Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Integrated Performance Exception Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Lee Cornell, Associate Director – Planning and Performance Ian Clift, Senior Performance Manager Isobel Clements, Chief of People and Organisational Development Xanthe Whittaker, Director of Elective Care Stacy Barron-Fitzsimons, Director for Medical Services Group Sally Bryant, Director of Midwifery Leanne Ashmead, Director of Children, Young People and Families Mark Arruda-Bunker, Service Director, Mental Health and Learning Disabilities Abbie Furnival, Service Group Director – Neighbourhoods and Communities Kerry White, Managing Director – Symphony Healthcare Services Emma Davey, Director of Patient Experience and Engagement
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	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	Our Integrated Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. In respect of the NHS England National priorities and success measures for 2025/26, the areas in which performance has been sustained or has notably improved include: • improving the percentage of patients waiting no longer than 18 weeks for treatment • The percentage of patients admitted,discharged and transferred from A&E within 12 hours.

	Other areas in which performance has been sustained or has notably improved include: • the percentage of patients waiting under six weeks to be seen by our community mental health services remained high. • the number of patients waiting 18 weeks or more from referral to be seen by our community services remains below set target. • patient satisfaction levels across our Symphony Healthcare practices remained high. • the recovery, reliable improvement, and reliable recovery rates for our Talking Therapies service all remain above the national standards. National priority areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • improving the percentage of patients waiting no longer than 18 weeks for a first appointment • the numbers of patients waiting 52 weeks or more for treatment. • performance against the headline 62-day cancer standard. • compliance in respect of Cancer 28 Day Faster Diagnosis. • compliance against the A&E delivery standard in respect of patients being admitted, discharged or transferred within four hours of attendance. • the average length of stay in our adult mental health wards.
Recommendation	The Board is asked to discuss and note the report.

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

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

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
This report has been assessed against the Trust's People Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities A range of key indicators, relating to waiting times for treatment including acute hospital services, cancer services, and mental health services, are routinely monitored to provide assurance that there is equity of provision and access in relation to people with protected characteristics. This includes standards delivered according to recorded ethnicity and learning disability. Our workforce measures also include indicators relating to ethnicity, gender and disability.

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

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

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

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	

SOMERSET NHS FOUNDATION TRUST

INTEGRATED PERFORMANCE EXCEPTION REPORT: SEPTEMBER 2025

TABLE OF CONTENTS

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

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

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

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

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

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

- CQIM NHS England Clinical Quality Improvement Metric
- HDS NHS Hospital Discharge Service: Policy and Operating Model
- ICB Locally agreed measure from the NHS Contract with Somerset Integrated Commissioning Board
- LTP The NHS Long Term Plan, 2019
- NHSC: National measure from the NHS Contract
- NOF NHS Oversight Framework for 2025/26
- NSG Measures derived from a range of guidance documents for Stroke services

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

CHIEF FINANCE OFFICER

NARRATIVE REPORT

NHS ENGLAND NATIONAL PRIORITIES AND SUCCESS MEASURES FOR 2025/26

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

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

- improving the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement against the November 2024 baseline.
- Improving 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.
- Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems.

For these measures, our performance in September 2025 was better than our target trajectory. Areas in respect of which we were underperforming against planned levels included:

- improving the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026 - with every trust expected to deliver a minimum 5%-point improvement against the November 2024 baseline.
- reducing the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026.
- improving A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within four hours in March 2026.
- reducing the average length of stay in adult acute mental health beds.

As at 30 September 2025, the percentage of patients waiting under 18 weeks for a first outpatient appointment increased to 70.6% but was below the plan level of 73.7%. As at 30 September 2025, the number of patients waiting over 52 weeks reduced to 1,740 which represents 3.0% of the waiting list against a target for September 2025 of 2.2%. The improvement to the position, compared to August 2025, is largely related to a reduction in long waiters and to a lesser extent the total waiting list size being higher than plan. A range of actions are in place to manage this position, including waiting list validation, and specialty-level planning and reporting arrangements. It is

acknowledged that the requirement to reduce 52-week waiters to less than 1% of the total waiting list by March 2026 will be a significant challenge, and one which we are likely not to achieve.

Compliance in respect of the A&E and UTC four-hour reporting standard decreased during September 2025 and remained below the current national reporting target of 76%. Combined rolling 12-month A&E attendances at MPH and YDH, for the period from 1 October 2024 to 30 September 2025, were 2.0% lower than the same months of 2023/24. A range of actions and developments are in progress to improve the position, including the Urgent Treatment Centre at Yeovil District Hospital being scheduled to go live during the week commencing 10 November 2025.

As at 31 August 2025 – the latest data available – we were below the compliance standard for the headline 62-day cancer standard, for which the national requirement is to improve performance to 75% by March 2026. Our performance during August 2025 was 70.0%, against a planning trajectory target of 71.8%. The main cause of the breaches for urology continues to be high demand which cannot be accommodated within available capacity. This is mainly for the diagnostic phase of cancer pathways, when tests are still being undertaken to confirm whether a patient has a cancer or a benign condition. Self-referral services continue to be piloted and rolled out for patients with symptoms of cancer, to encourage patients to come forward sooner to get checked out; this will also help to smooth demand. One substantive and one fixed-term urology consultant posts have been appointed to and colleagues are now in post; two consultants have also returned from maternity leave.

Also as at 31 August 2025, the percentage of patients diagnosed with a cancer or given a benign diagnosis within 28 days of referral was 71.3%. The highest volume of breaches of the FDS were in colorectal (29% of breaches; performance 52%), breast (19% of breaches, 73%) performance, gynaecology (13% of breaches; 63% performance), and head & neck (13% of breaches; 68% performance). Breast performance has improved, but remains lower than normal, related to an inability to recruit to a vacancy within breast radiology. The head & neck and gynaecology services have been experiencing high levels of demand. The colorectal and urology teams are taking part in the national 100 Days Matter challenge, which is aiming to deliver a 5% improvement in FDS performance by October 2025.

During 2025/26, there is a requirement to reduce the average length of stay in our adult acute mental health beds. As at 30 September 2025, the rolling three-month average length of stay within our adult mental health wards was 59.8 days, down from 64.7 days at the end of August 2025, but above the planning trajectory level of 55.0 days. To support an improvement, our inpatient Transformation Lead is attending daily Multi-Disciplinary Team (MDT) reviews to keep the focus on any issues and needs that might prevent discharge, and our Associate Medical Director is supporting clinical decision-making.

Responsive

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

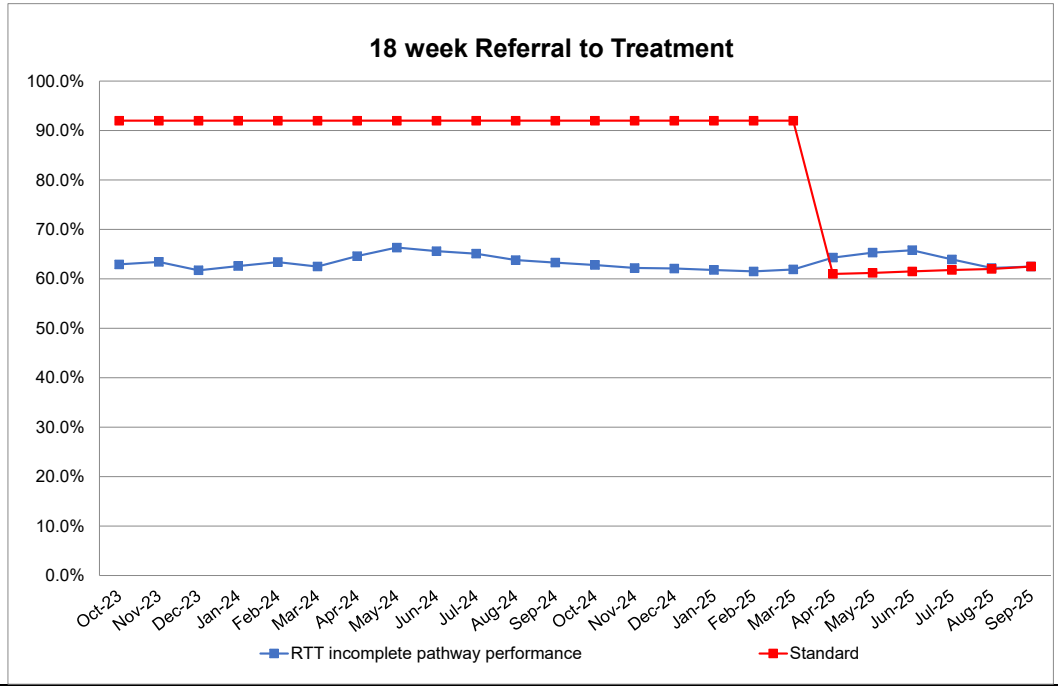
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT was 62.5% in September 2025, up by 0.3% from the August 2025 reported position. The percentage of patients waiting under 18 weeks for a first outpatient appointment increased to 70.6% in September 2025 but remained below plan.
- The total waiting list size increased by 220 pathways, and was 203 higher (i.e. worse) than trajectory (57,935 actual vs. 57,732 plan).
- The number of patients waiting over 52 weeks decreased to 1,740. This represents 3.0% of the waiting list against a target of 2.2%. This improvement is largely related to a reduction in long waiters and to a lesser extent the total waiting list size being higher than plan.
- The number of patients waiting over 65 weeks increased by eight to 157 at the month-end, against a national expectation of zero.
- Ten patients waited over 78 weeks RTT, which was a small increase on the August 2025 reported position of five.

Focus of improvement work

- A specialty-level RTT planning model was developed for 2025/26, which took account of the impact of productivity opportunities and quantifies the level of activity needed to meet the two new national targets of a 5% improvement in performance against the 18-week RTT and first appointment within 18 weeks standards. Delivery plans for the twelve lower-performing, high-volume specialties were refreshed in August 2025 and continue to be reviewed monthly.
- The Trust continues to take part in the national RTT Validation Sprint (please see the Elective Care narrative); this administrative validation of the RTT pathways delivered a 4.7% increase on baseline validation in quarter 2 and is helping to keep the waiting list flat.
- Monitoring reports for all the RTT standards are in place, along with reports to monitor the delivery against the core productivity measures, such as Advice & Guidance, Patient Initiated Follow-ups (PIFU), Did Not Attend (DNA rates) and capped theatre utilisation.

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 61.0% in August 2025, the latest data available; our performance was 62.2%. National performance decreased by 0.3% between July and August 2025; our performance decreased by 1.7%. The number of patients waiting over 52 weeks across the country decreased by 155 to 191,493 (2.6% of the national waiting list compared with 3.2% for the Trust). The number of patients waiting over 78 weeks nationally decreased by 13 to 1,416

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

Area	Mar	May	Jun	Jul	Aug	Sep
18-week trajectory	N/A	61.2%	61.5%	61.8%	62.0%	62.5%
18-week actual	61.9%	65.3%	65.8%	63.9%	62.2%	62.5%
First OPA 18 weeks trajct.	N/A	72.4%	72.7%	73.0%	73.1%	73.7%
First OPA 18 weeks plan	N/A	75.4%	74.1%	72.3%	68.2%	70.6%
52-week trajectory	N/A	2.2%	2.2%	2.2%	2.2%	2.2%
52-week actual	2.1%	2.8%	2.8%	3.0%	3.2%	3.0%

Responsive

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

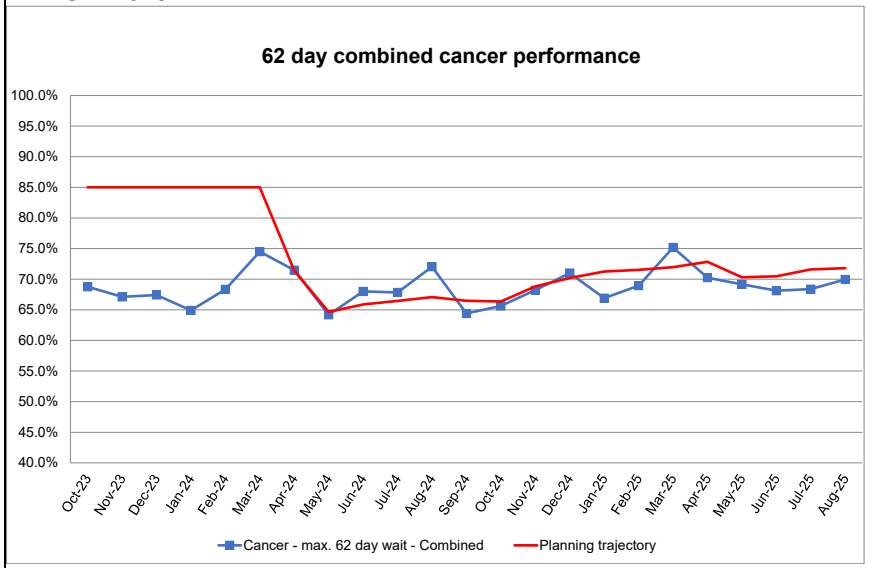
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 70.0% in August 2025, meeting the current national standard of 70%, but performance is below the planning trajectory.
- The main breaches of the 62-day combined cancer standard were in urology (37% of breaches), breast (15%) and skin (14%).
- The main cause of the breaches for urology continues to be high demand which cannot be accommodated within available capacity. This is mainly for the diagnostic phase of cancer pathways, when tests are still being undertaken to confirm whether a patient has a cancer or a benign condition. The breast breaches relate to the delays at the start of the pathway (please see the 28-day faster Diagnosis Standard exception report). The skin breaches relate to the seasonal rise in demand.
- Thirty-one GP referred patients were treated in August 2025, on or after day 104 (the national 'backstop').

Focus of improvement work

- Self-referral services continued to be piloted and rolled out for patients with symptoms of cancer, to encourage patients to come forward sooner to get checked out; this will also help to smooth demand. This includes the Somerset Bowel Service which is now live across three Primary Care Networks (PCNs).
- One substantive and one fixed-term urology consultant posts have been appointed to and colleagues are now in post; two consultants have also returned from maternity leave.
- Urology and Colorectal are taking part in the 100 Days Matter national pathway improvement challenge (please also see the Cancer report).
- Please also see the 28-day FDS Exception report, which provides details of the breast capacity actions, and the Elective Care report for details of endoscopy capacity improvements.

Line Chart



How do we compare

National average performance for providers was 69.1% in August 2025, the latest data available. Our performance was 70.0%. We were ranked 83 out of 148 trusts.

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

Recent performance

62-day GP cancer performance

Area	Mar	Apr	May	Jun	Jul	Aug
% Compliance	75.2%	70.2%	69.2%	68.1%	68.4%	70.0%
Trajectory	72.0%	72.8%	70.3%	70.5%	71.6%	71.8%

Responsive

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

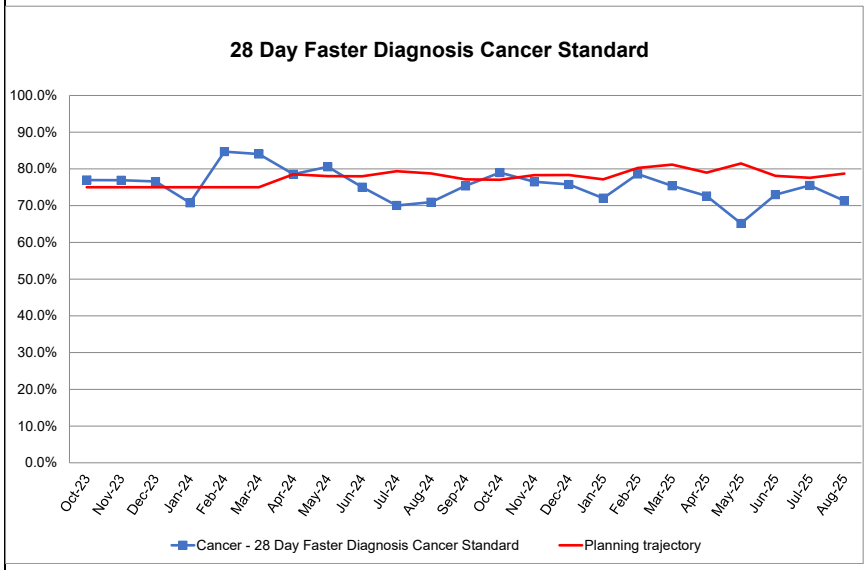
Current performance (including factors affecting this)

- The percentage of patients diagnosed with a cancer or given a benign diagnosis within 28 days of referral was 71.3%.
- The highest volume of breaches of the FDS were in colorectal (29% of breaches; performance 52%), breast (19%; 73%), gynaecology (13%; 63%) and head & neck (13%; 68%).
- The lower performance in colorectal is largely related to waiting times for CT colon scans and colonoscopies, which have increased due to reduced service capacity; the causes of this for endoscopies are multifactorial, including equipment failure, the loss of a locum, nursing and admin team shortages, and issues affecting booking efficiency.
- Breast performance has improved, but remains lower than normal, related to an inability to recruit to a vacancy within breast radiology. The head & neck and gynaecology services have been experiencing high levels of demand.

Focus of improvement work

- The colorectal and urology teams are taking part in the national 100 Days Matter challenge, which is aiming to deliver a 5% improvement in FDS performance by October 2205 (please also see the Cancer report).
- The breast service is attempting to recruit an additional member of the team, who can also provide breast radiology capacity; in the meantime, other radiology capacity is being used to support the service and Yeovil capacity continues to be used to support Taunton.
- A review of gynaecology demand is underway, to understand in which types of tumours there has been growth in demand; work is also ongoing to improve triage and tracking and increase hysteroscopy capacity.
- An advert is out for an ENT consultant; an insourcing contract has been awarded which will free-up capacity to see suspected cancers.
  Additional diagnostic capacity is being established, which will help improve colorectal FDS performance (please also see the Elective Care report).

Line Chart



How do we compare

National average performance for providers was 74.6% in August 2025, the latest data available. Our performance was 71.3%. We ranked 111 out of 140 providers.

Recent performance

Performance in recent months was as follows:

28-day Faster Diagnosis performance

Area	Mar	Apr	May	Jun	Jul	Aug
Trajectory	81.2%	79.0%	81.5%	78.1%	77.6%	78.7%
Compliance	75.4%	72.6%	65.2%	73.0%	75.5%	71.3%

Responsive

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

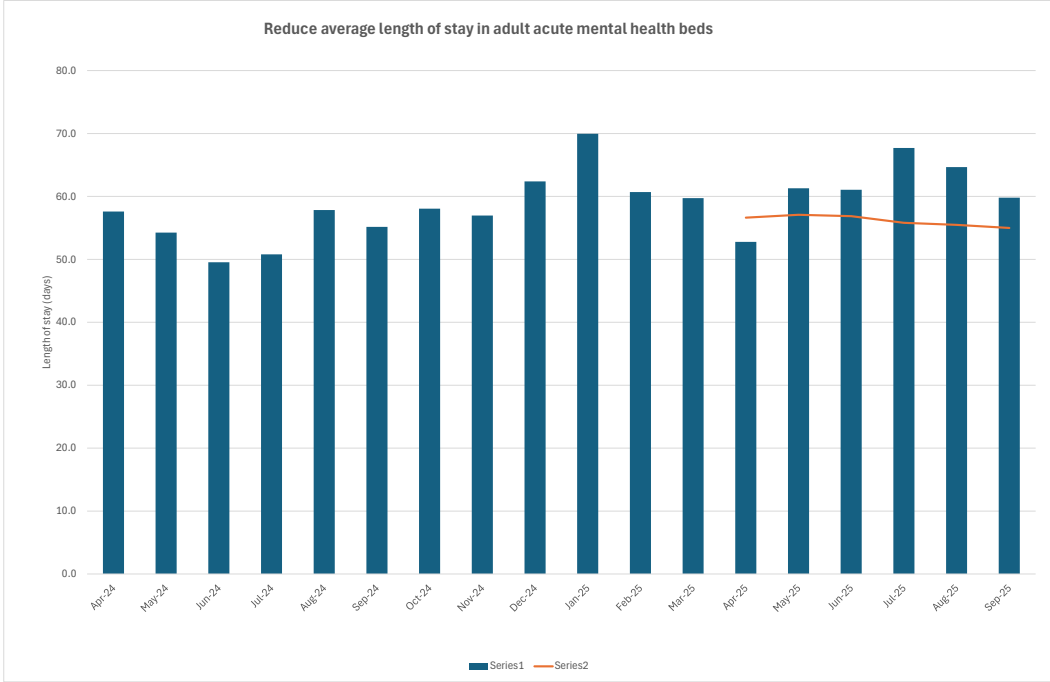
Current performance (including factors affecting this)

- During September 2025 the rolling three-month average length of stay within our adult mental health wards was 59.8 days, above the trajectory agreed with the Somerset Integrated Care Board to reduce our average length of stay from a baseline level of 57.0 days for the three months ending 30 November 2024, to an average of 53.1 days for the three months ending 31 March 2026.
- During September 2025 discharges totalled 42, an increase from 30 reported during August 2025.

Focus of improvement work

- Our average length of stay continues to miss the expected trajectory overall and within adult services, although this did improve in September 2025.
- Whilst Rowan ward data is positive, there are challenges within Rydon ward, contributed to by the patient cohort, Delayed Transfers of Care (DToC) and clinical decision-making.
- To support an improvement, our inpatient Transformation Lead is attending daily Multi-Disciplinary Team (MDT) reviews to keep the focus on any issues and needs that might prevent discharge, and our Associate Medical Director is supporting clinical decision-making.
- DToC increases are contributed to by staffing challenges within the Local Authority, with both sickness and vacancies.

Line Chart



How do we compare

The average length of stay in the three months to 30 September 2025 reduced, when compared to the three months to 31 August 2025.

Performance over the last six months

Area	Apr	May	Jun	Jul	Aug	Sep
Average length of stay	52.8	61.3	61.1	67.8	64.7	59.8
Operational plan	56.6	57.1	56.9	55.8	55.5	55.0

Responsive

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

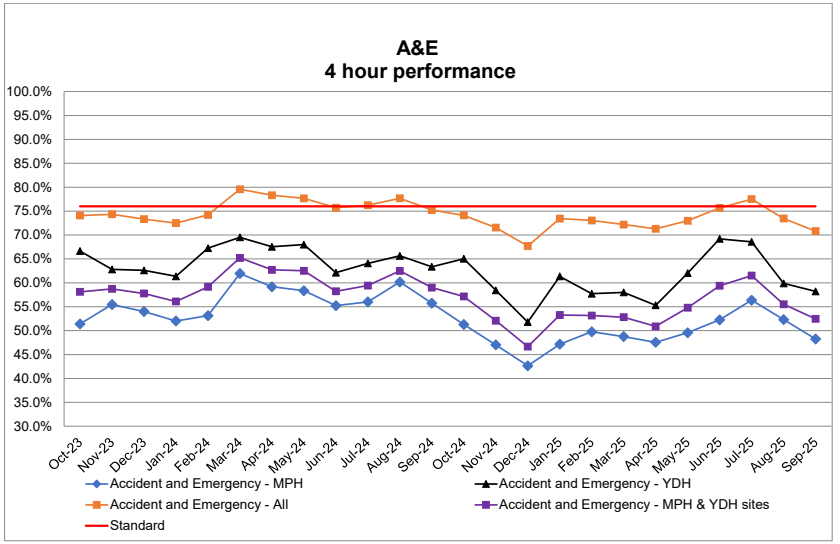
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 52.5% during September 2025, down from 55.5% in August 2025. With Urgent Treatment Centres (UTCs) compliance included at 98.5%, overall compliance was 70.8%, below the 76% national standard.
- Compliance in respect of our two A&E departments was:
    - Musgrove Park Hospital (MPH): 48.3%.
    - Yeovil District Hospital (YDH): 58.2%.
- Combined rolling 12-month A&E attendances at MPH and YDH, for the period from 1 October 2024 to 30 September 2025, were 2.0% lower than the same months of 2023/24.
- We are required to achieve an improvement in respect of the percentage of patients sending less than 12 hours in the departments, compared to the 2024/25 outturn. Between 1 April and 30 September 2025, 95.6% of patients spent less than 12 hours in the departments, which was above the 95.3% achieved in the 12 months ending 31 March 2025.

Focus of improvement work

- Critical incident and high Operational Pressures Escalation Levels (OPEL) levels have delayed preparation and presentation of the Same Day Emergency Care (SDEC) new working model.
- Consultant interviews for MPH ED were subject to withdrawal by applicants. Re-advertisement will take place in November 2025.
- Meetings to develop mental health and bariatric escalation processes are underway, covering both sites – recent meetings cancelled due to Critical Incident pressures.
- The Urgent Treatment Centre (UTC) working group for MPH is progressing, and work is commencing on a parallel case for MPH UTC staffing.
- The Care Co trial for calls to ED (initially MPH only), commenced in October 2025, where conveyance to ED may be avoided. Few calls have so far been received. This has been escalated and will be discussed at next UEC board.
- A UEC Learning and Improvement Network (LIN) bid is being prepared for short-term funding for RN to support the transfer team at MPH.
- The UTC at YDH is due to go live during the week commencing 10 November 2025.
- Quick reference guides for the Timely Handover Process (THP) will be prepared by 31 October 2025, for escalation if THP is not possible.

Line Chart



How do we compare

In September 2025, the national average performance for Trusts with a major Emergency Department was 61.1%. Our performance was 52.5%. We were ranked 94 out of 121 trusts. With Urgent Treatment Centre attendances included, we were ranked 70, with performance of 70.8%. National average performance was 72.5 %.

Recent performance

Area	Apr	May	Jun	Jul	Aug	Sep
A&E only	50.9%	54.8%	59.4%	61.5%	55.5%	52.5%
Including UTC	71.3%	73.0%	75.7%	77.5%	73.5%	70.8%

SOMERSET NHS FOUNDATION TRUST

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

No.	Priority	Success Measure	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
NP1	Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline	1,2	62.8%	62.2%	62.1%	61.8%	61.5%	61.9%	64.3%	65.3%	65.8%	63.9%	62.2%	62.5%	Per the planning trajectory, culminating in 67.3% in March 2026.		P
NP2		Improve the percentage of patients waiting longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline	1,2	74.3%	74.7%	73.7%	74.7%	73.8%	73.9%	74.7%	75.4%	74.1%	72.3%	68.2%	70.6%	Per the planning trajectory, culminating in 80.3% in March 2026.		F
NP3		Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	1,2	2.5%	2.3%	2.3%	2.4%	2.4%	2.1%	2.5%	2.8%	2.8%	3.0%	3.2%	3.0%	Per the planning trajectory, culminating in 1.5% in March 2026.		F
NP4		Improve performance against the headline 62-day cancer standard to 75% by March 2026	1,2	65.6%	68.2%	71.0%	66.9%	68.9%	75.2%	70.2%	69.2%	68.1%	68.4%	70.0%	Data not yet due	From March 2025 at or above trajectory =Green and below trajectory =Red		F
NP5		Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	1,2	79.0%	76.5%	75.8%	72.0%	78.6%	75.4%	72.6%	65.2%	73.0%	75.5%	71.3%	Data not yet due	From March 2025 at or above trajectory =Green and below trajectory =Red		F
NP6	Improve A&E waiting times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026: **Trust-wide performance**	2	74.1%	71.6%	67.7%	73.4%	73.0%	72.2%	71.3%	73.0%	75.7%	77.5%	73.5%	70.8%	From April 2025 >=76%= Green >=66% - <76% =Amber <66% =Red (the standard will rise to 78% in March 2026)		F
NP7		Improve A&E waiting times, with a higher proportion of patients admitted, discharged or transferred from ED within 12 hours across 2025/26 compared to 2024/25 - **Trust-wide performance**	2	97.0%	96.7%	96.0%	95.5%	95.2%	95.3%	92.9%	93.9%	94.9%	95.5%	95.6%	95.6%	From April 2025 >=95.3% = Green <95.3% = Red		P
NP8	Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds	2,6	58.1	57.0	62.4	70.0	60.7	59.7	52.8	61.3	61.1	67.8	64.7	59.8	Per the planning trajectory, culminating in 53.1 days in March 2026.		F
NP9	Live within the budget allocated, reducing waste and improving productivity	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	6	£17,862K	£20,290K	£22,460K	£24,679K	£26,790K	£28,921K	£1,827K	£3,489K	£5,098K	£6,747K	£8,247K	£9,731K	>=30% reduction= Green >=25% - <30% reduction =Amber <25% reduction =Red		P
NP10		Close the activity / WTE gap against pre-Covid levels (adjusted for case mix)	6	To be included in the six-monthly Productivity report.												To be confirmed.		
NP11	Maintain focus on quality and safety of services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'	1,2	Progress reported via regular updates to our Quality and Governance Assurance Committee.												To be confirmed.		
NP12	Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people	1	Clarification sought from NHS England as to how this is to be monitored and assessed.												To be confirmed.		

Sector-Based Performance Summaries

NARRATIVE REPORT

NEIGHBOURHOODS AND COMMUNITY SERVICES

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

Achievements

- Engagement work with the public around community hospital transformation has been taking place during August and September 2025. This will extend into October 2025, followed by engagement with staff and town councils with dates booked in Crewkerne and Burnham-on-Sea in November 2025 around a proposal for a test and learn.
- 550 members of the public have completed the Director of Patient Experience and Engagement's, survey as part to the public engagement.
- Hospital at Home: In October 2025 the team have surpassed a total of 7,000 admissions since the service began. In September 2025, we received a total of 311 referrals, a new high, and above the profiled plan level for the month. The team had 308 admissions (197 Frailty, 111 Respiratory), which was also a new high, exceeding the previous high of 305 in January 2025. The average caseload level in September 2025 was 100 (50 Frailty, 50 Respiratory), up from 85 in August 2025.
- Community service waiting times: the number of people waiting over 18 weeks from referral to first appointment (excluding dental) reduced slightly, from 473 as at 31 August 2025 to 465 as at 30 September 2025, and remained below the 2025/26 reporting standard of 536. No patients had waited 52 weeks or more.
- Waiting times for our community mental health services for older people remain low. As at 30 September 2025, 99% of people waiting to be seen had waited under six weeks.

