Public Board Meeting

Tue 10 March 2026, 09:30 - 13:05

Meeting Rooms 1-3 at Wynford House, Lufton Way, Lufton, Yeovil, BA22 8HR

NHS Somerset NHS Foundation Trust

Agenda

09:30 - 09:35
5 min

1. Welcome and Apologies for Absence

Note *Chair*

- 00 Programme for the Day - 10 March 2026 v1.1.pdf (1 pages)
- 100326 - Public Board Agenda v1.2.pdf (3 pages)

09:35 - 09:35
0 min

2. Register of Interests and Declarations of Interests relating to items on the agenda

Note and Receive *Chair*

- Enclosure 01 - Register of Interests.pdf (5 pages)

09:35 - 09:35
0 min

3. Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 13 January 2026

Approve *Chair*

- Enclosure 02 - Minutes of the January 2026 Public Board meeting v1.2.pdf (14 pages)

09:35 - 09:35
0 min

4. Minutes of the Somerset NHS Foundation Trust's Extraordinary Public Board meeting held on 10 February 2026

Approve *Chair*

- Enclosure 03 - Minutes of the February 2026 Extraordinary Public Board meeting v1.pdf (2 pages)

09:35 - 09:35
0 min

5. Action Log and Matters Arising

Review *Chair*

- Enclosure 04 - Action Log public.pdf (3 pages)

09:35 - 09:50
15 min

6. Questions from Members of the Public and Governors

Receive *Chair*

09:50 - 10:00
10 min

7. Chair's Remarks

Note *Chair*

10:00 - 10:20
20 min

8. Chief Executive and Executive Director Report

Peter Lewis

- National and Regional Developments/ Policy Updates
- Reports and Assurance updates including:
  - Learning from Deaths Framework: Mortality Review progress Report (Q3)

- Guardian of Safe Working Report
- Use of the Corporate Seal

Enclosure 05 - Chief Executive and Executive Director Report.pdf (13 pages)

10:20 - 10:35 (15 min)

9. Patient Story: Andrew's experience

Receive *Emma Davey/Kelly Hutchins/Mark Dott*

Enclosure 06 - Patient Story - Andrew's experience.pdf (5 pages)

10:35 - 10:50 (15 min)

10. Update on Paediatric and Maternity Services at Yeovil District Hospital

Receive *Mel Iles*

10:50 - 11:05 (15 min)

11. Q3 Board Assurance Framework and Corporate Risk Management Report

Receive *Mel Iles*

Enclosure 07 - Q3 Board Assurance Framework and Corporate Risk Management Report.pdf (57 pages)

11:05 - 11:10 (5 min)

12. Research and Innovation Committee Terms of Reference

Approve *David Shannon*

Enclosure 08 - Research and Innovation Committee Terms of Reference.pdf (6 pages)

11:10 - 11:25 (15 min)

Refreshment Break

Aim 2 – Provide the best care and support to people

11:25 - 11:45 (20 min)

13. Integrated Performance Report

Receive *Pippa Moger*

Enclosure 09 - Integrated Performance Exception Report - March 2026.pdf (75 pages)

11:45 - 11:50 (5 min)

14. Assurance report from the Quality and Governance Assurance Committee meeting held on 28 January 2026

Receive *Rosie Benneyworth*

Enclosure 10 - Assurance Report from the QGAC Committee - 28 January 2026.pdf (5 pages)

11:50 - 12:05 (15 min)

15. Maternity & Neonatal Quarter 3 (2025/26) Quality & Safety Report

Receive *Sally Bryant*

Enclosure 11 - Maternity & Neonatal Quarter 3 2025 26 Quality & Safety Report.pdf (6 pages)

12:05 - 12:20 (15 min)

16. CQC Maternity Service User Survey

Receive *Sally Bryant/Emma Davey*

Enclosure 12 - CQC Maternity Service User Survey.pdf (26 pages)

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

12:20 - 12:30 (10 min)

17. Finance Report (M10)

Receive *Pippa Moger*

Enclosure 13 - Board finance Report M10.pdf (8 pages)

12:30 - 12:35
5 min

18. Assurance report from the Audit Committee meeting held on 14 January 2026

Receive *Paul Mapson*

Enclosure 14 - Assurance Report from the Audit Committee - 14 January 2026.pdf (5 pages)

12:35 - 12:40
5 min

19. Assurance report from the Charitable Funds Committee meeting held on 20 January 2026

Receive *Graham Hughes*

Enclosure 15 - Assurance Report from the Charities Committee - January 2026.pdf (5 pages)

12:40 - 12:50
10 min

20. Approval of 2026/27 Revenue Budget

Approve *Pippa Moger*

Enclosure 16 - Approval of 2026 27 Revenue Budget.pdf (13 pages)

12:50 - 12:55
5 min

21. Capital Programme 2026/7-2029/30

Approve *David Shannon*

Enclosure 17 - Capital Programme 2026 7-2029 30.pdf (7 pages)

For Information

12:55 - 13:00
5 min

22. Follow-up questions from Members of the Public and Governors

Receive *Chair*

13:00 - 13:00
0 min

23. Any other business

All

13:00 - 13:00
0 min

24. Risks identified

All

13:00 - 13:05
5 min

25. Evaluation of the effectiveness of the Meeting

Chair

13:05 - 13:05
0 min

26. Items to be discussed at the Confidential Board Meeting

- Minutes of the Confidential Board meeting and Extraordinary Confidential Board meeting
- Notes of the Board Development sessions
- Summary Staff Survey 2025 Results
- Quarterly Investigation, Disciplinary and Employment Tribunal Oversight Report
- Healthset (Electronic Health Record)
- Contracts for approval (commercially sensitive)
- Minutes of the Finance Committee meetings
- Maternity update
- Yeovil District Hospital

13:05 - 13:05
0 min

27. Withdrawal of Press and Public

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

13:05 - 13:05
0 min

28. Close and Date of Next Meeting

12 May 2026

Somerset NHS Foundation Trust

PROGRAMME FOR THE DAY

Board of Directors

Tuesday 10 March 2026
Meeting Rooms 1-3, Wynford House, Lufton Way, Lufton, Yeovil, BA22 8HR

		Timing
1	**Arrival and Coffee**	**09:15 – 09:30**
2	**Public Board of Directors**	**09:30 – 13:05**
	Break	11:10 – 11:25
3	**Lunch**	**13:05 – 13:35**
4	**Confidential Board of Directors**	**13:35 – 16:10**
	Break	14:50 – 15:05

NHS
Somerset
NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 10 March 2026** at **9.30 am** in Meeting Rooms 1-3 at Wynford House, Lufton Way, Lufton, Yeovil, BA22 8HR.

If you are unable to attend, would you please notify Julie Hutchings, Board Secretary and Corporate Services Manager at Somerset NHS Foundation Trust by email on julie.hutchings1@somersetft.nhs.uk

Yours sincerely

Dr Rima Makarem
Chair

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**	Note	Chair	09:30	Verbal
2.	**Register of Interests and Declarations of Interests relating to items on the agenda**	Note and receive	Chair		Enclosure 01
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 13 January 2026**	Approve	Chair		Enclosure 02
4.	**Minutes of the Somerset NHS Foundation Trust's Extraordinary Public Board meeting held on 10 February 2026**	Approve	Chair		Enclosure 03
5.	**Action Log and Matters Arising**	Review	Chair		Enclosure 04
6.	**Questions from Members of the Public and Governors**	Receive	Chair	09:35	Verbal
7.	**Chair's Remarks**	Note	Chair	09:50	Verbal
8.	**Chief Executive and Executive Director Report** • National and Regional Developments/ Policy Updates • Reports and Assurance updates including:		Peter Lewis	10:00	Enclosure 05

		Action	Presenter	Time	Enclosure
	• Learning from Deaths Framework: Mortality Review progress Report (Q3) • Guardian of Safe Working Report • Use of the Corporate Seal				
9.	**Patient Story: Andrew's experience**	Receive	Emma Davey/ Kelly Hutchins/ Mark Dott	10:20	Enclosure 06
10.	**Update on Paediatric and Maternity Services at Yeovil District Hospital**	Receive	Mel Iles	10:35	Verbal
11.	**Q3 Board Assurance Framework and Corporate Risk Management Report**	Receive	Mel Iles	10:50	Enclosure 07
12.	**Research and Innovation Committee Terms of Reference**	Approve	David Shannon	11:05	Enclosure 08
	Refreshment Break: 11:10 – 11:25				
	Aim 2 – Provide the best care and support to people				
13.	**Integrated Performance Report**	Receive	Pippa Moger	11:25	Enclosure 09
14.	**Assurance report from the Quality and Governance Assurance Committee meeting held on 28 January 2026**	Receive	Rosie Benneyworth	11:45	Enclosure 10
15.	**Maternity & Neonatal Quarter 3 (2025/26) Quality & Safety Report**	Receive	Sally Bryant	11:50	Enclosure 11
16.	**CQC Maternity Service User Survey**	Receive	Sally Bryant/ Emma Davey	12:05	Enclosure 12
	Aim 6: Live within our means and use our resources wisely				
17.	**Finance report (M10)**	Receive	Pippa Moger	12:20	Enclosure 13
18.	**Assurance Report from the Audit Committee meeting held on 14 January 2026**	Receive	Paul Mapson	12:30	Enclosure 14
19.	**Assurance Report from the Charitable Funds Committee meeting held on 20 January 2026**	Receive	Graham Hughes	12:35	Enclosure 15
20.	**Approval of 2026/27 Revenue Budget**	Approve	Pippa Moger	12:40	Enclosure 16

		Action	Presenter	Time	Enclosure
21.	**Capital Programme 2026/7-2029/30**	Approve	David Shannon	12:50	Enclosure 17
For Information					
22.	**Follow-up questions from Members of the Public and Governors**	Receive	Chair	12:55	Verbal
23.	**Any other business**		All		Verbal
24.	**Risks identified**		All		Verbal
25.	**Evaluation of the effectiveness of the Meeting**		Chair	13.00	Verbal

26. Items to be discussed at the Confidential Board Meeting

- Minutes of the Confidential Board meeting and Extraordinary Confidential Board meeting
- Notes of the Board Development sessions
- Summary Staff Survey 2025 Results
- Quarterly Investigation, Disciplinary and Employment Tribunal Oversight Report
- Healthset (Electronic Health Record)
- Contracts for approval (commercially sensitive)
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28. Close and Date of Next Meeting 13:05

12 May 2026

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Interests
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Rima Makarem, Chair
DATE:	10 March 2026

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	Where a member of the Somerset NHS Foundation Trust Board has an Interest, or becomes aware of an Interest, which could lead to a conflict of interests in the event of the Board considering an action or decision in relation to that Interest, the Interest must be considered as a potential conflict and must be declared. The Register of Interests is part of the mechanism through which the Somerset NHS Foundation Trust Board will ensure the integrity of their decision-making processes. Board members are also required to orally declare at each meeting specific Interests in respect of items on the agenda Board members are reminded that any new or relinquished Interest should be advised to the Board and updated on the electronic database within 28 days of becoming known. Board members will be prompted at least annually to review declarations they have made and, as appropriate, update them or make a nil return. The Register as presented reflects the position as at 2 March 2026.
Recommendation	The Board is asked to: • **Note** the Register of Interests and to make any further declarations where appropriate.

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

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

Equality 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)
Public or staff involvement or engagement has not been required for the attached report.

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

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

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

REGISTER OF INTERESTS

Trust Board as at 2 March 2026

NHS Somerset NHS Foundation Trust

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Rosie	Benneyworth	Non-Executive Director	Outside Employment	Member	Royal College of GPs	01/07/2025		03/12/2025
Rosie	Benneyworth	Non-Executive Director	Outside Employment	Interim CEO since 2022	Health Services Safety Investigations Body	01/07/2025		03/12/2025
Darshan	Chandarana	Non-Executive Director	Outside Employment	Managing Director	Neopath Ltd	01/02/2025		
Darshan	Chandarana	Non-Executive Director	Outside Employment	Senior Vice President of AI	ThoughtWorks	12/01/2026		
Isobel	Clements	Chief People Officer	Outside Employment	Governor, Board member	Weston College	22/01/2025		
Isobel	Clements	Chief People Officer	Loyalty Interests	Sister-in-law works in the Pharmacy Department at Musgrove Park Hospital	Somerset NHS Foundation Trust			
Isobel	Clements	Chief People Officer	Loyalty Interests	Nephew works as a Physio Assistant within Musgrove Park Hospital	Somerset NHS Foundation Trust			
Olena	Doran	Non-Executive Director	Outside Employment	Professor in Biomedical Research, and Dean for Research and Enterprise	University of the West of England (UWE), Bristol	01/04/2024		30/11/2025
Deirdre	Fowler	Chief Nurse and Midwife	Nil Declaration					
Tom	Frederick	Associate Non-Executive Director	Outside Employment	Director	Oliver Wyman	01/04/2024		
Andrew	Heron	Chief Operating Officer/Deputy Chief Executive	Loyalty Interests	Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust (and is involved in a sub contract for liaison and diversion services)	Avon and West Wiltshire MH Partnership NHS Trust	17/03/2022		02/01/2026
Andrew	Heron	Chief Operating Officer/Deputy Chief Executive	Loyalty Interests	Member of the Board of Directors and line manager to the Managing Director as a wholly owned subsidiary of Somerset NHS Foundation Trust.	Symphony Healthcare Services	01/04/2024		02/01/2026
Graham	Hughes	Non-Executive Director	Outside Employment	Chairman SSL	Simply Serve Ltd	01/01/2022		04/04/2025
Melanie	Iles	Chief Medical Officer	Nil Declaration			04/11/2024		
Inga	Kennedy	Non-Executive Director	Outside Employment	Director-Trustee	The White Ensign Association	01/04/2024		12/02/2026
Peter	Lewis	Chief Executive	Outside Employment	Management Board Member	Somerset Estates Partnership (SEP) Board			
Peter	Lewis	Chief Executive	Outside Employment	Director	Somerset Estates Partnership Project Co Limited			
Rima	Makarem	Trust Chairman Trust Board	Outside Employment	Lay member (remunerated) since 2019	General Pharmaceutical Council	01/01/2025		12/06/2025
Rima	Makarem	Trust Chairman Trust Board	Outside Employment	Chair (remunerated) since 2020	Queen Square Enterprises	01/01/2025		12/06/2025
Rima	Makarem	Trust Chairman Trust Board	Outside Employment	Chair (unremunerated) since 2021	Sue Ryder	01/01/2025		12/06/2025
Paul	Mapson	Non-Executive Director	Nil Declaration			10/12/2025		

All Interests have been declared in line with the Conflicts of Interest Policy

REGISTER OF INTERESTS

Trust Board as at 2 March 2026

NHS Somerset NHS Foundation Trust

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Pippa	Moger	Chief Financial Officer	Outside Employment	Non-Executive Director/Shareholder Director	Simply Serve Limited	04/04/2025		
Pippa	Moger	Chief Financial Officer	Outside Employment	Board member	Southwest Pathology Services (SPS) Board	04/04/2025		
Pippa	Moger	Chief Financial Officer	Outside Employment	Director on JV	Shepton Mallet Health Partnership	04/04/2025		
Pippa	Moger	Chief Financial Officer	Loyalty Interests	Step daughter works as Ward Manager for the Trust	Somerset NHS Foundation Trust	04/04/2025		
Pippa	Moger	Chief Financial Officer	Loyalty Interests	Son works as Payroll Lead and Technical Support for the Trust	Somerset NHS Foundation Trust	04/04/2025		
Pippa	Moger	Chief Financial Officer	Outside Employment	Director of JV - SEP	Somerset Estates Partnership Project Co Limited	04/04/2025		
Alexander	Priest	Non-Executive Director	Outside Employment	Chief Executive	Mind in Somerset	04/12/2023		24/11/2025
Jade	Renville	Director of Corporate Services	Outside Employment	I am Joint Director of Corporate Affairs/Services across Somerset ICB as well as Somerset NHS Foundation Trust.	NHS Somerset ICB	06/07/2024		
Jade	Renville	Director of Corporate Services	Outside Employment	Richard Huish Multi Academy Trust Director since 1/9/2019 (Chair of Trust from January 2023) Note - System doesn't let you enter a commencement date prior to April 2024, but the role started on 1 September 2019.	Richard Huish Multi Academy Trust	01/04/2024		
Jade	Renville	Director of Corporate Services	Loyalty Interests	Since 01/08/2003 - Father is Director and Owner of Renvilles Costs Lawyers NB: System only lets you add a commencement date since April 2024.	Renvilles Costs Lawyers	01/04/2024		
David	Shannon	Director of Strategy and Digital Development	Outside Employment	Company Director of PHI Ltd (Predictive Health Informatics). The company was established to deliver an i4i grant through the National Institute for Clinical Research. The Trust is a shareholder in the Company and this directorship represents the Trust in its shareholding.	Predictive Health Intelligence LTD	14/03/2022		04/04/2025
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Wife is employed as a PA within the Neighbourhoods and Primary Care Directorate	Somerset NHS Foundation Trust	01/12/2022		04/04/2025
David	Shannon	Director of Strategy and Digital Development	Outside Employment	Director of SHS - a subsidiary of YDH providing primary care services	Symphony Healthcare Services	10/01/2022		04/04/2025
David	Shannon	Director of Strategy and Digital Development	Outside Employment	Board member of the Joint venture between Synlab uk, Somerset FT and YDH for the provision of pathology services	Somerset Pathology Services	10/01/2022		04/04/2025
David	Shannon	Director of Strategy and Digital Development	Outside Employment	Board member of the Somerset Estates Partnership with Prime Plc	Somerset Estates Partnership	01/04/2023		

All Interests have been declared in line with the Conflicts of Interest Policy

REGISTER OF INTERESTS

Trust Board as at 2 March 2026

NHS Somerset NHS Foundation Trust

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Daughter is employed by Somerset FT as a Healthcare Assistant	Somerset NHS Foundation Trust	10/01/2022		04/04/2025
David	Shannon	Director of Strategy and Digital Development	Outside Employment	Shareholder Director	Simply Serve Limited	01/07/2024		

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 13 JANUARY 2026 IN MEETING ROOMS 1-3, WYNFORD HOUSE, LUFTON WAY, LUFTON, YEOVIL, BA22 8HR

PRESENT

Dr Rima Makarem	Chair
Graham Hughes	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Paul Mapson	Non-Executive Director
Darshan Chandarana	Non-Executive Director
Rosie Benneyworth	Non-Executive Director
Alexander Priest	Non-Executive Director
Tom Frederick	Associate Non-Executive Director
Peter Lewis	Chief Executive
Andy Heron	Chief Operating Officer/Deputy Chief Executive
Pippa Moger	Chief Finance Officer
Mel Iles	Chief Medical Officer
David Shannon	Director of Strategy & Digital Development
Isobel Clements	Chief People Officer
Deirdre Fowler	Chief Nurse and Midwife
Jade Renville	Director of Corporate Services

IN ATTENDANCE

Ben Edgar-Attwell	Director of Governance
Neil Jackson	Deputy Service Director, Mental Health & Learning Disabilities Directorate [items 15-16]
Andreas Papadopoulos	Medical Director for Mental Health & Learning Disabilities [item 16]
Fiona Reid	Director of Communications

APOLOGIES

Inga Kennedy	Non-Executive Director
Olena Doran	Non-Executive Director

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. Rima Makarem opened the meeting at 9:30am and welcomed all present to the Public Board meeting, including members of the Public and Trust Governors. She confirmed that the meeting was quorate and thanked attendees for their continued commitment during what she acknowledged had been an exceptionally demanding period for the organisation. Apologies for absence were received as above.

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

2.1. The Board received and noted the Registers of Directors' Interests. The Chair invited members to declare any interests relating to items on the agenda. No declarations of interest were made.

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

3.1. The minutes of the Public Board meeting held on 4 November 2025 were **approved** as a true and accurate record.

4. ACTION LOG AND MATTERS ARISING

4.1. The Board reviewed the Action Log and noted progress against previously recorded actions including the completion of the Fuller report referenced previously and the updates relating to planning guidance and the transition-related Board Assurance Framework action. No additional matters arising were identified beyond those already captured in the agenda.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC/GOVERNORS

5.1. The Chair noted that a statement had been received from Gerald Smith raising concerns about the Trust's response to a previous Freedom of Information request, describing the letter he received as inappropriate and stating that he did not wish to receive similar correspondence again. He emphasised the importance of regular access to stroke performance information and expressed his view that this should not require repeated Freedom of Information requests or reliance on Section 8 of the Act. In response, Peter Lewis thanked Mr Smith for raising the issue and confirmed that the Trust would review the approach taken. He agreed that stroke performance information could be shared proactively and would be followed up outside the meeting. **ACTION:** Review how stroke performance data is shared, with a view to sharing this on a more proactive basis.

6. CHAIR'S REMARKS

6.1. Rima Makarem reported that Inga Kennedy continues to recover and hopes to return by March, passing on her thanks for colleagues' messages and her wish to deliver a patient story at the next meeting.

6.2. Rima Makarem informed the Board that Martyn Scrivens had requested to step down from his role for personal reasons and would finish at the end of February. Interim arrangements have been agreed, with the proposal for Rosie Benneyworth to take on responsibility for chairing Symphony Healthcare Services and Darshan Chandarana chairing the Finance Committee, while further discussions with Lead Governor Jack Torr and Deputy Lead Governor Neil Thomas would take place regarding future recruitment.

6.3. Rima Makarem reflected on recent engagements, including organisation and participation of a cross-system workshop focused on children's early years'

development, more of which would be discussed later in the agenda. She also noted that she and Peter Lewis would shortly be recording an episode of the "Voices of Care" podcast and webinar, which she hoped would further highlight the Trust's work and priorities.

