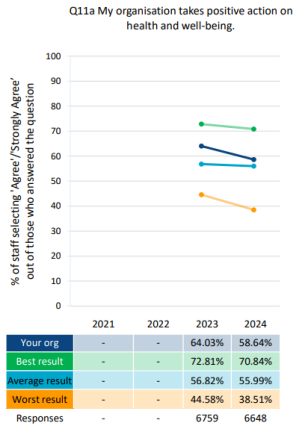
Staff Survey (2) – themes and sub-scores



Consistent and sustained overall result with previous year but……

….significant decline in perceived positive action on health and wellbeing by organisation



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28/10/2025 4

4

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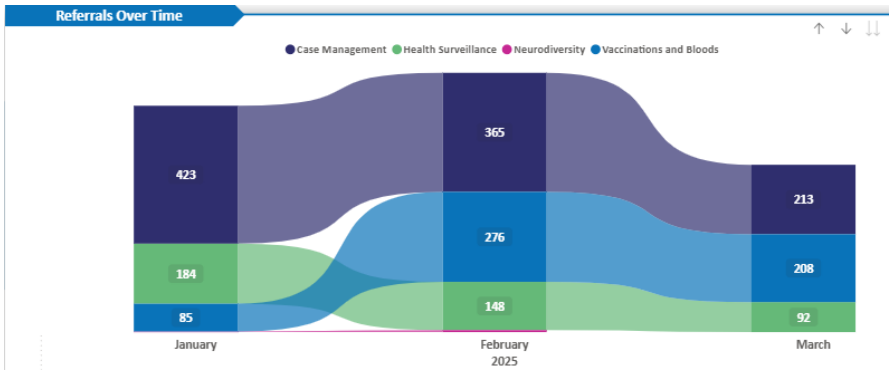
Occupational Health Data - PAM

Referrals Made

NHS Somerset NHS Foundation Trust



Steady build over time.

Most were for management referrals

Work In Progress List now means vaccinations and other processes can be started.

Referrals Made Continued

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Time to Refer

Main illnesses for colleagues not in work:
Mental Health, MSK, Gastro, GU/Gynae and other known causes.

8

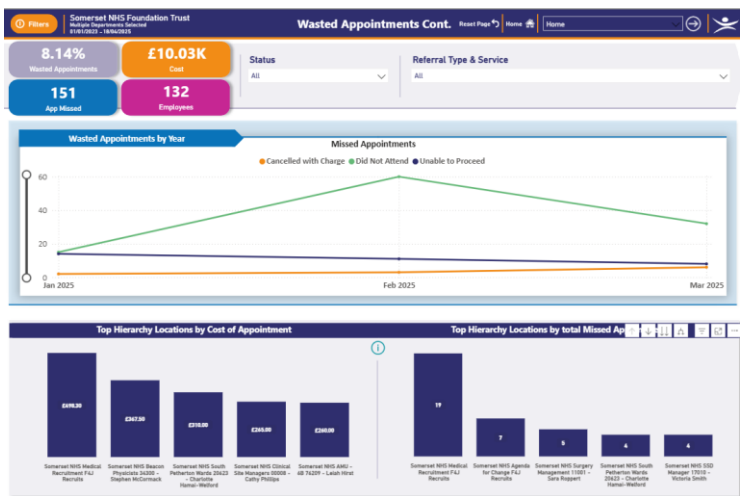
Appointment Overview

NHS Somerset NHS Foundation Trust

Over 1,000 colleagues have been seen in 12 weeks.

Wasted Appointments

NHS Somerset NHS Foundation Trust



Top Locations by Cost

- Fit4Jobs recruits
- Beacon Physicists
- South Petherton Wards

Top Locations by missed appointments

- Recruitment Medical Fit4Jobs Recruits

Occupational Health Services Feedback

NHS Somerset NHS Foundation Trust

"The system was easy to use and making the referral was straightforward. The colleague was seen promptly."

"The process was good and the report was helpful in supporting my colleague".