Challenges

- Financial recovery conversations and plans continue to be worked through, with a focus on discretionary spend and the completion of Quality and Equality Impact Assessments (QEIAs).
- Hospital at Home Caseload: Continues to be lower than planned, however, there is continued improvement. As at 17 October 2025, the team had had 168 admissions (111 Frailty, 57 Respiratory), which projects to a month-end total of 372, which would be a new high.
- There are some challenges around the utility of our Care Co-ordination Hub engagement with SWAST and there are some cases where decision making around avoiding a conveyance to ED is hampered by Rapid Response capacity. This has come to light

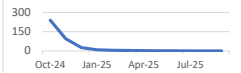
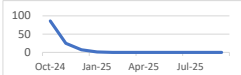
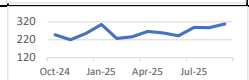
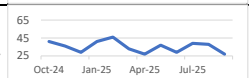
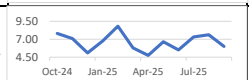
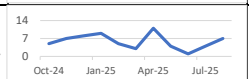
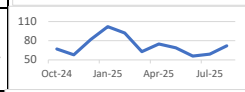
during the recent Critical Incident and demonstrates a gap in business continuity arrangements when services like Discharge to Assess (D2A) and Rapid Response are full.

Actions to Address Underperformance:

- Referral levels, and also numbers of admissions to the hospital at home (virtual) beds have both recently increased following engagement work undertaken by the service with general practices and Primary Care Networks. From 1 October 2025 hospital at home has been providing inreach to the Acute frailty units as part of a six-month trial.
- Care Co-ordination Hub: actions include producing an escalation framework which includes notification to the senior service leadership teams where community services lack capacity to accept referrals from Care-Co, and to produce escalation plans for receiving community services on actions required to free up capacity during periods of increased demand or reduce capacity due to workforce gaps.

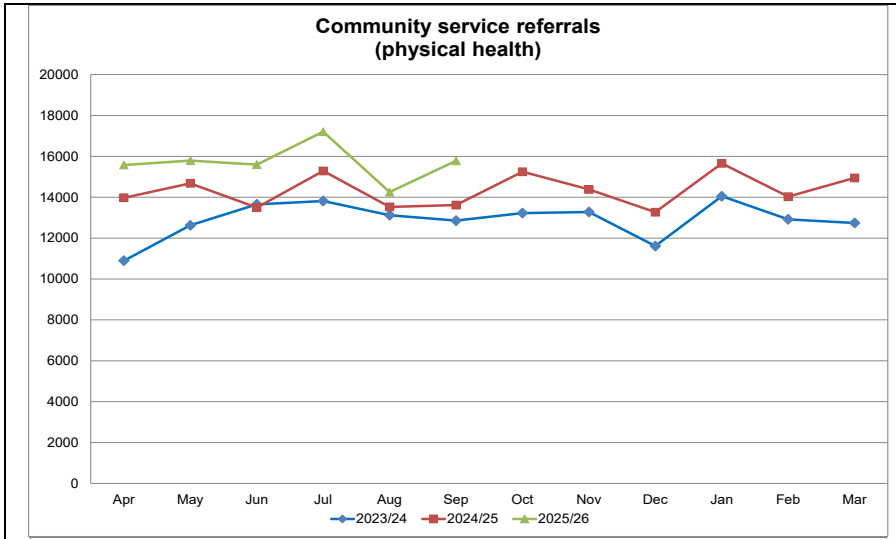
SOMERSET NHS FOUNDATION TRUST

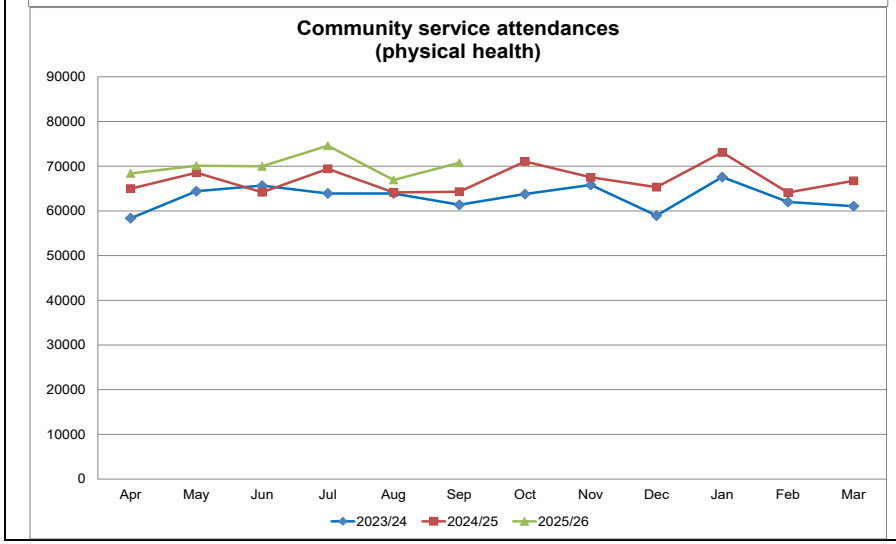
NEIGHBOURHOODS AND COMMUNITY SERVICES

No.	Description	Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
NC1	Mental health referrals offered first appointments within 6 weeks Older Persons mental health services	ICB	1,2,3	97.8%	94.7%	97.7%	91.1%	96.2%	96.2%	97.5%	98.0%	100.0%	96.8%	97.2%	99.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
NC2	Community service waiting times: number of people waiting over 18 weeks from referral to first appointment (excluding dental)	SFT	1,2,3	1,426	1,061	768	592	576	589	554	536	472	405	473	465	From April 2025 <536 = Green >536 = Red		P
NC3	Community service waiting times: number of people waiting over 52 weeks from referral to first appointment (excluding dental)	PAF	1,2,3	240	95	26	9	5	4	2	1	1	0	0	0	From April 2025 0 = Green >0 = Red		P
NC4	Community service waiting times: percentage of people waiting over 52 weeks from referral to first appointment (excluding dental)	PAF	1,2,3	2.82%	1.10%	0.29%	0.10%	0.05%	0.04%	0.02%	0.01%	0.01%	0.00%	0.00%	0.00%			P
NC5	Community service waiting times: number of people waiting over 104 weeks from referral to first appointment (excluding dental)	SFT	1,2,3	86	25	7	1	0	0	0	0	0	0	0	0			P
NC6	Intermediate Care - Patients all ages discharged home from acute hospital beds on pathway 0 or 1	HDS	1,2,3	95.0%	95.0%	93.8%	94.4%	95.5%	95.0%	95.5%	94.9%	94.9%	94.5%	95.3%	95.3%	>=95%= Green >=85% - <95% =Amber <85% =Red		?
NC7	Urgent Community Response: percentage of patients seen within two hours	NHSC	1,2,3	87.4%	87.1%	93.4%	92.6%	92.7%	90.9%	91.9%	93.0%	92.6%	93.5%	92.0%	Data not yet due	>=70%= Green >=60% - <70% =Amber <60% =Red		P
NC8	Hospital at Home - Caseload Size	VWOF	1,2,3	70	66	68	72	84	89	92	77	77	74	85	100	>167 = Green >134 - <167 =Amber <134 =Red		F
NC9	Hospital at Home - Admissions	VWOF	1,2,3	248	220	255	305	227	237	266	258	242	289	288	308	>419 = Green >377 - <419 =Amber <377 =Red		F
NC10	Total number of patient falls - community hospitals	NHSC	2	41	36	29	41	46	33	27	37	29	39	38	27	Monitored using Statistical Process Control rules. Report by exception.		
NC11	Rate of falls per 1,000 occupied bed days - community hospitals	NHSC	2	7.81	7.08	5.10	6.76	8.82	5.78	4.75	6.65	5.52	7.32	7.62	5.99	Monitored using Statistical Process Control rules. Report by exception.		
NC12	Community hospitals - number of pressure ulcers	NHSC	2	5	7	8	9	5	3	11	4	1	4	7	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC13	Rate of pressure ulcer damage per 1,000 occupied bed days	NHSC	2	0.95	1.38	1.41	1.48	0.96	0.53	2.01	0.54	0.19	0.75	1.40	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC14	District nursing - number of pressure ulcers	NHSC	2	67	58	82	102	92	63	75	69	56	59	72	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC15	Rate of pressure ulcer damage per 1,000 district nursing contacts	NHSC	2	2.11	1.88	2.60	3.10	3.15	2.02	2.36	2.11	1.72	1.78	2.32	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC16	Total number of medication incidents in a community setting	NHSC	2	40	17	32	43	22	24	31	21	36	27	27	45	Monitored using Statistical Process Control rules. Report by exception.		

Operational context

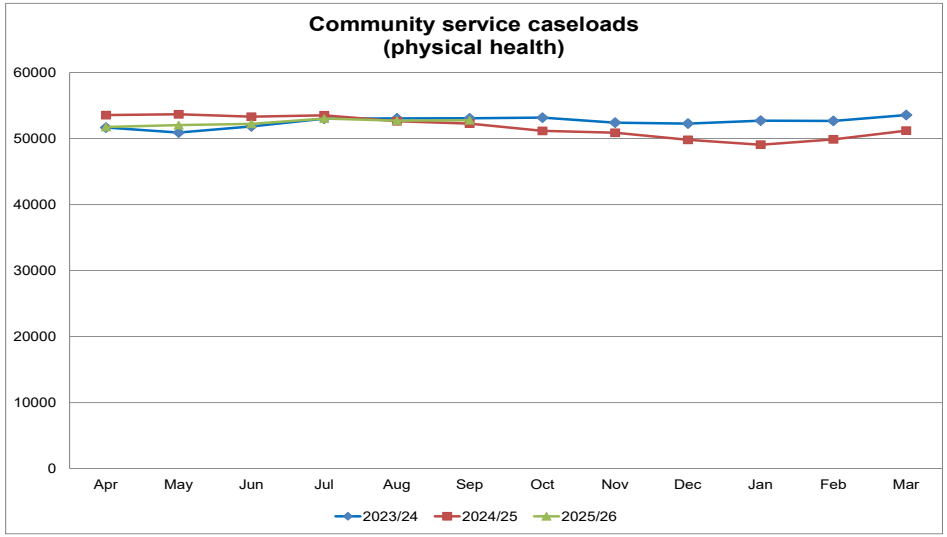
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





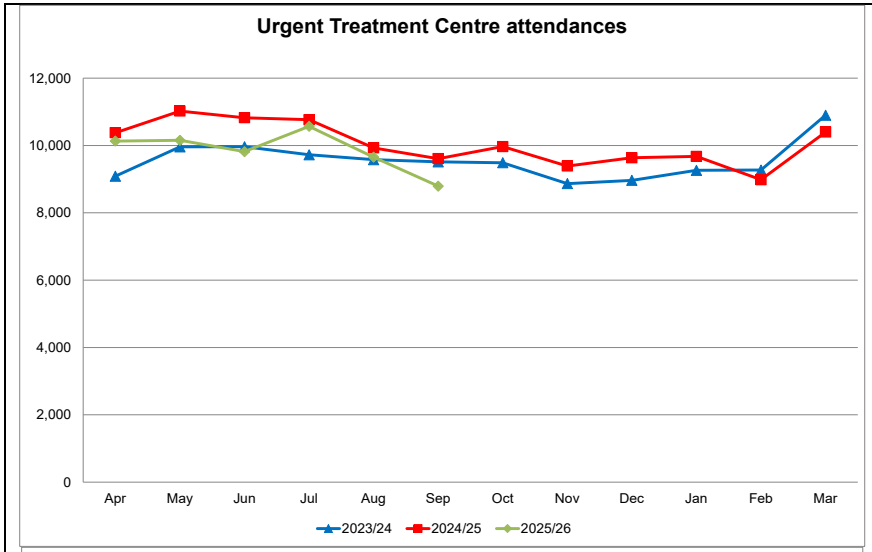
Summary:

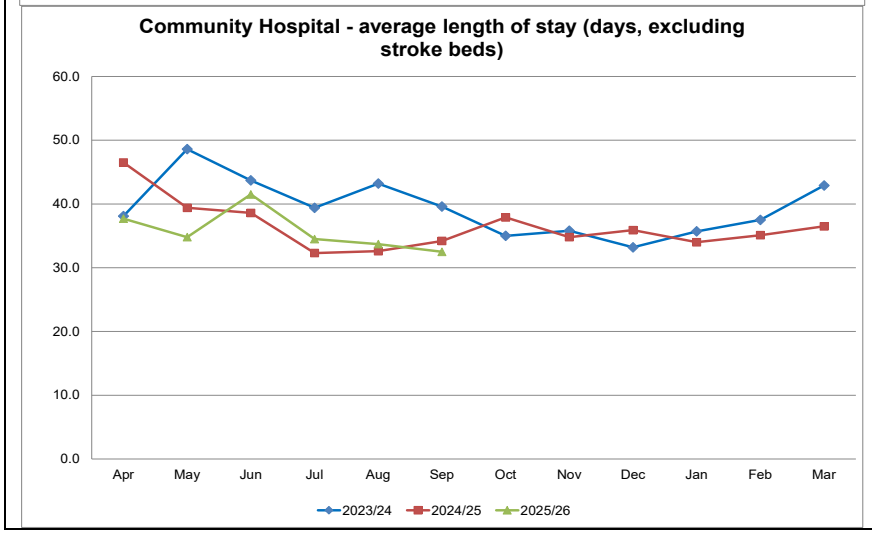
- Direct referrals to our community physical health services between 1 April and 30 September 2025 were 11.4% higher than the same months of 2024 and 22.4% higher than the same months of 2023. Services with the highest increases include Rapid Response, Diabetes Integrated Care and District Nursing.
- Attendances for the same reporting period were 6.4% higher the same months of 2024 and 11.4% higher than the same months of 2023.
- Community service caseload levels as at 30 September 2025 were 1.0% lower than as at 30 September 2024, and 0.5% lower than as at 30 September 2023.



Operational context

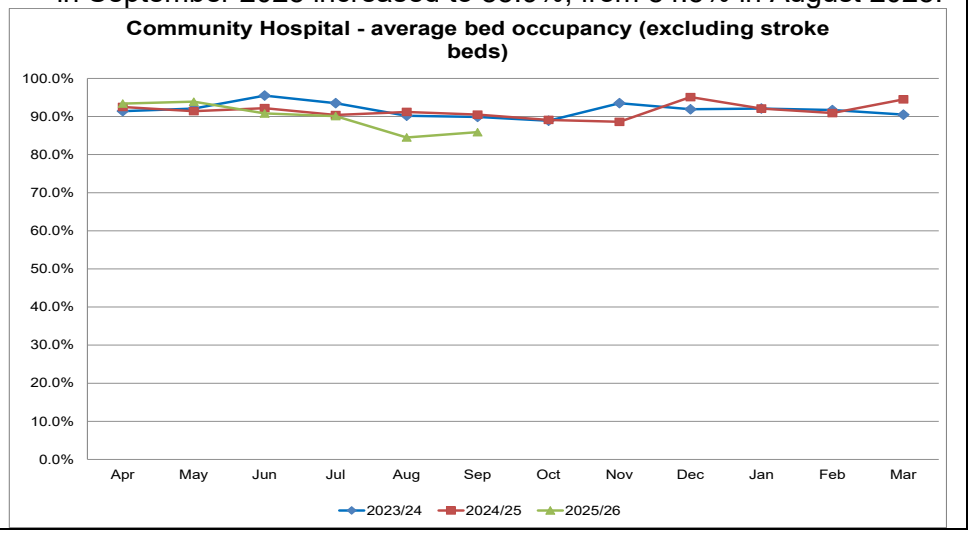
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





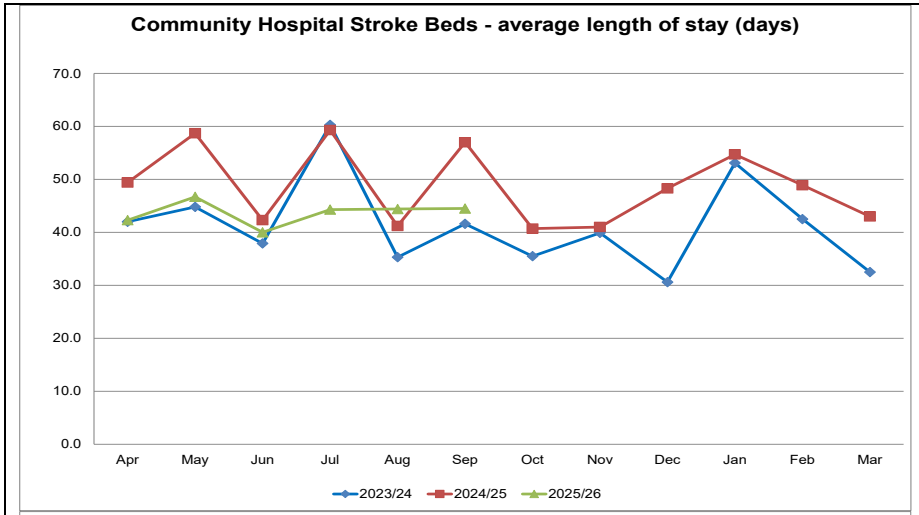
Summary:

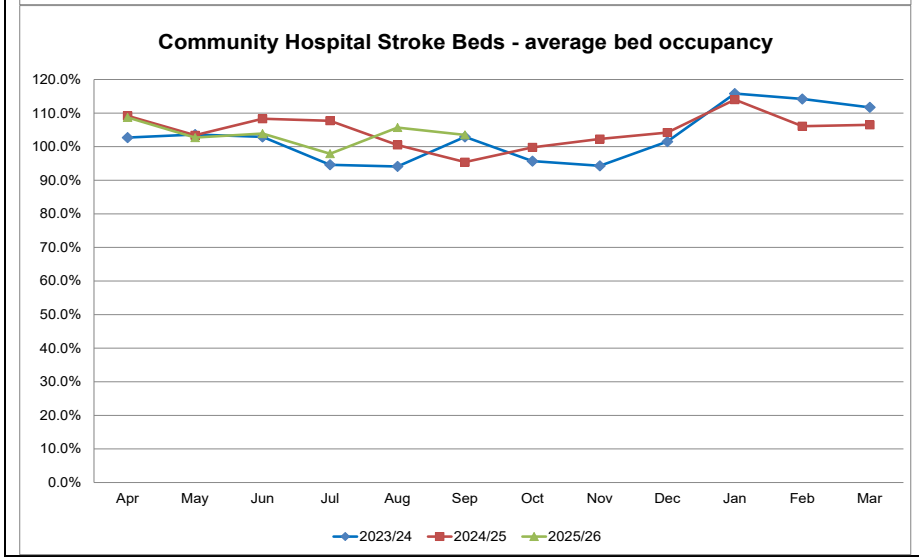
- Between 1 April and 30 September 2025, the number of Urgent Treatment Centre attendances was 5.5% lower than the same months of 2024 but 2.2% higher than the same months of 2023. During September 2025, 98.5% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%.
- The average length of stay for non-stroke patients in our community hospitals in September 2025 was 32.5 days; a decrease compared to August 2025. During September 2025, two patients discharged had a length of stay of 100 days or more. The rolling 12-month average length of stay in respect of non-stroke patients ending 30 September 2025 was 35.8 days, compared to 36.9 days for the 12-month period ending 30 September 2024.
- The community hospital bed occupancy rate for non-stroke patients in September 2025 increased to 85.9%, from 84.5% in August 2025.



Operational context

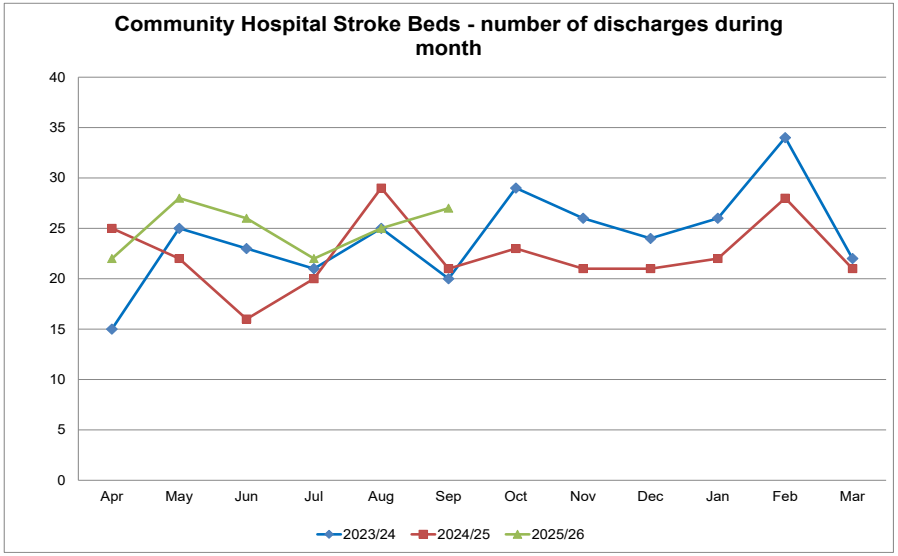
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay for stroke patients in our community hospitals in September 2025 slightly increased to 44.5 days, from 44.4 days in August 2025. Three patients were discharged with lengths of stay of 100 days or more. The rolling 12-month average length of stay in respect of stroke patients for the period ending 30 September 2025 was 44.9 days, compared to 44.6 days for the 12-month period ending 30 September 2024.
- Stroke bed occupancy in September 2025 decreased compared to August 2025.
- During September 2025 there were 27 discharges of stroke patients, compared to 25 during August 2025.



NARRATIVE REPORT

SYMPHONY HEALTHCARE SERVICES

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

What is Going Well

- **Finance 2025/26**
  Financial budget for 2025/26 and Cost Improvement Programme are on plan.
- Patient satisfaction levels remain high.

What Requires Improvement and Planned Actions

- **GP Vacancy Rate (S4):**
  The GP vacancy rate deteriorated in September 2025, but is expected to improve as offers have been accepted for replacements.

- **Average time for calls in queue (S7):**
  This has deteriorated, primarily due to very high sickness levels in our patient support advisor team in September 2025. This was mainly due to cold-like symptoms.

Other updates

The primary focus within Symphony is the ongoing alignment of contracts for Highbridge and Burnham, with the official merger set for 11 November 2025. The newly combined entity will be known as Symphony North Healthcare. In parallel, engagement activities continue including a meeting with MP Adam Dance on 3 October 2025 as plans progress for the proposed merger of South Somerset West Primary Care Network, targeting a launch date of January 2026.

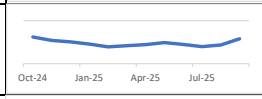
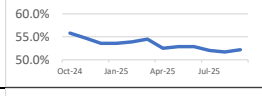
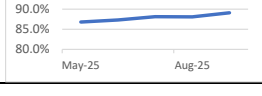
In September 2025, South Somerset West Primary Care Network (part of Symphony) partnered with SFT Perioperative Services to deliver the first collaborative super clinic. Feedback has been overwhelmingly positive, and plans are in motion to make this a regular initiative, with evaluation of its impact already underway.

Awards

- Dr Harvey Sampson (former Symphony Director) was awarded a British Empire Medal for his services to general practice in Somerset.
- Kate Williams (Nursing Director – Symphony) was awarded the ‘Winner’ of the NHSE SW Community and Primary care Nursing Awards on 16 October 2025.
- Lauren Jagelman was highly commended as student /nursing associate of the NHSE SW Community and Primary care Nursing Awards on 16 October 2025.

SOMERSET NHS FOUNDATION TRUST

SYMPHONY HEALTHCARE SERVICES

No.	Description	Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
S1	Dementia diagnosis rates for patients aged 65 years plus	OPG	1,3,4	53.9%	53.9%	53.5%	52.6%	52.3%	51.9%	52.5%	53.1%	54.0%	53.8%	54.1%	54.1%	>=66.7%= Green >=61.7% - <66.7% =Amber <61.7% =Red		F
S2	Increase the % of patients with hypertension treated according to NICE guidance	OPG	1,2,3	91.5%	91.5%	91.5%	91.5%	91.5%	91.5%	70.0%	72.0%	73.5%	73.3%	72.4%	73.1%	>=Above trajectory = Green <below trajectory = Red To achieve 85% by March 2026		P
S3	Increase the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance	OPG	1,2,3	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	65.0%	65.0%	55.0%	65.0%	61.0%	61.0%	>=50%= Green >=40% - <50% =Amber <40% =Red. Target to be achieved by year end		P
S4	GP Vacancy rate	SHS	6	8.0%	6.0%	7.0%	8.0%	1.0%	2.0%	4.0%	7.0%	4.0%	2.0%	3.0%	6.0%	=<5%= Green >5% - <10% =Amber >10% =Red		?
S5	Percentage of total Quality and Outcomes Framework (QOF) points	SHS	1,2,3	84.0%	86.0%	87.0%	89.0%	93.0%	95.0%	75.0%	75.0%	75.0%	75.3%	76.4%	77.4%	Profiled target: 95% by year end		P
S6	Patient satisfaction rate	SHS	2,3	93.4%	92.6%	90.3%	92.4%	94.3%	92.6%	92.1%	91.8%	89.7%	92.1%	90.4%	91.1%	>=85%= Green >=75% - <85% =Amber <75% =Red		P
S7	Average time for calls in queue	SHS	2,3	07:27	06:30	06:05	05:29	04:42	05:01	05:20	05:52	05:23	04:45	05:12	06:58	=<4 minutes = Green >4 minutes - =<6 minutes = Amber >6 minutes = Red		F
S8	Ask My GP/Klinik/AccuRX/Anima – percentage of requests raised online	SHS	2,3	55.8%	54.7%	53.6%	53.6%	53.9%	54.5%	52.5%	52.9%	52.9%	52.0%	51.7%	52.2%	>=50%= Green >=40% - <50% =Amber <40% =Red		P
S9	Seen within two weeks of request (acute team only)	SHS								83.6%	86.8%	87.3%	88.1%	88.1%	89.1%	>=90%= Green >=80% - <90% =Amber <80% =Red		F

NARRATIVE REPORT

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

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

What is going well

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

A significant and sustained improvement has occurred in bed management and patient flow following the 'Breaking the Cycle' week; a further week is planned for November 2025. There have been no new inappropriate Out of Area or Out of Trust admissions since 16 September 2025, with much improved acute bed availability.

The number of women accessing specialist community Perinatal mental health service remains better than the planned level, and the percentage of people beginning treatment with our Early Intervention in Psychosis service with a NICE-recommended care package within two weeks of referral was 86.4% in September 2025, significantly above the 60% national standard. Home Treatment service and Psychiatric Liaison continue to exceed the expected standards for access.

Talking Therapies continues to perform well in a number of areas, and the Reliable Recovery rate remained compliant, after the one-month dip in July 2025. The percentage waiting under six weeks has continued its improving position, and is now slightly under the 75% target at 73.1%. Compliance is measured on the discharge of the patient, and current performance reflects an issue affecting the service around 12 months ago, when there were no assessment workers and the service was struggling to recruit. This target is expected to be met in the next month.

What is going less well

Waiting times for our community mental health services increased in September 2025, with only 87.5% being seen within six-weeks, however this is contributed to by reduced capacity over the summer leave period and is expected to return to compliance. The demand on Community Mental Health Services (CMHS) for ADHD patients and their care and delivery is continuing to cause challenges, and a two-tier system. The current practice is for a patient with a private diagnosis, often through Right to Choose, being directed to CMHS

rather than the ADHD service, despite ADHD not being a mental illness. A review of the current pathway and referral routes is being undertaken to clarify expectations to patients and referrers. Whilst this will not address overall ADHD capacity challenges, it will stop private patients getting a quicker service (seen within a six-week target time) than those referred directly to the ADHD service. A full ADHD transformation model has been presented to the Integrated Care Board (see focus of improvement work).

VTE and physical health reporting remain below the reporting standards, however this is predominantly an issue of where the information is recorded, and not that these checks are being missed. Manual audits evidence that these are being completed, primarily by resident doctors, but within the progress notes, which means they are not picked up for automated reporting.

Whilst many targets within Talking Therapies continue to be met, there are a few that remain challenged. The number of people discharged having received at least two treatment appointments, continues to miss the trajectory, although the gap significantly narrowed in September 2025. Further planned recruitment is key to meeting this target. The number of people who did not have their second treatment appointment within 90 days of the first appointment has continued to deteriorate. Work is taking place on the step 2 offer, which is “assess to treat” and has no-to-low waits – these are courses and workshops as well as low intensity CBT – in addition to putting on some bespoke assessment training to ensure people are on the right pathway using a stepped care model if it is appropriate.

Communication within the team has been undertaken to be clear with staff about what our offer is, based on the commissioned model, rather than trying to offer something for everyone. Step 3 patients waiting 18 weeks or more for commencement of therapies is not a national target, but there is additional funding specifically for this area, although the service have not yet been able to recruit to this.

Focus of improvement work

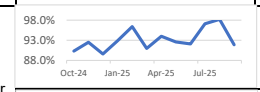
The Service Group leadership have reviewed their strategic plans, and focus, for the next 6-18 months. Key areas of focus are the continuation of the Inpatient Transformation programme; financial management; ADHD; OMH/CMHS interface and identity; and Clinical Pathways, including clinical recording standards.

A community mental health services review commenced in September 2025 to review demand and capacity, improve multidisciplinary team working the interface and pathways between the Community Mental Health Service (CMHS) and Open Mental Health (OMH), support workforce planning with the relevant skill-mixes, and determine where there are further opportunities for recurrent cost improvement savings.

Primary Care challenges are identified as an area that requires particular focus, as OMH was set up as a non-medical delivery service (and with no additional resource), but some GPs are refusing to prescribe anti-depressants or anti-psychotics if being supported by OMH, which is also contrary to the ICS formulary. Early discussions have started with the Managing Director of Symphony Healthcare Services to see whether improvements are possible. Support is also requested to review the system formulary, which stipulates all psychotropic medicines require shared care, which is inconsistent with neighbouring systems.