6.4. Rima Makarem thanked all colleagues for their continued efforts during what has been an exceptionally pressured winter period and emphasised the importance of maintaining visibility, compassion and collective leadership across all services despite the operational challenges being faced.

7. CHIEF EXECUTIVE AND EXECUTIVE DIRECTORS' REPORT

7.1. Peter Lewis presented the Chief Executive's report, noting it was intentionally shorter but came during significant operational pressure. Demand had been extremely high since 29 December 2025, with both acute sites in sustained escalation. January's usual post-Christmas pressures were intensified by high levels of respiratory illness (influenza and RSV) and wider system pressures, particularly in primary care. He highlighted positive feedback from a recent education quality review, emphasising its importance for recruitment and the Trust's long-term attractiveness as an employer. He also noted achievements in the written report, including national recognition at the HSJ Awards for South West mental health work and Simply Serve Limited (SSL) securing ISO accreditation.

7.2. Andy Heron reported that both acute sites were under considerable strain, reflecting regional pressures, with the South Western Ambulance Service Foundation Trust experiencing record call and conveyance numbers. Seasonal illness patterns were atypical, with flu peaking later, remaining high, and showing a secondary rise. RSV and other respiratory viruses were increasing acuity, especially among older adults. Occupancy reached the high 80s at Musgrove Park Hospital and low 90s at Yeovil District Hospital ahead of the holiday period, but pressure remained consistently high in the period immediately following Christmas. Some days saw arrivals 20–30% above predicted conveyance levels. Staff sickness persisted despite improved flu vaccination uptake. He commended operational, medical and nursing teams for their collective response, remarking that "today may be peak difficulty."

7.3. Paul Mapson queried whether pressures stemmed from patient volume or delayed discharges. Andy Heron confirmed discharge processes had improved and flow was slightly better than in previous weeks, but volume remained the dominant issue. Primary care staffing gaps were also generating additional walk-ins. Deirdre Fowler noted that patient acuity remained high, particularly with respiratory conditions.

7.4. Rosie Benneyworth sought assurance on maintaining patient safety and dignity during the use of corridor care. Deirdre Fowler acknowledged the difficulty, stressing that corridor care should not be normalised, but consistent oversight, monitoring and reasonable adjustments were in place. No significant safety incidents had been observed, but vigilance remained essential, including around potential moral injury to patients and staff.

7.5. Mel Iles introduced the "Every Minute Matters" programme, which will be launched with Professor Brian Dolan, designed to reduce unnecessary delays in patient care

by improving decision-making and earlier movement through pathways. Standards for medical colleagues would be simplified and prioritised to support consistent engagement beyond the Emergency Department. In response to Rosie Benneyworth's query on reduced Hospital@Home (H@H) and UTC activity, she acknowledged earlier uptake challenges but confirmed performance was improving. She expressed disappointment at the initial impact of "Call Before You Convey," with only four daily diversions, though recent pressures had increased numbers into the tens as crews gained confidence and further engagement occurred.

7.6. The Board discussed mortality indicators, including the HSMR figure of 107, which Rosie Benneyworth described as concerning. Mel Iles agreed to review the data, believing it remained within normal limits. Robust medical examiner processes were in place, with deep dives and dissemination of learning as required. Paul Mapson noted the long-standing nature of the issue and the need for continued scrutiny. Peter Lewis reiterated that palliative care coding differences contributed to variation but confirmed the Trust would not alter coding practice. Outlier areas continued to be reviewed. **ACTION**: Mortality indicators and HSMR data to be reviewed, with a further update to be provided.

7.7. Martyn Scrivens asked what would be different in the rollout of "Every Minute Matters," noting similar initiatives over the past year. Mel Iles said earlier efforts had not reached enough consultants, whereas this programme would involve more clinicians directly. Peter Lewis added that the focus would be on multidisciplinary processes from admission to discharge, not only delayed discharge. The Board then discussed the UTC model. Andy Heron described ongoing work to refine streaming and triage and the need for rapid adjustments after Christmas. Rosie Benneyworth and Paul Mapson asked whether UTCs could operate as the first point of entry. Andy Heron agreed in principle but noted challenges with layout, workforce confidence and clinical leadership, confirming the area was being redesigned.

7.8. Graham Hughes queried the slow early uptake of "Call Before You Convey" and whether the South Western Ambulance Service had fully adopted it. Andy Heron acknowledged the slow start but reported improvements during recent periods of high pressure, with more diversions into community episodes and H@H accepting up to ten patients in a day. Consistent use outside extreme-pressure periods and better communication about successful cases were still required.

7.9. Rima Makarem asked about the restructuring of patient engagement functions now under Deirdre Fowler's leadership. Deirdre Fowler explained she assumed responsibility on 1 January 2026 and would review gaps and opportunities to move from reactive engagement to more proactive co-production. Dr Makarem welcomed the approach and requested future updates.

7.10. The Board **endorsed** the Freedom to Speak Up priorities in the report.

8. UPDATE ON PAEDIATRIC AND MATERNITY SERVICES AT YEOVIL DISTRICT HOSPITAL

8.1. The Board received a verbal update from Mel Iles on the progress toward the planned reopening of paediatric and maternity services at Yeovil District Hospital.

Mel Iles confirmed that there had been no significant new developments since the previous Board meeting but emphasised that work continued at pace. The target date for reopening remained 21 April 2016, with intensive onboarding and supported induction underway for newly appointed consultants. She noted that paediatricians from Musgrove Park Hospital were providing ongoing support, and that an oversight group and associated workstreams were in place to ensure safe relaunch of services, including the development of rotas and the repatriation of staff previously deployed to neighbouring hospitals.

8.2. Mel Iles briefed the Board on the recent visit by Baroness Amos prior to Christmas, which had included a session with Executive Directors and the Senior Leadership Team. Further individual interviews were scheduled, including those for herself, Deirdre Fowler, Peter Lewis, and Rima Makarem. The Trust also continued to meet monthly with the Maternity Safety Support Programme (MSSP) and the Integrated Care Board (ICB), with the ICB Chief Nursing Officer chairing key oversight groups. She confirmed that national attention on neonatal services had increased, and the Trust had secured obstetric support to strengthen preparations for the relaunch.

8.3. Rima Makarem referred to an uptick in incidents within the Integrated Performance Report and asked how far this related to adherence to clinical guidance and whether improvements were expected following reopening. Mel Iles explained that the Trust had not yet been able to test the full effect of new processes, but monitoring would be built into the relaunch workstreams. Deirdre Fowler added that improved reporting may reflect a strengthening safety culture. In response to questions from Tom Frederick about longer-term planning and the sustainability of service models across the region, Peter Lewis confirmed that the immediate focus remained on safe reopening, while regional strategic planning would sit with the ICB. Mel Iles noted that neonatal staffing and training issues were under close national scrutiny.

8.4. Rosie Benneyworth requested assurance that the Quality and Governance Assurance Committee (QGAC) was sufficiently sighted on emerging risks, particularly relating to neonatal safety and proposed that the uptick in incidents be reviewed by the Committee. Deirdre Fowler added that national evidence indicated a rise in neonatal-related events, though this was not currently reflected locally. **ACTION**: QGAC to consider whether national increases in neonatal and related events require enhanced monitoring.

9. UPDATE ON CHILDREN AND YOUNG PEOPLE SYSTEM EVENT WITH NAOMI EISENSTADT – 12 DECEMBER 2025

9.1. Andy Heron provided an update on the Children and Young People System Event held on 12 December 2025.

9.2. Rima Makarem explained that the session had originated from earlier Board discussions about strengthening early years provision and developing a more coherent long-term approach for children and families. She noted that although much of the national model for early years centres had been designed for urban environments, the principles still held value for Somerset if adapted to local context. Rima Makarem had invited Naomi Eisenstadt, who had led the development of Sure Start nationally, to speak at the event, and this had subsequently broadened into a

system-wide workshop involving the Trust, Somerset Council and the Integrated Care Board (ICB). The morning session included a keynote address from Naomi Eisenstadt and presentations from Alison Bell on Somerset's demographics and from partner organisations outlining existing early years activity across the county.

9.3. Andy Heron added that the afternoon sessions had focused on translating the discussion into practical and deliverable actions, with smaller groups identifying priority areas requiring immediate collaboration. He noted that Somerset Council's Director of Children's Social Care had committed to being personally involved in next steps, which he described as an important signal of system commitment. The initial focus will be on South Somerset West and Bridgwater, areas with higher deprivation and greater numbers of young people requiring coordinated support. He emphasised the need for the organisations involved to move beyond dialogue and into tangible delivery, acknowledging that previous attempts at system collaboration had sometimes stalled after early engagement. He also outlined opportunities to expand partnership working beyond health and social care to include schools, police and other local services.

9.4. Mel Iles commented that the event had been both inspiring and constructive, highlighting the strength of the work already underway across Somerset. She noted that while some successful approaches were already established in certain localities, there was a clear opportunity to extend these to other parts of the county to ensure greater consistency of support for children and families. She concluded that this was an important area of development, and that the Trust would continue to work with system partners on next steps.

10. CONSTITUTION AMENDMENTS – COUNCIL OF GOVERNORS TRANSITION

10.1. The Board considered the proposed amendments to the Constitution relating to the transition of the Council of Governors. Ben Edgar-Attwell introduced the report, outlining the rationale for the changes and confirming that the proposals followed the Council of Governors' approval of Option 5 – Transition at its meeting on 17 December 2025. He explained that the amendments were being brought forward in anticipation of the national legislative reforms expected under the Fit for the Future: 10-Year Health Plan, which would remove the statutory requirement for Councils of Governors from April 2027. Given that Somerset NHS Foundation Trust currently has one of the largest Councils nationally, with 42 Governors, and that the terms of 21 Governors will conclude in early 2026, this presented a natural opportunity to review the size and composition of the Council without curtailing existing terms.

10.2. Ben Edgar-Attwell summarised the proposal to reduce the size of the Council to 25 Governors, comprising 13 Public Governors, 5 Staff Governors, and 7 Appointed Governors, maintaining statutory compliance and ensuring proportional representation across the Trust's services. He drew attention to the revised allocations for public constituencies, the reduction in staff governor seats from 12 to 5, and the updated composition tables for appointed Governors. The Board noted that the amendments aimed to reduce administrative burden, maintain continuity, and avoid unnecessary elections for short-term tenures while ensuring that all key service areas remained represented.

10.3. Rima Makarem emphasised the importance of maintaining strong links with communities during this transition and confirmed that work would continue with the Council to strengthen how the Trust hears from and engages with local people. No questions were raised by Board members, and there was consensus that the proposals were well-reasoned and appropriately aligned to future legislative change.

10.4. The Board therefore **approved** the constitutional amendments as set out in the report.

11. ASSURANCE REPORT OF THE PEOPLE COMMITTEE MEETING HELD ON 9 DECEMBER 2025

11.1. Graham Hughes presented the assurance report, confirming that the Committee had considered a wide range of workforce matters at its meeting on 9 December 2025. He highlighted a colleague story presented to the Committee, which had illustrated the challenges colleagues face when delays in recruitment processes hinder the Trust's ability to fill posts efficiently. He noted that early improvements were being seen in time-to-hire metrics, though further work was still required. The Committee had also received an update from the Director of Medical Education on the national ten-point plan for resident doctors, with good work underway and valuable insight provided through attendance by two resident doctors. A suggestion was made that resident doctors be invited to a future Board development session to support wider understanding of their experiences. Mel Iles confirmed that this was already being planned.

11.2. The Board discussed appraisal performance. Graham Hughes reported that appraisal completion remained below target, with concerns not only about compliance but the quality of the conversations themselves. It was noted that responsibility for meaningful appraisals rests with all managers, not only the People Directorate. Rima Makarem reflected that the ten-point plan should ideally support the wellbeing of the entire workforce, not solely resident doctors. Isobel Clements explained that resident doctors often move frequently between organisations, leaving them without consistent "ownership" during their training journey, which is why the national plan remains important; however, she agreed that the Trust should consider how to track a broader set of wellbeing measures across all colleagues. She also referenced ongoing visa-related challenges, noting that recent changes to visa and settlement routes had created uncertainty for some staff. She confirmed that the Trust had extended visas for three colleagues through a national programme and continued to monitor the evolving policy landscape.

11.3. Committee discussions also touched on international recruitment. Isobel Clements noted that the national forecast for international recruitment had deteriorated and that the Trust may once again be asked to host international nurse recruitment activity. Despite these uncertainties, she expressed confidence in the Trust's processes for supporting colleagues with visa requirements. Graham Hughes commented that visa arrangements remained politically sensitive and subject to frequent shifts, requiring the organisation to remain agile. The Board noted the assurances provided through the report and the continued need for strong leadership, robust communication and consistent management practice to support the wellbeing and development of colleagues across the Trust.

11.4. The Board endorsed a rapid, organisation-wide assessment of visa and settlement entitlement changes and their workforce impacts. The Board delegated oversight to the People Committee, with an interim report in 6 weeks and a Board summary thereafter. The Chief People Officer is authorised to implement flexible recruitment controls, including a role-based approach to international recruitment (with potential temporary slow-down in nursing), informed by scenario modelling, service risk, and financial impacts. The Board approved adding this risk to the Corporate Risk Register with defined KPIs and trigger points. **ACTION:** Rapid Trust-wide assessment of visa and settlement rule changes to be completed by the People Committee, with an interim report due in six weeks and a summary to Board thereafter. Risk to be added to the Corporate Risk Register.

12. INTEGRATED PERFORMANCE REPORT

12.1. Pippa Moger presented the Integrated Performance Report for November 2025, highlighting strong community performance with waiting times at 93.9%, Urgent Community Response at nearly 94%, and no out-of-area mental health placements. Mental health indicators remained positive overall. Emergency Department 12-hour waits improved over Christmas, though four-hour performance continued to face pressure. No Criteria to Reside (NCTR) improved significantly to 17.2%, elevating the Trust's national ranking.

12.2. Challenges were reported in diagnostics due to staffing gaps in dexa scanning and endoscopy, and a decline in stroke performance at both acute sites due to bed pressures. Fourteen patients remained on long-waiter pathways as of 21 December 2025, with work underway to reduce these by month-end. Mental health length-of-stay data discrepancies were being resolved, and Talking Therapies performance was expected to meet the national standard once data was updated. Workforce indicators showed sustained mandatory training compliance.

12.3. Board members raised several questions. Martyn Scrivens queried mental health length-of-stay reporting, and Pippa Moger confirmed the issue related specifically to mental health datasets. Rosie Benneyworth questioned whether improvements in Symphony Healthcare Services' chronic disease indicators reflected real clinical gains; Mel Iles confirmed this was under review at the Symphony Board. Rima Makarem asked about pre-diabetes identification; Peter Lewis, Martyn Scrivens and Andy Heron described ongoing work on metabolic health and broader diabetes pathway redesign.

12.4. Rima Makarem requested a bar chart in future reports to illustrate performance versus demand for 4 hour A&E performance target. She also sought early insight into the impact of the Yeovil Urgent Treatment Centre opening; Andy Heron confirmed that benefits had not yet been fully realised and that rapid improvements to streaming and triage were required. Alexander Priest shared a public perspective that clinical confidence in streaming may be contributing to variation, which Andy Heron acknowledged. **ACTION**: Bar chart to be included in future reports to illustrate performance versus demand for 4 hour A&E performance target.

12.5. Further discussion covered improvements in mental health colleagues' physical-health training and recent progress in gynaecology long-wait pathways, which Andy Heron confirmed now had no remaining 65-week waiters.

13. ASSURANCE REPORT OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETINGS HELD ON 26 NOVEMBER 2025 AND 17 DECEMBER 2025

13.1. The Board received the assurance reports from the Quality and Governance Assurance Committee meetings of 26 November and 17 December 2025. Graham Hughes highlighted ongoing concerns relating to Strategic Aim 2, which remained above risk appetite. Patient flow challenges continued and were reflected in other reports. He emphasised the importance of learning from complaints and welcomed improvements in response rates, recommending that key risks be more clearly highlighted.

13.2. He also drew attention to digital readiness risks, noting that the forthcoming Electronic Health Record (EHR) implementation may temporarily heighten risk before benefits are realised. In discussion, Martyn Scrivens queried the nature of the concern and whether the digital team was fully engaged. David Shannon confirmed ongoing work to ensure governance, training and preparation were in place, acknowledging that some inherent risk was inevitable during system transition. Peter Lewis requested that the position be reviewed, given that the report identified the matter as requiring urgent attention. **ACTION:** Review digital readiness risks and the assessment flagged as requiring urgent attention.

14. ASSURANCE REPORT OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 16 DECEMBER 2025

14.1. Alexander Priest presented the assurance report from the Mental Health Legislation Committee meeting held on 15 December 2025. He reported positive feedback from the recent Care Quality Commission visit to Rowan 2 following the move from St Andrew's, noting that colleagues had been commended for the quality of care and their engagement. The Committee had received an update on restrictive interventions and discussed the continued progress being made in strengthening oversight and practice in this area. It also reviewed the developing systemwide Section 117 aftercare policy, which was expected to be agreed shortly.

14.2. The Committee had identified significant ongoing concerns relating to the availability of Approved Mental Health Professionals (AMHPs), which is managed by the local authority. Alexander Priest advised that staffing shortages and increased administrative requirements were resulting in delays to mental health assessments, creating operational challenges both for community teams and for Emergency Departments when individuals presented at times of heightened risk. Andy Heron confirmed that delays in AMHP availability could affect planning and safety within wards and Emergency Departments, as the timing of assessments was often unpredictable. Mel Iles asked whether actions were being taken to address this, and Alexander Priest confirmed that Andreas Papadopoulos was progressing follow-up discussions with local authority partners.

14.3. The Committee also considered training and compliance relating to the Mental Capacity Act and Deprivation of Liberty Safeguards, with work underway to strengthen training provision. Out-of-area placements remained extremely low compared with other systems, and the Committee commended the sustained effort to maintain this position. The report also highlighted emerging issues following the re-implementation of smoke-free ward policies, which had been temporarily relaxed during the COVID-19 pandemic.

14.4. The Board noted the assurances provided through the report and recognised the areas requiring continued oversight, particularly the risks associated with AMHP capacity.

15. INTENSIVE ASSERTIVE OUTREACH UPDATE

15.1. Neil Jackson presented an update on developments within the Intensive Assertive Outreach model and the wider programme to strengthen support for people with severe mental illness. He reminded the Board that this work had accelerated following the national review prompted by the murders committed in Nottinghamshire by Valdo Calocane, after which the Care Quality Commission (CQC) requested that systems review their local arrangements relating to risk management.

15.2. Neil Jackson explained that Lee Baker had led the development of a new standard operating procedure (SOP) for assertive outreach, now implemented across fourteen teams. Dedicated training and “reset days” had given teams greater clarity and consistency of approach. Work to improve data quality continued, with updates to the RiO electronic patient record system due by April to allow accurate identification of patients with severe mental illness and clearer visibility of assessment dates.

15.3. He confirmed that a new high-risk-of-harm-to-others list had been created and would be reviewed through six-monthly desktop assessments. Additional tools had been developed, including an Assertive Community Treatment – Transitional Model (ACT-TM) flow chart, strengthened links with forensic services, improved “risk to others” training, and enhanced multidisciplinary team (MDT) caseload management processes. Further work was underway to ensure that individual consultants were fully incorporated into caseload oversight. Neil Jackson also described new “did-not-attend” (DNA), discharge and disengagement protocols, and highlighted the significant progress made in completing the long-standing Section 117 Mental Health Act (MHA) aftercare policy, which was due for ratification at the end of January.

15.4. He noted ongoing challenges, including rising demand, variable team capacity, discharge pathways into primary care, and embedding digital improvements. Work also continued to extend the “stolen years” prevention philosophy – aimed at reducing premature mortality for people with severe mental illness – more widely across the organisation.

15.5. During discussion, Rima Makarem and Alexander Priest welcomed the breadth and depth of progress. Alexander Priest asked about continuity of suicide prevention leadership, and Neil Jackson confirmed that recruitment was underway for a strengthened patient safety and risk management role, which would include suicide prevention responsibilities. Rosie Benneyworth asked how the high-risk-of-harm-to-others list was shared across the system. Neil Jackson confirmed that forensic patients were discussed in Multi-Agency Risk Management (MARM) meetings, with flags applied on the RiO system and on the Somerset Integrated Digital e-Record (SIDeR). He acknowledged that further work was required to ensure consistent use of the list across organisations.

15.6. Rima Makarem also asked about learning from national practice. Neil Jackson confirmed that Somerset continued to contribute to and draw from regional discussions through the South West Mental Health Provider Collaborative.

16. THE IMPLICATIONS OF THE NEW MENTAL HEALTH BILL FOR PATIENTS AND SERVICES

16.1. Andreas Papadopoulos presented an update on the new Mental Health Bill, which received Royal Assent in December and represents the most substantial reform of mental health legislation in forty years. He explained that although the supporting Code of Practice had not yet been published, the direction of travel was clear: reduced reliance on restrictive practices, stronger patient rights, clearer justification for detention, and a much greater emphasis on personalised care planning.

16.2. He outlined the main changes, including legally required personalised care and treatment plans, “advanced choice documents” enabling legally binding care preferences, and more stringent detention criteria requiring demonstrable risk of harm rather than likelihood. While Section 2 detention would remain at 28 days, Section 3 detention would reduce from six months to three months, with more frequent tribunal review. Individuals with learning disabilities or autism could no longer be detained unless they also had a mental health condition. Police stations and prisons would no longer be classed as places of safety, and all patients would be entitled to advocacy, including culturally appropriate advocacy.