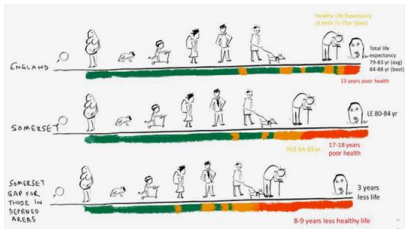
"It's frustrating that all colleagues aren't yet uploaded to the system"

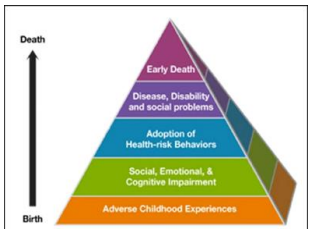
NHS Somerset NHS Foundation Trust

Colleague Support and Wellbeing Service Data

Recognising the inextricable link between Physical, Psychological and Emotional wellbeing and ensuring an equitable approach

NHS Somerset NHS Foundation Trust





Physio for you: Referrals Made

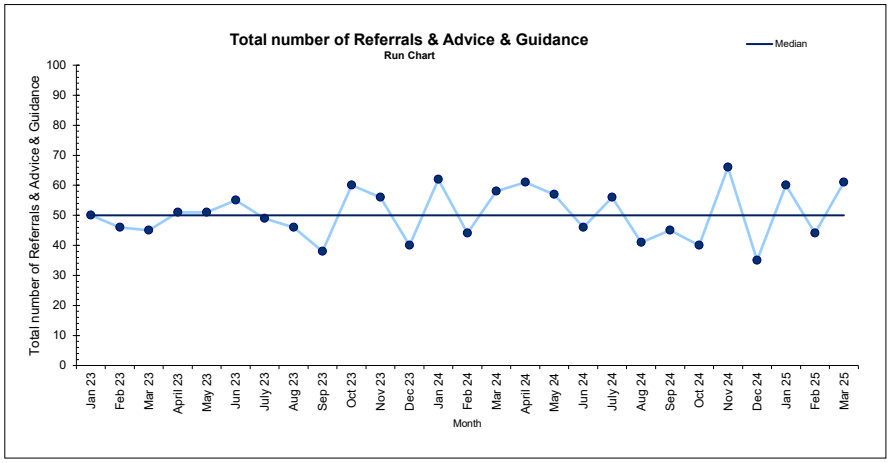
NHS Somerset NHS Foundation Trust

	Jan-25	Feb-25	Year total	Total since Sept 21 launch		Sept 21-Dec 24
Number of P4U self/manager referrals	61	64	125	**2753**		2628
Number of Colleagues who received an appointment within 5 working days	58	52	110	**2052**		1942
Percentage appointment within 5 working days	95%	81%				
Number of face to face follow ups	48	42	90	**1611**		1521
Percent requiring face to face follow up following initial consultation	79%	66%				

Colleague Support Service Support Line: Total Number of Referrals and Advice & Guidance

NHS Somerset NHS Foundation Trust

Date	Number of referrals per month
Jan 23	50
Feb 23	46
Mar 23	45
April 23	51
May 23	51
Jun 23	55
July 23	49
Aug 23	46
Sep 23	38
Oct 23	60
Nov 23	56
Dec 23	40
Jan 24	62
Feb 24	44
Mar 24	58
April 24	61
May 24	57
Jun 24	46
July 24	56
Aug 24	41
Sep 24	45
Oct 24	40
Nov 24	66
Dec 24	35
Jan 25	60
Feb 25	44
Mar 25	61
Total	1363