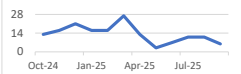
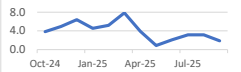
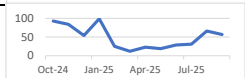
SOMERSET NHS FOUNDATION TRUST

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description		Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
MH1	Mental health referrals offered first appointments within 6 weeks	Adult mental health services	ICB	1,2,3	90.3%	92.5%	89.6%	92.9%	96.4%	91.0%	94.0%	92.6%	92.1%	97.1%	98.2%	91.9%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
MH2		Learning disabilities service	ICB		100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-			P
MH3	Percentage of women accessing specialist community Perinatal Mental Health service - 12 month rolling reporting		LTP	1,2	721	713	714	705	706	713	689	690	657	655	642	651	>=640 = Green <640 = Red		P
MH4	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		NHSC	1,2,3	100.0%	100.0%	91.7%	94.4%	93.8%	88.2%	81.3%	80.0%	86.7%	87.5%	88.9%	86.4%	>=60%= Green <60% =Red		P
MH5	Talking Therapies RTT : percentage of people waiting under 6 weeks		NHSC	1,2,3	86.9%	85.6%	79.4%	81.5%	73.6%	69.6%	66.0%	58.8%	60.3%	63.6%	64.3%	73.1%	>=75%= Green <75% =Red		F
MH6	Talking Therapies RTT: percentage of people waiting under 18 weeks		NHSC	1,2,3	98.3%	97.8%	98.4%	99.0%	98.4%	99.3%	98.7%	98.6%	100.0%	99.3%	99.2%	99.2%	>=95%= Green <95% =Red		P
MH7	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		NHSC	1,2,3	53.0%	56.9%	56.3%	56.3%	55.9%	58.4%	55.5%	57.6%	56.9%	50.3%	52.7%	50.7%	>=50%= Green <50% =Red		P
MH8	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Improvement		NHSC	1,2,3	73.6%	75.9%	71.0%	75.1%	72.4%	70.5%	72.7%	75.9%	74.2%	70.1%	74.3%	70.6%	>=67%= Green <67% =Red		P
MH9	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Recovery		NOF, NHSC	1,2,3	52.6%	52.6%	50.1%	53.9%	51.4%	54.2%	50.9%	56.6%	52.1%	47.3%	48.7%	48.0%	>=48%= Green <48% =Red		P
MH10	Adult mental health inpatients receiving a follow up within 72 hours of discharge		NHSC	1,2	96.9%	100.0%	97.1%	100.0%	94.6%	97.5%	96.7%	96.2%	94.9%	100.0%	94.3%	100.0%	>=80%= Green <80% =Red		P
MH11	Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end		LTP	1,2	4	2	1	1	6	3	2	2	4	3	3	2	1= Green >1 = Red		F
MH12	Percentage of adult inpatients discharged with a length of stay exceeding 60 days		NOF, PAF	2,3	28.6%	32.0%	33.3%	31.3%	33.0%	27.5%	27.1%	25.5%	30.2%	32.6%	34.8%	36.2%	To be confirmed		
MH13	Percentage of inpatients referred to stop smoking services		PAF	1,2	Reporting was planned to commence from May 2025. However, data anomalies have been identified. The topic lead is working with our Data Analytics team to investigate these and the issue and resolution is awaited												To be confirmed		
MH14	Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours		NOF, PAF	1,2,3	89.9%	90.7%	91.6%	93.0%	92.8%	90.0%	92.3%	90.8%	91.3%	90.2%	90.1%	91.2%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
MH15	Number of people accessing community mental health services with serious mental illness - rolling 12 month number.		NOF, PAF	1,2,3,4	10,048	10,035	10,071	9,974	9,965	9,916	9,805	9,744	9,977	10,113	10,141	Data not yet due	To be confirmed		

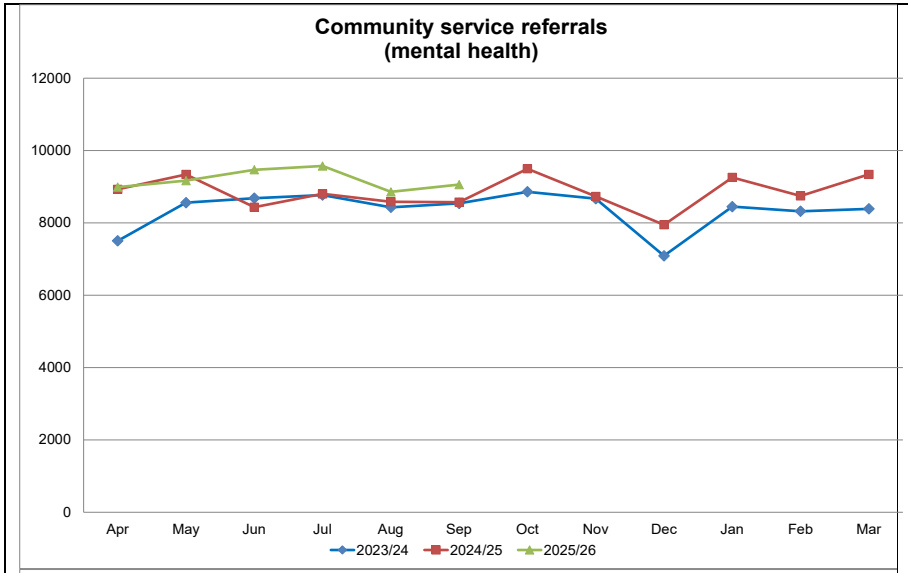
SOMERSET NHS FOUNDATION TRUST

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
MH16	Percentage of people with suspected autism awaiting contact for over 13 weeks (aged 18 or over)	NOF, PAF	2,3,4	86.7%	91.4%	90.3%	93.0%	97.0%	98.2%	97.0%	98.7%	98.0%	99.0%	98.2%	97.6%	To be confirmed		
MH17	Percentage of adults over the age of 65 with a length of stay beyond 90 days at discharge	NOF, PAF	2,3	2.3%	16.7%	5.1%	3.0%	11.4%	6.8%	4.3%	14.3%	6.7%	2.5%	Data awaited	Data awaited	To be confirmed		
MH18	Total number of patient falls - mental health inpatient wards	NHSC	2	13	16	21	16	16	27	13	3	7	11	11	6	Monitored using Statistical Process Control rules. Report by exception.		
MH19	Rate of falls per 1,000 occupied bed days	NHSC	2	3.8	5.0	6.4	4.6	5.2	7.9	3.9	0.9	2.1	3.2	3.2	1.9	Monitored using Statistical Process Control rules. Report by exception.		
MH20	Restrictive Interventions - total number of incidents	NOF, NHSC	2	63	98	45	77	90	119	114	72	155	108	43	69	Monitored using Statistical Process Control rules. Report by exception.		
MH21	Restrictive Interventions per 1,000 occupied bed days	NHSC	2	18.5	30.4	13.7	22.0	29.2	34.7	34.3	20.9	45.7	31.2	12.3	21.5	Monitored using Statistical Process Control rules. Report by exception.		
MH22	Number of prone restraints	NHSC	2	22	16	5	21	14	6	15	9	3	5	3	1	Monitored using Statistical Process Control rules. Report by exception.		
MH23	Prone restraints per 1,000 occupied bed days	NHSC	2	6.5	5.0	1.5	6.0	4.5	1.7	4.5	2.6	0.9	1.4	0.9	0.3	Monitored using Statistical Process Control rules. Report by exception.		
MH24	Total number of medication incidents in a mental health setting	NHSC	2	20	21	15	9	11	5	11	13	19	16	21	15	Monitored using Statistical Process Control rules. Report by exception.		
MH25	Ligatures: Total number of incidents	NHSC	2	34	42	40	41	64	66	130	192	126	89	130	54	Monitored using Statistical Process Control rules. Report by exception.		
MH26	Number of ligature point incidents	NHSC	2	0	1	1	0	0	1	0	0	1	1	0	0	Monitored using Statistical Process Control rules. Report by exception.		
MH27	Violence and Aggression: Number of incidents patient on patient (inpatients only)	NHSC	2	18	10	6	6	6	3	2	2	2	5	8	3	Monitored using Statistical Process Control rules. Report by exception.		
MH28	Violence and Aggression: Number of incidents patient on staff	NHSC	2	93	84	54	99	25	12	23	19	29	31	66	57	Monitored using Statistical Process Control rules. Report by exception.		
MH29	Number of Type 1 -Traditional Seclusion	NHSC	2	24	27	7	21	10	13	20	11	7	9	11	9	Monitored using Statistical Process Control rules. Report by exception.		
MH30	Number of Type 2 -Short term Segregation	NHSC	2	0	5	0	2	0	2	1	0	1	0	0	1	Monitored using Statistical Process Control rules. Report by exception.		

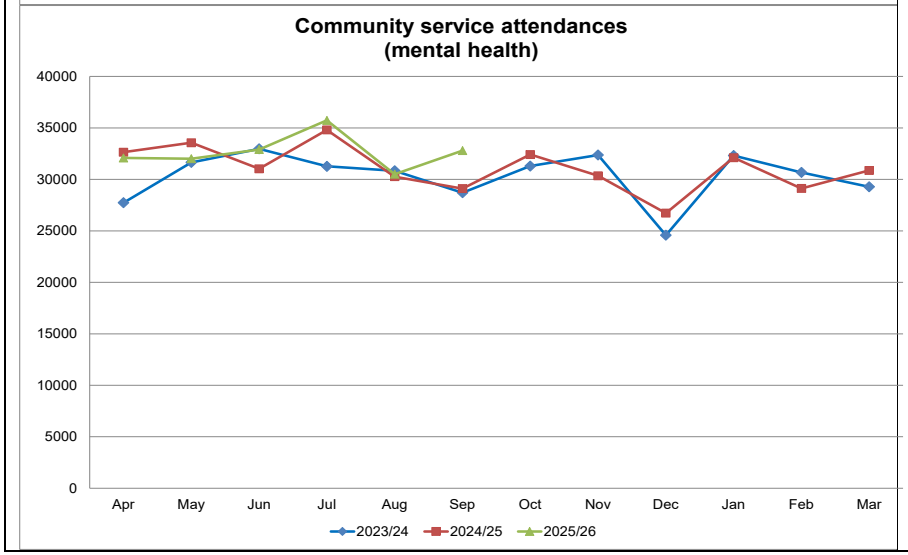
Operational context

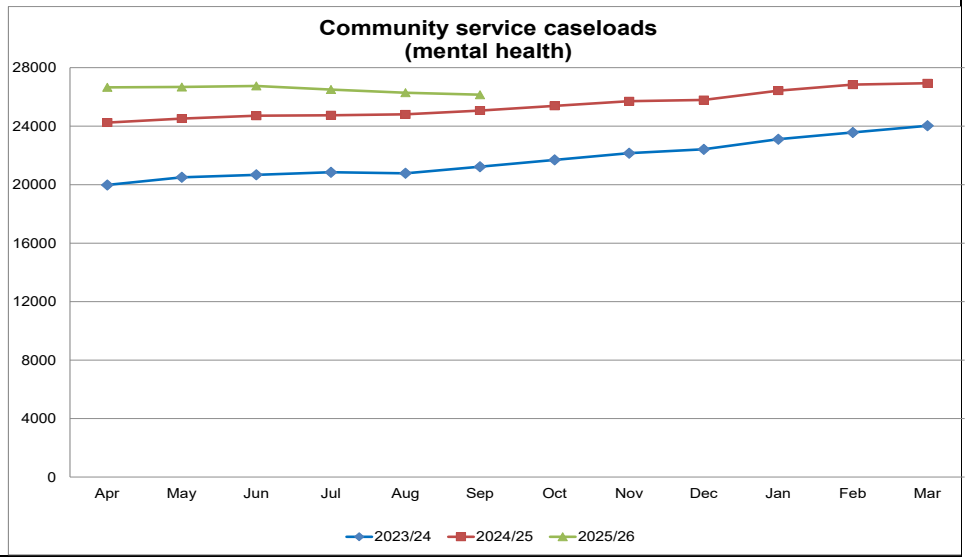
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.



Summary:

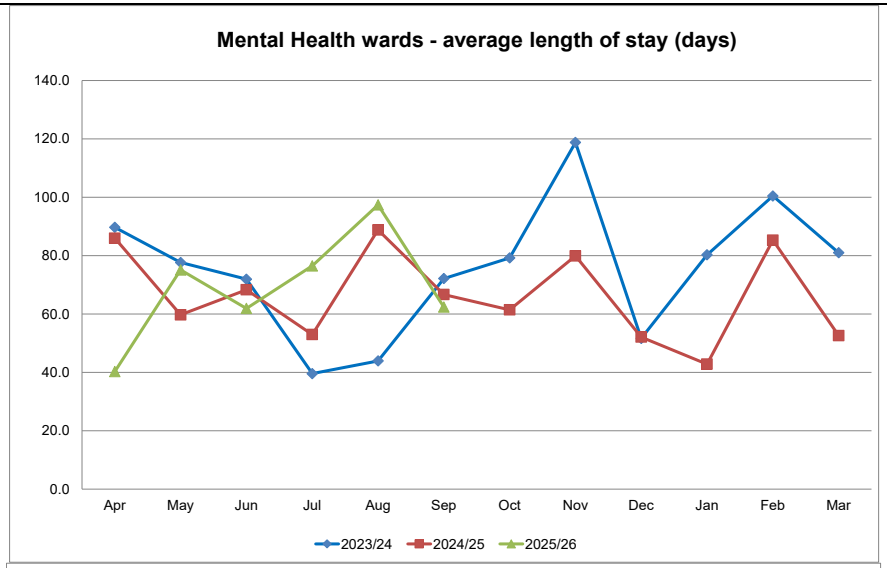
- Direct referrals to our community mental health services between 1 April and 30 September 2025 were 4.7% higher than the same months of 2024 and 9.2% higher than the same months of 2023.
- Attendances for the same reporting period were 2.4% higher than the same months of 2024 and 7.0% higher than the same months of 2023. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services.
- Community mental health service caseloads as at 30 September 2025 increased by 4.3% when compared to 30 September 2024 and were 23.2% higher than as at 30 September 2023. It should be noted that investment has facilitated the expansion of some community mental health services.

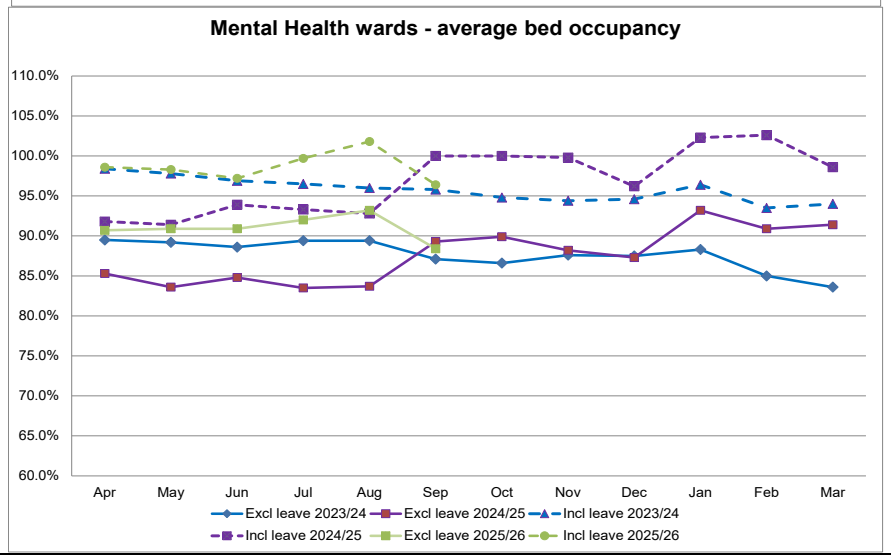




Assurance and Leading Indicators

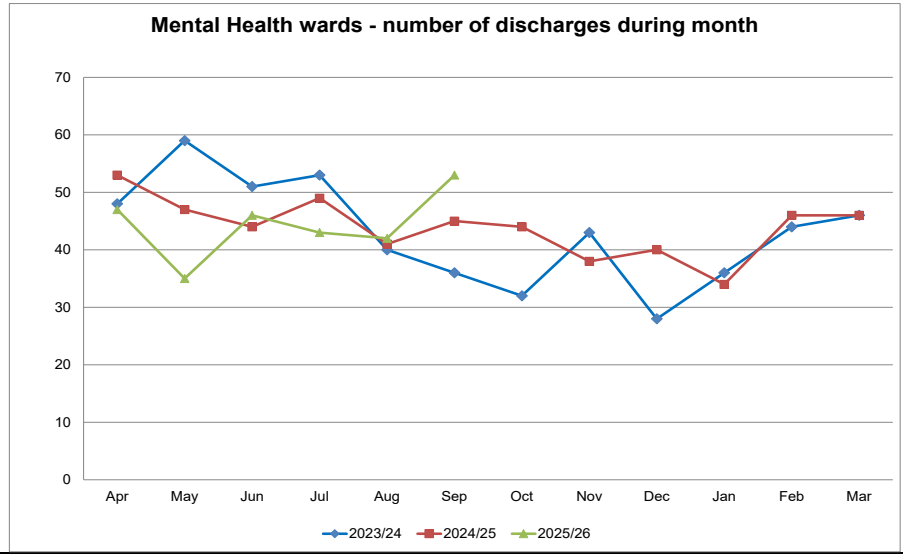
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay across all of our mental health wards in September 2025 was 62.4 days, down from 97.4 days in August 2025. During September 2025, 10 patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Willow ward 1 ward, our rehabilitation ward, who had a length of stay of 414 days. The rolling 12-month average length of stay for the period ending 30 September 2025 was 65.5 days, compared to 78.3 days for the 12-month period ending 30 September 2024.
- The mental health bed occupancy rates excluding leave and including leave both decreased compared to August 2025.
- A total of 53 patients were discharged in September 2025, up from 42 discharged in August 2025.



NARRATIVE REPORT

URGENT AND EMERGENCY CARE SERVICES

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

Ambulance handovers - During September2025, performance for the handover within 30 minutes of patient arrivals by ambulance at both MPH and YDH declined on both acute sites compared to August 2025. SFT was an early adopter of a maximum ambulance handover time last winter; from the end of July 2025 this maximum time band has formally been 45 minutes. Somerset continues to see higher than the south west regional average of ambulance handover conveyances by around 5%. Call before convey began in September 2025, with the aim of reducing attendances where alternatives in the community could be used. Utilisation has been low during this first month, as is conveyance to alternative pathways in hospital e.g. Same Day Emergency Care (SDEC).

Focus of improvement work:

- The Trust continues to work with colleagues from SWAST to support a reduction to the regional average on hear and treat rates, and see and treat demand conveyed to hospital.
- The YDH Urgent Treatment Centre (UTC) has unfortunately been delayed due to water damage in the diagnostics centre, delaying the movements of departments. However, a soft launch of UTC operations at YDH has been in place to support the availability of capacity within the department.
- An increase in escalation at the front door has resulted in delays to ambulance handovers and 12 hour waits; the Trust continues to review its bed base and escalation processes.

No criteria to reside - During September 2025, the percentage of occupied bed days lost due to patients not meeting the criteria to reside increased at MPH by 0.7%, compared to the previous month, and reduced at YDH by 0.7%. This remains above the system plan ambition for NCTR of 13% for SFT for September 2025.

SFT continues to perform well in discharging over 85% of our patients on a Pathway 0; for September 2025, this was 88.6%.

Focus of improvement work:
A continued drive to improve hospital-related delays as well as continued focused work on board rounds and criteria-led discharge. Focus on our capacity related delays across pathway 1, 2 and 3, working with system partners to understand the reduction in flow. Discharges to Pathway 1 remain the most challenged against the 10% target, with attainment in September 2025 of 6.7%, reflective of challenges in capacity.

Stroke
Patients admitted to a stroke ward within four hours continues to improve on both acute sites, and although performance remains below the target level. In September 2025, 57.1% of patients at MPH and 33.3% at YDH were admitted within four hours.

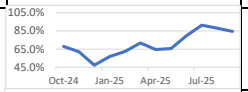
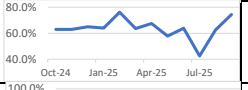
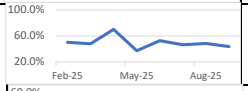
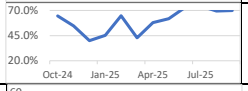
The percentage of our patients spending 90% of their time on a stroke ward improved at the YDH site compared to the previous month, to 74.4%, compared with 64.9% of patients at MPH site who spent 90% of their stay on a stroke ward.

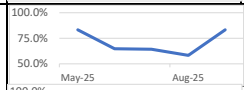
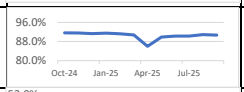
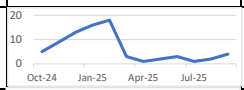
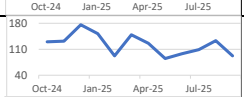
70% of patients at YDH saw a Stroke Specialist within 14 hours of admission, compared to 45.7% of patients on the MPH site.

Focus of improvement work:
- A Stroke Improvement Group has been established to focus on scanning, stroke consultant assessment and length of stay, with a specific focus on data capture and SSNAP indicators.
- Supported work is being undertaken to reduce the number of patients on the stroke wards who do not meet the criteria to reside, and who are awaiting onward care in the community and early supported discharge, to ensure that patients are therefore able to access a stroke ward in a timely way.

SOMERSET NHS FOUNDATION TRUST

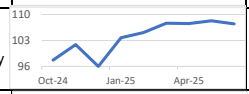
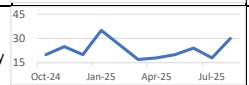
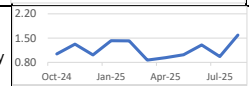
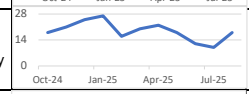
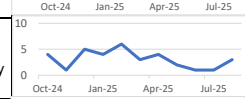
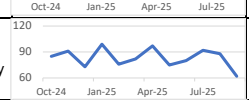
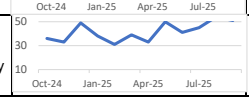
URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
UEC1	Ambulance handovers waiting less than 30 minutes	MPH	NHSC	2	67.9%	62.1%	47.3%	56.8%	62.4%	71.8%	64.6%	65.7%	79.6%	91.4%	88.2%	84.6%	>=95%= Green >=85% - <95% =Amber <85% =Red		F
UEC2		YDH			64.8%	62.3%	47.4%	52.8%	57.1%	62.3%	51.0%	62.2%	65.4%	66.9%	68.7%	67.6%			F
UEC3	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	SFT	2,6	6.4	6.9	6.9	7.2	7.0	6.9	6.9	7.0	6.7	6.3	6.6	6.6	Monitored using Statistical Process Control rules. Report by exception.		
UEC4		YDH			9.1	8.4	8.9	10.0	9.7	9.8	9.0	8.7	8.9	9.1	8.3	8.8			
UEC5	Patients not meeting the criteria to reside: percentage of occupied bed days lost	MPH	SFT	2,6	19.0%	22.7%	20.0%	19.5%	26.4%	26.0%	23.7%	26.7%	22.5%	22.3%	22.1%	22.8%	<=9.8%= Green >15% =Red		F
UEC6		YDH			21.3%	20.8%	20.2%	20.9%	26.2%	24.4%	18.1%	25.2%	22.8%	20.7%	21.3%	19.6%			F
UEC7	Percentage of Stroke Patients directly admitted to a stroke ward within four hours	MPH	NSG	1,2,4	58.6%	46.8%	60.4%	67.3%	53.3%	72.7%	75.0%	62.3%	72.2%	70.8%	47.5%	57.1%	>=90%= Green >=75% - <90% =Amber <75% =Red		F
UEC8		YDH			30.0%	36.6%	28.6%	23.3%	16.3%	32.5%	32.4%	41.9%	48.4%	27.0%	26.5%	33.3%			F
UEC9	Percentage of patients spending >90% of time in stroke unit - acute services	MPH	NSG	1,2,4	76.7%	70.3%	82.0%	78.8%	89.4%	89.4%	70.0%	81.7%	73.6%	79.1%	72.3%	64.9%	>=80%= Green >=70% - <80% =Amber <70% =Red		
UEC10		YDH			63.0%	63.0%	65.0%	64.0%	76.2%	63.6%	67.5%	57.8%	63.8%	42.5%	62.5%	74.4%			F
UEC11	Percentage of patients scanned within 20 minutes of clock start	MPH	NSG	1,2,4	48.6%	52.4%	50.9%	37.5%	50.0%	47.8%	70.0%	37.1%	52.7%	46.3%	48.4%	43.5%	>=32%= Green >=27% - <32% =Amber <27% =Red		P
UEC12		YDH			19.4%	14.3%	5.7%	12.9%	17.6%	16.7%	21.1%	14.5%	33.3%	51.1%	19.4%	22.5%			F
UEC13	Percentage of patients assessed by a Stroke Specialist Consultant within 14 hours of clock start	MPH	NSG	1,2,4	48.6%	52.4%	50.9%	37.5%	50.0%	39.1%	50.0%	48.4%	49.1%	50.7%	35.5%	45.7%	>=70%= Green >=60% - <70% =Amber <60% =Red		F
UEC14		YDH			64.5%	54.7%	40.0%	45.2%	64.7%	42.9%	57.9%	61.8%	72.7%	74.5%	69.4%	70.0%			
UEC15	Stroke: Median number of minutes of total therapy received per inpatient day	MPH	NSG	1,2,4	33	34	26	26	No Data	34	No Data	46	41	57	44	30	>=42= Green >=32 - <42 =Amber <32 =Red		

No.	Description		Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
UEC16	Stroke: Median number of minutes of total therapy received per inpatient day	YDH	NSG	1,2,4	33	34	26	25	24	21	42	53	35	35	45	42	>=42= Green >=32 - <42 =Amber <32 =Red		
UEC17	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the	MPH, YDH, Community Hospitals and Mental Health wards	NHSC	1,2,4	Changes made to reporting and audit processes. Reporting to fully commence from May 2025							83.3%	64.7%	64.3%	58.3%	83.3%	>=90%= Green >=80% - <90% =Amber <80% =Red		
UEC18	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	NHSC	1,2,4	92.3%	90.6%	90.6%	90.0%	84.2%	82.9%	96.9%	84.8%	90.0%	90.6%	92.0%	88.9%			
UEC19	Percentage of emergency patients screened for sepsis - Emergency Departments				92.8%	94.2%	93.9%	94.9%	100.0%	88.9%	88.2%	90.0%	100.0%	100.0%	91.7%	Data awaited			
UEC20	Percentage of patients admitted as an emergency within 30 days of discharge		NOF, PAF	2,3	9.8%	8.6%	9.6%	7.6%	8.3%	9.0%	8.9%	9.0%	9.0%	8.7%	9.5%	8.2%	To be confirmed.		
UEC21	Average number of days between planned and actual discharge date		NOF, PAF	2,3	2.8	2.7	2.7	2.8	2.8	3.1	3.1	2.7	2.6	2.6	2.5	2.3	To be confirmed.		
UEC22	Monthly number of inpatients to suffer a new hip fracture		PAF	2	1	1	2	4	2	0	0	1	1	1	0	1	To be confirmed.		
UEC23	Number of mental health patients spending under 12 hours in A&E		PAF	2,3	91.6%	91.6%	91.3%	91.5%	91.2%	90.7%	86.0%	89.9%	90.3%	90.3%	90.9%	90.7%	From April 2025 >=91.4% = Green <91.4% = Red		
UEC24	Percentage of over 65s attending emergency departments to be admitted		PAF	2,3	47.0%	47.1%	48.5%	48.8%	46.6%	45.9%	45.4%	45.1%	45.7%	44.2%	44.2%	44.3%	To be confirmed.		
UEC25	Percentage of under 18s attending emergency departments to be admitted		PAF	2,3	15.2%	15.9%	14.6%	14.7%	14.7%	13.5%	12.9%	11.3%	12.2%	12.2%	14.1%	13.9%	To be confirmed.		
UEC26	Percentage of inpatients referred to stop smoking services		PAF	1,2	Report awaited from topic lead who is liaising with our Data Analytics team to resolve some identified data quality issues.												To be confirmed.		
UEC27	Average daily number of medical and surgical outliers in acute wards during the month	MPH	NHSC	2	5	9	13	16	18	3	1	2	3	1	2	4	Monitored using Statistical Process Control rules. Report by exception.		
UEC28		YDH	NHSC	2	13	10	13	14	13	12	14	13	15	18	11	9	Monitored using Statistical Process Control rules. Report by exception.		
UEC29	Number of patients transferred between acute wards after 10pm	MPH	NHSC	2	104	85	152	146	117	99	85	96	75	83	82	103	Monitored using Statistical Process Control rules. Report by exception.		
UEC30		YDH	NHSC	2	130	132	176	152	92	149	126	85	98	109	133	92	Monitored using Statistical Process Control rules. Report by exception.		