16.3. Andreas Papadopoulos emphasised that the administrative workload for clinical teams would increase significantly, including greater documentation, more frequent tribunal reporting and additional legal oversight. He noted that Somerset was already ahead in areas such as assertive outreach and personalised planning, but extensive workforce development would still be required.

16.4. During discussion, Rima Makarem highlighted concerns raised nationally about delays to the Code of Practice and uncertainty about how the Bill would apply in acute and emergency settings. She asked which elements could be progressed now; Andreas Papadopoulos confirmed that the ethos of the Bill - personalised care, reduced restriction and patient choice - could be strengthened immediately. Rosie Benneyworth asked whether existing data would support the Bill’s requirements, particularly for protected characteristics. Andreas Papadopoulos and Alexander Priest confirmed gaps remained, noting that ethnicity data within the Patient and Carer Race Equality Framework was only around fifty per cent complete. Improving this was already a Mental Health Legislation Committee priority.

16.5. Alexander Priest raised concern about the large increase in administrative pressure on the Mental Health Act office. Andreas Papadopoulos agreed, predicting that demand might rise faster than the proposed eight-to-ten-year implementation period. Mel Iles welcomed the Bill’s focus on improved care planning but agreed that new administrative demands could stretch the workforce. Deirdre Fowler emphasised the importance of ensuring that reductions in restrictive practice did not compromise safety, noting colleagues already worked hard to minimise restrictions. Andreas Papadopoulos agreed this would require strong multi-agency support.

16.6. Paul Mapson observed that the reforms could create significant unfunded pressure on the Trust and asked whether national challenge was being raised about the lack of financial support. Martyn Scrivens added that technology and new models of working would likely be essential to manage the additional burden.

17. FINANCE REPORT

17.1. Pippa Moger presented the Month 8 financial position, confirming an in-month surplus of £800k, which remained breakeven to plan due to non-recurrent mitigations. She reported that £1.8m of funding for industrial action costs would appear in Month 9. Agency spending had reduced compared with October and continued to track towards the required 30% reduction. The cost improvement plan remained on track, supported by a VAT benefit from historic agency usage, though only a small proportion of this benefit would be recurrent, creating pressure for future years.

17.2. The capital programme was behind plan in November but was beginning to recover, with the year-end forecast remaining on plan. Cash stood at £48m, supported by capital slippage. Winter pressures were highlighted as the main financial risk, particularly with escalation beds, corridor care and additional staffing at both acute sites. In discussion, Pippa Moger confirmed that Freya Ward and Jasmine Ward remained open, with associated staffing costs continuing. Martyn Scrivens requested clearer distinction between winter-related spend and underlying run-rate pressures; Pippa Moger confirmed that this analysis would be presented to the Finance Committee. Alexander Priest also noted increasing financial pressures within local authorities and the potential impact on system flow.

17.3. Mel Iles briefed the Board on high paediatric demand before Christmas and noted that the respiratory syncytial virus (RSV) vaccination programme might help reduce pressures next year. Graham Hughes asked whether the Trust could influence vaccination timing, and Mel Iles confirmed that this was possible as the Trust delivers the programme. **ACTION**: Present to the Finance Committee an analysis separating winter escalation costs from underlying operational run-rate pressures.

18. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

18.1. Ray Tostevin asked for further assurance regarding the planned reopening of maternity services at Yeovil District Hospital, referencing the statement in the report that reopening on 21 April 2026 would be dependent on “specific safety criteria” being met. He asked how confident the Trust was that these criteria would be achieved in time. Mel Iles responded that she remained confident about the planned reopening date, explaining that the primary dependencies were securing sufficient midwifery staffing, repatriating colleagues who had been supporting Musgrove Park Hospital and Dorset County Hospital and ensuring neonatal nurse capacity. She added that upskilling and re-familiarisation work for colleagues was progressing, and although there were challenges, the necessary actions were on track.

19. ANY OTHER BUSINESS

Rima Makarem noted that this was Martyn Scrivens’ final Public Board meeting and expressed, on behalf of the Trust, her appreciation for his commitment and contribution. She highlighted his continued passion for the organisation and thanked him for his support during her first year as Chair. Martyn Scrivens reflected on his time with the Trust, stating it had been a pleasure and a privilege to serve and to work alongside colleagues across the organisation.

20. RISKS IDENTIFIED

20.1. No new risks were identified, however the Board noted the following key risks during the meeting:

- Workforce pressures including sickness absence, recruitment delays, and variable management capacity.
- Financial risks relating to winter escalation activity, underlying run-rate pressures, and increased financial instability within local authorities.
- Operational pressures within urgent and emergency care due to sustained high demand and effects on elective care pathways.
- Data quality gaps in mental health services, particularly incomplete protected characteristics and ethnicity data.
- Administrative and workforce implications arising from the new Mental Health Bill, including the expected increase in documentation and tribunal activity.
- Digital readiness concerns ahead of Electronic Health Record (EHR) implementation and the need to ensure safe processes and adequate training across services.

21. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

21.1. The Board reflected on the effectiveness of the meeting and agreed that the agenda allowed for thorough discussion of key issues, with particular value placed on the extended focus on mental health, which members felt was both timely and necessary. Board members noted that the balance between operational updates, strategic items and assurance reports was appropriate and facilitated clear scrutiny and challenge. Members acknowledged that the volume of business remained high, but the structure of the meeting supported effective debate and decision-making.

22. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

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

23. WITHDRAWAL OF PRESS AND PUBLIC

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

24. CLOSE AND DATE OF NEXT MEETING

24.1. The meeting closed at 12.35 pm. The next meeting will take place on Tuesday 10 March 2026.

NHS Somerset NHS Foundation Trust

EXTRAORDINARY PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRAORDINARY PUBLIC BOARD MEETING HELD ON 10 FEBRUARY 2026 VIA MS TEAMS

PRESENT

Dr Rima Makarem	Chair
Graham Hughes	Non-Executive Director
Martyn Scrivens	Non-Executive Director
Paul Mapson	Non-Executive Director
Darshan Chandarana	Non-Executive Director
Alexander Priest	Non-Executive Director
Tom Frederick	Associate Non-Executive Director
Olena Doran	Non-Executive Director
Rosie Benneyworth	Non-Executive Director
Peter Lewis	Chief Executive
Andy Heron	Chief Operating Officer/Deputy Chief Executive
Pippa Moger	Chief Finance Officer
Melanie Iles	Chief Medical Officer
David Shannon	Director of Strategy & Digital Development
Isobel Clements	Chief People Officer

IN ATTENDANCE

Julie Hutchings	Board Secretary and Corporate Services Manager
Mark Hocking	Deputy Chief Finance Officer

APOLOGIES

Inga Kennedy	Non-Executive Director
Deirdre Fowler	Chief Nurse and Midwife
Jade Renville	Director of Corporate Services

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. Rima Makarem welcomed all Board members and attendees to the Extraordinary Board meeting and confirmed that the meeting was quorate. Apologies for absence were received as above.

2. ITEMS TO BE DISCUSSED AT THE EXTRAORDINARY CONFIDENTIAL BOARD MEETING

2.1 Rima Makarem advised that the focus of the Extraordinary Confidential Board meeting would be on the 2026/27 Annual Plan and the Appointment of the Symphony Healthcare Services Chair.

3. WITHDRAWAL OF PRESS AND PUBLIC

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

4. CLOSE OF MEETING

4.1. The meeting closed at 9.30 am.

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON 13 JANUARY 2026

Minute	Action	By whom	Due date	Progress
Public Board meeting held on 4 November 2025				
7.3 - Planning guidance targets (in CEO report)	Update Board reports to include tracking of planning guidance metrics	Pippa Moger	13 January 2026	Complete - where details of metrics for 2026/27 are known, the Board report has / will be updated accordingly.
10.2 - 2025/26 Board Assurance Framework and Corporate Risk Register Report	Executive team to review and identify funding source for transition services role.	Exec team (Mel Iles)	13 January 2026	Plans are in place to appoint a nurse co-ordinator, supported by a Clinical Director for Transition, to map current practice and identify priorities. A steering committee and Transition Charter will be developed to guide this work. The role will sit within Neighbourhoods and Community but work across all service groups. Mel Iles is the Executive Lead.
Public Board meeting held on 13 January 2026				
5.1 – Questions from Members of the Public/Governors	Review how stroke performance data is shared, with a view to sharing this on a more proactive basis.	Fiona Reid	10 March 2026	Complete – area to be provided on website for sharing information proactively, as and when available.
7.6 – Chief Executive and Executive Directors' Report	Mortality indicators and HSMR data to be reviewed, with a further update to be provided.	Mel Iles	10 March 2026	Complete - HSMR for SFT is stable. MPH HSMR Is always higher than YDH but within tolerated limits. Our SHMI is within expected limits and better reflective of the nature of our acute and community trust

Minute	Action	By whom	Due date	Progress
				and was brought in nationally due to the limitations of HSMR which includes our community hospital data and is affected by palliative care coding. The HSMR for MPH for Jan is 111 and overall for SFT is 104.9. HSMR is also affected by co-morbidity coding. Info shared with Rosie Benneyworth.
8.4 – Update on Paediatric and Maternity Services at Yeovil District Hospital	Quality and Governance Assurance Committee (QGAC) to consider whether national increases in neonatal and related events require enhanced monitoring.	Deirdre Fowler/QGAC	10 March 2026	Complete - considered that current monitoring processes include sufficient oversight of adverse events, themes and trends. Situation for further discussion at MNIP.
12.4 – Integrated Performance Report	Bar chart to be included in future reports to illustrate performance versus demand for 4 hour A&E performance target.	Pippa Moger	10 March 2026	Complete - report updated to include demand.
11.4 - Assurance report of the People Committee meeting held on 9 December 2025	Rapid Trust wide assessment of visa and settlement rule changes to be completed by the People Committee, with an interim report due in six weeks and a summary to Board thereafter. Risk to be	Isobel Clements	April 2026	Complete - summary scheduled for May Board.

Minute	Action	By whom	Due date	Progress
	added to the Corporate Risk Register.			
13.2 - Assurance report of the Quality and Governance Assurance Committee meetings held on 26 November 2025 and 17 December 2025	Review digital readiness risks and the assessment flagged as requiring urgent attention.	David Shannon	10 March 2026	Complete - the digital readiness risks have been reviewed specifically related to the implementation of Healthset. There is a specific programme which has commenced. The specific urgent escalation has been reviewed to ensure there is continued support in the short term.
17.3 – Finance Report	Present to the Finance Committee an analysis separating winter escalation costs from underlying operational run-rate pressures.	Pippa Moger	10 March 2026	Complete - analysis presented to Finance Committee on 23 February.

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive and Executive Director Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ben Edgar-Attwell, Director of Governance and Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	10 March 2026

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

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

Links to Joint Strategic Aims (Please select any which are impacted on / relevant to this paper)
☒ Aim 1 Contribute to improving the 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)
The report includes a number of references to work involving colleagues, patients and system partners.

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

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1 BACKGROUND AND PURPOSE

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

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

2 NATIONAL AND REGIONAL DEVELOPMENTS / POLICY UPDATES

Independent Investigation into Maternity and Neonatal Services

2.1 The national Independent Investigation into Maternity and Neonatal Services in England, led by Baroness Amos, published its interim report on 26 February. The report highlights that maternity and neonatal services across England are not consistently delivering safe, equitable or compassionate care for too many women, babies and families, with concerns spanning all stages of the maternity pathway. It identifies six systemic factors contributing to pressures in the system: capacity constraints, culture and leadership challenges, racism and discrimination, poor responses and accountability when things go wrong, estates issues, and workforce limitations. We welcome the findings and will study the recommendations closely. As a Trust, we reiterate our apology to anyone who has experienced poor care, acknowledge the personal impact on families, and reaffirm our commitment to act decisively where safety concerns arise, to embed an open and learning culture, and to support all those who share their experiences with us.

National Policy and Strategic Developments

2.2 The new National Cancer Plan has also been published, which sets out a long-term approach to improving cancer outcomes, experience and equity over the next decade. The plan commits to meeting cancer waiting time standards by the end of this Parliament and aims for three in four people diagnosed with cancer to be cancer-free or living well five years after diagnosis by 2035.

Primary Care and GP Contract Developments

2.3 Primary care continues to undergo major reform following NHS England's release of the 2026/27 GP contract. The contract introduces a £485 million uplift and a new £292 million practice-level reimbursement scheme aimed at boosting GP capacity through expanded clinical sessions and recruitment. Practices are now required to provide same-day responses for clinically

urgent patient requests. The contract also strengthens patient choice, formalises collaboration with community pharmacy and updates the Quality Outcomes Framework by adding new obesity-related indicators and enhancing childhood vaccination incentives. Together, these changes reflect NHS England's wider strategy to modernise access, improve continuity of care and stabilise general practice performance under increased demand pressure.

Digital and Data Transformation

2.4 Digital transformation remains at the forefront of national priorities. NHS England has awarded a £33.6 million contract to TPXimpact to expand digital vaccination services across maternity, neonatal and school-age pathways, supporting the shift towards prevention and early intervention within the 10-year health plan. Alongside this, cyber-resilience efforts are being strengthened through national webinars aimed at primary care professionals, focusing on cyber threat awareness, resilience building and compliance with the Data Security and Protection Toolkit.

Public Health and Prevention

2.5 The government's new national obesity strategy has triggered an accelerated rollout of the weight-loss drug Mounjaro across primary care, including financial incentives of £3,000 for practices achieving prescribing targets. An £85 million pilot launching in July 2026 will test new access models via community pharmacies and digital platforms, aiming to eliminate regional variation and ensure equitable access to metabolic treatments.

NHS Providers and the NHS Confederation announce new merged membership organisation: The NHS Alliance

2.6 The NHS Confederation and NHS Providers have announced the name of the new national membership organisation created from their merger in January, which will represent and support the health system across England, Wales and Northern Ireland. From April 2026, The NHS Alliance will bring NHS leadership together, represent their views to government, and support them to improve their services at a time of significant pressure and transformation for the NHS. Our purpose will be to help improve the NHS and the health of the people of the UK.

2.7 The merger, which was confirmed in January, marks a significant milestone, bringing together two established national bodies to strengthen the collective influence, insight and support for NHS trusts, primary care, integrated care boards and independent and voluntary sector providers.

REGIONAL DEVELOPMENTS – SOUTH WEST

Screening, Prevention and Public Health

2.8 Across the South West, there has been continued improvement in key public health indicators. Breast screening uptake has risen, with 73.8% of eligible women now up to date and more than 531,000 women attending screening within six months of invitation, representing a year-on-year increase in timely participation and reflecting effective regional mobilisation efforts. HPV vaccination coverage also remains above the national average, although nearly 55,600 eligible young people in the region still remain unvaccinated, indicating persistent gaps in uptake that require targeted intervention to reduce inequalities in protection against HPV-related disease. Winter pressures have continued to affect frontline services, with flu and norovirus admissions increasing significantly, including an average of 262 daily hospital admissions for flu in early January, contributing to sustained operational strain within acute and emergency care settings across the region.

Elective Recovery and Productivity

2.9 Despite heightened winter demand, the South West has achieved exceptional progress in elective productivity, delivering more than one million elective operations in 2025 - the first time the region has reached this level of activity, representing a 16% increase on the previous year. This milestone has been enabled by improvements in theatre utilisation, expansion of day-case surgical pathways, and the adoption of digital tools and robotic technologies to streamline patient flow and maximise capacity across operating theatres.

Cancer Care

2.10 Cancer services in the South West are also set to benefit from the implementation of the new National Cancer Plan. With approximately 50,000 cancer diagnoses each year in the region, the plan is expected to support earlier diagnosis, faster access to treatment and improved long-term outcomes for patients. Regional adoption of the modernised pathways outlined in the plan is anticipated to strengthen equity and consistency of care across the South West, ensuring alignment with national ambitions for earlier detection and better survivorship outcomes

Digital Innovation and Workforce Modernisation

2.11 The region continues to advance its digital transformation agenda. Several South West trusts have begun deploying a new AI-powered rostering system which, in early trials, achieved a 97% reduction in unfilled shifts and a 98% reduction in temporary staffing costs, demonstrating significant potential to improve workforce flexibility, staff experience and financial efficiency across services. In parallel, Health Innovation South West has continued to deliver a range of improvement programmes and events, including training on perinatal quality improvement, workshops on respiratory pathway transformation and collaborative forums for adult social care. These initiatives are helping to

strengthen local capability, encourage system-wide learning and support sustainable innovation adoption across the region's health and care organisations.

3 CORPORATE UPDATES

Industry Skills Awards 2026 - UCS College Group

3.1 The Trust is preparing a series of nominations for the UCS College Group's Industry Skills Awards 2026 as detailed below, reflecting the strength and maturity of our strategic partnership with University Centre Somerset:

- Industry Skills Employer of the Year
- Technical Pathways Partner of the Year
- Industry Experience Partner of the Year
- UCS College Group Strategic Skills Partner of the Year

This collaboration continues to play a pivotal role in Somerset's future NHS workforce supply, spanning T Levels, apprenticeships, supported internships, functional skills and degree-level clinical pathways. The partnership has delivered particularly strong outcomes in apprenticeship recruitment and retention, with growing clinical pipelines across Nursing Associate, Registered Nurse Degree Apprenticeship and emerging AHP pathways, including diagnostic radiography and physiotherapy.

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

Assurance Report from the Executive Committee meetings held on 2 February 2026 and 2 March 2026

4.1 The Executive Committee met on 2 February and 2 March 2026 and received updates across operational, financial, workforce, quality, safety and transformation programmes. The organisation continued to experience sustained pressure across acute and community services through the winter period, with teams demonstrating resilience and effective cross-site working in responding to rota gaps, estates issues and high unscheduled care demand. The Committee noted the ongoing need to strengthen internal flow, discharge processes and Same Day Emergency Care, alongside developments in frailty and the redesign of multidisciplinary decision-making models within Mental Health services.

4.2 During the March meeting, the Committee also reflected on continuing operational pressures, notably within staffing across both acute sites, the impact of theatre cancellations following the national bone cement shortage, and the requirement to recover cancelled cases before the end of March. It was noted that bone cement supply had stabilised, enabling planned recovery activity to proceed, although some complexity within rebooking remained due to dual-operator cases. Wider operational pressures were highlighted, including out-of-hours staffing pressures for resident doctors, with Patchwork

implementation expected to support improved future rota gap visibility and management.

4.3 The Month 9 financial position (reported in February) demonstrated a surplus of £0.750m, breakeven to plan, with a cumulative year-to-date deficit of £6.796m. Although the Trust remained on plan, several financial risks required continued management, including increasing agency use in December, the low proportion of recurrent Cost Improvement Programme (CIP), pressures across Children, Young People and Families (CYPF), Medicine and Surgery. The Month 10 update (reported in March) confirmed a further surplus of £1.75m and a reduced year-to-date deficit of £5m, with agency spend continuing to perform favourably against prior year levels and capital delivery expected to accelerate following imminent contractual commitments, including the Electronic Health Record (EHR) programme. The Committee noted NHS England's concerns regarding the achievability of the 2026/27 savings requirement, particularly in the context of an £80m CIP, and highlighted the need to define alternative delivery options.

4.4 The Corporate Risk Register continued to demonstrate high organisational pressure, with more than twenty risks scoring 15 or above, including several at the highest scoring levels. Improvements had been made in risk articulation and training compliance, but a significant number of service-level risks were yet to be mapped to the corporate register. In March, the Committee reviewed two emerging risks which were yet to be reviewed and validated. Positive progress was noted in workforce resilience, medical workforce alignment and pressure ulcer harm, although the Committee emphasised the need to strengthen the link between service-level and corporate risk themes.

4.5 Exception reports from the Quality Assurance Group and Patient Safety Board highlighted continuing improvements within Community Mental Health services and ongoing progress against governance audit findings, but persistent concerns remained regarding cleaning standards, duty of candour, Mental Capacity Act / Deprivation of Liberty Safeguards (MCA/DoLS) compliance and variation in measurement approaches across sites. In March, the Committee received a detailed update on the cleaning service, noting high sickness, fragile workforce resilience, increased audit failures and rising complaints, requiring immediate operational and HR support. A number of challenges were also escalated from service groups, including high complaint volumes within CYPF and critical care risks within Surgery.

4.6 The Committee received the Q3 Learning from Deaths report, which showed continued learning relating to the deteriorating patient, communication with families and post-procedure monitoring. Mortality indicators, including Summary Hospital-level Mortality Indicator (SHMI), remained within expected ranges, with improvement sustained in fractured neck of femur mortality following recent operational pathway change. The Committee also noted high coronial activity. The Guardian of Safe Working report for the period to February 2026 confirmed exception reporting broadly in line with previous quarters, with immediate safety concerns largely related to hours-based issues and no fines or work schedule reviews.

4.7 Updates on major programmes included the Every Minute Matters initiative, ongoing improvements in Research and Development culture and performance, and strong progress towards the planned April reopening of Yeovil Special Care Baby Unit (SCBU) and maternity services, with workforce, estates and governance preparations nearing completion. In March, the Committee also received an extensive sustainability presentation from the Green Care Action Group, including the Trust's progress and opportunities in reducing environmental impact, supply chain vulnerability and the proposed rollout of reusable named theatre hats, which have demonstrated strong benefits in communication and safety.

Learning from Deaths – Quarterly Summary (Q3 2025–2026)

4.8 This report is presented in line with the National Guidance on Learning from Deaths (National Quality Board, 2017) and NHS Improvement requirements for Trust Board oversight. It provides an update on mortality review processes, key learning themes, and mortality indicators for the period October to December 2025.