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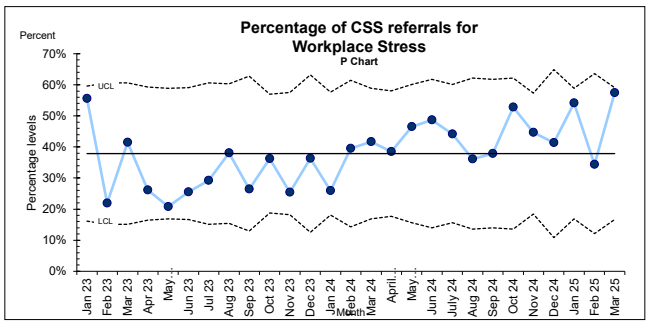
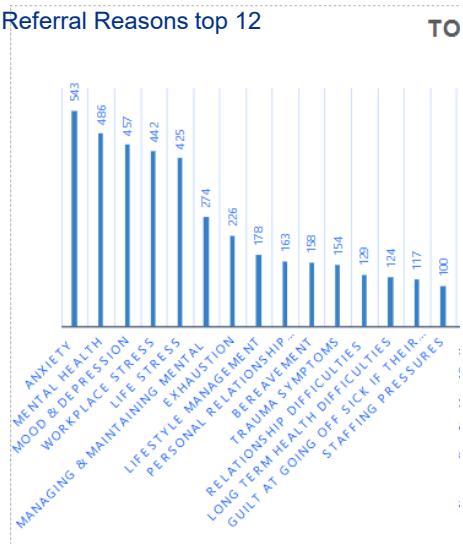
Referral Reasons





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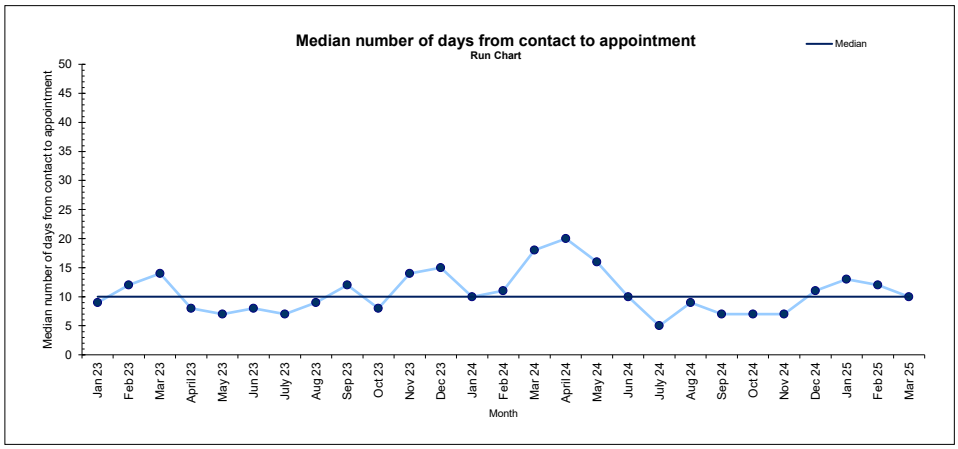
Contact to Appointment Data

NHS Somerset NHS Foundation Trust

Monthly calls to the Colleague support Telephone Line

Month	Median number of days from contact to appointment
Jan 23	9
Feb 23	12
Mar 23	14
April 23	8
May 23	7
Jun 23	8
July 23	7
Aug 23	9
Sep 23	12
Oct 23	8
Nov 23	14
Dec 23	15
Jan 24	10
Feb 24	11
Mar 24	18
April 24	20
May 24	16
Jun 24	10
July 24	5
Aug 24	9
Sep 24	7
Oct 24	7
Nov 24	7
Dec 24	11
Jan 25	13
Feb 25	12
Mar 25	10
Total	289



GAD & PHQ9 data

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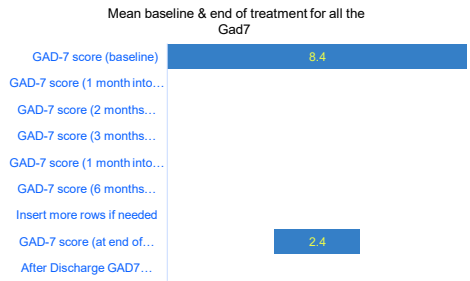
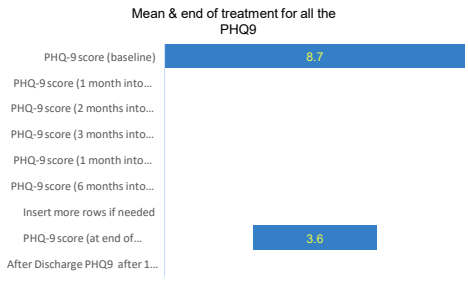
Monthly calls to the Colleague support Telephone Line