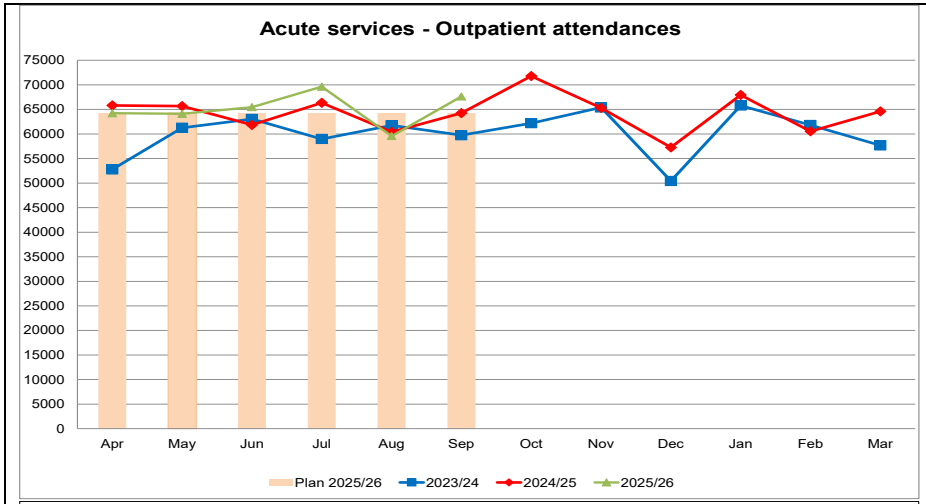
SOMERSET NHS FOUNDATION TRUST

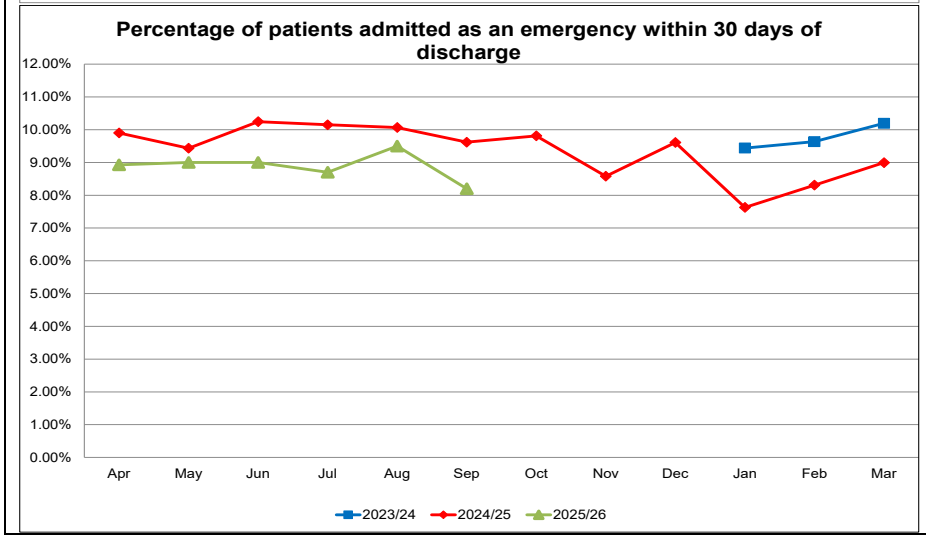
URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
UEC31	Summary Hospital-level Mortality Indicator (SHMI)		NOF, NHSC	2	97.7	101.88	96.01	103.73	105.13	107.65	107.56	108.3	107.48	Data not yet due - July 2025 to be reported after September 2025			Monitored using Statistical Process Control rules. Report by exception.		
UEC32	Total number of patient falls - acute services		NHSC	2	162	171	164	189	174	138	169	156	133	152	168	162	Monitored using Statistical Process Control rules. Report by exception.		
UEC33	Rate of falls per 1,000 occupied bed days - acute services		NHSC	2	5.38	5.80	5.26	5.22	6.05	4.46	5.62	5.20	4.70	5.32	5.86	5.39	Monitored using Statistical Process Control rules. Report by exception.		
UEC34	Number of pressure ulcers	MPH	NOF, NHSC	2	20	25	20	35	26	17	18	20	24	18	30	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC35	Rate of pressure ulcer damage per 1,000 occupied bed days	MPH	NOF, NHSC	2	1.04	1.33	1.02	1.42	1.42	0.87	0.93	1.02	1.30	0.97	1.59	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC36	Number of pressure ulcers	YDH	NOF, NHSC	2	18	21	25	27	16	20	22	18	12	10	18	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC37	Rate of pressure ulcer damage per 1,000 occupied bed days	YDH	NOF, NHSC	2	1.79	2.13	2.34	2.51	1.65	1.92	2.21	1.85	1.34	1.10	2.04	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC38	No. ward-based cardiac arrests - acute wards	MPH	NHSC	2	4	1	5	4	6	3	4	2	1	1	3	3	Monitored using Statistical Process Control rules. Report by exception.		
UEC39	No. ward-based cardiac arrests - acute wards	YDH	NHSC	2	1	1	0	4	4	5	0	2	1	2	3	2	Monitored using Statistical Process Control rules. Report by exception.		
UEC40	Total number of medication incidents	MPH	NHSC	2	85	91	73	99	76	82	97	75	80	92	88	62	Monitored using Statistical Process Control rules. Report by exception.		
UEC41	Total number of medication incidents	YDH	NHSC	2	36	33	49	38	31	39	33	50	41	45	54	51	Monitored using Statistical Process Control rules. Report by exception.		

Operational context

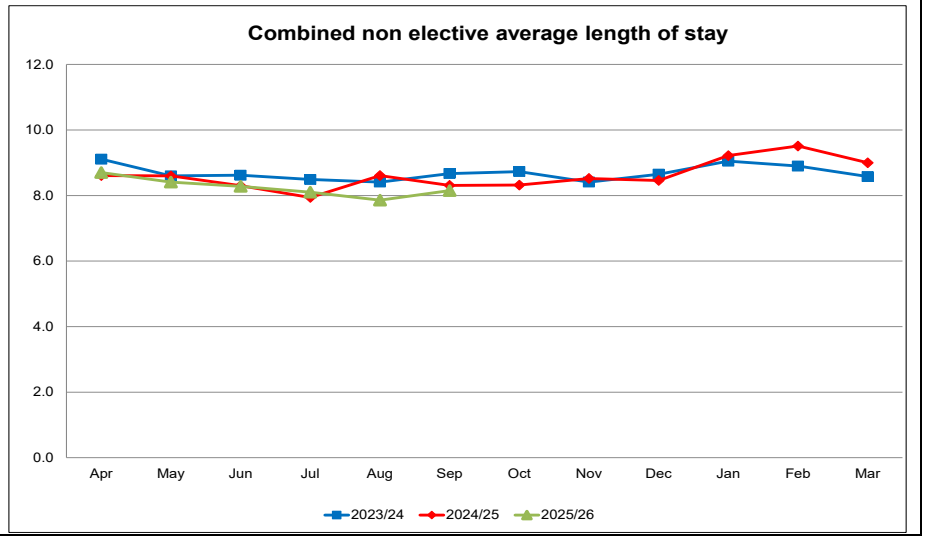
Acute services: This section of the report provides a summary of the levels of non-elective activity, emergency readmissions within 30 days, and non-elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- Between 1 April and 30 September 2025, non-elective admissions increased by 1.6% compared to the same months of 2024 and increased by 9.3% compared to the same months of 2023. Activity for 1 April to 30 September 2025 was 1.3% above the plan.
- Between 1 April and 30 September 2025, emergency readmissions totalled 6,878, 13.2% lower than the same period in 2024, when there were 7,926 readmissions.
- The trust-wide monthly non-elective average length of stay slightly increased slightly in September 2025 to 8.2 days, from 7.9 days in August 2025.



NARRATIVE REPORT

ELECTIVE CARE SERVICES

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

1) The percentage of patients receiving the diagnostic test they need within six weeks of the request being made was 79.7% at the end of September 2025, compared with 78.4% at the end of August 2025. The number of patients waiting over six weeks for a diagnostic test decreased in the period, from 2,390 to 2,264. Both the number of six-week waiters and the total waiting list size are better than plan. However, as the total waiting list size is 2,351 better than plan, our percentage performance is lower than plan. The end of October 2025 position is expected to show an improvement on the end of September 2025 position, due to the improved level of capacity in several services following the actions we have taken.

Table 1. The percentage of patients waiting over six weeks at month-end for one of the top 15 high-volume diagnostic tests.

	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
Trajectory (%)	88.6	90.3	89.4	92.0	93.8	95.0	76.0	75.7	77.4	78.2	79.2	81.0
Actual (%)	84.7	83.8	74.1	70.4	77.4	77.6	75.7	74.5	78.7	79.6	78.4	79.7
Total w/l	11039	10362	11754	13549	13622	13914	13914	13396	13426	12005	11057	11127

In the last year the number of over six-week waiters has been higher than plan due to a range of factors. This has included radiographer, echo physiologist and endoscopy nursing vacancies, sickness within radiology, loss of locums, equipment failure (scope washers), the need to staff the CT scanner installed in the Emergency Department from the autumn of 2024, an increase in patient complexity (more minutes of demand), challenges with newly implemented scheduling system which is resulted in bookings taking longer, vacancies within booking teams and the delayed opening of the Yeovil Community Diagnostic Centre (CDC). The following actions have been implemented over the past few months to increase capacity in these services:

- Insourcing (echo, MRI / CT vans, endoscopy Limited Liability Partnerships).
- Waiting List Initiatives (echo and radiology).
- Locum radiographers, sonographers and physiologists.
- MRI and CT scanning vans at Bridgwater and Yeovil (four vans).

- Endoscopy scope washers repaired.
- Additional CT and MRI scanning vans located at Minehead Community Hospital.
- Business case submitted and approved by NHSE for replacement endoscopy scope washers.
- Recruitment to endoscopy nursing vacancy gaps.
- Piloting drugless cardiac CT protocol adoption (supported by University Hospitals Plymouth).
- Locum agency support to increase the capacity for the ultrasound service.
- Six-day DEXA service now put in place with an increase in staffing.
- DEXA booking is now being undertaken by the booking team, to free-up the clinical technologist to undertake more scans.
- Approval of capital funding for the Diagnostic Centre at Bridgwater Community Hospital, with planning permission now approved and the build work commencing.

Additional actions being taken in the coming months include:

- Echo workforce upskilling with potential implementation of abbreviated scans which will reduce the amount of time it takes to carry-out a scan and hence release capacity.
- Replacement Bridgwater endoscopy scope washers now being procured and scheduled in.
- NHSE funding is being sought for further DEXA equipment
- Digital patient enabled booking solution to be progressed, to improve utilisation of scanning sessions and improve patient experience
- Opening of the Yeovil Community Diagnostic Centre – CT, including CT colon, MRI, ultrasound, endoscopy, audiology and echo.
- Development of the Diagnostic Centre at Bridgwater Community Hospital.

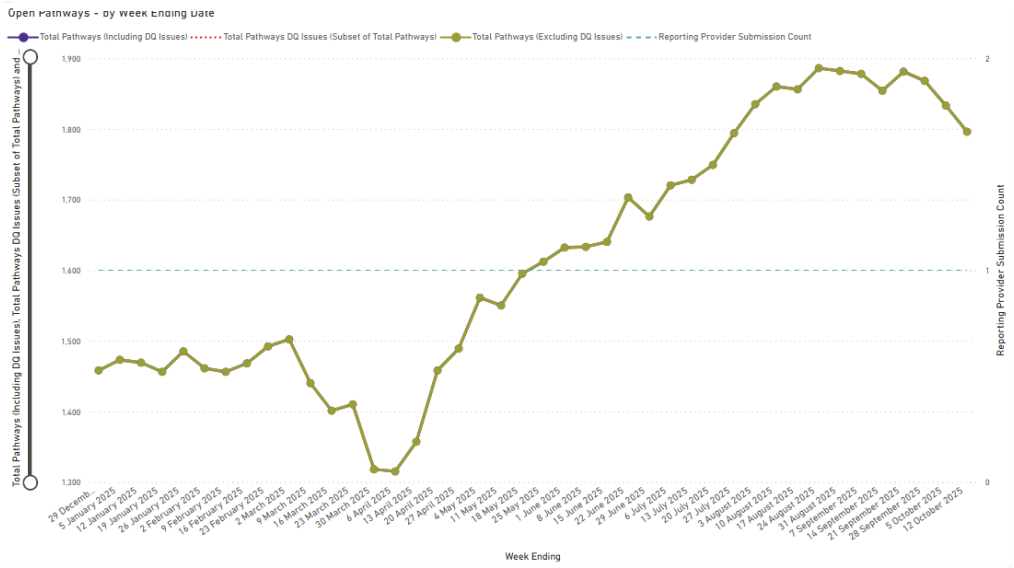
Table 2. The number of patients waiting over six weeks by diagnostic modality

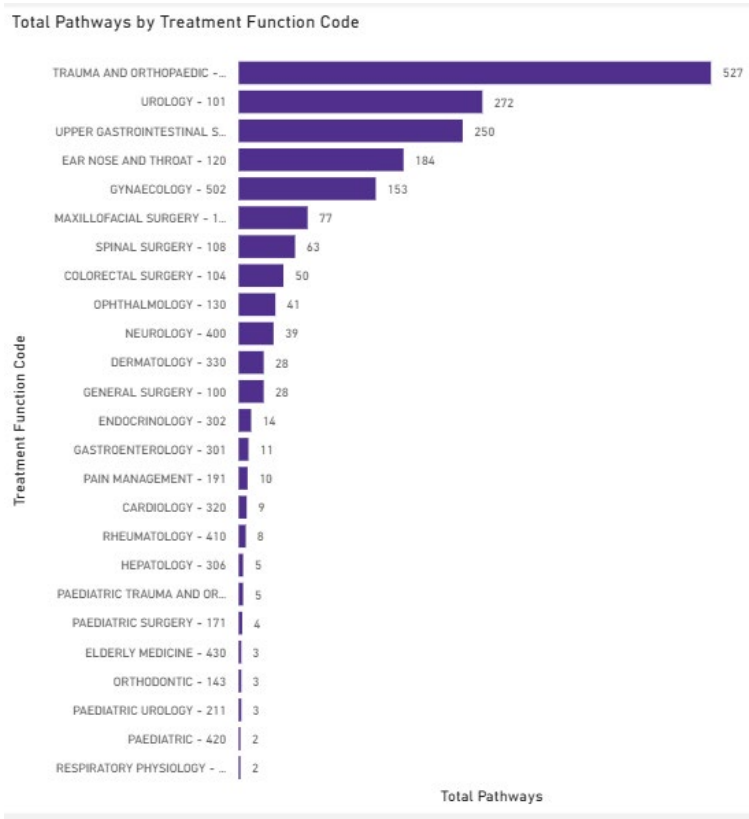
	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
MRI	385	376	343	640	691	499	461	335	260	148	130	96	136
CT	93	120	246	648	971	837	590	439	367	343	335	293	278
Ultrasound	34	62	52	89	583	251	429	849	1177	988	473	191	141
Barium Enema	16	17	35	40	44	44	71	71	61	30	23	21	21
DEXA	110	71	127	185	180	143	154	105	116	126	193	243	309
Audiology	77	59	47	181	157	148	167	176	90	92	163	111	120
Echo	1050	752	578	706	750	606	570	526	327	254	256	328	142
Neurophysiology	29	9	13	48	51	24	19	25	41	46	25	28	62
Sleep studies	80	75	88	159	174	165	159	124	175	130	86	53	14
Urodynamics	56	6	1	58	53	43	66	38	48	35	36	24	26
Colonoscopy	55	65	62	120	118	105	179	304	302	258	326	447	442
Flexi sigmoid.	21	29	27	47	56	44	77	104	103	109	139	215	222
Cystoscopy	1	8	19	41	38	36	40	44	21	16	30	16	19
Gastroscopy	44	42	39	82	149	129	175	248	327	280	231	324	332

2) Current performance against the four core RTT targets is as follows:

- 18-weeks RTT (plan 62.5%; actual 62.5%).
- First OPA within 18 weeks (plan 73.7%; actual 70.6%).
- 52-week waits (plan 2.2%; actual 3.0%).
- 65-week waits (157 against a national requirement of zero).

Graphs 1 and 2 – 52-week waiters as at 19 October 2025





The percentage of patients waiting on an RTT pathway for a first outpatient appointment, waiting under 18 weeks, remained below plan in September 2025. The reason for this is multifactorial and includes a reduction in referrals (shorter-waiting patients) compared with what is typical for this time of the year, and reduced capacity. We have struggled to establish additional clinic activity in the context of re-setting expectations around remuneration and increasing financial control in an environment where we do not earn more money for undertaking more elective work. There is also the impact of competing demands, because we are being asked to improve waiting times at both the front (i.e. outpatient appointments within 18 weeks) and the back end (i.e. over 52- and 65-week waiters) of RTT waiting lists.

The number patients waiting over 52 weeks decreased at the end of September 2025, but the number of 65-week waiters increased slightly. The main specialties making-up the current 52-week waiters are as shown above, with Trauma & Orthopaedics, Urology, Upper GI, ENT and Gynaecology making-up 77% of all current over 52-week waiters. There are, however, specialties which do not currently have significant volumes of 52-week waiters currently, that waiting list analysis suggests are future risks to achievement of the 1% of the waiting list, national 52-week wait target for March 2026. These include Maxillo Facial, which since the Dermatology service repatriation from Bristol has been providing plastics capacity for lesions on the head and neck, and the Endocrinology (Weight Management Service) which has been seeing heightened levels of demand due to the recent NICE guidelines on the use of weight loss drugs, which can be prescribed by secondary care to lower thresholds than primary care. Pain Management has also seen an increase in demand for its services, perhaps because of the length of waits for patients for other services such as Trauma & Orthopaedics. The 52-week wait position has improved in the last few weeks, mainly due to additional capacity coming on line including more insourcing (T&O), the return of two urologists from maternity leave, outsourcing of T&O patients to the Independent Sector, a reduction in the levels of annual leave and increased scrutiny as part of waiting list management, on patients due to breach 52 weeks in the coming month.

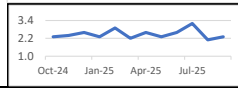
The 65-week waiters are largely in the same specialties as for the 52-week waiters, but with T&O making-up 40% of all the waiters. We are monitoring individual patient pathways in the December 2025 cohort, and pencilling in dates for appointment and surgery, to establish where we have gaps. Actions to get to zero 65-week waiters by December 2025, above those being taken to improve our 52-week wait position, largely relate to establishing additional capacity for the specific consultants / services where we have capacity gaps.

Refreshed plans to support the improvement in performance against all three RTT targets have been developed for the twelve high-volume specialties contributing most to the over 18-week waiters. This list is as follows and includes specialties which whilst performing generally well currently, have greater future performance risks: ENT, Urology, T&O, Upper GI, Spinal surgery, Maxillo Facial, Ophthalmology, Neurology, Cardiology, Endocrinology, Gynaecology and Pain Management. The plans developed include a significant focus on productivity as a primary means of delivering improvements, along with other ways of increasing capacity and throughput. These plans and associated trajectories were reviewed by a sub-set of the executive team at a meeting with Service Group Directors and the Director of Elective Care at the end of August 2025, and again in September 2025. Monthly review meetings are in place for all specialties. The themes for the main actions to improve RTT performance are as follows:

- Implementation of the Advice & Refer (Cinapsis) advice & guidance platform, which will enable enhanced referrals for all routine GP requests for secondary care opinion, with go-live dates for the following specialties by the end of November: Neurology, ENT, Urology and Cardiology (Endocrinology went live in October). This will reduce the number of patients needing to have an outpatient appointment and being added to the waiting list.
- Enhanced cross-site management of capacity to smooth demand and reduce maximum waiting times across Musgrove and Yeovil; this should reduce 52-week waiters (Cardiology, Gynaecology and Neurology).
- Increasing capacity through insourcing (T&O, ENT, gynaecology and upper GI); additional theatre capacity being allocated to T&O at Yeovil, with a shift in job plans from outpatients to theatres.
- Ambient Voice utilisation in clinic, to replace dictation of letters and increase patient throughput of clinics (neurology, ENT, T&O, maxillo facial and gynaecology).
- Reviews of referrals against referral criteria (endocrinology and pain management) which will reduce demand but also ensure higher clinical priority patients are seen sooner than they otherwise would be.

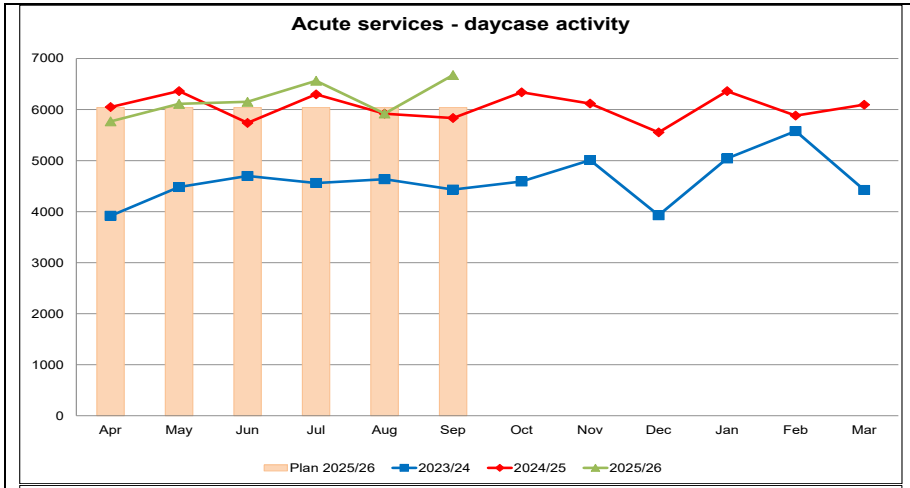
SOMERSET NHS FOUNDATION TRUST

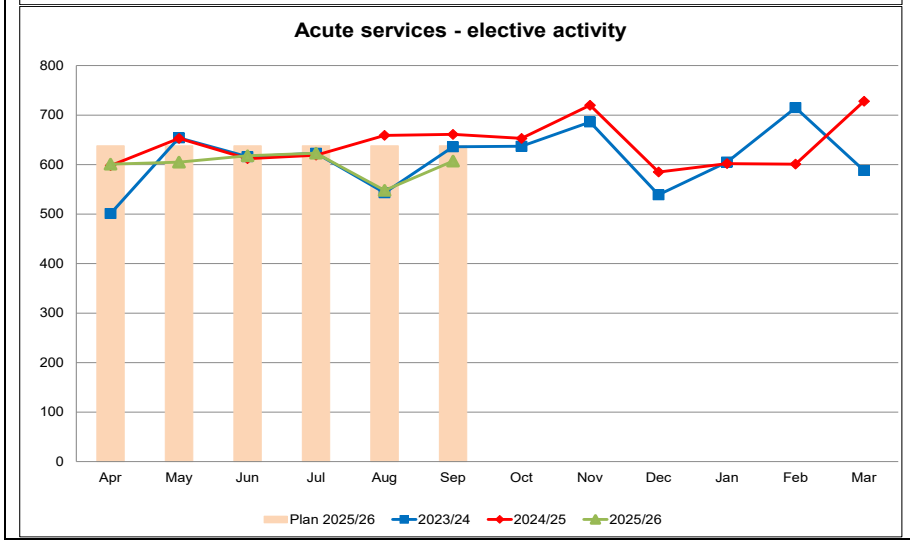
ELECTIVE CARE

No.	Description		Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
EC1	Diagnostic 6-week wait - acute services	MPH	NOF	1,2	87.4%	85.2%	72.9%	72.2%	77.4%	79.0%	79.7%	81.4%	83.6%	83.8%	80.3%	80.6%	From March 2024 At or above regional ambition 85% = Green Above trajectory = Amber Below trajectory = Red		F
EC2		YDH			77.6%	79.3%	77.0%	65.7%	77.6%	73.6%	65.5%	64.3%	67.5%	68.1%	73.2%	76.6%			F
EC3		Combined			84.7%	83.8%	74.1%	70.4%	77.4%	77.6%	75.7%	74.5%	78.7%	79.6%	78.4%	79.7%			F
EC4	52 week RTT breaches - Patients of all ages		OPG	1,2	1,445	1,371	1,364	1,388	1,406	1,257	1,438	1,572	1,588	1,749	1,826	1,740	From April 2023 At or below trajectory = Green Above trajectory = Red		F
EC5	52 week RTT breaches - Patients aged under 18		OPG		91	86	87	104	108	116	122	134	150	133	138	124			F
EC6	65 week RTT breaches - Patients of all ages		NHSC		198	144	142	146	117	81	86	112	108	136	149	157			F
EC7	Referral to Treatment (RTT) incomplete pathway waiting list size - all ages		NHSC		58,725	59,585	60,076	59,061	59,310	59,621	58,470	57,069	57,440	57,905	57,715	57,935			P
EC8	Referral to Treatment (RTT) incomplete pathway waiting list size - under 18		NHSC		4,273	4,203	4,207	4,214	4,189	4,331	4,115	4,128	4,312	4,160	4,027	3,967	From April 2025 at or below trajectory = Green above = Red		P
EC9	Rate of annual growth in under 18s elective activity - Rolling 12 months comparison of previous 12 months		NOF, PAF		19.9%	13.3%	11.0%	7.0%	5.3%	28.1%	-4.7%	-3.1%	-2.1%	-1.7%	-4.0%	-4.5%	To be confirmed		
EC10	Elective Care: Estimated time it would take to clear the waiting list if no new patients were added		PAF	1,2	Report being developed												To be confirmed		
EC11	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	SFT	2,6	2.3	2.4	3.9	2.5	3.0	2.7	3.0	3.5	3.1	2.9	2.4	2.7	Monitored using Statistical Process Control rules. Report by exception.		
EC12		YDH			2.3	2.4	2.6	2.3	2.9	2.2	2.6	2.3	2.6	3.2	2.1	2.3			

Operational context

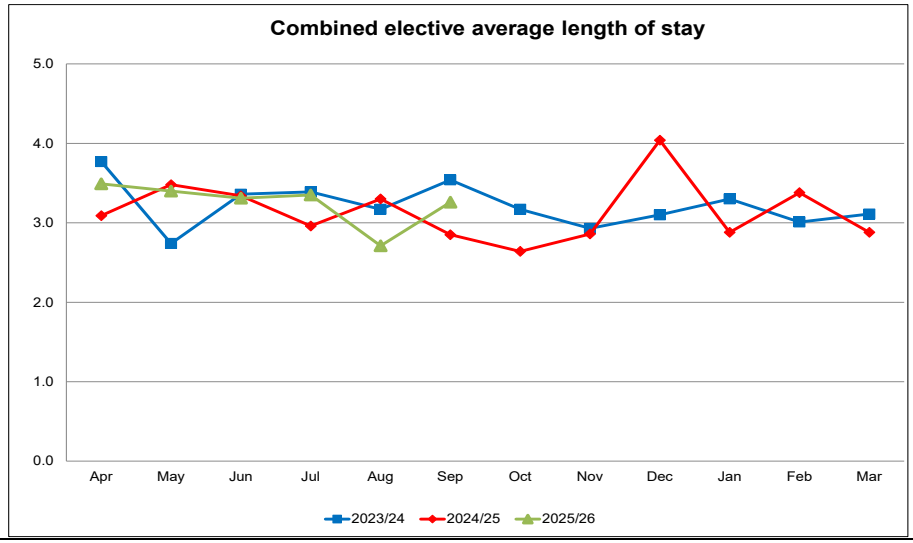
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





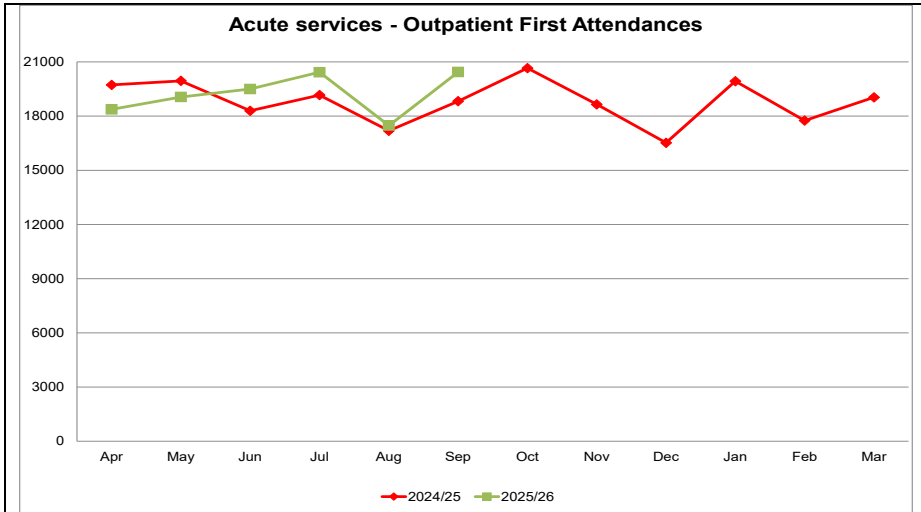
Summary:

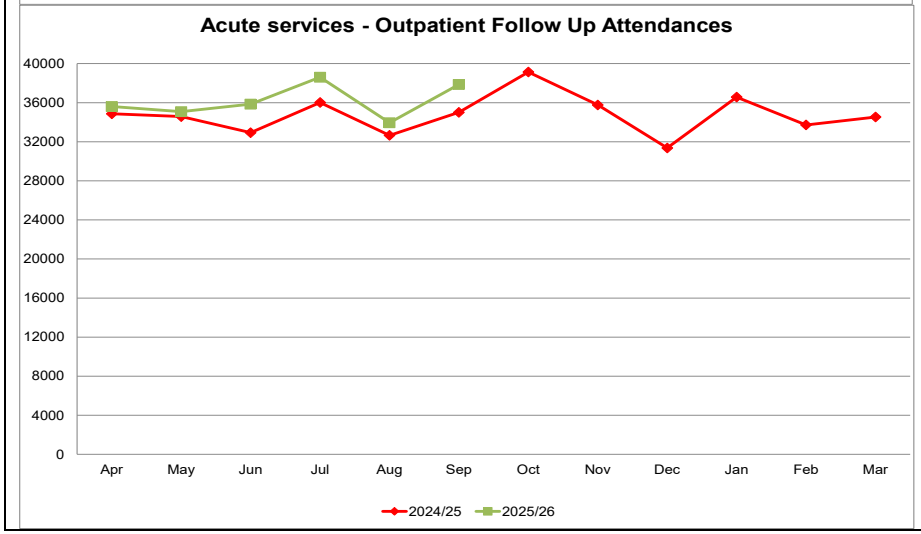
- The number of day cases undertaken by our acute services between 1 April and 30 Septembert2025 increased by 2.7% compared to the same months of 2024 and increased by 39.2% compared to the same months of 2023. Activity for the year to date was 2.6% above the current year plan.
- Over the same period, elective admissions were 5.3% lower than the corresponding months of 2024 but 0.8% higher compared to the same months of 2023. Activity for the year to date was 5.9% below the current year plan.
- The trust-wide monthly elective average length of stay increased for September 2025, to 3.3 days from 2.7 days in August 2025.