4.9 Key Highlights

- Reviews completed during the quarter continued to identify learning relating to recognition and escalation of the deteriorating patient, communication with families, and post-procedure monitoring.
- The Medical Examiner service scrutinised deaths across all settings and provided feedback on cases requiring further review through Structured Judgement Reviews and Mental Health Mortality Rapid Reviews.
- Two Patient Safety Incident Investigations were initiated where potential concerns in care were identified.
- Reviews of deaths of people with a Learning Disability identified no specific concerns.
- Coronial activity remained high, although no Regulation 28 reports were issued to the Trust during the period.

4.10 Mortality Indicators

- Mortality indicators remain broadly as expected at Trust level.
- The Summary Hospital-level Mortality Indicator (SHMI) is within the expected range across both acute sites.
- Diagnostic groups showing above-expected mortality continue to be monitored closely via the Mortality Surveillance Group, with further reviews commissioned where appropriate.

4.11 Emerging Learning Themes

- Escalation pathways and early recognition of deterioration, including assessment of patients following prolonged periods on the floor in community settings.

- Strengthened documentation and communication to support effective care planning, including clearer post-procedure monitoring guidance.
- Improved multi-disciplinary communication in relation to high-risk pathways and consent processes.
- Falls risk assessment and management, following learning from inquests and review activity.
- Continued positive examples of end-of-life care, with work underway to improve the environment for patients and families in mental health inpatient settings.

4.12 The Board is asked to note the report and the ongoing work to embed learning from deaths across all care settings.

4.13 The full Learning from Deaths report is available in the Reading Room for Board members.

Guardian of Safe Working for Post Graduate Doctors Report

4.14 The quarterly Guardian of Safe Working report for October 2025 to February 2026 highlights exception reporting activity across Somerset NHS Foundation Trust. Overall reporting levels were broadly consistent with previous quarters, with a reduction noted at Yeovil District Hospital (YDH) and stable levels at Musgrove Park Hospital (MPH). Patchwork exception reporting has now gone live and is expected to improve accessibility and increase reporting accuracy.

4.15 Key points:

- Immediate Safety Concerns (ISCs): Five ISCs were raised at MPH, all relating to hours-based concerns rather than direct safety risks, and five at YDH, one submitted in error and the remainder linked to low staffing levels during surgical and medical shifts.
- No fines or work schedule reviews were issued during the quarter.
- Exception reporting at MPH remained steady, with previous spikes in General Surgery and Urology not repeated; reporting at YDH showed a downward trend following higher levels seen last quarter.
- Weekend and out-of-hours exception reporting remained low, though rota gaps due to sickness and long-term vacancies continued to create pressure, particularly within Medicine.
- Patchwork reporting is now fully operational, with rostering functionality rolling out across specialties from April 2026, expected to improve visibility of rota gaps and strengthen proactive rota management.
- Resident Doctor Forum feedback highlighted ongoing concerns around payroll accuracy, parking and onsite facilities, and the transition to Patchwork.

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

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

Use of the Corporate Seal

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

4.19 The seal register entries over the period 1 November 2025 to 27 February 2026 are set out in the attached Appendix A.

Somerset NHS Foundation Trust

Appendix A

SOMERSET NHS FOUNDATION TRUST - SEAL REGISTER

1 April 2025 – 27 February 2026

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
02/04/2025	17	Lease Agreement – 9 Artillery Road, Yeovil	David Shannon	Peter Lewis
29/04/2025	18	Lease – Supply Connection – Convamore – Southern Electric Power	Pippa Moger	David Shannon
30/05/2025	19	Clearchannel Agreement – Bauer Media Group	David Shannon	Peter Lewis
30/05/2025	20	License for works – 27a Vicarage Walk, Quedam, Yeovil	David Shannon	Peter Lewis
04/06/2025	21	Licence to Underlet, Lease of garage 38, Cheddon Mews, Taunton	David Shannon	Isobel Clements
13/06/2025	22	JCT – Refurbishment of Phoenix and St Andrews Wards, Wells Priory	Peter Lewis	David Shannon
18/06/2025	23	Lease with Bauer Media Outdoor UK Limited	David Shannon	
25/06/2025	24	Deed documents for Ryalls Park and Oaklands Surgery (x6)	Pippa Moger	Andy Heron
16/07/2025	25	Deed of Variation of Contract between SFT and Ergea UK and Ireland Ltd	David Shannon	Isobel Clements
18/07/2025	26	Yeovil JCT Minor Works Building Contract	David Shannon	Peter Lewis
19/08/2025	27	Licence to Occupy, Rooms G15-G20, Fore Street, Bridgwater	Isobel Clements	Andy Heron
16/10/2025	28	Contract documents for alterations to form Aseptic Pharmacy - JHC Surveying Limited	David Shannon	Isobel Clements
24/10/2025	29	Renewal lease at The Exchange, Bridgwater	David Shannon	Pippa Moger
29/10/2025	30	HV1 Switchgear Contract, Musgrove	David Shannon	Peter Lewis
06/11/2025	31	Deed of Indemnity - SHS – Burnham and Highbridge	Pippa Moger	Peter Lewis

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
06/11/2025	32	Deed of Termination for Deed of Guarantee - SHS – Burnham and Highbridge	Pippa Moger	Peter Lewis
06/11/2025	33	Deed of Covenant – SHS - Burnham and Highbridge	Pippa Moger	Peter Lewis
06/11/2025	34	Deed of Guarantee and Indemnity – SHS - Burnham and Highbridge	Pippa Moger	Peter Lewis
30/01/2026	35	Lease – Multi-Storey Car Park, Quedam Shopping Centre – 90 Spaces	David Shannon	Isobel Clements
30/01/2026	36	Lease – Vincents Street Car Park, Quedam Shopping Centre – 60 Car Park Spaces	David Shannon	Isobel Clements
11/02/2026	37	Outpatient Pharmacy Contract with JHC Surveying	David Shannon	Peter Lewis
27/02/2026	38	Licence to Underlet Ashford Court	David Shannon	Peter Lewis

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Public Board of Directors
REPORT TITLE:	Patient Story - Andrew's experience
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and Midwife
REPORT BY:	Emma Davey, Director of Patient Experience and Engagement
PRESENTED BY:	Emma Davey, Director of Patient Experience and Engagement Kelly Hutchins, Associate Director of Patient Care, Surgical Service Group Mark Dott, Matron, Surgical Service Group
DATE:	10 March 2026

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	Storytelling is a powerful tool for understanding what truly matters to our patients and their families. Andrew's story has been chosen for the Board as it is representative of the wider themes we see through formal complaints particularly the need for compassionate, personalised care at every stage of the patient journey. It also demonstrates how patient feedback can drive organisational learning, change, and meaningful resolution for families.
Recommendation	The Board is asked to discuss and note the report

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

☐ Aim 1 Contribute to improving the 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)
As part of the formal complaint resolution and to support organisational learning, Andrew's family have given their permission for his story and their experience as a family to be shared.

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]
It is the intention to bring a patient story to each public Board of Directors and Andrew's story has previously been shared at the Patient Experience and Involvement Committee.

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

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

SOMERSET NHS FOUNDATION TRUST

PATIENT STORY

1. BACKGROUND AND PURPOSE

1.1. Patient stories are a powerful means of understanding what matters most to our patients and their families and of assuring the Board that learning from experience is driving improvement. Andrew's story has been selected for Board consideration as it reflects recurring themes identified through formal complaints, particularly the need for compassionate, personalised and well-coordinated care at every stage of the patient journey. It also demonstrates how patient feedback can, and should, lead to meaningful resolution for families.

1.2. Andrew's experience is not an isolated incident. It highlights broader, system-level issues that have been raised by patients and families through the complaints process. By bringing this story to Board, we acknowledge the impact of these experiences and reaffirm our commitment to learning from feedback. Patient stories like Andrew's are vital in shaping a culture of compassion, personalisation, and continuous improvement; ensuring that every voice leads to better care and genuine resolution.

2. KEY POINTS

2.1. Andrew, a young father with terminal cancer, and his family experienced significant distress during his final weeks at Musgrove Park Hospital. This included inconsistent communication, lack of coordinated palliative care, and failures to consistently deliver care in a manner that upheld dignity, compassion and respect.

2.2. The family submitted a formal complaint highlighting these concerns. Their request extended beyond an apology and investigation, seeking assurance that learning would be embedded through a review of end-of-life care practices to enable future patients and families to receive the support and respect they deserve.

2.3. The Trust's response was timely, empathetic, and transparent. This enabled a resolution meeting, chaired by the Matron, which provided clarity and answers, supported the family during their bereavement, and demonstrated a commitment to learning and improvement.

2.4. This story reinforces the importance of listening to patient and family feedback, recognising the emotional impact of care experiences, and using these insights to drive change. It directly supports strategic objective 2: providing the best care and support to people, and underlines the central role of compassionate, personalised care.

2.5. The Matron will provide a personal reflection on the case, outlining learning identified and the changes implemented in practice. This will include reflection of the value of building a personal connection with the family through the resolution meeting and how this case highlighted the need to move away from vague and non-committal communication towards clearer, time-bound and accountable responses.

2.6. The Associate Director of Patient Care (ADPC) will describe how the service group has strengthened its approach to learning from complaints, including clearer ownership of actions, monitoring outcomes, increased accountability to ensure improvements are sustained.

3. RECOMMENDATION

3.1. The Board is asked to note the patient story, reflect on the learning and actions described, and support the continued focus on compassionate, personalised end-of-life care and learning from complaints.

DIRECTOR OF PATIENT EXPERIENCE AND ENGAGEMENT

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Chief Executive
REPORT BY:	Head of Health & Safety and Risk
PRESENTED BY:	Chief Medical Officer
DATE:	13 February 2026

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

Executive Summary and Reason for presentation to Committee/Board	The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks*. Each Board Assurance Committee will receive the Corporate Risk Register (CRR) report with the specific risks assigned to them. The Committees will formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework. The highest areas of risk for the organisation are: • Insufficient capacity to meet demand, deliver against referral to treatment times and reduce waiting lists • Workforce recruitment and retention • Financial position • Aging estates - acute and community • Pressures in social care; intermediate care; and primary care • Delivery of digital transformation The compound risks to the organisation are: • Demand, capacity and flow constraints across services • Clinical safety and continuity of services • Workforce sustainability and wellbeing • Maternity and neonatal service pressures • Infrastructure and estate failures • Infection Prevention Control

	• Digital and information governance • Financial sustainability and strategic delivery If the compound risks were realised at the same time, the combined impact could be severe because these would interact and amplify each other. These risks are not isolated and if they materialise together, they can cascade into system wide failures. The potential consequences for the Trust from the compound risks are: • Increased patient safety and quality of care concerns • Reduced service resilience and ability to continue to deliver services • Reduced workforce wellbeing and ability to retain colleagues and recruit • Financial pressures and inability to achieve strategic aims • Increased regulatory interest and reputational concerns The combined effect can lead to loss of public confidence, regulatory intervention and strategic derailment.
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust CRR on 13 February 2026. The report focuses on the high risks scoring 15+ on the risk matrix and includes corporate risks and service group risks. The Board are asked to note the report and the risks identified.

Links to 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:					

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST
CORPORATE RISK REGISTER REPORT 13 FEBRUARY 2026

1. INTRODUCTION

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

2. PURPOSE OF THE REPORT

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

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 13 February 2026 as shown within Appendix 1.

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

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

2.5 The report also includes the corporate risks identified by Simply Serve Limited (SSL) and Symphony Healthcare Services (SHS) which are wholly owned subsidiary companies of SFT. These risks are shown as additional corporate risks for SFT (2192).

3. CORPORATE RISK REGISTER

3.1 There are currently twenty-two risks on the Corporate Risk Register detailed within the circle heat map, seven of which score 20 or 25, an increase of two risks since the last report. The headline titles for the top seven risks are:

- Risk 0012 Waiting times (20)
- Risk 1517 Risk of enforcement action from the Information Commissioners Office as a result of non-compliance with Data Protection Act due to the increased volume of subject access requests (20)
- Risk 1611 Failure to secure necessary infrastructure due to the assurance of availability of capital funding either locally or through national programmes (20)
- Risk 1789 Unsafe premises and environment (20)
- Risk 2192 SHS not becoming self-sustaining (20)
- Risk 3660* If patient identification processes remain inconsistent across the Trust then patients are at increased risk of harm due to misidentification (20)

- Risk 3673* Potentially unsafe staffing levels or inappropriate skill mix on shifts due to the collapse of the agency market which could have an adverse impact upon patient or service user safety (20)

New Risks

3.2 There have been six risks added to the Corporate Risk Register since the last report on 17 October 2025:

Risk No	Risk Description	Current Risk Score
1494	Risk of unsafe/delayed care; reduced ability to manage elective recovery; increased waiting lists; reduced colleague resilience; financial pressure and impact on operational leadership due to planned industrial strike action by resident doctors who are members of the BMA *This risk has been reopened following previously being archived*	20
3660*	If patient identification processes remain inconsistent across the Trust then patients are at increased risk of harm due to misidentification	20
3673*	Potentially unsafe staffing levels or inappropriate skill mix on shifts due to the collapse of the agency market which could have an adverse impact upon patient or service user safety	20
3563*	Inability to deliver a robust claims and inquest provision for the Trust due to the loss of experienced skilled staff member which could lead to delays in responding to meeting KPIs; backlog in sharing key information; inability to provide sufficient support and preparation for colleagues; and at inquest requiring use of external solicitors which has financial consequences	16
3616	Risk of regulatory action due to non-compliance with Health & Safety (Sharps Instruments in Healthcare) Regulations 2013	16
3536	Inability to deliver the data strategy for the Trust including the readiness for EHR and increased access to timely information due to failure to achieve the outcomes of the Data Transformation Programme as per the agreed plan resulting in continued use of legacy data architecture and manual reporting, reputation damage from failure to meet data requirements and increased risk with implementation of EHR	15

**Risk awaits approval on the risk register*

Increased Risks

3.3 There have been no risks which have increased since the last report on 17 October 2025.

Risks which have Reduced

3.4 There have been nine risks which have reduced since the last report on 17 October 2025:

Risk No	Risk Description	Previous Risk Score	Current Risk Score
3110	Inability to deliver safe, effective and sustainable neonatal inpatient service (YDH)	25	10
3059	Risk of the Trust failing to deliver its agreed financial plan due to unplanned cost pressures arising from operational activity; the under achievement of efficiency programmes; or a shortfall in the planned level of variable elective	20	16

	outcome. This could result in the risk of NHS England interventions and increased regulatory action which might require the Trust to take further unplanned and more robust actions to control expenditure		
3058	Risk of the Trust not delivering its CIP plans in full for 2025/26 due to delays in implementing schemes; slippage in agreed schemes; operational pressures reducing the in-year financial impact; and an inability for services to fully identify efficiencies to meet their required targets. This could result in an increased risk of NHS England intervention and regulatory action as a result of not achieving the Trust financial breakeven plan. This may require additional short and medium actions to reduce expenditure	**20**	**12**
1494	Risk of unsafe/delayed care; reduced ability to manage elective recovery; increased waiting lists; reduced colleague resilience; financial pressure and impact on operational leadership due to planned industrial strike action by resident doctors who are members of the BMA	**20**	**10**
2273	Risk of continued high levels of over 21 day length of stay and those patients waiting for care at alternative providers due to insufficient intermediate care capacity; insufficient community hospital provision; and at times insufficient specialist treatment centres for complex patients resulting in patients not being cared for in the most appropriate place; delays in patients onward care and treatment; adverse outcomes for patients; the Trust's ability to maintain performance standards; compromised colleague experience and cost to opening additional escalation areas	**16**	**12**
2191	Reduced colleague resilience due to workplace pressures and prolonged increased demand on services	**16**	**12**
2307	Inability to deliver quality and safe services; meet performance indicators; meet strategic aims of the organisation and realise the benefits of the mergers due to the current medical workforce establishment not mapped to year on year increasing demand. This will result in poor patient experience; patient safety could be compromised; lack of equity in case across the organisation; services could be closed; and impact on colleague experience	**16**	**9**
2044	Inability to deliver quality and safe services; meet performance indicators; meet strategic aims of the organisation and realise the benefits of the mergers due to long standing vacancies within some specialities where there are chronic national shortages within the senior doctor workforce. This will result in poor patient experience; patient safety could be compromised; lack of equity in case across the organisation; services could be closed; and impact on colleague experience	**16**	**6**
2053	If the current rates of episode of care pressure ulcers continues and if there continues to be missed opportunities to mitigate the risk of low level pressure ulcer harms deteriorating, then the cost, in terms of actual harm to patients and the financial burden to the Trust and wider health and social care system will continue to be high and there will continue to be high volumes of moderate or above harm associated with pressure ulcers	**15**	**9**

Risks which have been Archived

3.5 There has been one risk which have been archived from the Corporate Risk Register since the last report on 17 October 2025:

Risk No	Risk Description	Previous Risk Score
2306	Inability to deliver quality and safe services; meet performance indicators; meet strategic aims of the organisation and realise the benefits of the mergers due to vacancies rates within trainee doctor workforce due to the national shortage of trainees; Deanery allocations; and the structure of run throughs. This will result in poor patient experience; patient safety could be compromised; lack of equity in case across the organisation; services could be closed; and impact on colleague experience	15

Risk Appetite & Risk Tolerance

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

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

Compound Risks

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

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

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

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

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

- Financial sustainability and strategic delivery

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

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

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

Emerging Risks

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

3.15 It is a responsibility of the Board to horizon scan and identify external risks that may impact on the delivery of its strategy. The Head of Health & Safety and Risk and the Trust's Risk Managers will monitor the emerging risks scoring 12 on the Service Group and Corporate services risk registers and highlight these within this report to the Board and its Committees.

4. RISK MANAGEMENT ARRANGEMENTS UPDATE

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

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

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

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

4.5 Progress is being made with the development of the Risk Management Strategy 2026-2029 following stakeholder discussions during 2025.

5 CONCLUSION

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

6 RECOMMENDATION

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

Corporate Risk Register 13 February 2026

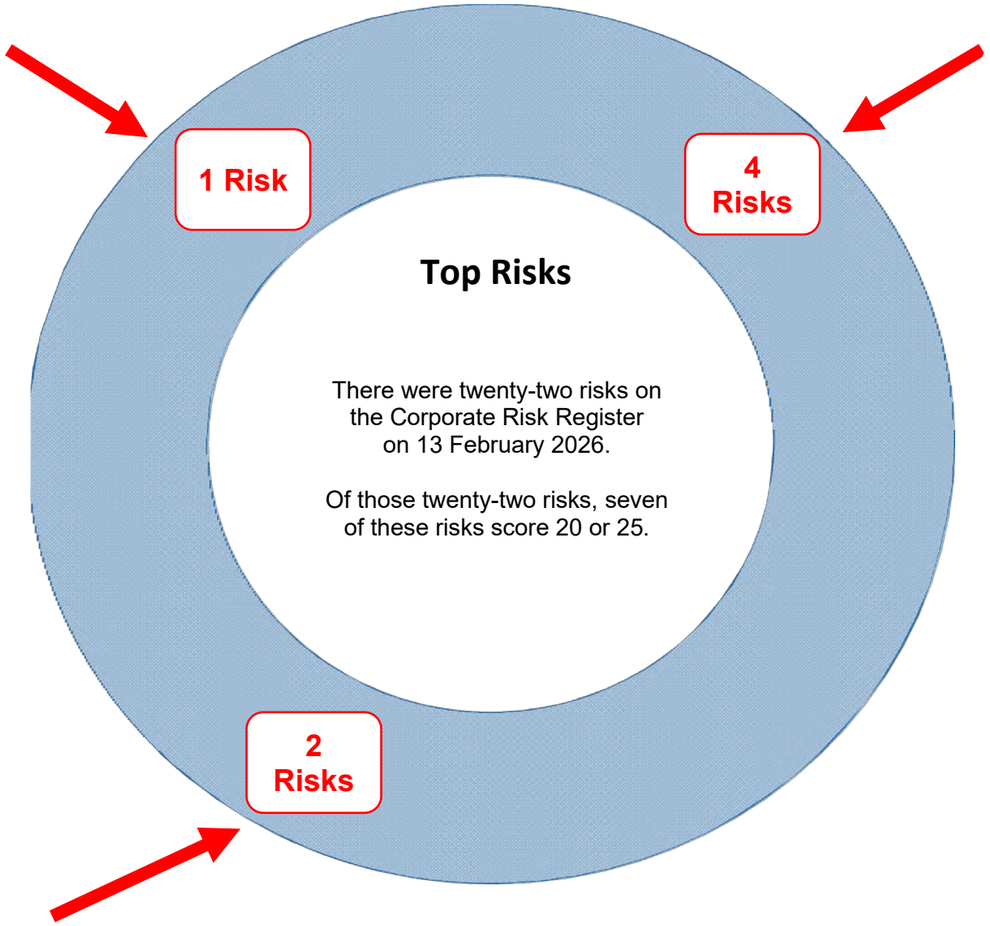
NHS Somerset NHS Foundation Trust

People Committee

20	R3673*	Potentially unsafe staffing levels or inappropriate skill mix on shifts due to the collapse of the agency market which could have an adverse impact upon patient or service user safety
NEW	SA5	
16	R2770	Inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients due to systemic discrimination
⇔	SA5	
16	R3222	Inconsistent provision of rest/wellbeing spaces across SFT impacting on colleague health and wellbeing
⇔	SA5	
16	R3563	Inability to deliver robust claims and inquest provision
NEW	SA5	

Financial Committee

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



Quality & Governance Committee

20	R0012	Waiting Times
⇔	SA2	
20	R1517	Risk of enforcement action from the Information Commissioners Office as a result of non-compliance with Data Protection Act due to the increased volume of subject access requests
⇔	SA7	
20	R1789	Unsafe premises and environment
⇔	SA2	
20	R3660*	If patient identification processes remain inconsistent across the Trust then patients are at increased risk of harm due to misidentification
NEW	SA2	
16	R0007	Referral to Treatment Times
⇔	SA2	
16	R0673	Current capacity and future resilience of primary care in Somerset
⇔	SA3	
16	R1238	Fire Compartmentation
⇔	SA2	
16	R1878	Inefficient use of Safeguarding resource due to the current need to develop workarounds for using the multiple systems to ensure delivery of a safe Safeguarding Service
⇔	SA7	
16	R2838	Inability to provide a transition service for young people with complex needs post March 2025 due to the project funding ceasing
⇔	SA4	
16	R2923	Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas
⇔	SA2	
16	R3616	Risk of regulatory action due to non-compliance with Health & Safety (Sharps Instruments in Healthcare) Regulations 2013
NEW	SA2	
15	R0004	Demand
⇔	SA2	
15	R0862	Use of escalation beds across SFT
⇔	SA2	
15	R2462	Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for decontamination due to not having a dedicated decontamination lead in place
⇔	SA2	
15	R3536	Inability to deliver the data strategy for the Trust including the readiness for EHR
NEW	SA7	

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

7. BOARD ASSURANCE FRAMEWORK & CORPORATE RISK REGISTER

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

Board Assurance Framework

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

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

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

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

Corporate Risk Register

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

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

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

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

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

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

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

8. VALIDATION OF RISKS

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

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

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

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

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

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

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

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

9. RISK APPETITE AND RISK TOLERANCE

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

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

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

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

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

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

9.7 Each of the risks on the Corporate Risk Register have been assigned to the most relevant strategic aim (*figure 1*) for the organisation 2025/26, including for SSL where relevant (*figure 2*) for 2025/26. The risk has then been RAG rated to

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

Figure 1

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

Figure 2

Simply Serve Limited Strategic Objectives 2025/26		Risk Appetite
1	Support SFT to deliver the clinical strategy	**Seek (4)**
2	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	**Significant (5)**
3	Live within our means and use our resources wisely	**Financial Management - Open (3)** **Commercial - Seek (4)**
4	Develop a high performing organisation delivering the vision of the trust	**Seek (4)**

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2025/26 Q3 Board Assurance Framework
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Ben Edgar-Attwell, Director of Governance
PRESENTED BY:	Mel Iles, Chief Medical Officer
DATE:	10 March 2026

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

Executive Summary and Reason for presentation to Committee/Board	The purpose of this paper is to present the Q3 2025/26 Board Assurance Framework (BAF) to the Board of Directors. The BAF provides a consolidated and structured view of the Trust's strategic risks, controls and assurance arrangements, aligned to the Trust's seven strategic aims. This iteration reflects developments during Q3, updated risk scores, revised programmes, and emerging operational and quality issues.