Feedback – Colleague Support Line

March 2025

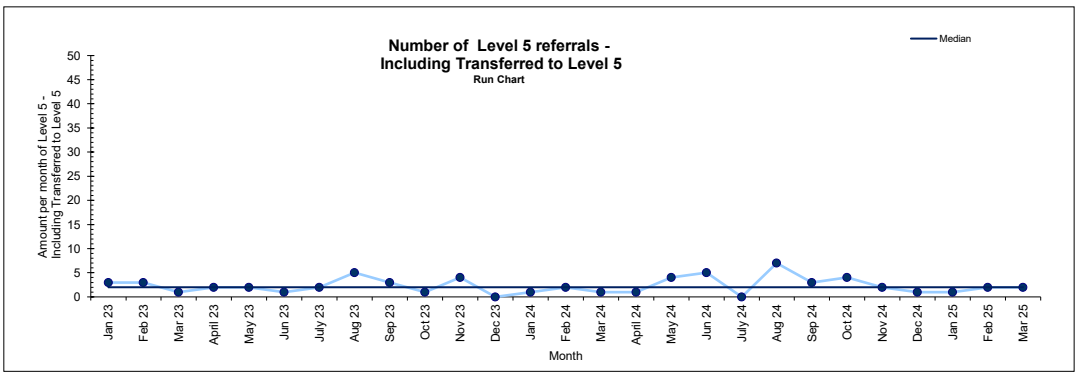
I want to say a huge thank you for your support at a time when I was processing the events that happened. You gave me the space to process and also the validation of my feelings about what happened. Thank you again for being so easy to talk with.

If I'm honest, I did not think this service was going to be of much help, but i can honestly say it has helped me a lot and i finished with the reassurance that if I have a blip, I can call the colleague support line for a one-off chat.

Amazing service, essential given the pressures on staff, really helped me to stay in work and manage work and home life during a difficult time in my life.

This service and the ladies I spoke to on my initial call and then my 2nd call made a big difference to how I was feeling - sometimes it's nice just to talk about things that are making you anxious at work and be listened to because it does not matter how small or large the issue is , it causes anxiety/ stress and a simply conversation with an independent person can really help .

Number of Level 5 (Specialist) Referrals



There has been a 13% increase in level 5 referrals between 2023/24 and 2024/25 financial year

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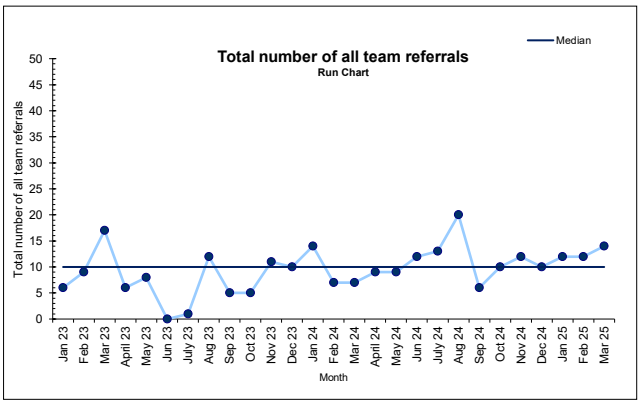
Team Intervention Referrals

- Referral reasons:
  - Consultation
  - PIRC
  - Supervision
  - Team Support
  - Compassion Circle
- Upward trend
- Increasing demand:
  - Longer response times
  - Stricter Criteria
  - Prioritisation of resources



24% increase in team referrals year on year (2023/24 – 24/25)

Feedback:
'Thank you for all the sessions you have done with our team recently. We are very grateful for your time and for the kind, caring and compassion that you have given us throughout this difficult period for our team. We all feel that you have really listened to us and helped guide us where to go next…'