Operational context

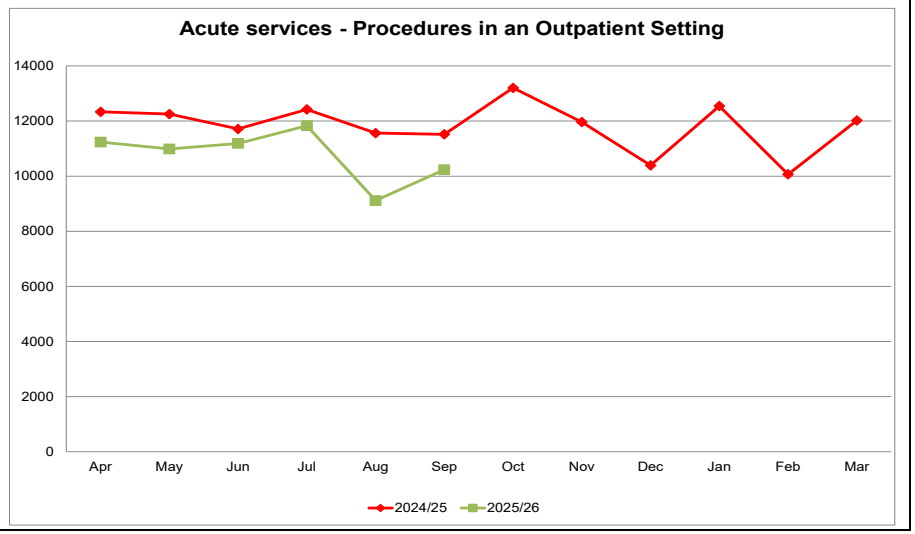
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- The number of first outpatient attendances undertaken by our acute services between 1 April and 30 September 2025 increased by 1.9% compared to the same months of 2024.
- Over the same period, follow up outpatient attendances were 5.3% higher than the corresponding months of 2024.
- Between 1 April and 30 September 2025, the reported number of procedures undertaken within an outpatient setting decreased by 10.0% compared to the same months of 2024. Due a backlog of coding, the reported numbers for April to September 2025 will be understated.



NARRATIVE REPORT

CANCER SERVICES

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

1) 28-day Faster Diagnosis Standard (FDS) performance declined from 75.5% in July 2025 to 71.3% in August 2025 and remains below the national standard (77.0%) and current national average performance (74.6%). Five tumour sites are the main contributors to the breaches of the standard, as shown in Table 1, together making up 89% of breaches. The reason for the lower than forecast performance is largely higher than expected levels of demand not able to be met due to reductions in internal capacity for a range of reasons. The main actions being taken to improve performance are shown below:

- GIRFT national 100 Days Matter challenge continuing for colorectal and urology (see following page).
- Continuing to try to increase endoscopy utilisation/ productivity through backfilling vacant nursing and booking team posts and reviewing options to reduce water quality / scope washer resilience; insourcing continues.
- Out to advert for breast radiology consultant, but with limited interest in the post to date, not yet translating into an appointment. Radiology is diverting capacity to breast where possible (with small impacts on cross-sectional imaging waits).
- A new breast registrar started in August 2025, providing increased breast capacity. The Yeovil site is also seeing patients from the Musgrove catchment area to even-out waiting times.
- ENT is out to advert for consultant surgeon. Two middle grades were appointed in the summer.
- An ENT insourcing contract has recently been awarded which will help release capacity for suspected cancer clinics.
- Plans are being developed to change the neck lump model at the start of the pathway to nurses arranging ultrasound and then consultant reviews to discharge or see in clinic.
- Gynaecology is reviewing demand by tumour site to understand the recent increase in referrals. There has been an overall increase, but it is believed that suspected vulva cancer referrals have increased.
- The gynaecology navigator has started to phone patients with their results where cancer has been excluded as a diagnosis. A review of tracking is also underway, to see if effectiveness can be improved.

Table 1. Top five tumour sites contributing to FDS performance in August 2025, showing performance for these tumour sites in July 2025.

Tumour sites	Breaches (Jul 25)	Performance (Jul 25)	% of breaches (Jul 25)	Breaches (Aug 25)	Performance (Aug 25)	% of breaches (Aug 25)
Colorectal	189	62%	28%	197	52% ↓	29%
Breast	147	75%	22%	130	73% ↓	22%
Head & Neck	75	76%	11%	89	68% ↓	13%
Gynaecology	66	74%	10%	89	63% ↓	13%
Urology	106	61%	16%	80	67% ↑	12%

The Trust continues to take part in the national Get It Right First Time (GIRFT) improvement workstreams for the urology and colorectal 100 'Days Matter' challenge. The actions being taken primarily focus on pathway redesign, which should help to reduce the waiting time for the diagnostic phase of cancer pathway and hence improve 28-day Faster Diagnosis performance, with a target 5% improvement in performance relative to Q4 2024/25 by October 2025 having been set. Good progress is being made in completing the actions to which we have committed. We have already seen improvements in FDS performance in urology across July and August 2025, relative to the May and June 2025 positions (see Table 2). Colorectal performance remains below where would want it to be due to longer than optimal waits for endoscopy, with the service currently having significant nursing challenges. We will continue to monitor FDS performance for these tumour sites against the improvement goal.

For September 2025 we are expecting to report Trust FDS performance above that reported in August 2025. October's performance to date is also expected to demonstrate an improvement on the September 2025 position.

Table 2. FDS performance in colorectal and urology

Tumour site	Q4 24/25	Target Oct 25	April 25	May 25	June 25	July 25	August 25
Colorectal	52%	57%	57%	40%	49%	62%	52%
Urology	52%	57%	53%	38%	50%	61%	67%

2) 62-day referral to cancer treatment performance was 70.0% in August 2025, meeting the current national standard of 70%, but performance is below the planning trajectory. It is primarily the same tumour sites (i.e. urology, breast and to a lesser extent colorectal) which have been driving the recent lower than plan performance, although the seasonally high levels of skin cancer referrals has also resulted in an increase in 62-day breaches. The actions being taken to improve FDS performance will also improve 62-day performance because the diagnostic (FDS) phase of the pathway is a sub-set of the overall 62-day standard, although there is typically a one-month lag between improvement in FDS performance and improvements observed in 62-day performance. Most notably, the improvement in urology FDS performance is expected to start to deliver improved 62-day performance. In September 2025 performance against the 62-day standard is expected to be again circa 70% on final reporting (i.e. at the current national performance standard).

SOMERSET NHS FOUNDATION TRUST

CANCER SERVICES

No.	Description	Source	Links to strategic aims	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Thresholds	Trend	Variation / Assurance
C1	31 day wait - from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment	NHSC	1,2	93.7%	94.1%	90.1%	93.7%	93.7%	97.1%	96.7%	95.4%	95.0%	95.2%	93.6%	94.1%	>=96% = Green >=Above trajectory = Amber <below trajectory = Red		
C2	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104	OPG	1,2	22	33	23	13	17	28	25	32	20	36	19	31	0= Green >0 = Red		
C3	Cancer: 62-day wait from referral to treatment for urgent referrals – Breast	OPG	1,2	89.7%	88.9%	82.9%	82.4%	77.8%	80.0%	87.5%	78.7%	62.2%	75.9%	74.6%	70.9%	At or above trajectory =Amber and below trajectory =Red		
C4	Cancer: 62-day wait from referral to treatment for urgent referrals – Colorectal	OPG	1,2	51.1%	59.5%	57.1%	45.2%	50.0%	46.2%	58.1%	55.2%	50.0%	53.8%	60.0%	67.8%	At or above trajectory =Amber and below trajectory =Red		
C5	Cancer: 62-day wait from referral to treatment for urgent referrals – Gynaecology	OPG	1,2	69.2%	74.2%	82.4%	72.2%	80.0%	75.0%	77.8%	78.9%	100.0%	80.0%	62.5%	75.0%	At or above trajectory =Amber and below trajectory =Red		
C6	Cancer: 62-day wait from referral to treatment for urgent referrals – Haematology	OPG	1,2	53.8%	66.7%	100.0%	76.9%	77.8%	93.8%	78.9%	78.6%	100.0%	84.6%	75.0%	78.9%	At or above trajectory =Amber and below trajectory =Red		
C7	Cancer: 62-day wait from referral to treatment for urgent referrals – Head and Neck	OPG	1,2	81.8%	58.8%	47.1%	62.5%	69.0%	34.6%	77.8%	68.8%	72.7%	91.7%	52.6%	51.4%	At or above trajectory =Amber and below trajectory =Red		
C8	Cancer: 62-day wait from referral to treatment for urgent referrals – Lung	OPG	1,2	64.3%	53.1%	53.7%	70.8%	54.2%	71.2%	73.1%	69.8%	75.5%	60.0%	57.6%	65.4%	At or above trajectory =Amber and below trajectory =Red		
C9	Cancer: 62-day wait from referral to treatment for urgent referrals – Other	OPG	1,2	100.0%	72.2%	80.0%	100.0%	83.3%	33.3%	88.9%	92.9%	100.0%	50.0%	100.0%	84.6%	At or above trajectory =Amber and below trajectory =Red		
C10	Cancer: 62-day wait from referral to treatment for urgent referrals – Skin	OPG	1,2	68.8%	65.5%	75.5%	72.9%	75.0%	85.9%	92.8%	98.7%	91.6%	92.0%	81.4%	83.1%	At or above trajectory =Amber and below trajectory =Red		
C11	Cancer: 62-day wait from referral to treatment for urgent referrals – Upper GI	OPG	1,2	97.3%	78.9%	80.0%	83.7%	72.6%	80.8%	91.1%	63.2%	82.1%	69.2%	66.7%	95.8%	At or above trajectory =Amber and below trajectory =Red		
C12	Cancer: 62-day wait from referral to treatment for urgent referrals – Urology	OPG	1,2	33.9%	53.5%	51.6%	68.7%	56.2%	51.5%	52.8%	37.5%	39.9%	40.7%	58.3%	52.7%	At or above trajectory =Amber and below trajectory =Red		
C13	Cancer: Percentage of all cancers diagnosed that are diagnosed at stage 1 or 2 (75% to be achieved by 2028)	PAF	1,2	73.2%	67.9%	72.9%	75.6%	68.5%	70.6%	72.4%	73.8%	72.8%	71.9%	70.9%	75.5%	>=60.1%= Green >=55.1% to <60.1% = Amber <55.1% =Red		

NARRATIVE REPORT

MATERNITY SERVICES

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

Following the announcement made on Monday 15 September 2025, that SFT Maternity services have been selected as one of 14 Trusts for the national independent Maternity and Neonatal Investigation, the Trust has now received provisional dates of 27 and 28 November 2025, when the investigation team will be conducting the SFT visit. The team have asked our Maternity and Neonatal Voices Partnerships (MNVP) lead to arrange two service user listening events, one to hear from families who have experienced baby loss specifically, and one for anyone who wishes to share their experience of maternity and neonatal care with SFT. SFT welcome this inclusion as an opportunity to share all the improvements made since the CQC inspections in November 2023 and also to provide another check and balance to ensure focus is on the right areas. The service is looking forward to learning from the national review report when it is published. In preparation for the investigation, SFT Maternity & Neonatal Leads have reviewed the published Terms of Reference for the national investigation and are undertaking a series of benchmarking exercises against national standards and refining the risk register.

The trust continues to monitor the impact of the temporary closure of YDH services. There have been no reported incidents since the temporary closure, where outcomes are directly linked to the temporary closure. There has been no notable increase in Home Births or BBAs (born before arrival) for the YDH cohort since the temporary closure. Activity continues to be split evenly between DCH and MPH. Since the Trust announcement on 14 October 2025 that, as long as specific safety criteria are met, the Trust will re-open YDH Maternity & Neonatal services on 21 April 2026 the Children and Young People (CYP) and Families Leadership team are now working with stakeholders and system partners including Dorset County Hospital to action plan the safety criteria. An initial meeting was held on Friday 17 October 2025 and a detailed project plan is in development.

The service continues to make good progress with service improvements and closed the maternity CQC action plan in October 2025. A total of 89 of 93 defined actions were closed. The service agreed not to pursue the remaining four actions due to feasibility or context; these were:

1. **Data control.** Organisational issue – related to two separate F2 databases. This has now been resolved with standardised reporting in place.
2. **Recruitment to obstetricians** – this remains a challenge and is being monitored through the Maternity and Neonatal Improvement Programme MNIP.

3 and 4. **Review of transfers from Mary Stanley Unit** – as the unit is now closed to births, there is no opportunity for review, and these actions are no longer applicable. Should we re-open the unit to births, we will revisit these actions and build them into quality and safety monitoring of the service.

On Thursday 16 October 2025, SFT met with the CQC, and details of the action plan were presented alongside a detailed overview of the progress made in all 7 key lines of enquiry (KLOEs):

- Maternity estate and security
- Second theatre and procedure room
- Triage
- Governance
- Policies and guidelines
- Clinical audit
- Training and appraisal

The service is delighted to share that the new MBRRACE report has identified SFT Maternity services as the only service in the South-West to have lower than national average Perinatal Death Rates. Further detail in relation to Clinical Quality Improvement Metrics (CQIMS) is presented in the Maternity & Neonatal Quarterly Safety & Quality Report.

SOMERSET NHS FOUNDATION TRUST

MATERNITY SERVICES

No.	Description	Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
M1	Babies readmitted to hospital who were under 30 days	CQIM	2	5	5	9	4	3	7	4	2	0	0	0	0	Monitored using Statistical Process Control rules. Report by exception.		
M2	Babies who were born preterm - less than 37 weeks gestation	CQIM	2	22	22	25	22	32	17	13	15	26	13	15	16	Monitored using Statistical Process Control rules. Report by exception.		
M3	Percentage of babies where breast feeding was initiated	CQIM	1,2	89.1%	88.0%	85.3%	90.7%	84.8%	84.6%	88.3%	86.7%	84.4%	86.1%	87.7%	88.2%	>=80%= Green >=75% - <80% =Amber <75% =Red		
M4	Percentage of babies with an APGAR score between 0 and 6	CQIM	1,2	1.4%	3.0%	2.3%	1.2%	1.5%	0.9%	0.3%	2.4%	1.6%	0.7%	1.6%	1.8%	=<1%= Green >1% - =<2% =Amber >2% =Red		
M5	Women who had a 3rd or 4th degree tear at delivery	CQIM	2	7	9	9	7	5	9	6	5	7	6	8	7	To be confirmed, following benchmarking against regional performance.		
M6	Women who had a postpartum haemorrhage (PPH) of 1,500ml or more	CQIM	2	9	11	11	15	10	14	13	2	10	6	15	9	To be confirmed, following benchmarking against regional performance.		
M7	Women who were current smokers at booking appointment	CQIM	1,2	6.0%	8.7%	7.6%	6.9%	6.6%	7.6%	6.3%	8.6%	7.0%	5.9%	6.4%	6.7%	No target level.		
M8	Women who were current smokers at delivery	CQIM	1,2	7.1%	6.8%	10.1%	8.4%	6.0%	9.1%	5.8%	4.2%	5.4%	6.8%	6.6%	4.2%	=<10%= Green >10% - =<12% =Amber >12% =Red		
M9	No. of still births	CQIM	2	1	1	2	0	0	0	0	0	1	0	0	0	Monitored using Statistical Process Control rules. Report by exception.		
M10	No. of babies with Hypoxic Ischaemic Encephalopathy Diagnosis (rate per 1,000 births)	CQIM	2	0.0	0.0	3.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	Monitored using Statistical Process Control rules. Report by exception.		
M11	Babies under observation should have Newborn Early Warning Score assessment recorded as per trust clinical guidelines.	SFT	1,2,4		86.5%		86.4%			89.2%			84.9%			>=90%= Green >=80% - <90% =Amber <80% =Red		
M12	Babies under observation who have NEWS score alerts should be escalated to the paediatrics team for review	SFT	1,2,4		92.3%		100.0%			100.0%			93.3%					

NARRATIVE REPORT

CHILDREN AND YOUNG PEOPLE'S SERVICES

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

Children and Young People's Eating disorders service

Eating disorder services (CEDS) have started to stabilise in terms of staffing, with retention rates improving and a significant reduction in agency nursing use. The three-month rolling performance for the reporting period ending 31 Augst 2025 was 90.8%, with 59 referrals out of 65 being seen within four weeks, against the 95% mandated standard.

For SFT, performance was 93.3% (28 out of 30 referrals seen inside of four weeks), and for SWEDA compliance was 88.6% (31 out of 35 referrals seen inside of four weeks).

Children and Young People's Community Mental Health service

CAMHS remains one of the best-performing teams nationally in terms of waiting times, with 97.1% of children and young people waiting less than six weeks for their first appointment as of 30 September 2025. This consistently exceeds the 90% green threshold, reflecting robust triage and referral management. However, the service is not immune to the wider system pressures. Following the return to school after the summer break, there has been a noticeable uptick in referral levels, which is beginning to test the capacity of the team to maintain their waiting list performance.

Primary care dental service

Community Dental Services across Dorset and Somerset are demonstrating clear progress in addressing operational challenges, particularly in relation to workforce stability, resulting in waiting list reductions. The Somerset service has seen significant improvements in the waiting lists for five consecutive months.

In June 2025, the service launched its 2025/26 Productive Care Initiatives in collaboration with the Data Science Team. These initiatives aim to optimise appointment allocation and reduce waiting times in Somerset. The programme is now well embedded, with active

engagement from all teams. Encouragingly, data indicates a reduction in waiting list numbers for the fourth consecutive month. As at 30 September 2025, the general waiting list stood at 2,252 patients waiting over 18 weeks, a reduction of 168 from the previous month, reflecting consistent month-on-month improvement.

The General Anaesthetic (GA) waiting list for young people exceeding 18 weeks has also shown sustained improvement over the past seven months, decreasing to 491, which is the first time it has been below 500 in over 12 months. Further reductions are anticipated. To support this, Dorset ICB had approved a business case for additional theatre slots through to August 2025, which has been extended due to theatre refurbishments that took longer than planned. Productivity has been affected by dentist availability within the GA pool, theatre staff sickness, and recent strike action.

In Somerset, the forthcoming opening of a new surgical facility is expected to double Paediatric GA capacity, representing a significant enhancement to service delivery. A Consultant in special care has forged relationships with a paediatric consultant in Bristol who has agreed to support the service from November 2025 with training support and guidance for dentists looking to join the GA pool to improve resilience.

Despite successful recent dentist recruitment efforts, 1.4 WTE dentists have recently resigned for reasons of relocation and to pursue academic opportunities. This will impact on overall performance, but skill mixing will be used through the recruitment of dental therapists to mitigate some of this impact across both counties.

At a national level, discussions are currently underway regarding the potential inclusion of community dental waiting lists in the nationally reported Referral to Treatment (RTT) statistics. The service is actively participating in these conversations, attending engagement sessions and working closely with the Trust's Performance and Information teams to ensure alignment, readiness and accuracy of data sets.

Despite ongoing pressures, the outlook for Community Dental Services in Dorset and Somerset remains positive. Progress is being driven by a combination of strategic recruitment, data-informed planning, and robust system-wide collaboration. Encouragingly, staff morale is also showing signs of improvement with the support of the OD Team.

Acute Paediatric service

National Paediatric Early Warning System (PEWS)

This month's compliance results indicate an upward trend since September 2025. Notably:

- **MPH:** Compliance for September 2025 was 66.7%, an increase compared with August 2025.
- **YDH:** Compliance for September 2025 was 88.9%, an increase compared with August 2025, and a shift from red to amber status.

Focused education for both doctors and nurses is being prioritised to improve compliance further. Work to introduce ePEWS within YDH Emergency Department is also underway.

There is still significant improvement work to be done in this area, which is being led directly by the Service Group Associate Director of Patient Care.

CYP Neurodevelopmental Partnership (CYPNP) service

Referrals continue significantly to exceed service capacity. As expected, August 2025 saw a seasonal dip in referral volumes due to school holidays; however, the waiting list numbers continued to increase from 3,827 patients as at 31 July 2025 to 3,862 as at 31 August 2025. This has resulted in referral-to-assessment times extending to 30 months. Notably, the number of patients waiting over 104 weeks rose from 704 to 723. In addition, the number of patients waiting 52 weeks or more was 245 above the trajectory shared with both the ICB and NHSE. September 2025 data is not yet available, but a continued rise in demand is to be expected.

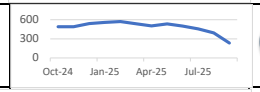
In response to ongoing pressures, the team developed and piloted a 'one stop shop' service model, aimed at improving pathway efficiency. This model enabled the delivery of an additional 35 appointments per month and significantly enhanced the service-user experience. Feedback has been overwhelmingly positive. Unfortunately, it has not yet been possible to extend the pilot due to limitations in clinic space, which are still under review. An alternative venue is actively being explored. However, progressing this option will require approval for a modest capital investment to make the space suitable, along with agreement on the very low annual rental costs.

Despite these innovations, the deterioration in waiting times remains unacceptable. The team has worked exceptionally hard to improve patient flow through triage, provide advice and support to families on the waiting list, and deliver educational packages to schools, GPs,

and parents. The service's risk score has now been raised to 16, reflecting ongoing concerns and repeated discussions with the ICB regarding insufficient funding to meet current demand.

SOMERSET NHS FOUNDATION TRUST

CHILDREN AND YOUNG PEOPLE'S SERVICES

No.	Description		Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
CYP1	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		NHSC	1,2,3,4	-	-	-	-	-	-	-	-	-	-	-	Data not yet due	>=95%= Green >=85% - <95% =Amber <85% =Red		
CYP2	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)			1,2,3,4	66.7%	64.5%	75.0%	79.5%	86.5%	71.7%	72.7%	73.8%	93.2%	92.5%	90.8%	Data not yet due	>=95%= Green >=85% - <95% =Amber <85% =Red		
CYP3	Increase the number of CYP accessing mental health services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019		NOF, OPG	1,2	4,730	4,795	4,900	4,970	5,010	5,216	5,246	5,315	5,408	5,524	5,451	Data not yet due	From April 2025 >=4,075 = Green <4,075 = Red		
CYP4	Mental health referrals offered first appointments within 6 weeks	Children and young people's mental health services	ICB	1,2,3	97.8%	96.3%	97.5%	97.3%	98.8%	99.0%	95.6%	100.0%	96.8%	100.0%	96.7%	97.1%	>=90%= Green >=80% - <90% =Amber <80% =Red		
CYP5	Improve A&E waiting times, with a minimum of 76% of patients admitted, discharged and transferred from ED within 4 hours in March 2026: Trust-wide performance - Under 18 years old		PAF	2	80.0%	71.3%	68.9%	78.3%	74.5%	70.6%	73.7%	76.8%	78.1%	80.6%	77.6%	77.1%	From April 2025 >=76%= Green >=66% - <76% =Amber <66% =Red (the standard will rise to 78% in March 2026)		
CYP7	Community dental services - General, Domiciliary or Minor Oral surgery waiting 18 weeks or more		SFT	1,2,3	2,394	2,543	2,688	2,631	2,629	2,544	2,516	2,532	2,523	2,495	2,420	2,252	From April 2024 <1,979 = Green >=1,979 = Red		
CYP3	Community dental services - General, Domiciliary or Minor Oral surgery waiting 52 weeks or more				489	491	540	559	571	538	502	535	501	456	393	234	From April 2024 <574 = Green >=574 = Red		
CYP4	Community dental services - Child GA waiters waiting 18 weeks or more		SFT	1,2,3	586	603	627	624	626	567	563	552	551	537	522	491	From April 2023 <463 = Green >=463 = Red		
CYP5	National paediatric early warning system (PEWS) - Medium risk: percentage reviewed by the nurse in charge	MPH	SFT	1,2,4	30.0%	42.1%	23.8%	28.6%	57.1%	46.2%	70.0%	43.8%	62.5%	100.0%	57.1%	66.7%	>=90%= Green >=80% - <90% =Amber <80% =Red		
CYP7		YDH	SFT	1,2,4	Reporting solution adopted at MPH implemented at YDH from January 2025			85.7%	66.7%	76.9%		100.0%	100.0%	100.0%	71.4%	88.9%			

NARRATIVE REPORT

PEOPLE

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

Areas of Success / Celebration

- September 2025 saw enthusiastic engagement and a steep acceleration in the number of job plans being signed off, with a compliance increase of around 30% (201 job plans) during the month. We achieved our target of 60% just before the October 2025 deadline and are now working hard to achieve 95% sign-off. An ambitious deadline of the end of October 2025 has been set for completion of the 2025/26 job planning round so that we can then start to look to 2026/27 and complete job plans prospectively. A successor to the Medical Job Planning Lead was appointed in September 2025. The new lead will work alongside the current lead for the remainder of the financial year, to ensure a smooth handover and to provide some additional capacity during a period of significant change and development in job planning.

- The 93.9% mandatory training compliance rate for September 2025 is at the highest level in the last year, with all service groups increasing their compliance levels, and an increase in the number of colleagues in-date with all of their mandatory training. The focus remains on the improvement of attendance for adult basic life support training. Colleagues are being asked to cancel their place if they cannot attend and to not book more than one session.

Areas of Concern

- Appraisal compliance declined by 1% in the last month, which means performance remains below the compliance level. People Business Partners are linking with key stakeholders to:
  - Influence the perceived value of appraisals and improve compliance.
  - Ensure targeted support and reminders to low compliance areas.
  - Review any incorrect hierarchies on ESR to ensure data validity.
  - Reinforce expectations through local leadership meetings.

Focus Areas

- Work is moving at pace to strengthen data recording and insights on formal case work, with a particular focus on understanding inclusion data and utilising existing systems such as RADAR to capture data. Feedback from managers around their confidence and capability in handling employee relations cases is enabling targeted intervention and the creation of 11 bitesize videos covering capability, sickness absence, welfare meetings, and organisational change, and 1:1s have been developed with more to follow. Impact measures are in place for this learning. Improved HR toolkits are being positively received. Sexual misconduct is the second-most frequent reason for investigation, and the most frequent reason for suspension/exclusion; additional resource has been allocated to support the sexual safety working group. The quality and length of investigations and the length of suspension remain areas of focus.

- The introduction of a restriction on external recruitment during October 2025 could affect the vacancy position if the restriction remains in place longer than 6-12 weeks, due to the lack of external recruitment to replace leavers. The risk could be increased use of temporary staffing. It is proposed that temporary adjustments be made to thresholds to recognise the restriction, with Green at <8.5%, Amber at 8.5–9%, and Red > 9%. This would acknowledge the impact of the freeze while maintaining realistic expectations.

SOMERSET NHS FOUNDATION TRUST

PEOPLE

No.	Description		Source	Links to strategic aims	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
P1	Mandatory training: percentage completed	Combined	SFT	5	93.7%	90.9%	92.2%	92.6%	92.8%	92.8%	93.0%	93.0%	93.2%	93.2%	93.5%	93.9%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber		P
P2	Monthly percentage of days lost due to sickness absence		NOF	5	5.5%	5.6%	5.8%	5.7%	5.3%	4.8%	4.6%	4.8%	5.1%	5.2%	4.9%	5.0%	SPC (Upper Control Limit 5.4%)		
P3	Sickness absence levels - rolling 12 month average (Trust-wide)		NOF	5	5.1%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.1%	5.0%	5.0%	SPC (Upper Control Limit 5.2%)		
P4	Career conversations (12 months)		SFT	5	78.5%	79.8%	80.4%	78.5%	77.8%	78.2%	77.0%	77.0%	76.4%	77.4%	78.7%	77.7%	>=90%= Green >=80% - <90% =Amber <80% =Red		F
P5	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		SFT	5	7.7%	7.7%	7.9%	8.0%	7.8%	7.8%	8.4%	8.3%	8.4%	8.3%	6.7%	7.8%	<=5%= Green >5% to <=7.5% =Amber >7.5% =Red		F
P6	Retention rate – rolling 12 months percentage of colleagues in post		SFT	5	88.7%	88.7%	88.8%	88.8%	89.0%	89.1%	89.1%	89.4%	89.5%	89.6%	89.4%	89.7%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red		P
P7	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	SFT	1,5	21.6%			22.5%			23.2%			24.4%			>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red		P
P8		Who are female	SFT	1,5	57.9%			58.2%			57.9%			58.7%					F
P9		With a recorded disability	SFT	1,5	3.9%			4.0%			4.2%			4.8%					P
P10	Job planning: Percentage of Consultant and SAS doctor job plans signed off		SFT	5	New measure - reported from March 2025.					21.5%	6.6%	10.2%	12.8%	20.2%	31.6%	60.4%	>=95%= Green >=85% to <95% =Amber <85% =Red		F
P11	Percentage of patient-facing staff receiving a 'flu vaccination		PAF	1,5	Reporting to run from October 2025 to January 2026.												>=80%= Green >=70% to <80% =Amber <70% =Red		
P12	Number of formal HR case works (disciplinary, grievance and capability).		SFT	5	49	62	47	50	50	63	58	69	55	68	86	88	SPC (Upper Control Limit 78		F

NARRATIVE REPORT

PATIENT EXPERIENCE AND INVOLVEMENT

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

What is going well

The volume of Care Opinion stories has remained relatively consistent over recent months. At the time of reporting, responses have been provided to all but three stories. Positive feedback themes continue to highlight compassionate and attentive care, with numerous comments commending staff for their kindness and patience. This month the percentage of complaints responded to within the agreed time frame increased from the previous month, to 62.0%.

What is going less well

The staffing vacancy level within the team continues to affect certain workstreams, such as the promotion of Care Opinion through awareness stands. As such, the number of care opinion stories has not increased, and we have not returned to the peak of 60 stories recorded at the end of 2024.

The intensified focus on improving the quality of complaint responses, prompted by the rise in second letters over the past three months, continues. Complaint responses continue to be returned to service groups as part of the Quality Assurance (QA) process conducted by the complaints team, to ensure accuracy of information and comprehensive responses to all questions. Consequentially, this continues to impact on response timeframes, with the objective of achieving resolution with the initial response. Time for the QA process (10 working days) is already included in the timeframes provided to the service groups, however delays occur in the complaints team receiving the draft response letters. These delays are attributed to the following factors:

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

-

The complaints team analyse the rationale behind the requests for second response letters, which serve as a crucial indicator of the quality and effectiveness of initial complaint responses. This month the number continued to demonstrate special cause variation, with ten second letters received, an increase from seven and eight in the previous two months. There has been a significant increase in formal complaints closed over the past three months, and this increase in second letters may be proportionate to this increase. The second letters relate to the Medical, Neighbourhoods and Clinical Support and Cancer Service groups (Medical seven, Neighbourhoods two, CSCS one). The request for second letters were due to:

Inadequate Explanations: six complainants found the explanations provided in the response letters to be inadequate. Four requested a further written response and two requested a meeting.
Additional Questions: Two complainants requested additional responses as they had further questions following the receipt of the initial response letter.
Incomplete Addressing of Concerns: One complainant felt that their concerns had not been fully addressed in the initial response.
Dissatisfaction following resolution meeting: One complainant was not happy with the outcome of the resolution meeting and wanted a written response to submit to the PHSO.