Recommendation	The Board is asked to:
	• Review and consider the Q3 2025/26 Board Assurance Framework.
	• Provide focused scrutiny of Aims 1 and 7, which are reserved for Board oversight.
	  ○ Aim 1: Contribute to improving the health and wellbeing of the population and reducing health inequalities.
	  ○ Aim 7: Deliver the vision of the Trust by transforming our services through research, innovation, and digital technologies.
	• Note the strategic risks that remain above appetite and the mitigation actions underway.
	Provide feedback to inform the final-year iteration of the 2025/26 BAF.

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

☒ Aim 4 Respond well to complex needs ☒ Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture ☒ Aim 6 Live within our means and use our resources wisely ☒ Aim 7 Deliver the vision of the Trust by transforming our services through, innovation, research and digital transformation

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

Equality 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 Equality considerations underpin many elements of the BAF, particularly workforce and quality-related risks. The People Strategy and Inclusive Board Framework continue to drive improvements; however, progress against KPIs remains mixed, and cultural indicators require sustained focus.

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)
Public or staff involvement or engagement has not been required for the attached report.

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

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

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

SOMERSET NHS FOUNDATION TRUST

2025/26 Q3 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1. This report presents the Q3 2025/26 Board Assurance Framework, providing the Board of Directors with an updated assessment of the Trust's strategic risks, controls, assurance and performance against the seven strategic aims. The report highlights areas of progress, persistent challenges, changes in risk, and system-wide factors influencing delivery. It also identifies the specific strategic aims, Aim 1 and Aim 7, that require direct Board-level oversight.

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

2. OVERVIEW OF STRATEGIC AIMS AND OBJECTIVES

2.1. The Trust continues to operate under significant operational and financial pressure, with risk exposure remaining high in several areas. The Q3 BAF reflects ongoing complexities across urgent and emergency care, intermediate care capacity, paediatric safety, maternity service suspension, digital infrastructure, and organisational culture. Despite this, there has been meaningful progress across several programmes, including digital medicines rollout, Hospital at Home expansion, paediatric recruitment, and improvements in long-wait elective pathways.

2.2. Risk appetites remain exceeded in areas such as urgent care access, workforce shortages, and digital infrastructure. Many system-wide factors, including primary care resilience, social care capacity, and community care constraints, continue to materially influence the Trust's ability to deliver planned improvements.

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

2.3. This is a Board-reserved Aim and therefore requires Board-level scrutiny.

2.4. Significant progress continues in the development of a comprehensive population health programme. A Consultant in Public Health is now leading the emerging Population Health Delivery Plan, overseen by the new Population Health Programme Board. The "Stolen Years" initiative remains a cornerstone of health inequalities work, addressing the marked disparity in physical health outcomes for people with severe mental illness.

2.5. Early diagnosis pathways continue to expand successfully across multiple tumour sites, with strong engagement from primary care and positive patient experience. Pathways such as Bleeding After Menopause, Breast 111, and Somerset Bowel Service demonstrate high diagnostic yields and rapid access times. New early identification projects, including oesophageal cancer risk stratification, are demonstrating innovation in upstream detection. The ADHD

care model also continues to progress well following positive evaluation within Central Mendip PCN.

2.6. Risks remain within appetite overall; however, persistent challenges with analytics capacity, data visibility, and population health coordination continue to shape the risk profile.

Aim 2: Provide the best care and support to people

2.7. The Trust continues to operate under sustained operational pressure, with repeated escalations to critical incident during December and January and continued challenges relating to flow, discharge, and bed occupancy. The suspension of maternity and neonatal services in Yeovil remains a significant service and quality concern, contributing to increased pressure at Musgrove Park Hospital. Recruitment of five new paediatric consultants was underway, with the expanded rota delivering improved evening and weekend coverage in Yeovil, and a target date of 21 April 2026 set for reopening the SCBU and maternity unit.

2.8. Performance against national priorities remains mixed. While progress has been achieved in reducing 65-week waiters, performance against flow metrics, A&E waiting times, discharge indicators, and intermediate care capacity remain off trajectory. Several risks under this aim remain above appetite, including paediatric safety concerns, workforce shortages, estate condition risks, and ED demand pressures.

Aim 3: Strengthen care and support in local communities

2.9. This Progress continues across urgent community response, Hospital at Home (H@H), and the Somerset West integration programme. H@H has achieved its second-highest monthly caseload, with Somerset now reporting the third-highest caseload per capita regionally. The integration programme in South Somerset West has been intensified following Board request, with a relaunch and strengthened programme governance now in place.

2.10. Risks remain within appetite but highlight challenges in workforce availability, UTC acuity-related pressure, and achieving sustainable neighbourhood-level transformation. System dependencies continue to be a major influence on delivery.

Aim 4: Respond well to complex needs

2.11. Changes in the scope of regional planning have introduced delay in the CAMHS Tier 4 alternative programme, now focused predominantly on eating disorders. This shift necessitates a new business case and has created an unmet need for a small cohort of young people. Transition pathways, particularly for young people with complex physical health needs, remain significantly behind schedule following the end of the Transition Lead role, although there are plans in place for the recruitment of a new role to support this work.

2.12. The eSTEP programme continues to scale, with 15,000 completed plans. The focus is now on quality improvement through roadshows, primary care engagement, and development of quality metrics. Risks under this aim are predominantly driven by intermediate care capacity and paediatric concerns.

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

2.13. The People Strategy continues into its third year, with progress across learning and education, workforce transformation and inclusive leadership. Retention remains stable and above trajectory, although national and local engagement measures have declined in line with broader NHS trends. The internal audit of cultural maturity confirms strong foundations but highlights the need for deeper embedding of inclusive governance and leadership behaviours.

2.14. Risks relating to burnout, systemic discrimination, and rest space provision remain significant and require sustained organisational attention. Appraisal compliance, although improving, continues to fall short of target thresholds.

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

2.15. The Trust's financial plan continues to target breakeven for 2025/26. While total CIP delivery is forecast to be achieved, only around 30% is recurrent, posing continued medium-term financial risk. Productivity programmes continue to be implemented, including the deployment of ambient voice technology across multiple specialties.

2.16. Risks under financial management remain above appetite, including system-wide pace of change, elective activity delivery, and non-recurrent dependency. Digital and estate investment constraints also continue to shape risk exposure.

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

2.17. This is a Board-reserved Aim and therefore requires Board-level scrutiny.

2.18. Q3 has seen substantial digital progress, including expansion of electronic prescribing into mental health services, the deployment of digital medicines across all service areas, continued scaling of ambient voice technology, and pilots of virtual nursing and interactive care models.

2.19. The Electronic Health Record procurement has concluded with the preferred supplier identified, with contract award and an associated Inter-Trust Agreement expected in March 2026. The timeline remains extremely tight due to required national approval and capital allocation deadlines. Research activity continues to progress with the Somerset Research Partnership and developments in medical education planning.

2.20. Risks under this aim remain significantly above appetite, driven by digital infrastructure, EHR implementation timescales, and estates safety.

3. CONCLUSION

3.1. The Q3 BAF reflects a Trust operating under significant operational pressure with several strategic risks remaining above appetite. Despite this, notable progress has been achieved across digital transformation, population health, community care, paediatrics, and workforce development.

3.2. Many challenges are system-wide and require continued collaboration across the Somerset ICS, particularly concerning primary care resilience, discharge capacity, and digital infrastructure.

3.3. Aims 1 and 7 require particular focus from the Board, given their reserved oversight status and the scale of interdependency, ambition, and risk.

4. RECOMMENDATION

4.1. The Board is asked to:

- Review and note the Q3 2025/26 Board Assurance Framework.
- Provide focused scrutiny on Aim 1 and Aim 7, which are reserved for Board oversight.
- Discuss areas where risks remain above appetite and consider whether further mitigation or Board-level action is required.
- Offer feedback to inform the Q4 year-end BAF refresh.

DIRECTOR OF GOVERNANCE

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26 – Q3 Summary

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

Ref	Exec Owner	Corporate Aim & Objectives/Programmes	Overseeing Committee	Risk Appetite
6	PM	**Live within our means and use our resources wisely** 1. Deliver the 2025/26 financial plan and deliver the financial strategy and reduction in recurrent deficit 2. Drive up productivity across all six service groups via the productive care programme, including transformation and the deployment of new digital/AI based technologies 3. Estates strategy review to ensure capital funds are prioritised and national funding sources utilised where applicable in the context of the changed operating environment	**Finance**	⇔
7	DS	**Deliver the vision of the Trust by transforming our services through innovation, research and digital transformation** 1. Level up digital offer across our services – Digital medicines management and electronic documentation Objective/Programme 2. Conclude Full Business case for Electronic Health Record and appoint the preferred provider. 3. Develop our relationships with Medical Schools specifically the Biomedical Research Centre with Exeter University	**Board**	⇔

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

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

Narrative Overview

SFT has employed a Consultant in Public Health to help develop and lead a Population Health Delivery Plan. The plan will be owned by a Population Health Programme Board chaired jointly by the Chief Medical Officer and the Director of Strategy & Digital Development, with membership from across the organisation plus external representatives. The Population Health Programme Board met for the first time in November 2025.

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

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

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

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

SFT Objectives / Programmes

1	**Improve the physical health of mental health inpatients and community MH patients with SMI**	**On Plan**
	Community: 1. Wellbeing and Depot Clinics – delivery of services reviewed and standardised, emphasising the need for monitoring and interventions around physical health and communication between different health care providers - GPs etc. Also currently working on improving capacity and using digital dashboard to improve patient checks.	

	2. Physical and Wellbeing Clinics SOP updated 3. Digital dashboard set up that allows compliance with monitoring standards to be checked and provides individual patient information. Covers wellbeing, depot and clozapine clinics and allows for follow ups and reminders. The Dashboard feeds into Service Group governance. 4. Audit of SOP implementation and further barriers to improving compliance Inpatients: 5. System in place for inpatient physical health monitoring to ensure monitoring is completed on time with weekly reports 6. Auditing physical health monitoring (Cardio-metabolic monitoring) for patients on inpatients wards in Taunton, to assess compliance with cardio metabolic screening. This will then be replicated on other sites. 7. Engagement with on call resident doctors to improve knowledge; 8. Induction handbook for resident doctors updated to reflect the importance of physical health monitoring 9. Physical Health Monitoring SOP for Inpatients – completed and awaiting ratification.	
2	**Increase opportunities for self-referral/early diagnosis with a focus on areas with current lower access rates**	**On Plan**
	Bleeding after menopause service – 1038 referrals received into the service with 60 cancers diagnosed. On average patients are seen within 7 days of completing the referral form and patient feedback highlights that 97% of patients are very satisfied with the service. Somerset Bowel Service – The service has been rolled out to 8 PCNs in Somerset. 572 patients have referred themselves with 15.2% of patient having a FIT positive and of those 35% of patients are being identified as having high risk factors to developing colorectal cancer. Breast 111 Online Pathway – 930 patients have accessed the 111 online form since launching in Feb 2025 of which 7% of patients have been diagnosed with cancer, this is a higher conversion rate than the Urgent Suspected Cancer Pathway, reassuring the team that the correct people are being triaged through to secondary care appointments. Project has recently been included in the National Cancer Plan as a case study of good practice. Somerset Chest x-ray Service – The service has been rolled out to 8 PCNs Somerset. Referral rates are lower but engagement is ongoing with community pharmacy etc and 119 patients have so far completed a referral form for the service with 4 patients being diagnosed with cancer, one of these at early stage. Engagement continues to be very positive within Primary care as the team continues to raise awareness and ensure all services are rolled out across Somerset. To date the team have received just over referrals 2,659. Patient feedback continues to be collected and is very positive with further deep dives planned with patient groups.	

	The business case for the continuation of these services has been developed and is currently with the ICB for final approval for an agreement of a local tariff to fund the services going forward. To further strengthen Somerset's Earlier Diagnosis Programme, the team has launched a new case-finding project focused on Oesophageal cancer. This initiative is a first for the team and aims to identify patients at higher risk by searching GP records against agreed criteria, such as high BMI or being a current or former smoker. Patients who meet these criteria are invited to complete a simple assessment form, and if eligible, they are offered a capsule sponge procedure. This minimally invasive test can detect Barrett's oesophagus, a condition that may develop into Oesophageal cancer, enabling patients to enter regular surveillance and reduce their future risk. The project has initially launched in one GP practice in Bridgwater, with plans to roll out across Somerset.	
3	**Develop an innovative service for assessment, treatment and monitoring of adults with ADHD**	**On Plan**
	A model for delivering care for adults with ADHD has been developed, that proposes delivering care at a PCN footprint level by a specialist practitioner, most likely an NMP. Following triage, referrals are stratified and diverted to the most appropriate practitioner, who carries out an ADHD assessment. The assessment is shorter than that recommended by NICE but results have been validated as part of a pilot. A pilot in Central Mendip PCN has demonstrated that the model of care can diagnose and manage ADHD in adults. An Expenditure Proposal for system wide implementation was discussed by the ICB on 22 December and received broad support. Detailed planning for rolling out the new service is underway. Contracting options are being explored with the ICB and General Practice Support Unit (GPSU), ahead of finalising the business case. Engagement with system partners is ongoing, with a current focus is on supporting Primary Care with leaner referral pathways and working with them to provide resources to patients who enquire about ADHD and raise awareness about the options available to patients and what they can expect from current pathways.	

Risks - Scoring and Appetite

Risk Appetite over Time – Aim

Significant 20-25				
January 2025	**April 2025**	**July 2025**	**October 2025**	**January 2026**
Within appetite	Within appetite	Within appetite	Within Appetite	Within Appetite

Risks to Aim

		Radar Ref.	Score
1	Population Health may not get the focus required	**R1613**	**9**

2	Approach to Population Health may be uncoordinated	**R1615**	**8**
3	Lack of analytic support and visibility of data	**R1616**	**9**

Risks to Objectives

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

Controls and Assurance

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

NHS Somerset NHS Foundation Trust

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

	Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Peri-op anaemia: pats receiving intravenous iron	Green: 5=< Red: <7	5	12	6	11	8	12	13	9	Data not yet due			
Diabetes: pats on hybrid closed loops	192 in Year 1	Data requested											
Smoking status: acute inpatients	Green: >=60% Red: <55%	41%	43%	45%	46%	46%	48%	46%	51%	51%	51%		
Smoking quit rates: Mental health inpatients	Green: >=55% Red: <50%	100%	100%	100%	100%	0%	100%	75%	50%	0%			
Percentage of cancers diagnosed that are diagnosed at stage 1 or 2	Green: >=60.1% Red: <55.1%	73.5%	71.8%	72.5%	70.8%	76.2%	73.0%	68.6%	73.1%	Data not yet due			
Suicide/Self harm prevention: MH Staff	Green: >=365 Red: <350	378	378	377	375	369	360	360	355	352	350		
Suicide/Self harm prev: non-MH	Green: >=165 Red: <150	214	214	212	209	202	202	202	203	202	203		
Years in good health (females)	Green: National best quartile: 64.3 years Red: National worst quartile: 58.1 years	63.2	63.2	63.2	63.2	63.2	63.2	63.2	63.2	63.2			
Years in good health (males)	Green: National best quartile: 63.8 years Red: National worst quartile: 57.6 years	63.2	63.2	63.2	63.2	63.2	63.2	63.2	63.2	63.2			

NHS
Somerset
NHS Foundation Trust

Board Assurance Framework 2025/26

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

Narrative Overview

The Trust remains committed to its overarching aim of delivering the best possible care and support to people, guided by its strategic objectives and national priorities. While progress has been made across several domains, challenges persist that require continued focus. The strategic aim of 'providing the best care and support to people' is mainly monitored by KPIS from the NHSE System Oversight Framework (SOF). As we refresh our Strategy in Somerset Foundation NHS Trust we will also explore KPIS which give us more assurance of our provision of care from an 'outcome' perspective as well as from an operational perspective. We will endeavour to understand what our colleagues and service users tell us about the care they receive and deliver as well as including a wider range of metrics.

The Trust is making steady progress in delivering the 2025/26 national priorities, as outlined in its annual operating plan. However, performance remains mixed. Reducing the number of patients who no longer meet the criteria to reside in an acute bed remains a significant challenge. The Trust continues to operate in a high-risk environment, with escalations to critical incident throughout December and January. Additional capacity has been a significant challenge with maximum escalation beds opened and increased corridor care experienced during periods of extremis. A consistent process of monitoring and reporting on the quality of care in these areas is currently being finalised and will be presented via our governance process.

In addition to the operational challenges faced in adult acute areas, the suspension of maternity and neonatal services, is still impacting local delivery of maternity care in the Yeovil area as well as increasing operational challenges in MPH. Ongoing actions to re-open the unit with clear criteria to safely staff the unit remain a priority.

The Paediatric CQC Section 29a Warning Notice highlighted the need to increase presence of senior decision makers on the acute paediatric ward during evenings and weekends on the Yeovil District Hospital site. To support delivery of this, CYP & Families has successfully recruited five new Consultant Paediatricians to the Somerset Paediatrics team. These new colleagues will be part of the expanded Yeovil District Hospital acute paediatric rota and will also hold cross-county responsibilities within the wider Somerset Paediatric team. Two of the five new colleagues have already started in post, with the remaining three colleagues joining by June in February, March and August 2026. With interim support from locum colleagues, the new acute paediatric rota went live on 16/01/2026 12/01/2026, providing evening and weekend cover senior medical presence that meets the national standards set out by the Royal College of Paediatrics and Child Health. Parallel workstreams continue to develop the strategy, vision and culture for the Somerset Paediatrics service, to further improve the experience and safety of care for children and their families and to further optimise the educational offer for resident doctors in training.