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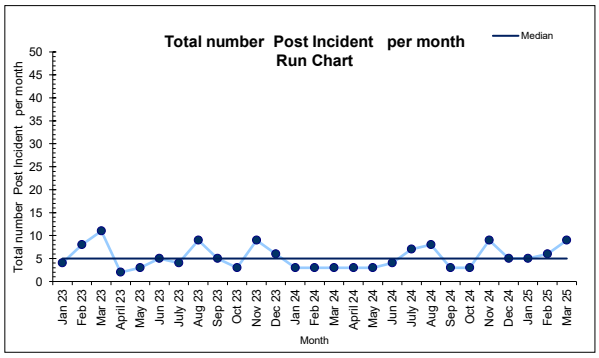

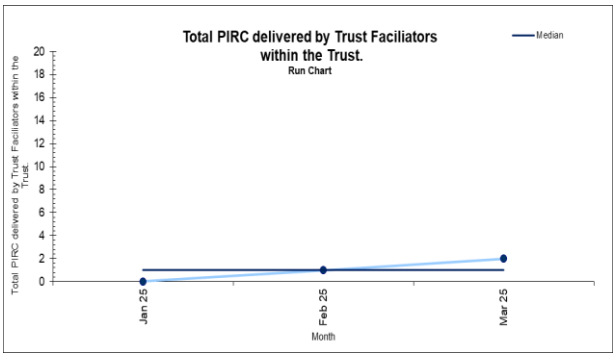

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Mediation, resolution and Coaching

Kindness, Respect, Teamwork
Everyone, Every day

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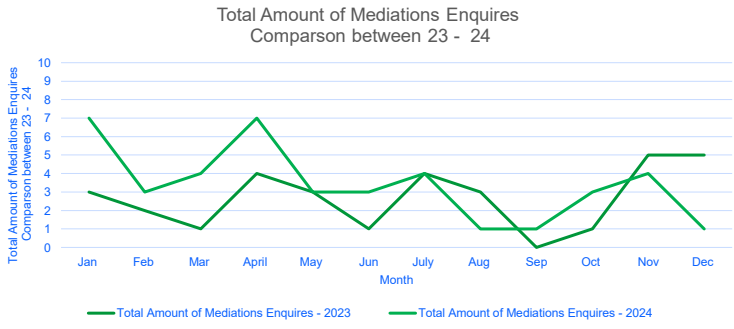
Mediation Enquiries 2023/24

Date	Total Amount of Mediations Enquires - 2023	Total Amount of Mediations Enquires - 2024
Jan	3	7
Feb	2	3
Mar	1	4
April	4	7
May	3	3
Jun	1	3
July	4	4
Aug	3	1
Sep	0	1
Oct	1	3
Nov	5	4
Dec	5	1
Total	32	41



12% year on year increase of mediation requests

Kindness, Respect, Teamwork
Everyone, Every day

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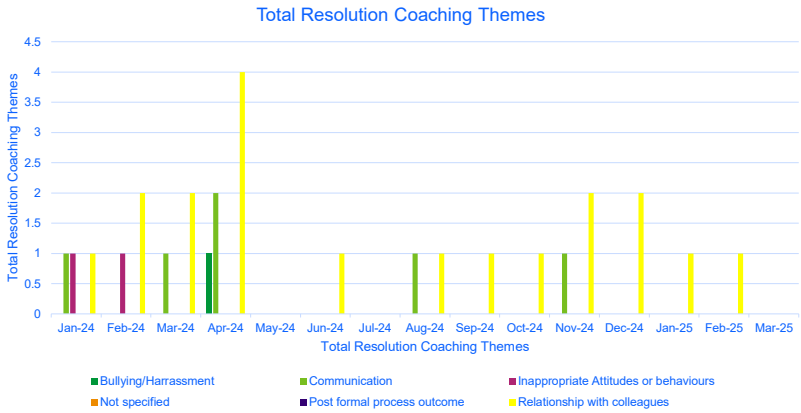
Resolution Coaching Themes

- Yellow indicates themes relating to relationship with colleagues
- Green reflects theme of communication

Both reflect relational aspect of difficulties



Mediation and resolution services Feedback – 'Soothing the System'

"I found the facilitators very helpful. They were able to interpret my thoughts that were heightened and confused by emotion and present them back in a clearer and constructive way".