Focus of improvement work

- Patient Voice volunteers continue actively to encourage patients on the wards to share their experiences via Care Opinion and provide assistance to those who require support to complete their story on the platform.
- The service tree for Care Opinion is being completed, which ensures we have responders set up in every department in the Trust. The team will then work with the Communications team to promote awareness of Care Opinion.
- Targeted work with services that have not previously managed complaints, to identify the support required to ensure the process is efficient, timely and responses are compassionate.
- A weekly sitrep of service group positions regarding formal complaints is provided to the Director of Patient Experience and Engagement. This report aims to provide senior leadership with oversight, particularly focusing on complaints that are 'at risk' (between 30 and 40 days old), to facilitate a more efficient escalation process.
- Escalation processes specific to individual Service Groups (Families, Neighbourhoods, and Surgical) have been developed, including escalation to Associate Medical Directors and Associate Directors of Patient Care prior to complaints breaching the time frame.
- Regular meetings between Associate Directors of Patient Care and the Head of Patient Experience to identify causes of delays and potential solutions.
- Regular tracker meetings between complaint co-ordinators and service groups to identify potential delays and escalate concerns.

- A review of targets to ensure alignment with national standards.
- A working group has been developed to perform an organisational diagnostic against NHS Complaint Standards. The first meetings took place in November and December 2024, and February 2025. The next meeting, scheduled for September 2025, will review progress against the NHS Complaint Standards action plan.
- Development of an interactive dashboard to increase visibility and timeframes of complaints is under way.

SOMERSET NHS FOUNDATION TRUST

PATIENT EXPERIENCE AND INVOLVEMENT

No.	Description	Source	Links to strategic aims	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Thresholds	Trend	Variation / Assurance
PE1	Care Opinion: Number of stories per month	SFT	2	41	44	42	60	56	42	39	46	48	48	38	34	33	35	34	Increase from 2024/25 baseline		
PE2	Care Opinion: Percentage of stories with responses	SFT	2	90.2%	95.5%	97.6%	91.7%	85.7%	100.0%	94.9%	100.0%	100.0%	97.9%	100.0%	100.0%	100.0%	100.0%	91.2%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE3	Percentage of complaints responded to within the timescale agreed with the complainant	SFT	2	New reporting - to commence from September 2024		63.0%	39.1%	31.3%	47.8%	25.0%	47.6%	50.0%	39.3%	54.5%	73.3%	73.3%	56.8%	62.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE4	Number of complaints resulting in second letters	SFT	2	4	3	0	1	1	1	1	4	2	3	2	5	7	8	10	Monitored using Statistical Process Control rules. <=5 = Green >5 = Red		
PE5	Percentage of formal complaints fully upheld	SFT	2	7.7%			9.0%			13.6%			17.6%			14.8%			Compare to national average		
PE6	Percentage of formal complaints partially upheld	SFT	2	78.8%			73.1%			75.8%			63.7%			62.3%			Compare to national average		

Appendix 1 – Infection Control and Prevention – September 2025

MRSA bloodstream infections	Commentary on MRSA /MSSA BSIs
Musgrove Park Hospital = 1 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Total year to date = 4**	There are no national thresholds assigned to MRSA or MSSA bloodstream infections (BSI). However, there is a zero tolerance of MRSA BSIs and as a Trust we have an internal threshold for MSSA. Case numbers for MRSA are on an upward trend for the Trust with a rate of 1.62 per 100,000 occupied bed days. This is in line with the regional rate (1.64) and the national rate (1.33). Case numbers for MSSA are stable but with an overall increasing trend since the end of the COVID pandemic. Regionally increases are also being seen. For our Trust the area of focus for improvement work is still peripheral cannulae. As reported last month a Southwest task group is being set up to investigate the drivers for this increase, this group is yet to meet.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 2 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 0 **Internal Threshold = 64** **Total year to date = 29**	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 8 Yeovil District Hospital = 4 Community Hospitals / Mental Health = 0 **Threshold = 100** **Total year to date = 66**	The most common sources to date for this financial year continue to be urine and biliary. No new issues have emerged so far therefore work continues to focus on cases linked to urinary catheters. The overall burden of disease is in the community. **E. coli** Case numbers for E. coli remain stable but are above trajectory. We have the 3rd lowest rates of E. coli (29.25 per 100,000 occupied bed days) in the region. **Pseudomonas** Case numbers for Pseudomonas are higher than the same period last year and there has been a small spike in numbers during September. **Klebsiella** Case numbers for Klebsiella are stable apart from an unusual spike in July but overall are double where they were at the same point last year. It is unclear what resulted in the spike during July, the post infection reviews have not revealed any clear reasons. The most common sources remain urine and biliary.
Klebsiella bloodstream infections	
Musgrove Park Hospital = 1 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0 **Threshold = 36** **Total year to date = 30**	

Pseudomonas bloodstream infections	
Musgrove Park Hospital = 4 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0 **Threshold = 12** **Total year to date = 14**	No progress has been made in the Integrated Care Board to plot the community cases on a heat map geographically, but this remains the beginning action of the joint piece of work.
C. difficile	**Commentary on C. difficile**
Musgrove Park Hospital = 5 Yeovil District Hospital = 5 Community Hospitals / Mental Health = 0 **Threshold = 91** **Total year to date = 55**	Despite rising case numbers, regionally we have the second lowest rates of infection. Almost all cases are driven by antibiotic use. This is a national issue, and central work is being undertaken to understand the reasons for increases.
Respiratory Viral Infections - inpatients	**Commentary on Respiratory Viral Infections**
COVID (Trust Cases) = 154 Musgrove Park Hospital = 95 Yeovil District Hospital = 47 Community / Mental Health = 12 **Influenza = 24 (Inpatients)** Musgrove Park Hospital = 14 Yeovil District Hospital = 10 **Respiratory Syncytial Virus (RSV) = 7 (Inpatients)** Musgrove Park Hospital = 6 Yeovil District Hospital = 1	**Respiratory Viruses** • COVID-19 case numbers continue to rise through September. • Influenza numbers remain stable and relatively low with no significant increase during September. • RSV case numbers have increased during September but remain low. Information on the 2025 Winter in Southern Hemisphere has been released. Australia experienced an influenza season that started earlier than normal, peaking between June and July with high community transmission rates. Children aged 0-9 experienced the highest infection rates and hospitalisation / severe outcomes mainly affected those over 65yrs. They have also experienced higher levels of RSV (50% higher than 2024). Predictions for Europe forecast a high-burden, early and potentially severe flu season for Europe this winter, possibly start mid-October. The triple threat of flu, RSV and COVID-19 remains. Point of Care analysers are on order for both Emergency Departments, AMU Barrington and 6B AMU. This will enable rapid respiratory virus testing to enable appropriate placement of patients and reduce the need to hold patients in ED.

Outbreaks	Commentary on outbreaks
COVID = 10 Musgrove Park Hospital = 8 Yeovil District Hospital = 1 Community / Mental Health = 1 **Norovirus = 0** **Carbapenemase Producing Organism (CPO)** • **YDH -** Since January 2022 there have been 104 cases of CPO identified on the YDH site.	Outbreaks are starting to increase but remain relatively low. **Carbapenemase Producing Organism (CPO) - YDH** This has been managed as a Trust-wide outbreak which has spanned two key time periods, January 2022 to August 2023 and December 2023 to the current time. There are two different resistance mechanisms involved. The genes that encode for these resistance mechanisms can move between different species of bacteria which makes the linking of cases in the outbreak more challenging. This is the reason that more specialist testing has been required from UKHSA. The work identifying whether this is an ongoing outbreak or endemic in our Yeovil community population continues but this is labour intensive and requires time. The screening strategy is also under review.
Surgical Site Infections	**Commentary on Surgical Site Infections**
Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions. **Musgrove Park Hospital Site** Continuous surveillance for Total Hip Replacement (THR), Total Knee Replacement (TKR) and Spinal Surgery has been in place on the MPH site since 2009.	**Musgrove Park Hospital Site** • **Hip Replacement** Within the last year (September 2024 to August 2025) a total of 344 operations were undertaken with no infections identified. • **Knee Replacement** Within the last year (September 2024 to August 2025) a total of 249 operations were undertaken and 2 infections identified giving an infection rate of 0.8% which overall remains in line with the national benchmark of 0.4%. • **Spinal Surgery** Within the last year (September 2024 to August 2025) a total of 319 operations were undertaken and 1 infection identified giving an infection rate of 0.31%. The infection rate remains below the national benchmark of 1.1%. • **Caesarean Section** Surveillance started in June 2025 and was one of the assurance controls in place to support the use of the procedure room as a second theatre. During June a

Yeovil District Hospital Site Continuous surveillance on total hip replacement surgery has been in place on the YDH site since April 2022 and continuous surveillance was commenced on total knee replacement surgery from January 2024.	total of 135 operations were undertaken, and one patient was readmitted with an infection giving an infection rate of 0.7%. In addition, patients are asked to self-report infections, one patient reported an infection giving an infection rate of 0.7%. However, the response rate from patients was low, only 28 patients responded. This is likely to be due to the pressures of motherhood during the first month following birth. Since then although IPC have continued to collect the data, but the clinical teams have been unable to support surveillance. The IPC team will undertake some basic checks of readmissions and any specimens, but this cannot be classed as true surveillance. **<u>Yeovil District Hospital Site</u>** • **Hip Replacement** Within the last year (September 2024 to August 2025) a total of 348 operations were undertaken with no infections identified. • **Knee Replacement** Within the last year (September 2024 to August 2025) a total of 443 operations were undertaken with no infections identified. The national rate is calculated over the period April 2019 to March 2024 and therefore not directly comparable to trust infection rates. However, as a trust the national benchmark is always used as a guide.

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee September meeting
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Inga Kennedy, Chair of the Quality and Governance Assurance 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 Committee met on 24 September 2025 and reviewed the Quarter 2 BAF, Corporate Risk Register, and key quality and safety reports. Assurance was received on maternity and paediatric service plans, the launch of the Patient Safety Faculty, and progress on the Patient Experience Strategy. Concerns remain around performance against RTT and ED targets, stroke services, appraisal completion, and digital resilience. The Winter Plan was endorsed, noting significant financial, operational, quality and safety risks.
Recommendation	That the Board notes the assurance provided and the key risks highlighted, particularly those relating to Strategic Aim 2, maternity and paediatrics, winter planning, and digital infrastructure.

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?**
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 MEETINGS OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE HELD ON 24 SEPTEMBER 2025

1. PURPOSE

1.1. The report provides a summary of the key items discussed at the Quality Governance Assurance Committee (QGAC) meeting held on 24 September 2025 (Business Meeting), including assurance received, areas of concern, and risks/issues to be escalated to the Board.

2. ASSURANCE RECEIVED

2.1. The Committee reviewed the Quarter 2 Board Assurance Framework (BAF). Progress against national priorities remains mixed, with Strategic Aim 2 (Provide the best care and support to people) and Strategic Aim 3 (Strengthen care and support in local communities) continuing to operate above the Trust's risk appetite. Cancer 28-day Faster Diagnosis performance was sustained, but RTT 62-day cancer and ED four-hour targets remained below standard. The "no criteria to reside" metric remained behind target at 21.4% in July, despite actions such as Criteria-Led Discharge and follow-up from the 100-day sprint. Strategic Aim 4 objectives are largely on plan, although transition pathways for young people with complex needs have stalled following the end of the Transition Lead role.

2.2. The Committee received the Corporate Risk Register, noting 25 corporate risks, eight of which score 20 or above. Themes include maternity and neonatal services, workforce sustainability, infrastructure, and digital resilience. A new risk relating to HAZMAT/CBRN response at MPH was highlighted. The Committee welcomed improvements in risk articulation and the introduction of compound risk analysis to better understand interdependencies.

2.3. The Executive Quality and Safety Review provided assurance on maternity and paediatric services. No serious incidents have been reported in relation to the temporary closure of YDH maternity services. The Trust has been included in the national independent maternity services investigation programme. Recruitment to paediatric services was progressing, with four new consultants appointed. Planning for the safe reopening of maternity and neonatal services continued, with milestones and criteria under development at the time of the Committee.

2.4. The Committee received updates from the Patient Safety Board, including the launch of the Patient Safety Faculty on 1 September and development of a three-year Patient Safety Strategy. The Committee supported the strategy in principle, subject to further discussion on trust strategy development at the

Board in October. Two PSIIs were signed off, and work continues to embed learning from investigations.

2.5. The Governance Support Summary highlighted progress in closing the national bed rail safety alert and ongoing work on Regulation 28 responses. Health and safety reporting continues to rise, reflecting a positive reporting culture, though stress and anxiety remain the leading causes of absence. The Committee noted concerns regarding low compliance with dementia and delirium screening in ED and poor performance in the national rapid tranquilisation audit.

2.6. The Patient Experience and Engagement Report showed an increase in formal complaints (118 open cases) and a rise in second letters, often due to inaccuracies in initial responses. PALS cases increased by 9% in Q4, with only 50% meeting the 10-day response target. The Committee approved the new Patient Experience and Involvement Strategy in principle subject to the session on strategies at the Board Development Day in October.

2.7. The Learning from Deaths Q1 report was noted, with assurance provided on mortality review processes and the role of the Somerset Medical Examiner Service.

2.8. Finally, the Committee endorsed the Winter Plan and associated Board Assurance Statement, noting significant risks due to the absence of additional funding for escalation beds. The plan will remain subject to further refinement as required to maintain patient safety.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee noted several areas requiring continued focus. Performance against RTT, ED, and “no criteria to reside” targets remained below plan, with limited impact from recent improvement initiatives.

3.2. Stroke services continued to underperform, as indicated by SSNAP data, and while a Stroke Improvement Group has been established, significant improvement is still required.

3.3. Appraisal completion rates remain low, and feedback from the national survey suggests staff perceive limited value in the process, which continues to attract CQC scrutiny.

3.4. Mental health services also present challenges, particularly in relation to ED waiting times and poor audit performance in rapid tranquilisation.

3.5. In addition, the Committee discussed ongoing risks associated with digital infrastructure, including interoperability and resilience, and emphasised the need to progress the Electronic Health Record business case.

3.6. Finally, the Committee recognised the continued pressure on maternity and neonatal services at Musgrove Park Hospital following the temporary closure at YDH, noting that development of the timeline for safe reopening was underway.

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

4.1. The Committee agreed that Strategic Aim 2 remains above the Trust's risk appetite, driven by challenges in maternity, paediatrics, and patient flow. It also highlighted the potential for compound risks across workforce, estates, digital systems, and demand/capacity to amplify operational pressures if not managed effectively. Financial risk associated with winter planning was noted, given the absence of additional funding for escalation capacity.

4.2. The Committee further emphasised the need for alignment between the clinical and quality strategies and greater clarity on governance arrangements for clinical effectiveness. These issues will be escalated to the Board for consideration and oversight.

Inga Kennedy
CHAIR OF THE QUALITY GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 3 October 2024
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Phil Brice, Director of Quality Assurance and Involvement
PRESENTED BY:	Inga Kennedy, Chairman of the Quality and Governance Assurance Committee
DATE:	4 November 2024

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

Executive Summary and Reason for presentation to Committee/Board	The attached report sets out details of the annual reports discussed at the Quality and Governance Assurance Committee meeting held on 3 October 2024. The Committee received assurance in relation to: • Safeguarding Adults • Safeguarding Unborn Babies and Children • Emergency Planning, Response and Resilience (EPRR) • Patient Experience (including Complaints and PALS) • Infection Prevention and Control • Information Governance • Health and Safety The Committee acknowledged the excellent work over the last 12 months highlighted in all of the reports. The reports reflect a year of strong consolidation post-merger, with all the central teams fully integrated. However, some systems, policies, and processes have not reached that stage yet. The relatively small central teams face considerable demand; moreover, the devolved governance model introduced substantial effects on operational services and Service Groups, which were unfamiliar to many stakeholders

	and remained in the process of development. These aspects need further review in the coming year to ensure we have the right model and balance, to deliver positive assurance of sustainable improvements. Other clear themes emerging from the reports were the need for further improvements to the consistency of approach across the different parts of the organisation; the continued impact and risk of multiple digital systems; and the need to improve patient and carer engagement in our governance processes. Overall, the annual reports demonstrated high levels of assurance for the Trust across these key statutory and regulatory areas which we can provide to the Trust Board in the form of this summary report. The annual reports will be published on the Trust's public website for people to access.
Recommendation	The Board is requested to acknowledge the assurances provided, consider the topics addressed, and appreciate the positive outcomes highlighted in these reports, alongside areas for further improvement.

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?
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/Colleague 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.
Colleague 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 on an annual 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

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING

ANNUAL REPORTS – 2024/25

1. EXECUTIVE SUMMARY

1.1 The report sets out a summary of discussions relating to the following annual reports, which were considered by the Quality and Governance Assurance Committee at a meeting held on 3 October 2025, in line with the delegated authority from the Trust Board:

- Safeguarding Adults
- Safeguarding Children
- Emergency Planning, Response and Resilience (EPRR)
- Patient Experience (including Complaints and PALS
- Infection Prevention and Control
- Information Governance
- Health and Safety

1.2 In its review, the Committee acknowledged the excellent work over the last 12 months highlighted in all of the reports and the high levels of assurance provided. The reports demonstrate the specialist teams' and organisation's commitment and motivation, even under capacity constraints and operational pressures.

1.3 The Committee reflected on the positive integration of all these functions and acknowledged that, as we move to the future and delivery of an organisation that can deliver the principles of our strategy and the 10-year plan, this transformation will provide the scope – but also challenges – to further improve in these areas.

1.4 Other clear themes emerging from the reports were the impact that a single electronic health record would have on our abilities to understand and support all areas of compliance, and the impact of our aging estate and infrastructure.

1.5 Overall, the annual reports demonstrated high levels of assurance for the Trust across these key statutory and regulatory areas which we can provide to the Trust Board in the form of this summary report. The annual reports will be published on the Trust's public website for people to access.

1.6 The Board is asked to note the Committee's report and receive assurance of the levels of compliance and delivery demonstrated by the annual reports.

2. SAFEGUARDING ADULTS 2024/25 PRESENTED BY HEATHER SPARKS, NAMED PROFESSIONAL SAFEGUARDING ADULTS

2.1 The report provided the Committee with both assurance and evidence that Somerset NHS Foundation Trust fulfilled its statutory responsibilities to adults at risk of abuse, set against the guidance within the Care and Support Statutory Guidance 2020.

2.2 The areas of compliance covered in the report on which assurance was given included key safeguarding activities, trends, and developments across the Trust during the financial year. The report highlighted statutory responsibilities, training compliance, audit outcomes, and strategic alignment with national legislation and local safeguarding priorities.

2.3 The Committee noted the updates on safeguarding statutory areas including Section 42 enquiries, Safeguarding Adult Reviews, Domestic Abuse (including Domestic Abuse Related Death Reviews), Prevent, and Modern Slavery.

2.4 The Committee particularly noted:

- Levels of compliance with training have improved. By the end of 2024/25, level 3 compliance was at 86.5% which represented an almost increase of almost 10% from 2023/24.

- Following the re-mapping of Band 6 level 3 training, compliance was at 56.9% as of 30 June 2025 from a starting point of 0% in January 2025.

- Clearer tracking of s42 enquiries has been introduced. During the scope of the report, sixteen statutory s42 safeguarding enquiries were raised against the Trust, primarily involving concerns regarding neglect, acts of omission, and physical abuse. Key issues included lack of mental capacity assessments, treatment without consent, unsafe discharge planning, and poor ward-based personal care.

- There was a concern around resistance from some Trust colleagues to undertake s42 enquiries, when 'caused to do so' by the Local Authority Care Act (2014). This reluctance created some operational challenges, as some colleagues did not perceive this as part of their remit. Actions being taken to address these concerns include the launch of Section 42 workshops to build colleagues' knowledge, confidence and competence in completing S42 enquiries and development and regular review of s42 learning logs (review at 3, 6 and 12 month periods) which also supports the identification of wider trust learning. The Committee clarified that this was a multi-professional issue.

- Whilst still not mandatory, Domestic Abuse basic awareness training continues to be woven into Safeguarding Adults mandatory training via the local-processes e-learning and also within Safeguarding Adults and Safeguarding Children level 3 training. This ensures all staff will receive some level of Domestic Abuse awareness training.

- The clinical audit of safeguarding adults referrals in March 2025 confirmed effective referral processes and increased staff confidence. The audit identified a 150% increase in referrals to the Local Authority (average 25 per month in 2023/24 to average 75 per month in 2024/25). Actions include developing MARM workshop and enhancing referral outcome tracking.

- Self-neglect continues to be a prominent theme from safeguarding enquiries received into the Trust's Safeguarding Advisory Service (SAS), single point of contact (SPOC) as well as SARs. To help address learning needs in this area a Self-Neglect workshop will be developed and available to book via LEAP, this is in addition to the self-neglect section within the safeguarding adult level 3 training.

- Seven new DHR notifications were received. In all seven cases, the victims and / or perpetrators of harm were known to the Trust. In addition to the seven new DHR notifications, we continue to support a further six DHRs from the previous financial year which are at various stages of the DHR process.

- Key learning for the Trust from DHR's includes importance of domestic abuse routine enquiry (DARE), trauma-informed care, recognizing domestic abuse as a risk indicator for suicidal ideation / attempts / completion in victims (and perpetrators) and the importance of understanding the impact and nature of coercive control. Actions taken to address learning needs include – delivery of DARE workshops across MIUs, UTCs, and Emergency Departments.

- Trust participation in weekly MARAC (multi-agency risk assessment conference) meetings resulted in multi-agency discussions for 888 high-risk victims of domestic abuse including 593 children, 1551 associated children and 66 cases in which there were pregnancies. This resulted in research being undertaken for a total of 3313 individuals (victim, person causing harm, children) across 6 patient record systems. 9.64% of cases discussed were referred by SFT.

- Responsibility for MAPPA (multi-agency public protection arrangements) has moved back into Safeguarding during the year.

- In light of recent incidents, including the events in Manchester, there were plans to include more information around PREVENT within the Level 3 safeguarding training and consider further multi-agency

communications. Focused work has already been undertaken with CAMHS and mental health forensic services.

- Capacity within the central safeguarding service meant that some aims for the year were not achieved, including a service evaluation for domestic abuse and suicide. Recording across numerous patient record systems continues to be a concern (and is on safeguarding service risk register). The Committee noted the work being done to seek to address this across the Trust.

- Plans for 2025/26 included:

    - Development of skills session for Multi-Agency Risk Management (MARM) meetings
    - Self-neglect CPD workshop / possible self-neglect survey
    - Audits regarding s42 process, safeguarding adult referral outcomes, Prevent process
    - Joint work with Strategic Lead, Named Nurse Safeguarding Children regarding domestic abuse and children (in prep for next JATI inspection) – to develop a Domestic Abuse Level 3 CPD module
    - Review of MARAC processes
    - Review of DARDR (domestic abuse related death reviews) support and service resilience

The Committee discussed the opportunities to collaborate and share the CPD training with local education and other wider system colleagues.

2.5 The Committee agreed that the report provided significant assurance, noted the concerns and risks highlighted in the report, including those relating to multiple systems and risks associated with discharge planning, and thanked Heather and the Safeguarding adults for the high levels of assurance and excellent work reflected in the report. The Committee duly approved the report.

3. SAFEGUARDING UNBORN BABIES AND CHILDREN - PRESENTED BY NICOLE MITCHELL, NAMED NURSE FOR SAFEGUARDING CHILDREN

3.1 The report provided the Committee with both assurance and evidence that the Trust fulfilled its statutory responsibilities to protect children's rights to live in safety, free from abuse and neglect; to protect children from maltreatment in order to prevent the impairment of children's health and development; to work with other organisations to prevent and stop the risks and experience of abuse or neglect. This included working with Somerset Safeguarding Children Partnership.

3.2 The areas of compliance covered in the report on which assurance was given included:

- The Children Acts 1989 and 2004
- United Nations Convention on the Rights of the Child (UNCRC)
- Every Child Matters (2004 and 2015)
- National Service Framework for Children (2004)
- Working Together to Safeguard Children (2018)
- Intercollegiate Document (2019) Safeguarding Children and Young People: Roles and Competencies for Health Care Staff
- Children and Social Work Act (2017)
- CONTEST – Counter Terrorism Strategy (2018)
- Modern Slavery Act (2015)
- Domestic Abuse Act (2021)
- Domestic abuse Statutory Guidance (July 2022)

3.3 This included compliance with the Safeguarding and Protection of unborn Babies and Children Policy; the Safeguarding Clinical Supervision Policy; the Court Procedures for Safeguarding Unborn Babies and Children Policy; Safeguarding Children and Young People from Child Exploitation Policy.

3.4 The Committee particularly noted:

- The Safeguarding Advisory Service consistently fulfilled its statutory safeguarding duties in respect of Safeguarding and protecting Unborn Babies and Children during the reporting period.
- There were a total of 5163 contacts to the service in year, a small increase from the previous year (5154), following a marked increase from 2020 to 2023. During the reporting period, 35% of Safeguarding Advisory Service (SAS) contacts originated from Emergency Departments (ED) at Musgrove Park Hospital (MPH) and Yeovil District Hospital (YDH). These contacts primarily involved safety netting and scrutiny by the Safeguarding Advisory Service (SAS) of children presenting with safeguarding concerns, reflecting the high volume and urgency of ED interactions.
- The WREN Team experienced a 25.8% increase in advice requests, rising from 1,810 to 2,277. Improved data recording by the WREN

Team enabled more accurate identification of families experiencing social disadvantage or vulnerability.

- There was a 4.9% increase in compliance in safeguarding supervision during the year, across acute and community settings. Out of 1,424 eligible staff, 591 accessed supervision, resulting in a compliance rate of approximately 41.5%. The remaining 833 staff did not engage in supervision on a quarterly basis, falling short of the mandated 85% compliance required.

- A concerning pattern is emerging in safeguarding practice, with older children increasingly affected by serious harm outside the home. These cases often involve knife-enabled youth violence, repeated school exclusion or absence, frequent missing episodes, non-fatal strangulation, and signs of severe neglect, including malnutrition. This reflects the findings of the Joint Targeted Area Inspection (JTAI) and learning actions from this.

- The Service led and/or contributed to eight safeguarding audits and reviews, spanning both multi-agency and single-agency contexts. These audits provided critical assurance and insight into safeguarding practice, with a focus on:

    - Pre-birth safeguarding arrangements
    - Escalation pathways in complex cases
    - Child protection medicals
    - Multi-agency decision-making and thresholds

    Findings from the audit programme have informed strategic safeguarding priorities and contributed to system-wide learning. The Safeguarding Advisory Service has used these insights to influence policy, improve practice, and strengthen multiagency collaboration.

- The Service has actively engaged with key partners including the broad health system, Children Social Care, Education, and Police, ensuring a coordinated response to safeguarding concerns. This has included participation in Local Safeguarding Children Partnerships (LSCPs), Serious Case Reviews, and strategic forums.

- A comprehensive safeguarding training programme was delivered, supporting staff across the Trust to maintain competence and confidence in safeguarding practice. This included targeted sessions on emerging risks, learning from audits, and statutory responsibilities.

- The Service has contributed to external inspections and assurance processes, providing evidence of robust safeguarding arrangements and responding to recommendations for improvement.

- Priorities for 2025/26 are to:

- Strengthen data-informed safeguarding intelligence across the Trust and wider partnership.
- Enhance safeguarding supervision and support for frontline staff.
- Embed learning from audits and reviews into practice development.
- Continue to influence system-wide safeguarding strategy and policy.

- One of the biggest challenges and concerns for the service remains the multiple recording systems and lack of interoperability between them. This means that, unless the child is already known to Safeguarding Services and has a protection plan in place, there is additional work required to make sure that children are not missed. This will be addressed once a new Electronic Health Record (EHR) is in place but in the interim teams are working to find a way to use all of the multiple systems safely. Work is taking place at present to ensure colleagues use SIDeR+ transform family view and it is hoped that this can be embedded in RiO, which is the main system used by safeguarding to record contacts. This is a recognised risk on the corporate risk register.

3.5 The Committee considered the challenges of maintaining aspects of professional curiosity in the face of operational pressures and the steps taken by the team to support awareness and engagement. This included concerns around capacity and resources within the Trust and in the local authority.

3.6 The Committee agreed that the report provided significant assurance and approved the report.

4. EMERGENCY PLANNING RESILIENCE AND RESPONSE (EPRR) – PRESENTED BY ANDREW SINCLAIR, ASSOCIATE DIRECTOR OF RESILIENCE

4.1 The report provided the Committee with assurance that the trust was fulfilling its statutory responsibilities with regard to emergency planning and civil contingencies, and that the trust is fully compliant with the NHSE core standards for EPRR.

4.2 The Committee noted in particular:

- The completion of the annual NHSE EPRR Annual Assurance Self-Assessment against the national EPRR core standards and the submission of the self-assessment to the Somerset Integrated Care Board (ICB). The assessment is subject to a challenge meeting with the ICB later this month but has been submitted showing full

compliance against all core standards for the second year running. The Committee agreed that this was an excellent achievement.

- There was no deep dive assessment for 2024/25.

- The Committee noted the challenges in respect of Chemical, Biological, Radiological and Nuclear (CBRN) planning and contingency arrangements, in particular the extension of training and the facilities at the MPH site.

- There had been challenges to deliver a programme of live and tabletop exercises of plans across the organisation, due to operational pressures, but a number had been conducted, all of which have identified learning which has been shared across the Trust.

- The Committee discussed the risks in relation to developments within Somerset, in particular in relation to Hinkley Point, the new battery factory and Glastonbury Festival. It was agreed that proactive risk assessments for these areas were essential.