SFT Objectives / Programmes

1	**Delivery of 2025/26 national priorities and success measures**	**Behind Schedule**
	The Trust continues to make steady progress towards the delivery of the 2025/26 national priorities and success measures, in line with its operating plan for the year. There are some areas where performance remains challenged due to increased demand and backlog waiting lists. Our Integrated Performance Report sets out the key exceptions across the range of measures. The Trust was put into Tier 1 of national performance management in October due to the number of patients the Trust had waiting over 65 weeks for treatment at that time. There were no formal targets in place in the 25/26 NHS Operating Plan for treating all remaining 65-week waiters by the end of December 25. Good progress was made in reducing the over 65-week waiters across quarter 3, with the Trust reporting 18 over 65-week waiters for the end of December, which represents a significant reduction on the 141 reported at the end of October. These 18 cases had exceptional reasons for the breach of the 65-week maximum wait i.e. patient choosing to wait longer or patients not able to have treatment for medical reasons. Tiering meetings continue to be held every two to three weeks, with an expectation the focus with then move to 18-week RTT performance.	
2	**Reduce the number of patients who no longer have a reason to reside in an acute bed to no more than 15% of the bed base**	**Behind Schedule**
	The Trust has commissioned the GIRFT/ECIST team to support a renewed process reviewing our no criteria to reside (NCTR) patients to expedite discharge. This will complement our longer term sustainable 'Every Minute Matters' approach which will focus on culture change and refreshed MDT discharge processes. We continue to focus our reviews on over 14-day length of stay across 8 of our acute wards – unfortunately we have seen a slight deterioration in length of stay due to the complexities of patients and increased infection control position. There are some themes emerging through the reviews which we will be able to collate and address through the EMM steering group. As an immediate solution to support UEC access, improve capacity and maintain safety in YDH, the MSG have opened capacity on Freya ward and subsequently jasmine ward. This is currently being monitored with a plan to deescalate asap. Additionally, November has seen the opening of the UTC on the YDH site, the impact on flow will be evaluated and reported on in future reports. In addition, work is ongoing to strengthen the capacity and organisational awareness of the Hospital at Home team. The percentage of bed days lost due to patients not meeting the criteria to reside remains above our target of no more than 13%. As of the 15th January 2026, our performance was 24.9% of bed at YDH, 23.0% of beds at MPH which unfortunately shows a deterioration, again heightened by Infection control restrictions. A range of actions continue to be undertaken to improve patient flow, care for people at home where appropriate, facilitate timeline and appropriate discharge and address the difficulties in the domiciliary care market.	

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Open - 12				
January 2025	**April 2025**	**July 2025**	**October 2025**	**January 2026**
Above Appetite	**Above Appetite**	**Above Appetite**	**Above Appetite**	**Above Appetite**

Risks to Aim

		Radar Ref.	Score
1	Inadequately rated CQC paediatric services in the east of the county	R3110	10
2	Access to primary care / increasing ED demand	R0673	16
3	Shortfalls in system capacity to enable timely discharge		16
4	Age of acute and community estates	R1789	20
5	Workforce shortages	R2044	16

Risks to Objectives

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

Controls and Assurance

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

NHS Somerset NHS Foundation Trust

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

		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Patient Initiated follow up (PIFU)		Green: >=5% Red: <4%	8.1%	7.9%	8.3%	8.0%	8.1%	8.5%	8.2%	8.2%	7.8%	8.0%		
Clostridium difficile cases in inpatient settings: YTD		Green: <91 annually Red: >96 annually	12	16	20	32	45	55	59	64	69			
Falls per 1000 bed days: YTD			5.38	5.2	5	5.1	5.25	5.27	5.31	5.27	5.31			
Pressure ulcers per 1000 bed days: YTD			1.31	1.2	1.16	1.08	1.17	1.18	1.18	1.18	Data not yet due			
Acute Home Treatment caseload		Green: >=134 Red: <120	92	77	77	74	85	100	107	98	99	100		
No criteria to reside: % of acute beds (month end position)		Green: =< 9.8% Red: >15%	25.6%	21.3%	19.8%	21.4%	21.6%	21.2%	21.4%	17.2%	21.7%			
Average length of stay of patients discharged from acute wards - (Excludes daycases, non-acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH		6.5	6.6	6.3	5.9	6.2	6.2	6.1	6.3	5.8	6.0		
	YDH		8.2	7.9	8.1	8.4	7.5	7.8	8.5	7.6	8.5	8.6		
Patients not meeting the criteria to reside: percentage of occupied bed days lost	MPH	Green: =< 9.8% Red: >15%	23.7%	26.7%	22.5%	22.3%	22.1%	22.8%	23.0%	22.3%	18.7%			
	YDH		18.1%	25.2%	22.8%	20.7%	21.3%	19.6%	16.5%	16.8%	19.5%			
Percentage of Stroke Patients directly admitted to a stroke ward within four hours	MPH	Green: >=90% Red: <75%	75.0%	62.3%	72.2%	70.8%	45.3%	53.3%	69.6%	65.3%	62.5%			
	YDH		32.4%	41.9%	48.4%	27.0%	26.5%	33.3%	27.8%	20.8%	28.6%			

Percentage of patients spending >90% of time in stroke unit – acute services	MPH	Green: >=80% Red: <70%	70.0%	81.7%	73.6%	79.1%	72.3%	63.3%	62.5%	76.0%	64.8%		
	YDH		67.5%	57.8%	63.8%	42.5%	62.5%	74.4%	61.0%	53.7%	54.0%		
Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement against the November 2024 baseline		Trajectory: Green: >=67.3% by March 2026 Red: <67.3% by March 2026	64.3%	65.3%	65.8%	63.9%	62.2%	62.5%	62.5%	62.3%	62.4%		
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement against the November 2024 baseline		Trajectory: Green: >=80.3% by March 2026 Red: <80.3% by March 2026	74.7%	75.4%	74.1%	72.3%	68.2%	70.6%	70.3%	70.7%	70.3%		
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026		Trajectory: Green: =<1% by March 2026 Red: >1% by March 2026	2.5%	2.8%	2.8%	3.0%	3.2%	3.0%	2.7%	2.3%	2.4%		
Improve performance against the headline 62-day cancer standard to 75% by March 2026		Trajectory: Green: >=75% by March 2026 Red: <75% by March 2026	70.2%	69.2%	68.1%	68.4%	70.0%	70.4%	69.6%	76.5%	Data not yet due		
Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026		Trajectory: Green: >=80% by March 2026 Red: <80% by March 2026	72.6%	65.2%	73.0%	75.5%	71.3%	71.9%	77.8%	78.5%	Data not yet due		

Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026: Trust-wide performance		Green: >=76% Red: <66%	71.3%	73.0%	75.7%	77.5%	73.5%	70.8%	71.0%	70.0%	70.7%			
Improve A&E waiting times, with a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25 – Trustwide performance		Green: >=95.3% Red: <95.3%	92.9%	93.9%	94.9%	95.5%	95.6%	95.6%	95.2%	95.3%	95.2%			
Reduce average length of stay in adult acute mental health beds		Green: =<53.1 days by Mar 26 Red: >58.1 days by Mar 26	61.1	59.1	61.9	68.7	70.5	76.3	74.2	66.3	60.6			
Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'			Progress reported via regular updates to our Quality and Governance Assurance Committee.											
Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - registered nurse should immediately inform the medical team caring for the patient		>=90%= Green >=80% - <90% =Amber <80% =Red		83.3%	64.7%	64.3%	58.3%	83.3%	80.0%	78.6%	72.7%			
National paediatric early warning system (PEWS) - Medium risk: percentage reviewed by the nurse in charge	MPH	>=90%= Green >=80% - <90% =Amber <80% =Red	70.0%	43.8%	62.5%	100.0%	57.1%	66.7%	73.3%	58.3%	81.0%			
	YDH		100.0%	100.0%	100.0%	100.0%	71.4%	88.9%	66.7%	100.0%	93.3%			

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

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

Narrative Overview

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

SFT Objectives / Programmes

1	**Community response including care-coordination, virtual ward and Call before Convey**	**On Plan**
	During December 2025, the Hospital at Home service had 185 admissions (93 Frailty, 92 Respiratory), resulting in a month-end total of 358, which is the second-highest monthly total since the service began. Similarly, the average caseload level in December was 106 (38 Frailty, 68 Respiratory), the second-highest monthly average since the service began, behind only October 2025 (107). The recent trend of improved performance in the H@H service has now resulted in SFT having the third highest per capita caseload in the South West region.	
2	**Fully implement the model of care between Somerset FT and Symphony in South Somerset West; test the outcomes and spread to other services in the county**	**Behind Schedule**
	Demonstrate improvements and benefit across the range of metrics developed to underpin the programme. Further work underway in the Performance and Improvement Teams to refine the available metrics for this objective. At the request of the Trust Board the priority of this programme has now been significantly enhanced and this in effect represents a relaunch of the SSW programme with dedicated senior programme management support and a new emphasis on developing a new integrated operating model at pace, a new fortnightly project steering group is being launched and this will be co-chaired by the Service Group Director for Neighbourhoods and Community Services and the Managing Director of Symphony. Senior membership from all of the Trust's other service groups has now been mandated.	

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

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Seek – 15-16				
January 2025	**April 2025**	**July 2025**	**October 2025**	**January 2026**
Within appetite	Within appetite	Within appetite	Within Appetite	Within Appetite

Risks to Aim

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

Risks to Objectives

		Radar Ref.	Score
Obj1	Intermediate care capacity limits home-first/virtual ward flow	**R2273**	**12**
	Primary care capacity/resilience	**R0673**	**16**
	Increased stress from acuity/volume at UTCs affecting responsiveness	**R3080**	**9**
Obj2	Symphony patient record update backlog	**R2683**	**9**
	Symphony not becoming self-sustaining	**R2192**	**20**
Obj3	Poor condition of Shepton Mallet CH portakabins	**R0534**	**20**

Controls and Assurance

Controls	Assurance
Risk Controls • Reports to Operational Leadership Team (OLT) • Reports to Quality, Outcomes, Finance and Performance meetings	**Risk Controls** • Board Development Programme • Operational Leadership Team meetings

• Hospital at Home Programme Board • Reports to South Somerset West Programme Board	• Regional oversight of implementation and performance of Hospital at Home
Oversight Arrangements for Governance and Engagement • Reports to Quality and Governance Assurance Committee • Integrated Neighbourhood Working Steering Group • Urgent Emergency Care Delivery Group	**Oversight Arrangements for Governance and Engagement** • Trust Integrated Performance Report • Intermediate Care performance report (weekly)

NHS Somerset NHS Foundation Trust

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

	Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Admissions prevented by Rapid Response/AHT	Green: >=500 Red: <450	540	619	578	593	573	606	592	535	541			
Patients admitted to Acute Home Treatment	Green: >=419 Red: <350	265	258	242	289	288	308	364	304	342			
Increase Open Mental Health attendances (12 month rolling)	Green: >=20,018 Red: <20,018	21,520	21,224	21,328	21,278	21,184	21,431	21,517	21,376	21,556			
Increase numbers of self-referrals – cumulative year to date	Green: >=30,181 annually Red: <28,672	2,554	5,014	7,504	10,135	12,557	15,126	17,758	20,193	22,584			
Urgent Community response <2hrs	Green: >=70% Red: <60%	91.90%	93.00%	92.60%	93.50%	92.0%	93.0%	91.3%	91.9%	93.8%	91.8%		
Treatment Escalation Plans – patient/family involvement	Green: >=90% Red: <80%	62.00%	68.00%	Data awaited									

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

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

Narrative Overview

The scope of plans for an alternative to a Tier 4 admission have changed, with a shift towards provision for young people with an eating disorder. This has introduced a risk of delay as a new business case is required and has also resulted in unmet need for young people at risk of admission, who do not have an eating disorder.

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

The number of completed eSTEPs on SIDeR+ has continued to grow and has now reached 15,000. Focus is now moving to improving the quality of eSTEPs, with the use of roadshows and the delivery of training in primary care.

Positive progress has been made to strengthen the Paediatric Team in Yeovil. Following recent interviews, a number of offers have been made to Consultant Paediatricians. A target date of 21 April 2026 has been set for the re-opening of the SCBU and maternity Unity at YDH.

SFT Objectives / Programmes

1	**Develop pathway for C&YP with complex health and care needs to avoid CAMHS tier 4 admission and minimise paediatric in-patient LOS**	**Behind Schedule**
	There has been a further change to the scope of the programme by the Southwest Provider Collaborative (SWPC), to focus predominantly on young people with an eating disorder. As a consequence, a new business case has had to be developed, which is currently awaiting internal approval ahead of submission to the SWPC. This is likely to delay implementation. The new scope excludes young people covered by the previous business case. Although numbers are small, a new pathway will need to be developed for this group. Initial conversations about that are underway with Dorset.	
2	**Improve transition from children's to adult services**	**Signficantly Behind Schedule**
	Work to define a programme of support for young people with complex physical health needs transitioning to adult services has stalled, due in part to the end of a fixed term Transition Lead role leading the work. Local, tactical approaches involving transition meetings are taking place but their impact is limited in the absence of a strategic approach to transition.	

	For mental health transition arrangements are generally well established, with CAMHS and adult mental health services co-operating well, although resource constraints, including in adult social care, can impact on transition.	
3	**Convert all TEPS to digital format and make them available across all information systems via SIDER**	**On Plan**
	The number of completed eSTEPs has reached 15,000. The focus now is on quality with the development of a set of quality metrics. A series of eForm Roadshows is being scheduled, along with attending all-staff training sessions at each GP surgery across the county, to showcase best practice.	

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Seek – 15-16				
January 2025	**April 2025**	**July 2025**	**October 2025**	**January 2026**
Within Appetite	Within Appetite	Within Appetite	Within Appetite	Within Appetite

Risks to Aim

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

Risks to Objectives

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

Controls and Assurance

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

NHS Somerset NHS Foundation Trust

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

	Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CYP Eating Disorders - Routine	Green: >=95% Red: <85%	91.2%	90.5%	96.4%	97.0%	98.2%	85.7%	87.5%	88.1%	90.30%			
Reduce time in ED: intensity users	Green: =< 75,081 Red: >78,835	77,909	78,778	77,679	76,643	77,963	77,901	78,201	79,565	80,800			
Time to assessment in CYPNP	Green: =<16 weeks Red: >20 weeks	71	90.4	95.6	98.6	78.7	72.4	23.8	33.1	49.3			
Av wait for assessment: adults w/ASD (weeks)	TBC	79	81	83	84	86	88	90	90	93			
Homeless service: annual referrals	Green: >696 Red: <696	802	788	817	774	761	782	798	816	823	830		
Dementia diagnosis rate - Symphony	Green: >=66.7% Red: <61.7%	52.5%	53.1%	54.0%	53.8%	54.1%	54.1%	54.6%	54.2%	54.1%			
No criteria to reside: % of acute beds	Green: =< 9.8% Red: >15%	25.6%	21.3%	19.8%	21.4%	21.6%	21.2%	21.4%	17.2%	21.7%			
Personalised care planning tbc													

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

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

Narrative Overview

Delivery of this aim continues through the People Strategy 2023–2028, with a focus during 2025/26 on consolidating progress from Years 1 and 2 and implementing the objectives set out below.

Retention remains the hero measure of the People Strategy, reflecting its critical importance in maintaining safe, high-quality services. This is supported by engagement, advocacy, motivation, and involvement scores from the National Quarterly Pulse Survey (NQPS).

Retention has continued to sit comfortably within the expected parameters, increasing throughout 2025, reaching 89.4% at the end of 2025. There has been a marked reduction in colleagues leaving within their first year, historically this group represented the largest proportion of leavers. The largest group is now those with two to three years' service.

Nationally and locally, NQPS results are showing signs of decline, however, for SFT performance remains above national benchmarks in all four measures with involvement and motivation showing the most sustained movement, and engagement and advocacy remaining strong. Although performance remains broadly in line with national trends, the gap between SFT and the national average is narrowing, and the Trust is not yet achieving its ambition to sit within the top 10% of organisations nationally.

The upcoming NHS Staff Survey results (Q3) will be a key indicator of colleague experience. The national results will be published in early March 2026, at which point we can complete comparison work. Initial review of the results confirms the response rate fell from 51% in 2024 to 45.6% in 2025 with 7 of the 9 people promise themes deteriorating from 2024.

Improvement in these areas requires sustained, meaningful, and long-term interventions; quick fixes do not deliver lasting impact. Evidence shows that higher colleague engagement is directly linked to lower mortality, reduced sickness absence and fewer patient complaints, making consistent focus on engagement and motivation essential despite the challenging operating environment. Leadership capability is central to this, and continued delivery of leadership development programmes is critical to equipping leaders with the required skills.

The recent internal audit of the Culture Maturity Review provides further assurance. The audit confirms that the Trust has solid cultural foundations, effective strategies and clear governance in place to support a compassionate, inclusive and learning culture. Recommendations focus

	on embedding existing frameworks, rather than identifying new or unexpected concerns, reinforcing confidence that the Trust's current priorities and approach are appropriate. Key priorities remain: • Leadership development across the Compassion, Collaboration and Curiosity frameworks. • Addressing stress and burnout, which continues to present a significant workforce risk (current risk score: 12). • Improving appraisal quality and compliance. Progress remains slow, as reflected in Board and People Committee metrics. A deep dive at the December People Committee agreed targeted actions to strengthen both the completion and quality of appraisals.

SFT Objectives / Programmes

1	**Year 3 People Strategy priority: Learning, Education and Training (LET) Programme aligned to national stat/mandatory training reform**	**On Plan**

A three-year review of Learning, Education and Training (LET) commenced in 2024/25 to establish a clear baseline of current performance following Model Hospital Corporate Benchmarking results that placed SFT in terms of cost in the highest quartile. The review aims to strengthen regulatory compliance, alignment with Trust objectives, learner experience, curriculum quality, governance, financial arrangements and technology readiness.

Year 1 delivery has focused on establishing a robust baseline, with the following progress achieved:

- Visibility of LET expenditure has significantly improved, with a full mapping of education income, its use, and the proportion of budget that is influenceable for savings. A dedicated cost centre has been created, providing clear financial oversight.
- Full costing of mandatory and role-essential training has been completed and shared with service groups. This provides service groups with clarity on the cost of releasing colleagues for training and enables more informed decision-making.
- A pilot within the Proactive Care team is assessing the impact of training on patient outcomes and experience. Early qualitative feedback is positive, and work is underway to secure robust quantitative measures. The learning from this pilot will inform a standardised evaluation framework to be rolled out later in 2026.

Overall, year 1 has established the transparency and baseline needed to target improvements in Years 2 & 3. Strengthened financial oversight and clearer planning across service groups now provide the foundations for the next phase, where reviewing the mapping of mandatory and role-essential training in line with NHSE requirements will directly support the Year 2 aim of reducing cost and releasing time to care.

2	**Year 3 People Strategy priority: Employee Relations improvement programme**	**On Plan**

The Employee Relations (ER) Improvement Programme is designed to shift the Trust toward a more compassionate, proactive, and sustainable approach to people management. Its purpose is to reduce the current over-reliance on formal HR processes by strengthening manager capability, improving early resolution, and enhancing the visibility and understanding of ER activity across the organisation.
Baseline diagnostic work, including leadership confidence surveys, case reviews, and analysis of informal queries, has confirmed high case volumes, significant demand for informal advice, and the need for targeted improvements in disciplinary, sickness and investigation processes. This reflects a predominantly reactive culture that creates delays, inconsistencies and increased risk.

Progress to date includes strong engagement in the Trust's new leadership programmes, development of practical ER support resources (including videos and toolkits), and structured development plans for the HR Advisory team. Early implementation of digital tools, improved team learning structures, and the introduction of a triage model are helping manage current pressures while enabling a gradual shift toward earlier, manager-led resolution.

The next phase will focus on embedding these new resources, strengthening case reporting to improve organisational insight, developing specialist HRA capability, and implementing formal KPIs. These will measure changes in manager confidence, timeliness of investigations, team satisfaction, and reduction of tribunal risk.

Key Risks
If not addressed, this could result in:

- Increased employment tribunals, particularly discrimination-related
- Financial cost associated with tribunal defence and settlements
- Reputational damage
- Higher sickness absence and turnover
- Deterioration in staff survey results
- Leadership time diverted into case management rather than improvement activity

Key Drivers

- Limited manager confidence and capability to address issues early
- Insufficient emphasis on fair, proactive processes and discrimination awareness
- Lack of trained investigators creating delays

Current Controls

- HR Advisory support and formal case management processes
- Policies and procedures in place
- Identified Gaps
- Reactive culture persists
- High caseloads and suspension rates
- Poor colleague experience of ER processes

	• Limited proactive intervention and variable uptake of training While the programme is progressing to plan and is following the seven stages of Quality Improvement, measurable improvement is not yet evident. This reflects the scale of change required and the time needed to embed new behaviours, systems and capabilities.	
3	**Implement new model for people services function**	**On Plan**
	The People Services Transformation Board has been established to provide governance and oversight of the transformation of people services function. This will address the increasing demand on a service which is fragmented, labour intensive and not designed to meet the changing expectations and demographics. The People Services Transformation Board has agreed to scope external partners to work alongside the People Services team act as a strategic partner to enable the alignment of HR best practice, introduce a digital roadmap to improve efficiencies and support culture integration. The People Services function is key in creating compassionate and inclusive cultures, supporting leaders and ensuring a learning culture. Following the mergers, there remains opportunities to rationalise the service and redesign the focus as a core specialist enabling service. To achieve this the service needs to transform through the adoption of digital solutions which are automated or self-service. This will contribute toward reducing cost while improving the delivery of services which are designed around the diverse needs of the organisation. While this was the original plan, our focus has now been redirected by the rollout of the national People Services Target Operating Model (TOM). The national TOM requires us to work closely with the South West region to design and develop a regional TOM, alongside undertaking several foundational activities. These include workforce vendor consolidation, policy and process standardisation, data standardisation and cleansing, reviewing automation opportunities, and supporting the ongoing development of the people profession. This programme of work will underpin and directly support the priorities of the People Transformation Board, which will oversee progress. It will also ensure the organisation is well positioned to realise the benefits of the new EHR and to deliver on the ambitions set out in the digital strategy.	
4	**Implement Inclusive Board governance framework (embed all aspects of EDI into board decision making) and ensure the board has the skills and experience to understand and address the needs of diverse communities**	**On Plan**
	Reducing inequalities requires visible commitment and active engagement from senior decision makers. Evidence shows that when senior leaders set clear expectations, articulate inclusion as an organisational priority, and embed it within strategy, organisations make stronger and more sustained progress.	