"Facilitated conversion made me listen and be listened appropriately and a clearer idea of the other party point of view"

"Very Helpful, thought provoking and helped to resolve some of our issues"

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Impact and costs

Kindness, Respect, Teamwork
Everyone, Every day

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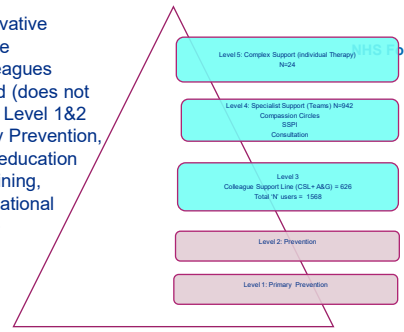
Benefits Realisation SFT Colleague Support Service April 24 – March 25

Apr 2024 – March 25
High level assumptions:

- Percentage benefit derived based on hierarchy of need
- There may be duplication in colleagues accessing support offerings
- Average colleague salary – mid-point B6 (NHS A4C) – £37,361.72 /year - £19.16/hour - £143.69/day (7.5hrs)
- Average colleague sickness – 16 days in rolling 12-month period (i.e. no increase since 2022)
- Based on agency bookings data - £47.22 per hour estimation for a Band 6 agency level, which, in terms of annual cost, equates to about the cost of a top of scale Band 8a when considering we don't pay for annual leave
- 1 person being sick for 16 days @ mid-point B6 = £2,299.04 (minus agency backfill)
- 1 person being sick for 10 days @ mid-point B6 = £1,436.90 (minus agency backfill)
- 1 person being sick for 5 days @ mid-point B6 = £718.45 (minus agency backfill)
- Not factored into calculations: retention, increase in agency costs, backfill
- Unknown savings in reduction in colleague A&E attendances, use of mental health crisis services, use of secondary mental health services, use of primary care

Conservative estimate N=colleagues reached (does not include Level 1&2 Primary Prevention, psychoeducation and training, organisational impact)



2023 – 2024 NHS funding - £334,139 **Trust commitment to funding 2024-2025**	**Estimate 1 assumptions** • Maximum benefit across all interventions CSL 100% 670 Team interventions 100% 806 Individual therapy 100% 32 Total N= 1508 • 16 days sickness (average) **£2,292**	**Estimate 2 assumptions** • Medium benefit across all interventions CSL 75% 502.5 Team interventions 75% 604.5 Individual therapy 75% 24 TOTAL 'n' = **1131** • 10 days sickness (2 weeks) **£1,436.90**	**Estimate 3 assumptions** • Low benefit across all interventions CSL 50% 335 Team interventions 50% 403 Individual therapy 50% 16 TOTAL 'n' = 754 • 5 days sickness (1 week) **£718.45**	**Estimate 4 assumptions** • Extremely low benefit across all interventions CSL 25% 167.5 Team interventions 25% 201.5 Individual therapy 25% 8 TOTAL 'n' = **377** • 1 day sickness **£143.25**
Approx cost avoidance	1508 x £2,292 = **£3456336**	1194 x £1,432.50 = **£1620157.5**	754 x £718.45 = 541711.30	377 x £143.25 = **54005.25**
Approx Return on Investment (ROI) For every £1 spent: X £'s avoided	£334,000 : £**3593856** **£1 : £10.35**	£334,000 : £**1620157.5** **£1 : £4.85**	£334,000 : £541711.3 **£1 : £1.62**	£334,000 : 54005.25 **£1 : 0.16**

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Ambitions

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Plans for 2025/26

Colleague Support and wellbeing: continue integration work to develop integrated aims, reporting profiles and maximise benefits of approach

Continue to develop OH offer under new contract

Continue to build on physical health projects (SASP, Health Fair Pilot), identify and collate relevant measures and set timeline for anticipated progress.

Coaching, Mediation and Resolution: Relaunch internal offers with new support structures to enhance offer for all colleagues

Develop and deliver Compassionate Leadership training in conjunction with L&OD to operationalise, embed and infuse compassion through practice, policy and organisational approach.