- A 3-5 EPRR plan is in development which will bring together the major incident arrangements for the two acute hospitals into a single plan. It will also prioritise local risk assessments to support business continuity planning and response to incidents – taking the learning from feedback debriefs on live events that have occurred – such as the recent Exmoor coach crash.

- The Committee discussed the risks in relation to cyber security and opportunities to learn from other trusts which had experienced attacks. The Committee noted the strong digital security functions and business continuity arrangements.

- Other challenges include the ongoing risk relating to another emerging pandemic, the UK economic situation and global political unrest. The Committee also reflected on the impact of the current and proposed restructuring across the NHS to the existing command and control arrangements.

4.3 The Committee agreed that the report provided significant assurance and approved the report.

5. PATIENT EXPERIENCE AND ENGAGEMENT - PRESENTED BY EMMA DAVEY, DIRECTOR OF PATIENT EXPERIENCE AND ENGAGEMENT, CAROLINE WALKER, HEAD OF PATIENT EXPERIENCE AND KRYSTLE PARDON, HEAD OF PATIENT ENGAGEMENT

5.1 The report sets out an overview of the area of work for 2024/25 and the Trust's activity in relation to patient experience, PALS and complaints and the opportunities for learning and service improvement.

5.2 The Committee noted that the patient experience and engagement team was now fully recruited and beginning to deliver its newly developed strategy.

5.3 The Committee noted in particular from the report:

- The number of formal complaints received was 318. This represented a small increase from 314 the previous year. However, the Trust has continued to fail in its target to have a 90% target for all formal complaints to be responded to within an agreed timeframe of 40 – 60 days.

- Of the closed formal complaint cases 11% were fully upheld, 73% were partially upheld, and 16% were not upheld. The Trust is identified as an outlier in respect of the percentage of complaints not upheld (lower) and partially upheld (higher). Work is underway to review this.

- 9 Formal Complaints were referred by complainants on to the Parliamentary and Health Service Ombudsman during the year.

- The key categories that emerged from formal complaints and PALS enquiries in the last year were: communication, clinical treatment, waiting times and attitude of staff.

- An upgraded RADAR system was implemented for formal complaints to enhance communication efficiency, monitor complaint progress, and identify delay points for guiding improvements.

- The total number of PALS enquiries for the year was 4923 (an increase from 4317 the previous year). Over 2,500 enquiries were information only and dealt with directly by the PALS advisors. Of these, 37 concerns were not resolved via the PALS process and were then escalated to the formal complaint process for further review and resolution. This accounted for less than 1% of the total PALS caseload.

- Work is underway to develop and implement the latest RADAR build for PALS, which is anticipated to significantly enhance oversight, data accuracy, and reporting capabilities.

- In 2024/25, we performed an organisational diagnostic and self-assessment against the first 14 NHS Complaint Standards. There is a plan to benchmark against the final 4 standards in 2025/26.

- Over the past year, the Patient Engagement team has made significant strides in enhancing inclusivity, responsiveness, and service quality across the Trust. Key initiatives and outcomes included a successful trial of the Wordskii on Wheels digital translation service. Following positive feedback, 21 additional devices are being procured for Trust-wide rollout.

- Sign Language Week was promoted Trust-wide, resulting in increased awareness and basic proficiency in British Sign Language among staff.

- Targeted community engagement outreach efforts focused on less heard voices, including carers, refugees, individuals with sensory impairments, LGBTQ+ youth, and the homeless.

- Engagement activities included visits to groups such as the Somerset Diverse Communities Women's Conversation Group and Gypsy Roma Travellers.

- The Big Conversation initiative revealed high satisfaction with care quality and facilities, but concerns remain around waiting times, staffing, communication, and service coordination.

- Friends and Family Test (FFT) responses rose, with consistently positive ratings. Insights from this feedback have informed service improvements.

- The National Urgent and Emergency Care Survey 2024 showed the Trust performing on par with peers in most areas, and exceeding expectations in several key metrics.

- The National Maternity Patient Survey showed valuable recommendations for antenatal, labour, and postnatal care.

5.4 The Committee considered the challenges around demographics and reporting, particularly of complaints and PALS and noted the plans in place to address this. The Committee also explored steps being taken to increase co-production, particularly linked to clinical and service developments.

5.5 The Committee agreed that the report provided good assurance and approved the report.

6. INFECTION PREVENTION AND CONTROL – PRESENTED BY VAL YICK, LEAD NURSE FOR INFECTION PREVENTION AND CONTROL

8.1 The Committee received the report which provided an overview of the infection prevention and control activity during the year and assurance on investigation and learning from outbreaks.

8.2 The Committee noted in particular:

- There were 4 Trust attributed Methicillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections compared with 3 the previous year.

- There were 77 Trust attributed Methicillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections compared with 66 the previous year. This is an increase in case numbers and is part of an increasing trend seen since 2021.

- There were 90 Trust apportioned cases of *Clostridioides difficile* infection compared to 94 in the previous year. Although case numbers have not significantly changed this year, overall there is a national increase in case numbers. The Trust still has one of the lowest *Clostridioides difficile* infection rates in the region.

- There were 124 Trust attributed E. coli bloodstream infections, case numbers are stable in comparison to the previous year.

- There were 46 Trust attributed *Klebsiella species* bloodstream infections, case numbers are stable in comparison to the previous year.

- There were 14 Trust attributed *Pseudomonas aeruginosa* bloodstream infections, compared with 18 the previous year.

- There were 1597 inpatients with confirmed COVID-19 and 120 outbreaks. Overall inpatient numbers of COVID-19 were less than the previous year and slightly less outbreaks occurred.

- There were 1044 inpatients with influenza in the Trust this winter and 33 outbreaks. Case numbers were more than double in comparison to the previous winter.

- There were 482 inpatients with Respiratory Syncytial Virus in the Trust this winter, 44% were under the age of 5 years.

- Three categories of surgical site infection surveillance were included in the 2024/25 programme: total knee replacement, total hip replacement and spinal surgery. The position was largely positive. There are two areas of concern within surgical site which are normothermia and some of our patient risk factors. We are still doing work with theatres using a national tool which looks at all theatre

practice from the patient flow at the minute of pre-assessment clinic right through to full recovery at home.

- Hand hygiene Trust wide compliance remained good at 95% but there is research underway to look more closely at this compliance level.

- Areas of particular concern are the rising rates of our healthcare associated infections which are still rising each year. This is mirrored regionally and nationally. C diff. instances have risen by nearly 50%. The Staph Aureus MSSA has risen by 12% nationally. In relation to staph aureus in particular, we know that in the trust we have direct links with peripheral vascular cannulas resulting in some of our bloodstream infections with staph aureus, which is the focus of work, mainly in cardiology at MPH.

- At YDH the biggest concern is in relation to carbapenemase-producing organisms (CPO). The Trust has had had in excess of 80 patients linked to this outbreak. There is limited patient to patient transmission so is most likely directly from the environment in which they are in. Significant controls have been put in place already, including twice weekly drain disinfection. The biggest risk is our water supply and our waste water stream but changes will take some time to implement and take effect. The Committee discussed alternative potential strategies to address this risk.

8.3 The Committee recognised the continued pressure on the team; the excellent levels of assurance received by the reports; and the ongoing need to adapt to changes in guidance and the need to consider alternative technologies and resource to support this work.

8.4 The Committee agreed that the report provided significant assurance and approved the report.

7. INFORMATION GOVERNANCE – PRESENTED BY LOUISE COPPIN, HEAD OF INFORMATION GOVERNANCE AND DATA PROTECTION OFFICER

7.1 The report provided the Committee with assurance that the Trust is fulfilling its statutory responsibilities with regard to the Data Protection Act 2018 and the Freedom of Information Act 2000.

7.2 The Committee noted in particular:

- That the final assessment of the Data Security and Protection toolkit for the trust was submitted in June 2025 with a level of Standards Met.

- The internal audit on the Toolkit was undertaken in February/March 2025 and that the recommendations relating to available evidence were corrected prior to the Toolkit submission. The internal audit had rated the quality of the Trust's Toolkit return as high and in line with the requirements of the independent assessment framework.

- Colleague training has consistently been above 90% for the year and was 92.9% on 31 March 2025.

- The Trust now has an accurate picture of its almost 500 assets, all with information asset owners, contract and procurement information, and online training has been implemented for the information asset owners so they can be sure of their responsibilities. Compliance with this was at 98.73% at year end.

- The Trust received 744 requests under the Freedom of Information Act in the year, a further increase from last year (712) and a 38% increase since 2020/21. There were 4 requests for internal reviews during the year and no cases referred to the Information Commissioner's Office (ICO).

- The main area of concern remains compliance with data subject access requests as this year the Trust is likely to receive over 4,727 data requests which is a small increase from the previous year (4262) but a 46% increase on the number of requests received since 2020. Due to a significant increase in the number of requests and ongoing staffing issues, there is a backlog of data access requests causing problems with compliance requirement of one calendar month. Our average response rates within the required timeframe are around 45-50%. We have more than doubled staffing resource, but this has not kept pace with the increasing volumes. The Information Commissioner's Office (ICO) is aware of our backlog and our continued efforts to rectify this issue and the Trust is at risk of enforcement action if it cannot address this. This issue is on the corporate risk register.

- There were 821 security incidents reported during the year. 358 were confirmed breaches and 444 near misses. The main issues were unsecured areas; data posted to incorrect recipients; email misdelivery; inaccurate record-keeping; insecure storage and inappropriate access to records.

- Spot checks and other activities were used to keep a focus on compliance. The Committee noted the processes in place to investigate and take action in the event of inappropriate access or sharing of information by colleagues.

- The Committee noted examples of appropriate information sharing supporting quality care, in line with the Caldicott principles.

7.3 The Committee agreed that the report provided significant assurance and approved the report.

8. HEALTH AND SAFETY – PRESENTED BY SAMANTHA HANN, HEAD OF HEALTH, SAFETY AND RISK AND CARMELA TUCKER, HEALTH AND SAFETY MANAGER

8.1 The report provided the Committee with continued assurance that the processes and systems that are in place for managing health and safety within the Trust remain effective and are compliant with the Health and Safety at Work etc. Act 1974 and other legislation protecting colleagues, patients and visitors at our sites.

8.2 Due to timings, this report was being presented to the Committee in advance of it being considered by the Health and Safety Committee. Any changes, following discussion at the Health and Safety Committee in October would be shared with the Committee and included in the final published version.

8.3 The Committee noted in particular:

- The completion of the reviews of COSHH, DSE and RIDDOR policies. First Aid and Safer Moving and Handling policies were not reviewed in year but will be confirmed in the 2025/26 report.

- Levels of event reporting for health and safety have been maintained since implementation of LfPSE.

- Training compliance remains over 95% for health and safety training, which is excellent. Compliance at the end of 2024/25 was 96.63%.

- An internal audit of compliance against health and safety standards indicated moderate assurance for both design and implementation with recommendations in line with our own assessment.

- The team has supported the successful appointment of a new occupational health provider which will hopefully improve triangulation of data for health surveillance and support for colleagues to make their working environments and conditions safer.

- There remains a challenge regarding resources and capacity within the central team, aligned with the different structures and expectations of the legacy organisations.

- Availability of trade union health and safety representatives has remained a challenge, but the existing reps are committed and there are some new reps coming on board.

- It is planned to develop a five-year strategy which will set out the vision for health and safety in the trust, defining the process and provision. The team continues to develop the arrangements within Service Groups, corporate teams and on all our sites to ensure compliance and improve the safety arrangements for our colleagues, visitors and patients. The challenges of local arrangements – including building manager checklist and workplace monitors have meant slow progress.

- Our devolved governance relies on the topic links and reports to support the process. There remain a small number of gaps in the topic lead structure, as a result of integration, but work has progressed in estates and facilities in particular to improve this.

- Work has moved forward to address the issues identified in the HSE inspection of safer sharps at YDH and subsequent enforcement notice but there remain areas of non-compliance in other areas of the Trust that are being addressed.

- The Committee considered the position, particularly around safer moving and handling, and the hotspots of challenge across the Trust and the capacity and facilities available to support training and competency.

8.4 The Committee agreed that the report provided significant assurance and approved the report.

CHAIR OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board of Directors
REPORT TITLE:	Maternity & Neonatal Quarter 2 Quality & Safety Report
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse & Midwife
REPORT BY:	Sally Bryant, Director of Midwifery and Deputy to the Chief Midwife
PRESENTED BY:	Sally Bryant, Director of Midwifery and Deputy to the Chief Midwife
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	For assurance of the safety & quality of maternity & neonatal services **The report outlines key achievements in the quarter:** • Closing CQC action plan • More work on improving governance systems and data quality • SFT identified by recently published MBRRACE report to have a lower than national average perinatal mortality rate (no mortality in Q2) • Trust appointed Chief Nurse / Midwife to provide expert executive advocacy and oversight for perinatal services
Recommendation	The Board of Directors is asked to support focus on: ○ Further work to improve triage services ○ Maternity Incentive Scheme, final evidence submission for Year 7 ○ MNIP continued delivery and oversight of actions ○ NHSE MSSP support to drive key improvement including culture ○ Preparation for national maternity investigation (Amos Review) ○ Planning for YDH re-opening

Kindness, Respect, Teamwork
Everyone, Every day

	The Trust Board is asked to: • Review the Q2 2025/26 Quality & Safety report • Note the actions being taken in response to themes/trends identified • Not the assurance for compliance with the MIS undertaken in Q&GAC

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

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.
MNVP provide service user feedback and work with SFT colleagues as quorate members of all quality & safety meetings within the governance workstream

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]
Report has been reviewed and discussed at Safety Champions Board and LMNS Programme Board

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

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

SOMERSET NHS FOUNDATION TRUST

1. BACKGROUND AND PURPOSE

1.1 This report and associated MIS safety action briefing reports provide a comprehensive overview of maternity and neonatal safety, quality, and service delivery across Somerset NHS Foundation Trust for Q2 2025/26. It reflects progress, challenges, and assurance across clinical outcomes, service user experience, workforce, and regulatory compliance.

1.2 **The report outlines key achievements in the quarter:**

- Closing CQC action plan
- More work on improving governance systems and data quality
- SFT identified by recently published MBRRACE report to have a lower than national average perinatal mortality rate (no mortality in Q2)
- Trust appointed Chief Nurse / Midwife to provide expert executive advocacy and oversight for perinatal services

2. The planned focus for Q3:

- Further work to improve triage services
- Maternity Incentive Scheme, final evidence submission for Year 7
- MNIP continued delivery and oversight of actions
- NHSE MSSP support to drive key improvement including culture
- Preparation for national maternity investigation (Amos Review)
- Planning for YDH re-opening

3. Areas of concern:

- YDH – work required to achieve safety criteria for re-opening
- Amos Review – uncertainty of format of review and impact of scrutiny
- Delays to IOL and increase in Robson Group 1
- Continued challenge to capture and report data related to health inequalities.
- Noted increase in moderate harm and above incidents in Feb and Aug

4. Mitigations in place:

- Stakeholder meetings commenced to develop action plan for safe YDH re-opening
- Work to understand and articulate risk associated with YDH re-opening

- Reviewing ToR for national investigation, sharing comms with staff as we find out more
- Audit commissioned to inform future improvement work. Safety Huddles implemented
- Local SPC created in order to inform improvement actions and report accurately. Soft and hard intelligence triangulated to identify themes
- Review of Feb and Aug incidents to understand if resident doctors rotation relevant to increases

5. MIS Safety Action Briefing Reports:

- A report detailing all deaths in quarter 2, including those supported for review using the Perinatal Mortality Review Tool (PMRT), has been written and will be discussed at the Safety Champion Board on the 24th October. The report also provides further details on deaths which have occurred since the 1st December 2024 which have previously been reported on; the standards being monitored via safety action 1 of the Maternity Incentive Scheme (MIS) associated with PMRT have all been met or are anticipated to be met in the required timeframes. Identifying themes linking the deaths which occur in each quarter has been difficult due to low numbers, however a theme emerging more broadly associated with PMRT and other case review relates to the maternity triage service and a triage working group has been set up in response to this. A copy of the report is available for review in the Admin Control.

- NHS Digital have published provisional results for data submitted to the Maternity Services Data Set for July which indicates that we have met the requirements of MIS safety action 2. Final results are anticipated to be published in the coming days.

- An update on the two quality improvement projects started last year designed to reduce term admissions to the neonatal unit and / or length of separation of mother and baby are due to be presented to the LMNS Programme Board on the 21st October and the Safey Champion Board meeting on the 24th October. This is in line with the requirements of MIS safety action 3.

- An audit to monitor attendance to the list of clinical scenarios outlined in the Royal College of Obstetricians and Gynaecologists guideline 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' confirming where a consultant must attend, or where the consultant must attend unless the most senior doctor present has documented evidenced as being signed off as being competent, was undertaken between July – September. A consultant or the most senior doctor present was in attendance for a total of 164 of the 165 qualifying scenarios which occurred during this time. The single instance of non-attendance was discussed at the labour ward forum on the 17th October where an action plan to try and prevent future non-attendance was agreed. To be compliant with one of the obstetric medical workforce elements of safety action 4 of MIS, attendance at 80% of qualifying scenarios is required with instances of non-attendance discussed

and actions agreed – we will be able to declare compliance with this requirement. The audit report is available to review in full in the Admin Control.

- The maternity service has implemented the Royal College of Obstetricians and Gynaecologists guidance 'Guidance on the engagement of long-term locums in maternity care in collaboration with NHS England, Scotland, and Wales'. Whilst no new long-term locums joined the service during the six-month period monitored to demonstrate compliance with the MIS obstetric medical workforce element of safety action 4: April – September 2025, the tool used to assess compliance with this guideline was completed at the point of appointment of a long-term locum who joined the service in the Autum of 2024 and who re-joined the service in the summer following a month's break. A report outlining this is available in the Admin Control.

- The neonatal medical workforce and the neonatal nursing workforce do not currently meet the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing or neonatal nursing standards. Action plans previously developed to address deficiencies with this have been updated to demonstrate progress and new actions have been added. Risk assessments have been undertaken to capture the risk associated from not meeting these standards and are available on the risk register and will be monitored via matneo and service group governance. A detailed breakdown of each team's position against these standards and associated action plans can be found in respective reports available to view in the Admin Control. The Committee are invited to minute that the service does meet either set of BAPM standards and to review and formally agree both action plans . Whilst the service doe not currently meet BAPM standards, compliance with the neonatal medical and neonatal nursing elements of MIS safety action 4 can still be declared through the provision of agreed plans which are also shared with the LMNS (scheduled for review at the LMNS Programme Board on the 21st October), the Safety Champion Board, and the Neonatal Operational Delivery Network.

- The meeting for quarter 2 in the series of quarterly quality review meetings to monitor implementation of version 3 of the Saving Babies Lives Care Bundle is scheduled for the 28th October. An update will be provided to Q&GAC by the end of the year confirming whether the LMNS are satisfied that sufficient progress has been made in line with the locally agreed improvement trajectory.

- An action plan co-produced by the maternity service and Maternity and Neonatal Voices Partnership (MNVP) has been developed focusing on the findings in the annual CQC maternity survey data publication and was additionally shared with the LMNS Programme Board, in line with MIS safety action 7 requirements. A briefing report is available in the Admin Control.

- A review of maternity and neonatal quality and safety is undertaken by the Q&GAC quarterly via the Maternity & Neonatal Quarterly Safety & Quality Report.

- This report details a minimum data set as outlined in the PQSM. This report is presented by a member of the Perinatal Leadership Team to provide supporting context. In line with the PQSM, this report includes a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey. The maternity & Neonatal culture action plans are available for review in Admin control. The Q2 S&Q report and culture improvement action plans have been discussed at length in the Safety Champions Board. Q2 S&Q report is available in the Admin Control.

- The Trust's claims scorecard data (as below) has been reviewed alongside incident, compliant and other quality and safety metrics and discussed at the safety champion board meeting. A theme identified for quarter 2 is a delay in treatment and there is a corresponding action to undertake a thematic analysis around this. Details of this are available in the quarter 2 safety action quality report. This theme and the agreed action are also in line with the Trust's Patient Safety Incident Response Plan.

  A recent media article highlighting more than £23 million paid as compensation for claims relating to birth injuries in the past five years by SFT, it is important to note the following:

  - The number of claims/potential claims notified in 2020-2025 and the amounts paid out between 2020-2025 do not necessarily relate to the same cohort of cases. For example, payments made in 2023/24 may relate to cases notified in earlier financial years, particularly where cases are large or complex and some payments will relate to periodic payments from cases settled in previous years. Similarly, claims and potential claims notified to NHS Resolution in 2023/24 may not be settled in that year: in cases where a patient has indicated that they may be contemplating a claim and NHS Resolution is notified, a formal claim may only be made many months or even years later. Moreover, many patients do not pursue an initial intention to make a claim and therefore may never become a "claim". The number of claims received now includes EN (Early Notification) claims.

  - Larger member organisations and those which provide more complex treatments may receive more claims than smaller organisations or those providing low risk care. NHS services in Somerset have been merged, in fact, since 2020 three Trust's in Somerset have merged to form Somerset NHS Foundation Trust (SFT), this will have an impact on the figures shown for SFT. The Trust also provides labour ward services and claims arising from childbirth represent a significant element of expenditure under CNST (as will be the case nationally). Claims may be made long after the original event, especially where the patient concerned is a child.

  - It is important to note the size of different NHS organisations differs considerably and each NHS organisation face different levels of risk because of the variations in the nature and complexity of the procedures they perform.

Claims Scorecard April 15 – March 25

Top injuries by volume:	Top injuries by value:
• Adtnl/unnecessary operation (12) • Psychiatric/Psychological Damage (11) • Stillborn (10) • Unnecessary pain (6) • Brain Damage (6)	• Brain damage (6) • Cerebral palsy (1) • Cystic growth (1) • Adtnl/unnecessary operation (12) • Fatality (4)
Top causes by volume:	**Top causes by value:**
• Failure/delay in diagnosis (6) • Fail/delay in treatment (6) • Fail to make resp to abnrm FHR (6) • Fail to recog. Complication of (5) • Fail to warn – informed consent (5)	• Fail to warn – informed consent (5) • Fail to make resp to abnrm FHR (6) • Failure / Delay Diagnosis (6) • Delay in performing operation (4) • Not specified (3)

Complaints Q2 25-26

Labour Care / Birth Experience (13)
Ward Care (4)
Listening to Women's Concerns (3)
Consent / sharing information (3)
Staff conduct (3)

Incidents Q2 25-26

Issues / delays at every stage of Induction of Labour process
Strong theme of issues with triage
Results lost to follow up across service
Inconsistent steroid usage
Inconsistent escalation of clinical concerns
Preventable term admissions to the neonatal unit (ATAIN)

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at
a Trust level (Board or directorate) quality meeting

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Themes Q2 25-26

- Induction of labour delays
- Communication with women and families – informed consent issues
- Delay in treatment – missed recognition/escalation of abnormal blood results (links with previous claims and complaint about not feeling heard)
- Inconsistent escalation of clinical concerns
- Issues with maternity triage

Learning Q2 25-26

- Increase in IOL at MPH due to suspension of services at YDH
- Issues with communication, not listening to women, informed consent issues seen across claims, complaints and incidents
- Escalation Charter launched but not yet embedded
- Absence of dedicated obstetric and midwifery triage leads

Action Plan Q2 25-26 Not started | In progress | Completed

Thematic analysis to understand results mgmt.	By 30/11/2025
Escalate communication issues with women and families to MNIP (Culture workstream)	By 31/10/2025)
Audit delays at all stages of IOL	By 30/11/2025
Triage: Ongoing QI for call handling. No obstetric triage lead in current plan, escalate to MNIP	By 31/10/2025
Governance team to link incidents to Escalation Charter	By 30/11/2025

Kindness, Respect, Teamwork
Everyone, Every day

The full Perinatal Quality & Safety Q2 Report is available within the reading room for Board members.

SALLY BRYANT
DIRECTOR OF MIDWIFERY AND DEPUTY TO THE CHIEF NURSE AND MIDWIFE

NHS
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NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Mental Health Legislation Committee held on 17 June 2025
SPONSORING EXEC:	Jade Renville, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Paul Mapson, Member of Mental Health Legislation Committee
DATE:	2 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 Mental Health Legislation Committee met on 16 September 2025. Positive assurance was received on Ash Ward and advocacy services. Key risks include AMHP staffing shortages, bed flow challenges, and increased Out of Area Treatment referrals. This report provides assurance and highlights these issues for Board oversight.
Recommendation	The Board is asked to note the assurance provided and the key risks identified, including bed capacity, AMHP availability, and community patient management.

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?**
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 MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 16 SEPTEMBER 2025

1. PURPOSE

1.1. The report sets out the items discussed at the meeting held on 16 September, along with the assurance received by the Committee and any areas of concern identified.

2. ASSURANCE RECEIVED

2.1. Ash Ward. The report from the unannounced visit contained positive feedback and key strengths were identified, including:

- good carer feedback;
- good advocacy arrangements in place;
- use of least restrictive interventions;
- care plans; and
- activities and rehabilitation.

Only one concern was raised around documentation of intramuscular medication and consent. Assurance was given that the form is consent in itself, however actions have also been taken to address the concern.

2.2. The joint Section 117 policy for the ICB, local authority and Trust is expected to be signed off at the next Governance meeting.

2.3. Swan Advocacy. The Swan Advocacy representative reported a positive relationship with the wards, and a stable service has been maintained. The organisation is facing additional pressures, particularly from an external hospital to SFT, however this has not impacted on the service provided to the Trust.

2.4. Patient and Carer Race Equality Framework (PCREF): A working group has been set up to consider the national framework to improve mental health service focus. In time, this will also be applied to other services. The Trust may need to consider a long-term regular forum to engage with multi-cultural, diverse and marginalised communities within Somerset. This work will be audited by the CQC.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. Allied Mental Health Professional (AMPH) services have had staffing difficulties due to sickness and difficulties in recruiting. However, the new

AMHP Lead joined the Committee for the first time which will help facilitate cross organisation communication.

3.2. Wessex House remains closed, and staff have been redeployed to support adult services. Relationships with other Tier 4 CAMHs units/services remains very good.

3.3. There has been in increase in referrals for Out of Area Treatment (OATS) Somerset patients, especially for PICUs due to a mixed gender PICU not being appropriate.

3.3.1. A 'breaking the cycle week' has taken place and another is planned for late autumn.
3.3.2. It is of note that the Trust is still in the lower quartile of placements compared to other trusts across the country.
3.3.3. A bid has been submitted for two additional extra care areas at Rydon. This would help reduce the number of OATS.

3.4. Other current risks highlighted to the committee:

- *Bed Flow Challenges:* The risk score is 20, however, this will be reviewed. Consideration is being given as to how patients are admitted as well as discharged.
- *Delay in care due to AMHP request for a referral form to be completed:* Discussions are taking place with the local authority to streamline process. Confirmation was given that if a situation was urgent a request could be made via a phone call.

- *Inadequately Managed Cohort of Community Patients:* There are concerns that there is a cohort, in the community who are not adequately managed through our current CMHS resource or via our available ICB funded forensic service. Risk score to be reviewed.

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

4.1. New risks highlighted/Items to be reported to Board:

- Bed capacity
- Availability of AMHPs
- Potentially inadequately managed cohort of community patients
- Positive CQC report regarding Ash Ward
- Positive relationship with Swan Advocacy
- Improvement on fit for discharge

Alex Priest
CHAIR OF THE MENTAL HEALTH LEGISLATION COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Group Finance report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
PRESENTED BY:	Pippa Moger, Chief Finance 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	The Finance report sets out the overall income and expenditure position for the Group. It includes commentary on the key issues, risks, and variances, which are affecting financial performance.
Recommendation	The Board is requested to discuss and note the report.

Links to 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)
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 – e.g. in Part B]
Monthly report

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

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

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT

1. SUMMARY

1.1 In September, the Trust recorded a deficit of £0.164m. This was on plan for the month and the Trust remains on plan year to date with a deficit of £9.394m.