In this context, we set out to partner with the Board to strengthen their capability, build shared understanding, and identify practical ways in which senior leaders could actively lead on inclusion.

Achievements and Successes

To support the Board's role in driving inclusion, we developed an Inclusion Governance and Accountability Framework that sets out how senior leaders can influence, steer, and model inclusive practice across four core themes:

1. Vision

Ensuring that inclusion is woven throughout the organisation's identity—our values, priorities, and objectives—and is reflected in how we design, communicate, and measure progress.

2. Leading by Example

Setting the tone for inclusive behaviours, decision making, and everyday leadership, demonstrating what it means to champion equity in practice.

3. Accountability

Holding individuals, teams, and the organisation to account for embedding inclusive practices and modelling inclusive behaviours consistently.

4. Assurance

Seeking evidence that inclusion and equity are designed into our systems, processes, and cultures and that these efforts deliver real impact for colleagues and patients.

The framework was presented and discussed at a Board development day. This resulted in a series of actions to strengthen strategic direction and clarify expectations around inclusive leadership. One major outcome was the creation of a clear, SFT-specific definition of inclusion, authentic to who we are and what we stand for. The Board agreed the following statement:

"At SFT, we believe inclusion is essential.
For our patients, for our colleagues, and for better care.
We listen to every voice, and we work to remove every barrier."

This definition now provides an anchor for future strategy, decision making, and cultural development.

Challenges

Over the past 12 months, the Board has seen significant changes in membership. While this has brought valuable diversity in experience, backgrounds, and perspectives, as well as strong overall support for inclusion, it has also made it difficult to maintain a consistent narrative throughout the year. As new members joined and roles shifted, we experienced periods where momentum and shared understanding needed to be rebuilt, slowing the cohesion and continuity of the inclusion agenda.

Progress Against KPIs

Formal KPIs for this strand of work have not yet been established, meaning there is currently no tangible set of measures to assess progress. However, organisational survey data can be used as a proxy indicator of cultural experience. Recent results show:

	• Little to no movement across most inclusion-related measures • Some declines, particularly within the compassionate culture sub-score While these results do not solely reflect Board-level activity, they highlight the importance of visible, consistent, and collective leadership to guide cultural change.

Risks – Scoring and Appetite

Risk Appetite over Time - Aim

Significant – 20-25				
January 2025	**April 2025**	**July 2025**	**October 2025**	**January 2026**
Above appetite	Above appetite	Within appetite	Within Appetite	Within Appetite

Risks to Aim

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

Risks to Objectives

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

Controls and Assurance

Controls	Assurance
Risk Controls • Objective 1 ○ Refresh Learning Committee with updated terms of reference to include relevant decision makers • Objective 2	**Risk Controls** • Objective 1 • Objective 2

○ Employee relations improvement programme ○ HR Advisory support available ○ Reporting to People Services Transformation Board ○ Decision Making Group (DME) replacing Clinical Officers Advisory Group (COAG) • Objective 3 ○ People Services Transformation Board ○ Productive People Services ○ Engagement with National TOM for People Services ○ Process mapping priority • Objective 4 ○ Workforce Inclusion Improvement Plan ○ Inclusive Board Action Plan	○ Internal audit ○ Self-assessment ○ Corporate benchmarking reported through Model Health System ○ HR case management data ○ Employment tribunal outcomes ○ People Committee Performance Report ○ Board Performance Report • Objective 3 ○ *Partial* – Interim measures are in place, but full mitigation depends on successful approval and implementation of digital investment. • Objective 4 ○ Board Development
Oversight Arrangements for Governance and Engagement • Reports to Exec Committee • Chief of People report to People Committee • People Committee • People Services Governance Committee	**Oversight Arrangements for Governance and Engagement** • Quality Assurance Group Topic Reporting

NHS Somerset NHS Foundation Trust

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

	Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Retention: to retain at least 88.3% of colleagues over a rolling 12-month period.	Green: >=88.3% Red: <83.3%	88.8%	89.0%	89.1%	89.1%	89.4%	89.5%	89.8%	89.8%	89.4%	90%		
National Quarterly Pulse Survey Engagement Score: To be within the top 10% of Trusts for the engagement score. This means achieving a score of 7.1 or higher.	Green: >=7.1 Red: <6.1	6.79			6.68			6.95			6.69		
National Quarterly Pulse Survey Advocacy Score: To be within the top 10% of Trusts for the advocacy score. This means achieving a score of 7.3 or higher.	Green: >=7.3 Red: <6.3	6.77			6.53			6.95			6.63		
Inclusion: % of colleagues in a senior role (Band 8a+ and consultants) who are female. The ambition is to represent the overall Trust position by 2028 with a trajectory for March 2026 of 69.8%.	Trajectory: Green: >=69.8% by March 2026 Red: <64.8% by March 2026	58.10%			58.70%			59%			Reported quarterly		
Learning Education and Training (LET): A reduction in the cost of mandatory and role essential training.	Green: Maintain or reduce spend Red: Increase in spend												
Disciplinary Investigations to take no more than 4 weeks.	Green<4 weeks Red: >6 weeks	New reporting		13	12		9.2	11.5	14.3	5.9			
Appraisal Compliance: To achieve 90% of colleagues with a completed appraisal in a 12-month period.	Green: >90% Red: <80%	77.0%	77.0%	76.4%	77.4%	78.7%	77.7%	79.8%	81.1%	82.4%	81.1%		
Board inclusion (Under development)													
Sickness absence: over rolling 12 months maintain levels within the upper control limit of 5.2%	Green 5.2<5.0 Red >5.2	5.2%	5.2%	5.2%	5.1%	5.2%	5.2%	5.2%	5.1%	5.1%			

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

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

Narrative Overview

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

SFT Objectives / Programmes

1	**Deliver the 2025/26 financial plan and deliver the financial strategy and reduction in recurrent deficit**	**Behind Schedule**
	Cost improvement plans continue to be developed for 2025/26 across the Group. The forecast is now showing that the CIP will be achieved in full but that only 30% is recurrent. The planning for 2026/27 – 2028/29 is underway which will include the underlying position and the CIP for the next 3 years.	
2	**Drive up productivity across all 6 service groups via the productive care programme, including transformation and the deployment of new digital/AI based technologies**	**Behind Schedule**
	Productivity opportunities being identified as part of service group efficiency plans. Following a successful pilot programme AI capability is now available across the Trust Microsoft CoPilot. The trail of ambient voice technology is complete and has shown significant productivity improvements across a number of specialties including adult ADHD, Dental and MSK services. A roll out of voice to text and ambient voice is continuing.	
3	**Estates strategy review to ensure capital funds are prioritised and national funding sources utilised where applicable in the context of the changed operating environment**	**On Plan**
	Core funding prioritised and programme is deliverable within available resources in 2025/26. Additional national funding available to support additional diagnostics, UEC and elective schemes. Business cases have been developed for the diagnostics and mental health Schemes. Approval has been received for the development of a Community Diagnostics Centre in Bridgwater.	

Risks - Scoring and Appetite

Risk Appetite over Time - Aim
Financial Management - Open - 12
Commercial – 15-16

January 2025	April 2025	July 2025	October 2025	January 2026
FinMan – above	FinMan – above	FinMan – above	FinMan – above	FinMan – above
Comm – within	Comm – within	Comm - within	Comm – within	Comm – within

Risks to Aim

		Radar Ref.	Score
1	Failure to identify and deliver sufficient recurrent CIP	**R3058**	**12**
2	Lack of pace of system-wide changes to address deficit		**16**
3	The Trust fails to deliver the elective activity trajectory	**R3060**	**12**

Risks to Objectives

		Radar Ref.	Score
Obj1	CIP Plans not being delivered in full	**R3058**	**12**
	Unplanned cost pressure from operational activities and activity levels not being delivered	**R3059**	**16**
Obj2	Failure to deliver elective activity trajectory	**R3060**	**12**
	Inability to fund new EHR	**R1840**	**20**
Obj3	Insufficient investment to reduce backlog maintenance	**R0003**	**16**
	Failure to secure necessary infrastructure/capital funding	**R1611**	**20**

Controls and Assurance

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

NHS Somerset NHS Foundation Trust

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

	Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial position v plan (YTD)	Green: >=plan Red: <plan	B/E	B/E	B/E	B/E	B/E	B/E	B/E	B/E	B/E	B/E		
% of CIP identified as recurrent	Green: >=70% Red: <40%	8%	12%	17%	23%	31%	29%	32%	32%	31%	30%		
Agency v plan (YTD)	Green: >=plan Red: <plan	£110k adv	£61k adv	£34k adv	£34k adv	£51K fav	£175k fav	£260k fav	£326k fav	£211k fav	£70k fav		
No criteria to reside: % of acute beds	Green: =< 9.8% Red: >15%	25.60%	21.30%	19.80%	21.4%	21.60%	21.2%	21.4%	17.2%				
Performance v workplan trajectory	Trajectory: Green: =<12,505 by March 2026 Red: >12,505	13,076	12,981	12,964				12,966	12,944		12,879		
Capital Expenditure v plan													

NHS Somerset NHS Foundation Trust

Board Assurance Framework 2025/26

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

Narrative Overview

As we move into the final quarter of the year, the digital portfolio has largely delivered its planned programmes of work. The implementation of electronic prescribing has moved into mental health services, we have expanded our use of the electronic prescription service, as well as deployment of copilot and pilot ambient voice technology. We have also piloted interactive care/virtual nursing within our acute inpatient services.

The procurement of the new Electronic Health Record (EHR) solution concluded our preferred supplier and the Full Business Case has been completed, subject to internal, regional and national approval processes. The Digital, Data and Technology strategy has been updated and the delivery plans for the next few years are being finalised, alongside planning for the Healthset (EHR) programme.

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

SFT Objectives / Programmes

1	**Level up digital offer across our services – Digital medicines management and electronic documentation**	**On Plan**
	Digital medicines deployment into mental health services is underway and is due to be complete by March. This completed the roll-out of digital medicines across acute, community and mental health services, proving a single digital medicine record for prescribing and administration across the Trust and sets us in a good position when we move to the EHR. The Electronic Prescription Service (EPS), which is a first of type in the NHS, allows the transfer of prescriptions to community pharmacists directly without the need for separate prescriptions. There are currently 40 services live with EPS across the Trust with plans to expand further. In December, over 4,700 prescriptions were processed via EPS. Ambient voice technology has been piloted in 16 services and will now be deployed at pace across the Trust. While the deployment will be supported by the digital team, services have been asked to take this forward at a local level to champion the adoption and manage the change. A medium-term plan for ambient voice technology will be worked up, pending national funding in 2026/27, to ensure we make best use of the technology ahead of the Healthset Programme.	

	Following the deployment of Epro across our acute sites, the introduction of ambient voice provides an opportunity to move to electronic outpatient documentation in YDH and a reduction in scanned outpatient documentation in MPH.	
2	**Conclude Full Business case for Electronic Health Record and appoint the preferred provider**	**On Plan**
	The procurement of the new Electronic Health Record (EHR) solution concluded with our preferred supplier identified. Contract negotiations are taking place, with the contract expected to be signed in March 2026. Alongside the contract, an Inter-Trust Agreement (ITA) is also being drafted to ensure SFT, as the lead authority on the contract, has the necessary legal agreements in place with the Dorset Trusts. The ITA will be signed alongside the EHR contract. The Full Business Case has been completed and submitted to the regional team. The case will progress through Trust and ICB governance in January, before the national approval board on 28 January and JIC at the beginning of February. The timeline for approval and contract award remains very constrained to ensure the allocated capital funding can be utilised within the financial year.	
3	**Develop our relationships with Medical Schools specifically the Biomedical Research Centre with Exeter University**	**On Plan**
	The Trust's collaboration and partnership with Exeter University Biomedical Research Centre continues. We are exploring the potential to expand undergraduate medical school placements in Somerset with the UoE. We have agreed a Memorandum of Understanding to formalise the collaboration, and we are engaged in direct conversations with the University regarding funding arrangements, student facilities, curriculum and accommodation. There are a number of issues of uncertainty which require resolution, and we are continuing our discussions prior to making a decision on the viability of increased student numbers. In addition, there has been the development of a Research and Innovation sub-committee.	

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Seek 15-16				
January 2025	**April 2025**	**July 2025**	**October 2025**	**January 2026**
Above Appetite	**Above Appetite**	**Above Appetite**	**Above Appetite**	**Above Appetite**

Risks to Aim

		Radar Ref.	Score
1	Electronic Health Record implementation – timeframe with procurement and implementation	**R1840**	**20**
2	Failure to secure/implement necessary digital/data/technology	**R1611**	**20**
3	Unsafe premises and environment/fire compartmentalisation	**R1789**	**20**

Risks to Objectives

		Radar Ref.	Score
Obj1	Imaging systems ↔ TrakCare/NHS Spine interoperability gap	**R2485**	**12**

	Lack of access to records across multiple systems (safety/data quality)	**R2542**	**12**
Obj2	EHR funding shortfall		**20**
	Risk EHR business case is not approved or delays to process	**R1840**	**20**
Obj3			

Controls and Assurance

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

NHS Somerset NHS Foundation Trust

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

	Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Research: active trials / studies open	Green: >=240 Red: <220	228	230	233					225		228		
Quality Improvement: training packages	Trajectory: Green: >=750 annually Red: <700	63	105	167	256	271	313	338	408				
Data Delivery Strategy on track	-	On plan	On plan	On plan	On plan	On plan	Behind plan	Behind plan	Behind plan	Behind plan			
Patient interactions via Patient Hub	Green: >=17,500 per month Red: <15,000	5,609	6,181	5,654	7,352	8.254	7,391	8,268	6,747				
Electronic Health Record on track	-	On plan	On plan	On plan	On plan	On plan	On plan	On plan	On plan	On plan			
WTEs freed up: Robotic Process Automation	Green: >=107 Red: <95	84	70	71	77	76	80	98	82	102			
Number of Services live with Ambient Voice Technology (cumulative)										16			
Number of Users live with Ambient Voice Technology (cumulative)										38			
Number of Services live with EPS (cumulative)		6	6	6	7	10	23	25	37	40			
Number of Prescriptions processed through EPS (per month)		853	998	1138	1205	1323	2948	4045	4059	4712			
Number of Licensed Users live with M365 Copilot (cumulative)					175	198	219	242	242	264			

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Research and Innovation Committee Terms of Reference
SPONSORING EXEC:	Director of Strategy
REPORT BY:	Associate Director of Improvement and Research
PRESENTED BY:	Director of Strategy
DATE:	10 March 2026

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 terms of reference for the proposed committee have been updated following the discussion at the Board away day in February.
Recommendation	The Trust Board is requested to approve the Terms of Reference for the Research and Innovation Committee and its subsequent establishment.

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

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

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

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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – e.g. in Part B]
The draft Terms of Reference were reviewed by the Trust Board Development Session in February 2026; comments have ben incorporated within this final version.

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

Research and Innovation Committee
Terms of Reference

TERMS OF REFERENCE

1. Strategic Statement

1.1 The primary purpose of the Trust Research and Innovation Committee is driving, promoting and supporting research and innovation culture across the Trust and through partnerships and collaborations.

1.2 The Committee is responsible for the development and implementation of the Trust Research and Development strategic plan, fostering a close and meaningful relationship between research, innovation and clinical practice, and ensuring strong governance in line with relevant policies, procedures and guidelines

1.3 Research and Innovation Committee will ensure its activities are linked to the Trust strategic priorities and values.

2. Authority

2.1. Statement of delegated authority from the Board, investigatory powers, and ability to seek external advice.

3. Membership

3.1 Details of the membership of the Committee will comprise:

- Non-Executive Director
- Director of Strategy and Digital Development
- Chief medical Officer
- Chief Nurse and Midwife
- Associate Medical Director for Research
- Associate Director of Improvement and Research
- Head of Research
- Up to 5 lead researchers representing clinical and operational practice including a representative from Symphony Healthcare Services
- Representatives up to 5 representatives from partner organisations including universities and local authorities

4. Attendance

4.1. Where a member is unable to attend, they may nominate a deputy to attend in their place provided this is agreed in advance with the Chair.

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

5. Quorum

5.1. A quorum shall be one-third of members eligible to attend including one Non-Executive Director and One Executive Director

6. Frequency of Meetings

6.1. Standard meeting schedule and provisions for extraordinary meetings.

6.2. A minimum of 4 meetings shall be held each year. An annual schedule of proposed dates shall be prepared in advance. Extraordinary meetings may be called at the request of the Chair.

6.3. The duration of meetings will be no longer than three hours

6.4. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1. Oversee the development and implementation of the Trust's Research and Development objectives and plans and ensure its alignment with the Trust Corporate Strategy, reflecting the Trusts unique position as an integrated provider of healthcare.

7.2. Evaluating annually its own performance and submitting annual reports to the Trust Board

7.3. Ensuring any task-and-finish groups or special interest groups are created as required to address specific research and innovation-related matters.

7.4. Overseeing the development and sustaining strategic partnerships and collaborations related to Research and Development. Specifically focusing on the development of academic roles and research programmes across all health and care settings.

7.5. Develop closer integration with PenArc, Health Innovation South West and Exeter Biomedica Research Centre

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

8. Duties

8.1. Making recommendations to the Trust Board of Directors on research related matters

8.2. Seek assurance that the regulatory requirements related to research and development are being met, including research governance and research ethics. Provide an oversight of research activity and performance.

8.3. Ensuring active consideration of equality, diversity and inclusion in the conduct of the Committee business and the provision of research activities.

8.4. Ensuring that risks arising from research and innovation activities are being managed and escalated appropriately, in line with the Trust's policies and procedures

8.5. The minutes of the meeting shall be formally recorded.

9. Discharge of Duties

9.1. The committee shall produce a quarterly report of its activities and assurance to the Trust Board.

10. Reporting and Accountability

10.1. The committee will report to the board on a quarterly basis

11. Subgroups and Working Groups

11.1. The committee will have the ability to establish working groups to undertake any specific areas of its duties and objectives, it Is anticipated that existing operational and executive groups will have delivery responsibility.

12. Relationships with Other Committees

12.1 The Committee will have links to other Board Subcommittees where there are any cross over of responsibilities and will escalate risks or issues which need the input of another committee.

13. Monitoring of Effectiveness

13.1. The committee will produce an annual workplan and undertake an annual review of effectiveness.

14. Review of Terms of Reference

14.1 These terms of reference will be reviewed on an annual basis, or more frequently in the event of significant political, organisational, or policy changes.

14.2 As part of the review consideration should be given to how the Committee can improve and better integrate practices which support equality, diversity and inclusivity.

Date Issued: March 2026
Review Date: April 2027

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:	10 March 2026

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. Areas in which performance has been sustained or has notably improved include: • performance against the 28 and 62 day cancer measures were above the compliance standards. • the average length of stay in our mental health wards was lower (i.e. better) than the planned level.

	• the percentage of patients waiting under six weeks to be seen by our community mental health services remained high. • the percentage of people waiting under six weeks from referral to be seen by our Talking Therapies service was better than the target level. • the percentage of patients waiting under 18 weeks from referral to be seen by our community services remains better than the target level. • the number of patients waiting 18 weeks or more to be seen by our community dental service remains below (i.e. better than) the target level for the fourth month in a row. • patient satisfaction levels across our Symphony Healthcare practices remain high. National priority areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • improving the percentage of patients waiting no longer than 18 weeks for treatment and for a first appointment • the numbers of patients waiting 52 weeks or more for treatment. • compliance against the A&E delivery standard in respect of patients being admitted, discharged or transferred within four hours and within 12 hours of attendance.
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: JANUARY 2026

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 performance against the headline 62-day cancer standard to 75% by March 2026.
- improving performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026.
- reducing the average length of stay in our adult acute and older persons mental health beds.
- reducing agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems.

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

As at 31 January 2026, the percentage of patients waiting under 18 weeks RTT was 61.8%, down slightly from 62.4% in December 2025. The percentage of patients waiting under 18 weeks for a first outpatient appointment reduced slightly to 70.2% in January 2026 and remained below plan. The number of patients waiting over 52 weeks reduced to 1,195 which represents 2.2% of the waiting list, against a plan level of 1.8% or lower. 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 may not achieve.

Compliance in respect of the A&E and UTC four-hour reporting standard reduced from 70.7% in December 2025 to 67.2% in January 2026 and remained below the current national reporting target of 76%. A range of actions and developments are in progress to improve the position, including trialling the booking of next-day appointments for patients with low acuity conditions (following clinical triage). The MPH Urgent Treatment Centre (UTC) clinical pathway modelling has been completed for architect review. A staffing business case is under way, in conjunction with the clinical design model. Point of care testing is also now live in both Emergency Departments.

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.