1.2 The main September headlines are:-

- The impact of backfilling the Resident Doctors who took industrial action increased by £0.213m in September, bringing the total value to £0.576m for the 5 days in July. There is no central funding to offset these or the costs of any future industrial action.
- September agency expenditure was £1.484m, this was £0.052m above the plan for the month but within the national target to reduce agency spend by 30%. In month spend was £0.015m lower than in August. On a comparable basis, the Trust spent £0.626m less than it did in September 2024 and year to date expenditure is £5.434m lower than in 2024/25.
- CIP of £4.066m was delivered in month, this was £0.566m above plan. September recurrent savings were £0.795m (20% of total). In total, recurrent savings of £15.637m are currently forecast to be delivered, representing 37% of the total forecast value of £42.6m, some way below the 65% target we set ourselves. The current forecast based on identified schemes is a gap of £7.4m, a £2.7m improvement on the August forecast.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the summary income and expenditure account to 30 September 2025:

Table 1: Income and Expenditure Summary September

Statement of Comprehensive Income	Annual Budget	Current Month 6			Year to date		
	£000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	1,034,008	85,971	85,175	(797)	518,272	516,142	(2,130)
Other Operating Income	77,443	6,837	6,613	(225)	36,371	37,181	810
Total operating income	**1,111,451**	**92,809**	**91,787**	**(1,021)**	**554,643**	**553,323**	**(1,320)**
Operating expenses							
Employee Operating Expenses	(767,665)	(64,413)	(65,332)	(919)	(389,123)	(395,488)	(6,365)
Drugs Cost: Consumed/Purchased	(77,557)	(6,076)	(6,365)	(289)	(41,035)	(42,108)	(1,073)
Clinical Supp & Serv Exc-Drugs	(72,626)	(6,533)	(5,803)	731	(38,436)	(38,406)	30
Supplies & Services - General	(32,491)	(2,583)	(2,412)	172	(15,780)	(17,470)	(1,690)
Other Operating Expenses	(152,834)	(12,442)	(11,409)	1,033	(75,623)	(65,410)	10,213
Total operating expenses	**(1,103,174)**	**(92,048)**	**(91,320)**	**728**	**(559,998)**	**(558,883)**	**1,115**
Operating Surplus/Deficit	8,277	761	467	(294)	(5,355)	(5,560)	(205)
Finance Expense	(14,177)	(1,174)	(889)	286	(7,036)	(6,060)	976
Finance Income	3,518	285	165	(120)	1,806	1,321	(485)
Other	0	0	(3)	(3)	1	(13)	(14)
Overall Surplus/(Deficit)	(2,383)	(128)	(259)	(131)	(10,586)	(10,312)	273
Depr On Donated Assets	1,216	102	100	(2)	608	817	209
Donated Assets Income	(1,412)	(353)	(21)	332	(706)	(156)	550
Amortisation	0	0	3	3	0	18	18
PFI UK GAAP Adjustments	2,579	215	12	(203)	1,290	239	(1,051)
Impairments	0	0	0	0	0	0	0
Adjustments to control total	2,383	(36)	95	131	1,192	918	(274)
Adjusted Financial Performance	(0)	(164)	(164)	0	(9,394)	(9,394)	0

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

- In September, total staffing was 12,974 WTE, 161 WTE under the planned establishment for the month of 13,136 WTE with the following variances: -
  - Substantive staffing was 151 WTE under the establishment plan.
  - Bank 49 WTE over plan.
  - Agency 22 WTE under &
  - Locums 37 WTE under the plan

2.3 Further information on September performance is set out in Tables 2 and 3 below:-

Table 2: Pay expenditure information

2025/26 Monthly Pay Expenditure analysis	Apr-25 £000	May-25 £000	Jun-25 £000	Jul-25 £000	Aug-25 £000	Sep-25 £000	2025/26 In Month Budget	F/(A) Variance £000	2025/26 Total £000	2025/26 YTD Budget £000	F/(A) Variance £000
Temporary staff											
Bank Staff	2,083	2,224	2,055	2,127	2,253	2,072	1,710	(361)	12,815	10,776	(2,039)
Medical Agency	1,251	1,178	1,175	1,167	1,082	1,107	998	(109)	6,960	6,242	(718)
Medical Locums	846	800	816	808	963	755	943	188	4,989	5,744	755
Nursing Agency	406	317	315	364	321	285	266	(19)	2,008	1,436	(572)
Other Agency	170	168	118	119	97	92	169	77	763	1,086	323
Total Temporary Staff	**4,756**	**4,687**	**4,480**	**4,585**	**4,716**	**4,311**	**4,086**	**(225)**	**27,535**	**25,284**	**(2,251)**
Nursing	16,525	16,473	16,437	16,715	15,964	16,569	17,225	656	98,683	104,122	5,440
Support to Nursing	6,368	6,342	6,372	6,020	6,482	6,150	5,705	(444)	37,734	34,693	(3,041)
Medical	13,858	13,752	13,742	14,734	14,699	14,710	13,314	(1,396)	85,494	78,685	(6,810)
AHP's	9,834	9,833	9,807	9,985	10,198	10,034	9,874	(160)	59,691	59,086	(605)
Infrastructure Support	10,548	10,483	10,698	10,604	10,749	10,484	10,516	32	63,565	63,853	288
Other	3,703	3,873	3,840	4,341	3,952	3,072	3,691	619	22,782	23,400	618
Substantive Staff	**60,835**	**60,756**	**60,896**	**62,398**	**62,044**	**61,019**	**60,327**	**(693)**	**367,949**	**363,839**	**(4,110)**
Total All Staff	**65,592**	**65,443**	**65,376**	**66,983**	**66,760**	**65,331**	**64,413**	**(918)**	**395,484**	**389,123**	**(6,361)**
% Temporary	7.25%	7.16%	6.85%	6.84%	7.06%	6.60%	6.34%		6.96%	6.50%	

Table 3: WTE information

2025/26 Monthly Workforce analysis	Apr-25 WTE	May-25 WTE	Jun-25 WTE	Jul-25 WTE	Aug-25 WTE	Sep-25 WTE	In Month WTE	In Month Budget WTE	F/(A) Variance WTE
Temporary staff									
Bank Staff	572.82	503.68	461.20	534.77	515.78	495.96	495.96	447.24	(48.72)
Medical Agency	57.89	55.77	55.19	56.24	50.27	50.74	50.74	51.79	1.05
Medical Locums	48.91	45.94	47.85	47.33	45.45	43.49	43.49	80.52	37.03
Nursing Agency	58.76	56.94	41.37	54.17	47.42	41.23	41.23	47.60	6.37
Other Agency	42.53	35.57	29.31	23.27	19.17	21.36	21.36	35.63	14.27
Total Temporary Staff	**780.91**	**697.90**	**634.92**	**715.78**	**678.09**	**652.78**	**652.78**	**662.78**	**10.00**
Nursing	3,515.03	3,505.84	3,502.40	3,475.99	3,486.50	3,519.73	3,519.73	3,472.00	(47.73)
Support to Nursing	2,008.96	1,990.93	1,995.47	1,989.30	1,983.46	1,909.43	1,909.43	1,870.82	(38.61)
Medical	1,215.27	1,218.17	1,210.91	1,215.12	1,268.22	1,274.89	1,274.89	1,269.68	(5.21)
AHP's	1,717.46	1,712.61	1,707.89	1,697.42	1,717.09	1,724.99	1,724.99	1,769.16	44.17
Infrastructure Support	2,743.25	2,766.59	2,767.95	2,771.36	2,758.36	2,760.38	2,760.38	2,820.87	60.49
Other	1,135.12	1,139.25	1,144.31	1,150.09	1,139.91	1,132.23	1,132.23	1,270.52	138.29
Substantive Staff	**12,335.09**	**12,333.38**	**12,328.93**	**12,299.28**	**12,353.55**	**12,321.65**	**12,321.65**	**12,473.05**	**151.40**
Total All Staff	**13,116.00**	**13,031.28**	**12,963.85**	**13,015.06**	**13,031.64**	**12,974.43**	**12,974.43**	**13,135.83**	**161.40**
% Temporary	5.95%	5.36%	4.90%	5.50%	5.20%	5.03%	5.03%	5.05%	

2.4 The annual Trust agency plan is £17.746m and is based on a c2.3% of planned pay spend. The plans represents a stretch target of a 40% reduction in agency pay spend when compared with 2024/25. At the end of September, we are £0.175m below the submitted plan and remain under the national target of a 30% reduction on 2024/25 expenditure.

2.5 Total medical agency in September was £1.107m (£0.025m higher than August). Vacancies continue to be the largest driver of agency usage and accounted for £0.823m (74% of the total SFT agency spend in month). In September SHS used £0.156m (August £0.175m) to cover gaps in their workforce, this was £0.019m lower than their spend in August.

2.6 In 2025/26 Trusts have also been given a national target to reduce their 2024/25 bank spend by 10%, this was reflected in both our financial and workforce plans. In September, the bank spend was £2.828m, £0.189m adverse to the plan of £2.639m. The whole time equivalent in September is 13.66 adverse to plan. There is an ongoing focus on rostering to ensure this is robust across all services.

3. COST IMPROVEMENT PROGRAMME

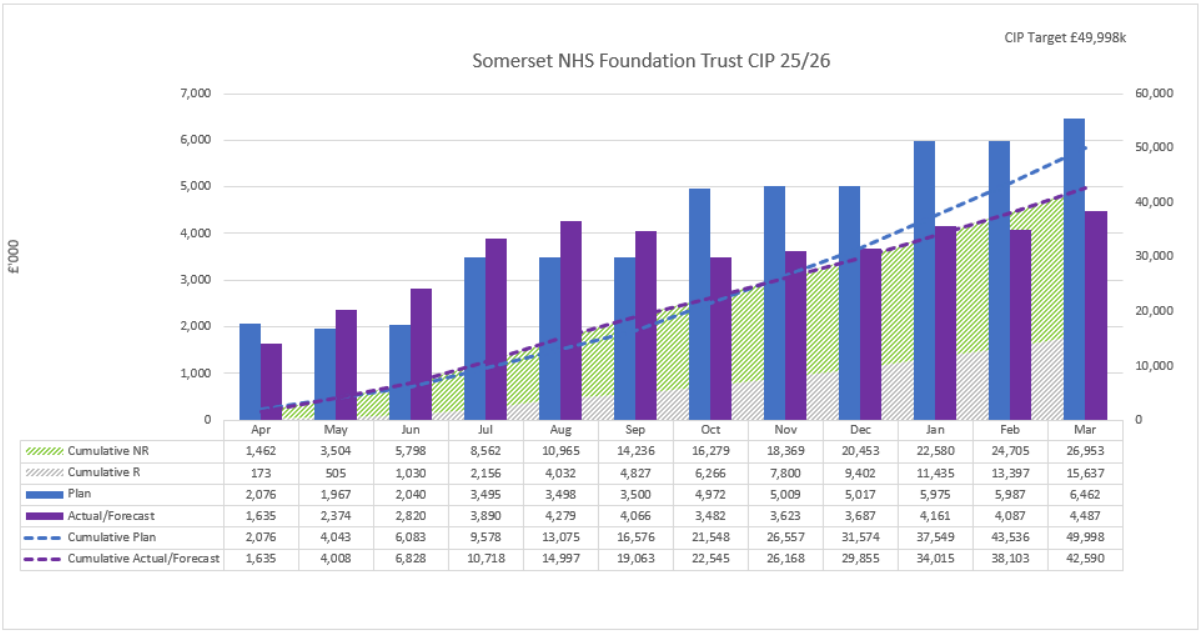
3.1 The Trust has set a CIP plan of £49.998m for the year and this has been fully allocated to clinical service groups, SSL, SHS and corporate areas.

3.2 In September, savings of £4.066m were delivered, £0.566m above plan. Of these, recurrent savings were £0.795m (20% of total). In total, recurrent savings of £15.637m are currently forecast to be delivered, representing 37% of the total forecast value of £42.6m, this is a reduction of £2.6m since August.

3.3 We continue to make progress and have reduced the value of the unidentified by a further £2.7m in September, meaning there is now a further £7.4m to be identified.

3.4 Further analysis is shown in the chart below: -

Chart 1: CIP Plan 2025/26



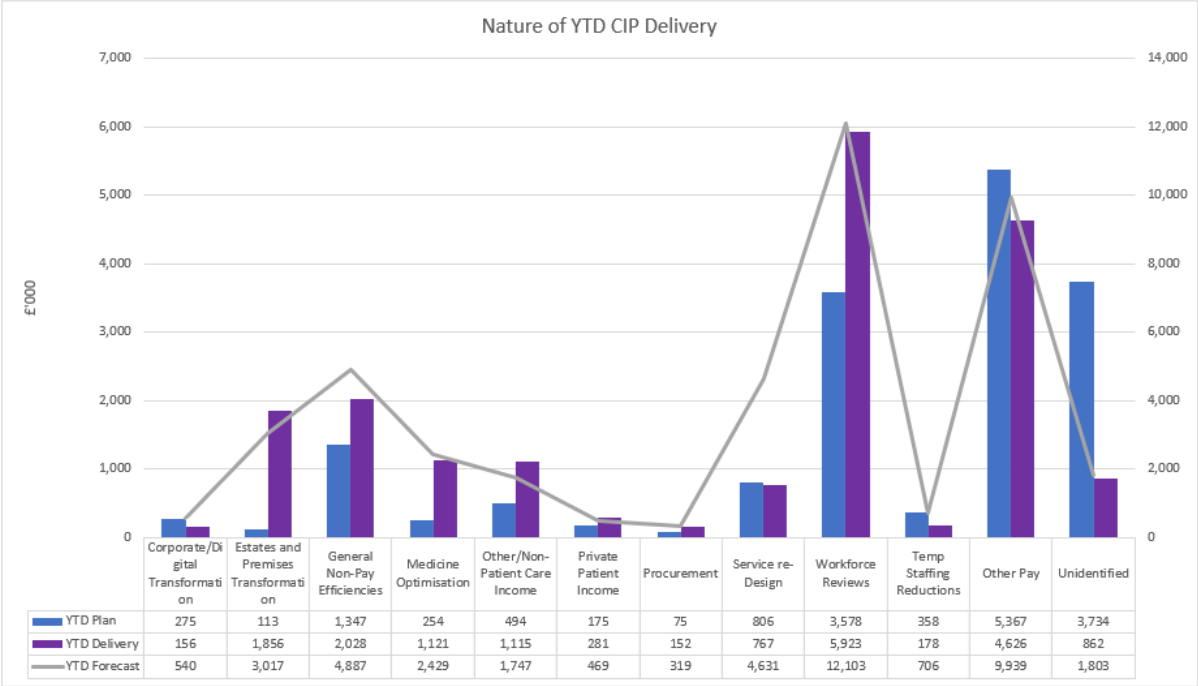
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative NR	1,462	3,504	5,798	8,562	10,965	14,236	16,279	18,369	20,453	22,580	24,705	26,953
Cumulative R	173	505	1,030	2,156	4,032	4,827	6,266	7,800	9,402	11,435	13,397	15,637
Plan	2,076	1,967	2,040	3,495	3,498	3,500	4,972	5,009	5,017	5,975	5,987	6,462
Actual/Forecast	1,635	2,374	2,820	3,890	4,279	4,066	3,482	3,623	3,687	4,161	4,087	4,487
Cumulative Plan	2,076	4,043	6,083	9,578	13,075	16,576	21,548	26,557	31,574	37,549	43,536	49,998
Cumulative Actual/Forecast	1,635	4,008	6,828	10,718	14,997	19,063	22,545	26,168	29,855	34,015	38,103	42,590

3.5 Significant work is ongoing to reduce the risk of currently identified schemes and close the gap in plans. Over 17% of the schemes currently forecast are high risk, with a further 24% rated amber. Although we continue to make progress as evidenced by the month on month reduction in unidentified efficiencies, the pace needs to increase to ensure we can close the gap fully by year end.

3.6 The nature of the schemes within the cost improvement plan year to date have been summarised and categorised below. A large element of the forecasted savings is classified as service redesign; £4.631m. Workforce

reviews; £12.103m and general non-pay efficiencies; £4.887m being the two next largest contributors, respectively.

Chart 2: Nature of CIP delivery

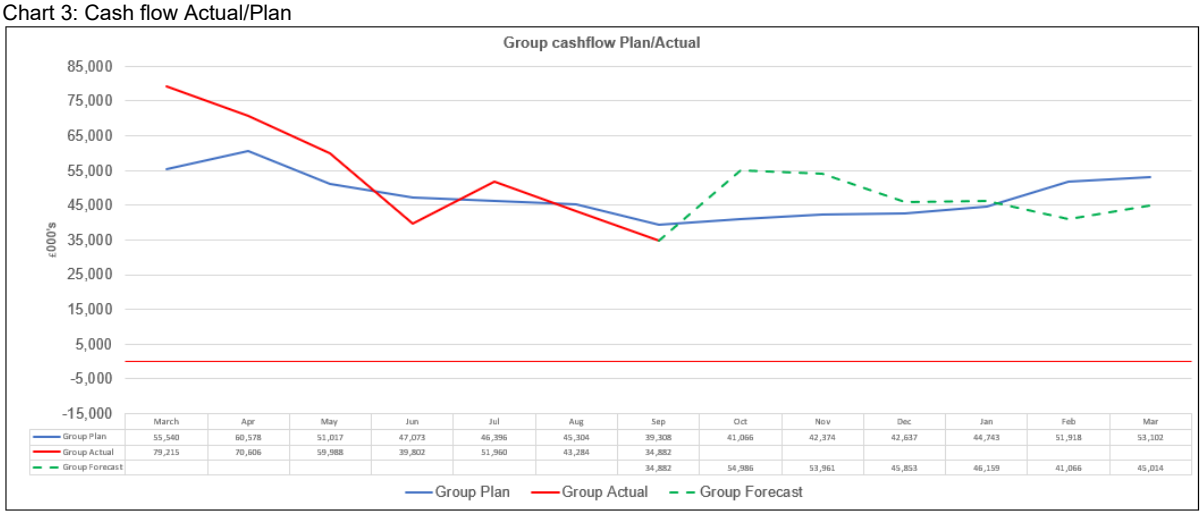


	Corporate/Digital Transformation	Estates and Premises Transformation	General Non-Pay Efficiencies	Medicine Optimisation	Other/Non-Patient Care Income	Private Patient Income	Procurement	Service re-Design	Workforce Reviews	Temp Staffing Reductions	Other Pay	Unidentified
YTD Plan	275	113	1,347	254	494	175	75	806	3,578	358	5,367	3,734
YTD Delivery	156	1,856	2,028	1,121	1,115	281	152	767	5,923	178	4,626	862
YTD Forecast	540	3,017	4,887	2,429	1,747	469	319	4,631	12,103	706	9,939	1,803

4. CASH

4.1 Cash balances at 30 September were £34.9m; £4.4m lower than plan, largely due to timing differences in PDC drawdowns for capital expenditure, due to be received in October. The group cashflow position including the updated forecast is shown below:-

Chart 3: Cash flow Actual/Plan



	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Group Plan	55,540	60,578	51,017	47,073	46,396	45,304	39,308	41,066	42,374	42,637	44,743	51,918	53,102
Group Actual	79,215	70,606	59,988	39,802	51,960	43,284	34,882						
Group Forecast							34,882	54,986	53,961	45,853	46,159	41,066	45,014

4.2 The Trust continues to monitor its level of cash closely to ensure it retains a level of cash sufficient to support day to day operational expenditure and the requirements of the capital programme. Delivery of the financial plan including cash releasing efficiency savings will be fundamental to this aim alongside continued close management of working capital.

5. STATEMENT OF FINANCIAL POSITION

Aug-25	Sep-25	Movement		Mar-25	Sep-25	Movement in Year
£000	£000	£'000		£000	£000	£000
46,996	43,574	(3,422)	Intangible Assets	35,549	43,574	8,025
400,797	408,217	7,420	Property, plant and equipment, other	409,854	408,217	(1,636)
28,255	28,077	(177)	On SoFP PFI assets	29,141	28,077	(1,064)
88,430	87,679	(751)	Right of use assets	89,834	87,679	(2,155)
14	14	0	Investments	14	14	0
14	14	0	Other investments/financial assets	14	14	0
2,867	2,880	13	Trade & other receivables > 1yr	3,063	2,880	(184)
567,372	**570,454**	**3,083**	**Non-current assets**	**567,469**	**570,454**	**2,986**
12,198	12,986	788	Inventories	11,281	12,986	1,705
21,018	25,475	4,457	Trade and other receivables: NHS receivables	5,338	25,475	20,137
29,014	33,150	4,136	Trade and other receivables: non-NHS receivables	18,796	33,150	14,354
0	0	0	Non current assets held for sale	496	0	(496)
43,284	34,882	(8,403)	Cash	79,215	34,882	(44,333)
105,514	**106,492**	**978**	**Total current assets**	**115,126**	**106,492**	**(8,634)**
(111,300)	(114,547)	(3,247)	Trade and other payables: non-capital	(103,068)	(114,547)	(11,479)
(6,842)	(6,599)	243	Trade and other payables: capital	(18,183)	(6,599)	11,584
(28,029)	(30,229)	(2,200)	Other liabilities	(18,455)	(30,229)	(11,774)
(14,205)	(14,442)	(237)	Borrowings	(16,046)	(14,442)	1,604
(5,775)	(5,389)	386	Provisions < 1yr	(9,440)	(5,389)	4,051
(166,151)	**(171,205)**	**(5,054)**	**Current liabilities**	**(165,193)**	**(171,205)**	**(6,013)**
(60,637)	**(64,713)**	**(4,077)**	**Net current assets**	**(50,067)**	**(64,713)**	**(14,647)**
(112,258)	(111,307)	951	Borrowings > 1yr	(112,989)	(111,307)	1,682
(2,781)	(2,801)	(20)	Provisions > 1yr	(2,871)	(2,801)	69
(1,315)	(1,294)	22	Other liabilities > 1Yr	(1,423)	(1,294)	129
(116,354)	**(115,402)**	**952**	**Total long-term liabilities**	**(117,282)**	**(115,402)**	**1,880**
390,381	**390,339**	**(42)**	**Net assets employed**	**400,120**	**390,339**	**(9,781)**
			Financed by:			
399,413.91	399,413.91	0	Public dividend capital	399,414	399,414	0
73,581	73,581	0	Revaluation reserve	73,581	73,581	0
(1,155)	(1,155)	0	Other reserves	(354)	(1,155)	(801)
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(79,360)	(79,618)	(258)	I&E reserve	(70,733)	(79,618)	(8,886)
			Other's equity			
372	589	217	Non-controlling Interest	683	589	(94)
390,381	**390,339**	**(42)**	**Total financed**	**400,120**	**390,339**	**(9,781)**

5.1 The movement in cash balances is due to capital expenditure incurred in advance of PDC drawdown (£8.409m approved and scheduled to be drawn down in October).

6. CAPITAL

6.1 Year to date, capital expenditure is £23.1m compared with the plan of £36.2m, resulting in an underspend of £13.1m. There are several timing differences within the internal programme around major enabling works; surgical scheme and 5th theatre slippage, which continue to be reviewed ensuring spend is considered later in the programme. Information at main scheme level is set out in Table 4 below.

6.2 The Trust has strengthened the monthly review process to scrutinise and drive through capital expenditure where underspends are identified. We will continue to monitor the effectiveness of this approach and make adjustments as necessary to support delivery of its capital programme.

Table 4: Capital Programme Summary

Capital Programme 2025-2026	Plan £000	Revised Budget £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000
Backlog Maintenance	6,647	6,711	2,437	1,923	(514)
Essential Facilities Improvement Works	1,885	1,585	675	848	173
Service Redesign Enabling Works	4,243	6,726	2,682	2,966	284
Service Redesign Enabling Works - Major	13,400	9,800	12,100	5,597	(6,503)
Infrastructure	350	433	116	44	(73)
Rolling IT & Digital Development	7,230	9,000	3,615	3,228	(387)
Equipment Replacement	5,126	5,126	1,900	1,007	(893)
Subsidiary Companies	260	260	130	102	(28)
Transfers	1,844	1,844	0	0	0
Leases	5,668	5,668	3,426	1,863	(1,563)
Total Internal Capital Envelope	46,653	47,153	27,081	17,577	(9,504)
Externally Funded Capital Schemes	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total Additional Schemes	58,381	36,315	9,130	5,570	(3,560)
TOTAL TRUST PROGRAMME	105,034	83,468	36,211	23,147	(13,064)

7. CONCLUSION & RECOMMENDATION

7.1 The Trust's financial plan remains on track; however, this position has been maintained largely through the use of significant non-recurrent funding. Therefore, the financial position continues to be extremely challenging and although we continue to make progress, there remains a significant risk to the delivery of our financial plan. National messaging remains very clear that organisations are expected to manage within their agreed resources.

7.2 The Financial Recovery Board FRB) continues to meet weekly, with a clear focus on identifying opportunities to reduce expenditure and/or enhance CIP delivery. While it remains difficult to quantify the impact of this work at this stage, maintaining momentum is essential. The FRB is committed to generating new ideas, tracking progress, and ensuring accountability for delivery across the organisation.

7.3 We are now experiencing heightened operational pressures (particularly at YDH) that are likely to persist throughout the winter period. Not only does this place additional financial pressures on the trust it will place additional workload pressures on managers and colleagues. We will need to ensure this does not detract from their focus on financial grip and control.

Pippa Moger
CHIEF FINANCE OFFICER

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Audit Committee October meeting
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer Jade Renville, Director of Corporate Services
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Paul Mapson, Chair of the Audit Committee
DATE:	4 November 2025

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

Executive Summary and Reason for presentation to Committee/Board	The Audit Committee met on 15 October 202. It reviewed the Quarter 2 BAF and Corporate Risk Register, noting several strategic aims remain above risk appetite. Assurance reports, audit updates, and the Counter Fraud report were considered. Key themes included recurring issues in limited assurance reviews, digital resilience, and preparations for the NHSCFA engagement visit. 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 strategic risks above appetite, compound risks, and governance effectiveness, and to support further work on digital oversight, fraud prevention, and committee effectiveness.

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

Kindness, Respect, Teamwork
Everyone, Every day

☐ 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 MEETING OF THE AUDIT COMMITTEE HELD ON 15 OCTOBER 2025

1. PURPOSE

1.1. The Audit Committee met on 15 October 2025 to review the effectiveness of internal control, risk management, governance, and assurance systems across the Trust. This report provides assurance to the Board on the matters discussed, highlights areas of concern, and identifies risks requiring escalation.

2. ASSURANCE RECEIVED

2.1. The Committee received the Q2 Board Assurance Framework (BAF) and Corporate Risk Register (CRR). The BAF continues to evolve, with several strategic aims remaining above risk appetite, particularly in relation to urgent care access, workforce capacity, financial sustainability, and digital transformation. The CRR included 25 corporate risks, eight of which score 20 or above. The Committee welcomed the inclusion of compound risk analysis and noted improvements in risk articulation and governance.

2.2. The Committee received six-monthly assurance reports from the Quality Governance Assurance Committee, People Committee, and Finance Committee. These reports provided assurance on the oversight of strategic aims and associated risks, including maternity and paediatric services, workforce transformation, and financial recovery. It was agreed that a report from the Mental Health Legislation Committee would be considered for future meetings.

2.3. External audit updates were received from KPMG, including a technical update and benchmarking insights. No significant concerns were raised, although the Committee noted the need for assurance into AI governance and the potential VAT implications for subsidiary companies.

2.4. The Counter Fraud Progress Report provided assurance on proactive and reactive investigations, with benchmarking data showing strong performance in fraud prevention. The Committee noted the upcoming NHS Counter Fraud Agency engagement visit and discussed the implications of the new “failure to prevent fraud” offence under the Economic Crime and Corporate Transparency Act.

2.5. Internal audit reports from BDO were reviewed, including progress updates, follow-up actions, and limited assurance reviews. The Committee discussed the findings of the Agency ID Checks audit, which highlighted gaps in compliance and the need for stronger ownership at ward level. The PEWS

audit raised concerns about sharing learning between sites and the robustness of feedback mechanisms, particularly in light of national developments such as Martha's Law.

2.6. The Committee also received reports on losses and special payments, single tender and quotation waivers, and proposed changes to procurement thresholds. The latter is being presented to the Boards of SFT and SSL for approval.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee identified several areas requiring further attention. Recurring themes in limited assurance reviews were noted, particularly around workforce processes, estates, and digital resilience, highlighting the need for stronger follow-up and triangulation of risks across committees.

3.2. The PEWS audit raised concerns about the lack of shared learning between sites and inadequate feedback mechanisms, which are critical in the context of national patient safety priorities. Similarly, the Agency ID Checks audit revealed inconsistent compliance and a need for greater local accountability.

3.3. The Committee also discussed the importance of strengthening oversight of digital transformation, AI governance, and cyber security within its remit to ensure robust assurance in these emerging risk areas.

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

4.1. The Committee agreed that strategic risks remain above appetite in several areas, including urgent care, workforce sustainability, and digital transformation. It also highlighted the potential for compound risks across estates, workforce, digital systems, and demand and capacity to exacerbate operational pressures if not managed effectively.

4.2. Governance effectiveness was identified as a priority, with a need for clearer assurance on the role and performance of Board sub-committees. In addition, the Committee noted the implications of the new "failure to prevent fraud" offence and the upcoming NHSCFA engagement visit, confirming that while current arrangements are strong, continued vigilance is required.

4.3. The Limited Assurance Reports would also be referred to the relevant committees for oversight and management.

Paul Mapson
CHAIRMAN OF THE AUDIT COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charitable Funds Committee July meeting
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	Ben Edgar-Attwell, Deputy Director of Corporate Services
PRESENTED BY:	Graham Hughes, Chairman of the Charity 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 Charitable Funds Committee met on 23 October 2025 and reviewed the financial position, fundraising performance, and governance arrangements. The charity remains financially strong, but income is lower than the previous year. The Committee noted progress on major commitments. 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 income volatility, project delivery delays, and the need to review the investment strategy.

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?**
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.

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 CHARITY COMMITTEE MEETING HELD ON 23 OCTOBER 2025

1. PURPOSE

1.1. The Charitable Funds Committee met on 23 October 2025 to review the financial position, fundraising performance, and governance of Somerset NHS Charity. 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 received the quarterly finance report for the period ending 30 September 2025. Total income for the half-year was £631k, compared to £833k in the same period last year, reflecting a reduction in group donations following exceptional contributions in 2024/25.

2.2. Investment income was £129k, lower than the previous year due to reduced deposit balances following the completion of the Breast Care Appeal. Expenditure to date was £428k, including increased fundraising costs and a £35k contribution to the Armed Forces Welfare Officer post. The charity holds £7.44m in reserves, with £5.08m in cash and £2.38m in investments, providing a strong liquidity position. The investment portfolio delivered a modest positive return despite market volatility.

2.3. The Committee noted progress on major commitments, including proposals for utilising the large anonymous donation received in 2024/25, with £1.35m earmarked for projects such as the MPH Urology development and community garden initiatives.

2.4. The fundraising report highlighted continued strong engagement, including the International Cycle 42 event raising over £20k, significant local donations, and a £39k legacy for Yeovil. Three legacies totalling £34.6k were received for Musgrove, and a strong pipeline of pledges remains. The Committee welcomed the development of new partnerships, including with Lyons Bowe solicitors, and noted upcoming events such as the Fire Walk in November.

2.5. The Committee also reviewed the Charity Charter and reaffirmed its commitment to funding projects that enhance patient and colleague experience beyond NHS provision.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee noted the decline in income compared to the previous year, driven by the absence of exceptional donations, and agreed to monitor trends closely.

3.2. Delays in finalising plans for cancer day unit developments were highlighted as a barrier to progressing donor-funded projects.

3.3. The Committee also discussed the need to revisit the investment strategy to maximise returns while maintaining liquidity, given the current cash position and future commitments.

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

4.1. The Committee confirmed that the charity remains in a strong financial position, with sufficient reserves to meet commitments. However, income volatility and reliance on one-off donations present ongoing risks. The Board should note the need for timely decision-making on capital projects to maintain donor confidence and the importance of progressing the investment strategy review to optimise income generation.

Graham Hughes
CHAIR OF THE CHARITABLE FUNDS COMMITTEE