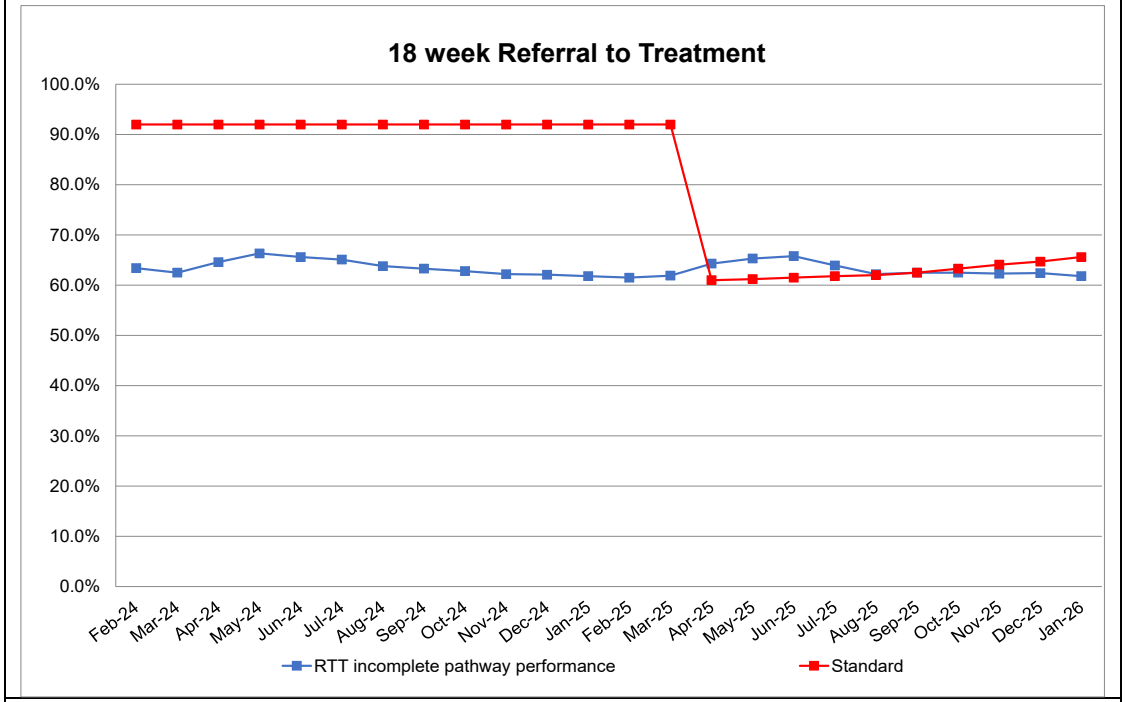
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT decreased to 61.8% in January 2026. The percentage of patients waiting under 18 weeks for a first outpatient appointment decreased to 70.2%.
- Total waiting list size decreased by 638 pathways and was better than trajectory (53,143 actual vs. 54,712 plan). This is mainly due to additional Advice & Refer specialties going live, additional RTT validation efforts and the endocrinology service closure.
- The number of patients waiting over 52 weeks decreased to 1,195 against a plan of 1,003. This represents 2.2% of the waiting list against the plan of 1.8% or less. In part the position is worse than trajectory because the waiting list size is lower (i.e. better) than plan.
- The number of patients waiting over 65 weeks decreased to 11 at the end of January 2026 against a national expectation of zero; two patients had waited over 78 weeks RTT.

Focus of improvement work

- A specialty-level RTT planning model was developed for 2025/26, which took account of productivity and quantified the level of activity needed to deliver 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 also see the Elective Care narrative); we are also developing ways to increase the levels of validation coverage of the waiting list.
- 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 61.5% in December 2025, the latest data available; our performance was 62.4%. National performance decreased by 0.3% between November and December 2025; our performance increased by 0.1%. The number of patients waiting over 52 weeks across the country decreased by 15,975 to 140,508 (1.9% of the national waiting list compared with 2.4% for the Trust). The number of patients waiting over 78 weeks nationally increased by 14 to 1,514

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

Area	Aug	Sep	Oct	Nov	Dec	Jan
18-week trajectory	62.0%	62.5%	63.3%	64.1%	64.7%	65.6%
18-week actual	62.2%	62.5%	62.5%	62.3%	62.4%	61.8%
First OPA 18 weeks trajct.	73.1%	73.7%	74.7%	75.8%	76.3%	77.7%
First OPA 18 weeks actual	68.2%	70.6%	70.3%	70.7%	70.3%	70.2%
52-week trajectory	2.2%	2.2%	2.2%	2.2%	2.0%	1.8%
52-week actual	3.2%	3.0%	2.7%	2.3%	2.4%	2.2%

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.

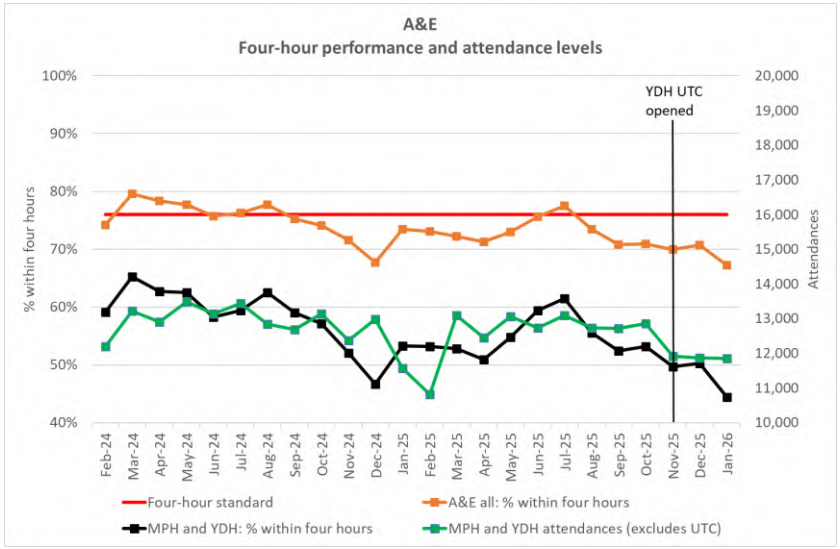
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 44.5% during January 2026, down from 50.3% in December 2025. With Urgent Treatment Centres (UTCs) compliance included at 96.6%, overall compliance was 67.2%, below the 76% national standard.
- Compliance in respect of our two A&E departments was:
    - Musgrove Park Hospital (MPH): 42.3%.
    - Yeovil District Hospital (YDH): 47.9%.
- At YDH the UTC became operational from 11 November 2025. In January 2026, 1,333 patients (92.8%) were seen discharged, admitted or transferred with four hours.
- Performance in January 2026 was particularly affected by high levels of demand and also a deterioration in patient flow due to increasing numbers of patients not meeting the criteria to reside. There were 7,243 ED attendances at MPH in January 2026 (2.5% higher than in January 2024 and 10.1% higher than in January 2025) and 5,934 at YDH (11.6% higher than in January 2024 and 21.3% higher than in January 2025).
- The average number of beds occupied by patients not meeting the criteria to reside rose from 160 in December 2025 (98 at MPH and 62 at YDH) to 195 in January 2026 (127 at MPH and 68 at YDH), the highest number since June 2025.
- Between 1 April and 31 January 2026, 94.7% of patients spent less than 12 hours in the departments, below the 95.3% for the 12 months ending 31 March 2025.

Focus of improvement work

- **Both**
    - Amendments to escalation messages and bed meeting updates in progress to highlight the longest delays (including those not bed-related).
    - Booking and Referral Standards - live by March 2026- go live date for test week first week of March 2026, ahead of schedule.
    - National chat group started to enable sharing of improvement ideas and provision of peer support at managerial level.
- **MPH:**
    - Dedicated paediatrics doctor on lates - visual reminders, such as lanyards have been put in place to identify this clinician.
    - Redirection and deflection SOP completed as a draft, sufficient for the start of test and learn in next two weeks – aim to extend to YDH asap.
    - Two consultants recruited, starting in the Summer of 2026.
    - ED Advanced clinical practitioner (ACP) roles (trainee) recruitment day is completed. Two offers accepted. Awaiting start date.
- **YDH:**
    - tACP interviews to be held in March 2026.
    - Streaming commenced in YDH UTC on 9 February 2026.
    - Frailty Same Day Emergency Care ACP posts started induction programme
    - nPEWS (paediatric early warning score) roll out complete.

Line Chart



How do we compare

In January 2026, the national average performance for Trusts with a major Emergency Department was 57.3%. Our performance was 44.5%. We were ranked 105 out of 121 trusts. With Urgent Treatment Centre attendances included, we were ranked 81 with performance of 67.2%. National average performance was 69.9%.

Recent performance

Area	Aug	Sep	Oct	Nov	Dec	Jan
A&E only	55.5%	52.5%	53.1%	49.7%	50.3%	44.5%
Including UTC	73.5%	70.8%	71.0%	70.0%	70.7%	67.2%

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	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	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	61.5%	61.9%	64.3%	65.3%	65.8%	63.9%	62.2%	62.5%	62.5%	62.3%	62.4%	61.8%	Per the planning trajectory, culminating in 67.3% in March 2026.		
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	73.8%	73.9%	74.7%	75.4%	74.1%	72.3%	68.2%	70.6%	70.3%	70.7%	70.3%	70.2%	Per the planning trajectory, culminating in 80.3% in March 2026.		
NP3		Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	1,2	2.4%	2.1%	2.5%	2.8%	2.8%	3.0%	3.2%	3.0%	2.7%	2.3%	2.4%	2.2%	Per the planning trajectory, culminating in 1.5% in March 2026.		
NP4		Improve performance against the headline 62-day cancer standard to 75% by March 2026	1,2	68.9%	75.2%	70.2%	69.2%	68.1%	68.4%	70.0%	70.4%	69.6%	76.5%	76.4%	Data not yet due	From April 2025 at or above trajectory =Green >=70% Amber <70% =Red		
NP5		Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	1,2	78.6%	75.4%	72.6%	65.2%	73.0%	75.5%	71.3%	71.9%	77.8%	78.5%	79.0%	Data not yet due	From April 2025 at or above trajectory =Green >=77% Amber <77% =Red		
NP6	Improve A&E waiting times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026: **Trust-wide performance**	2	73.0%	72.2%	71.3%	73.0%	75.7%	77.5%	73.5%	70.8%	71.0%	70.0%	70.7%	67.2%	From April 2025 >=76%= Green >=66% - <76% =Amber <66% =Red (the standard will rise to 78% in March 2026, and 82% in March 2027)		
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	95.2%	95.3%	92.9%	93.9%	94.9%	95.5%	95.6%	95.6%	95.2%	95.3%	95.2%	94.7%	From April 2025 >=95.3% = Green <95.3% = Red		
NP8	Improve mental health and learning disability care	Reduce average length of stay in adult acute and older persons mental health beds	2,6	63.1	62.8	61.1	59.1	61.9	68.7	70.5	76.3	74.2	66.3	60.6	67.1	From April 2025 at or below trajectory = Green above trajectory = Red		
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	£26,790K	£28,921K	-40.8% £1,827K	-40.7% £3,489K	-37.0% £5,098K	-35.5% £6,747K	-36.8% £8,247K	-35.8% £9,731K	-38.2% £11,040K	-39.2% £12,341K	-38.6% £13,798K	-38.5% £15,185K	>=30% reduction= Green >=25% - <30% reduction =Amber <25% reduction =Red		
NP10		Close the activity / WTE gap against pre-Covid levels (adjusted for case mix)	6	To be included in the 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.		

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

- Community hospital transformation: Stakeholder Reference Groups are currently in design phase across all five community hospitals with dates for the first meeting at Burnham-on-Sea and Crewkerne community hospital in February 2026. This will assist shaping the plans around a test and learn from April 2026, which includes the expansion of access to services through a temporary reduction in the inpatient bed base.
- Engagement with Somerset Overview and Scrutiny continued with an update provided to the group on 26 February 2026. This conversation went well with the committee supporting an extension of the Phase 1 test and learn to 12M (taking us to September 2026) and support for a 12-month test and learn to commence in Burnham-on-Sea and Crewkerne community hospitals.
- Hospital at Home received 342 referrals in January 2026, the second-highest monthly number since the service began (after October 2025: 365) but below the plan level for the month of 420.

Challenges

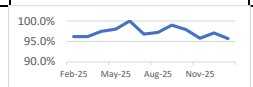
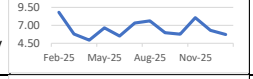
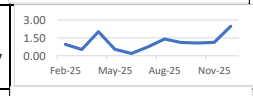
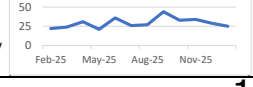
- Hospital at Home: In February 2026 the trajectory increases but the team are unable to meet this plan of 453. Gaps in frailty Advanced Clinical Practitioners (ACPs) and Band 5 nurses has caused some challenge but referrals turned away continue to be minimal and Respiratory teams are stepping in to support despite having very heavy caseloads.
- Community Hospital IP Staffing Fragilities: Vacancies within the ward teams at Burnham-on-Sea and Crewkerne have led to difficulty in keeping all 16 beds open at the two units. HCA shortages have led to periods where transfers in have had to be paused for a period of two - three days periodically.
- The number of closures for Burnham on Sea minor injury unit and Shepton Mallet urgent treatment centre due to 5.0 WTE vacancy at ENP level and short-term sickness is a concern.

Actions to Address Underperformance:

- External recruitment for Hospital at Home continues along with reinvigorated conversations with Surgery and Medicine around whether we can expedite the transfer of IV antibiotic treatment to home under the care of the specialty medical team and microbiology (but making use of Hospital at Home nurses to administer). The team are setting up increased remote monitoring which will ensure that the caseload can be better managed during periods of vacancies as stratifying which patients require a visit each day will be easier. Looking ahead to the pipeline of new starters and training requirements the team will not be fully to capacity in the frailty team until June 2026.
- The nursing leadership team are working with the deputy Chief Nurse Officer to provide more resilience to staffing with block agency booking in Burnham and Crewkerne until beds begin to reduce 1 April 2026 as part of the test and learn. The reduction in staff means that current colleagues are not required to go through an HR consultation which is positive.
- The UTC team have restarted work with Symphony on a collaborative approach to same day urgent care for Burnham-on-Sea to provide more resilient staffing and an agreement for Symphony to recruit to commence in early spring.

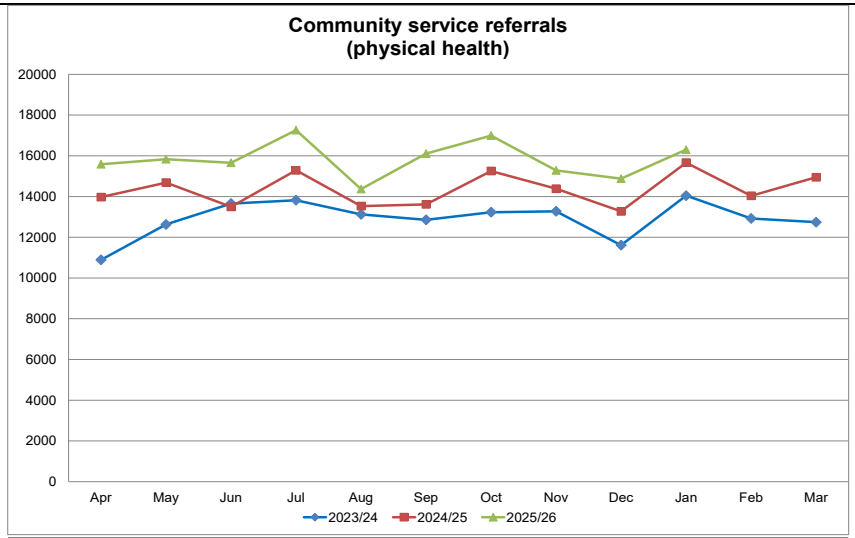
SOMERSET NHS FOUNDATION TRUST

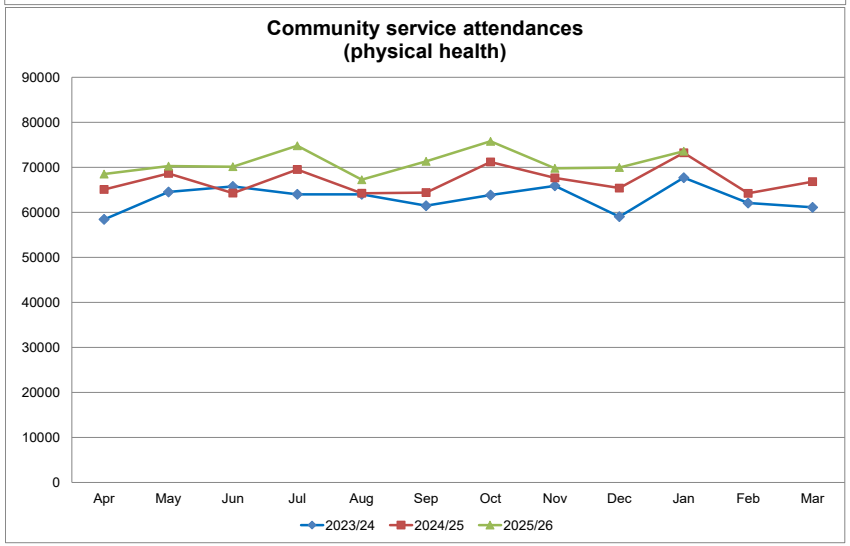
NEIGHBOURHOODS AND COMMUNITY SERVICES

No.	Description		Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
NC1	Mental health referrals offered first appointments within 6 weeks	Older Persons mental health services	ICB	1,2,3	96.2%	96.2%	97.5%	98.0%	100.0%	96.8%	97.2%	99.0%	97.9%	95.8%	97.1%	95.7%	>=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)	Numbers waiting	SFT	1,2,3	576	589	538	536	472	405	473	465	663	760	749	810	From April 2026 =<22% of the total waiting list = Green >22% of the total waiting list = Red		P
NC3		% waiting under 18 weeks	SFT	1,2,3	93.9%	94.0%	94.7%	95.1%	95.6%	96.4%	95.8%	95.7%	94.3%	93.9%	93.9%	95.8%	From April 2026 >78% = Green <78% = Red		P
NC4	Community service waiting times: number of people waiting over 52 weeks from referral to first appointment (excluding dental)		PAF	1,2,3	5	4	2	1	1	0	0	0	0	0	0	0	From April 2025 0 = Green >0 = Red		P
NC5	Community service waiting times: percentage of people waiting over 52 weeks from referral to first appointment (excluding dental)		PAF	1,2,3	0.05%	0.04%	0.02%	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%			P
NC6	Intermediate Care - Patients all ages discharged home from acute hospital beds on pathway 0 or 1		HDS	1,2,3	95.5%	95.0%	95.5%	94.9%	94.9%	94.5%	95.3%	95.3%	93.8%	95.2%	95.0%	92.1%	>=95%= Green >=85% - <95% =Amber <85% =Red		F
NC7	Urgent Community Response: percentage of patients seen within two hours		NHSC	1,2,3	92.7%	90.9%	91.9%	93.0%	92.6%	93.5%	92.0%	92.7%	91.2%	93.9%	91.9%	Data not yet due	>=70%= Green >=60% - <70% =Amber <60% =Red		P
NC8	Hospital at Home - Caseload Size		VWOF	1,2,3	75	82	88	86	82	76	79	86	97	102	101	99	>167 = Green >134 - <167 =Amber <134 =Red		F
NC9	Hospital at Home - Admissions		VWOF	1,2,3	227	237	266	258	242	289	288	308	364	304	313	342	>419 = Green >377 - <419 =Amber <377 =Red		F
NC10	Total number of patient falls - community hospitals		NHSC	2	46	33	27	37	29	39	38	27	27	36	28	27	Monitored using Statistical Process Control rules. Report by exception.		
NC11	Rate of falls per 1,000 occupied bed days - community hospitals		NHSC	2	8.82	5.78	4.94	6.65	5.52	7.32	7.62	5.99	5.78	8.06	6.29	5.73	Monitored using Statistical Process Control rules. Report by exception.		
NC12	Community hospitals - number of pressure ulcers		NHSC	2	5	3	11	4	1	4	7	5	5	5	11	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	0.96	0.53	2.01	0.54	0.19	0.75	1.40	1.11	1.07	1.12	2.47	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC14	District nursing - number of pressure ulcers		NHSC	2	92	63	75	69	56	59	72	66	77	74	65	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	3.15	2.02	2.36	2.11	1.72	1.78	2.32	2.08	2.37	2.32	2.11	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	22	24	31	21	36	26	27	44	33	34	29	25	Monitored using Statistical Process Control rules. Report by exception.		

Operational context

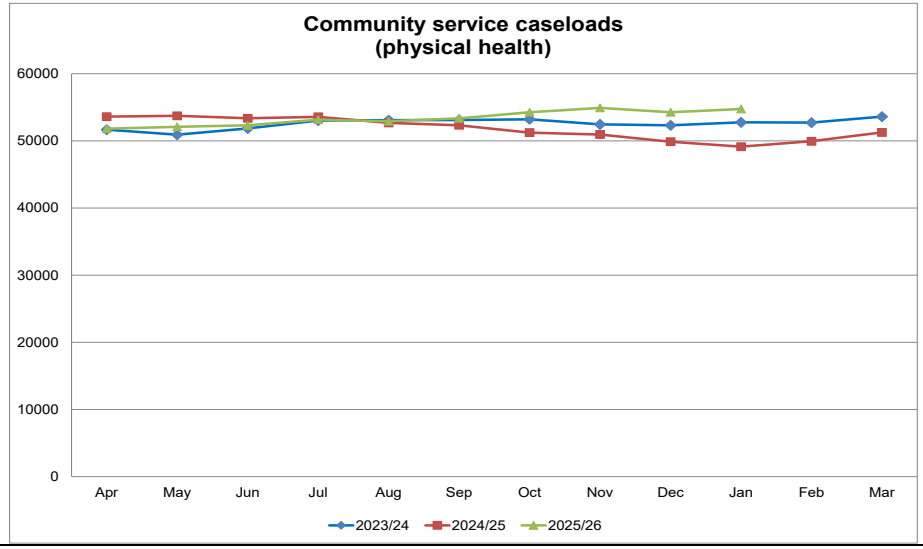
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





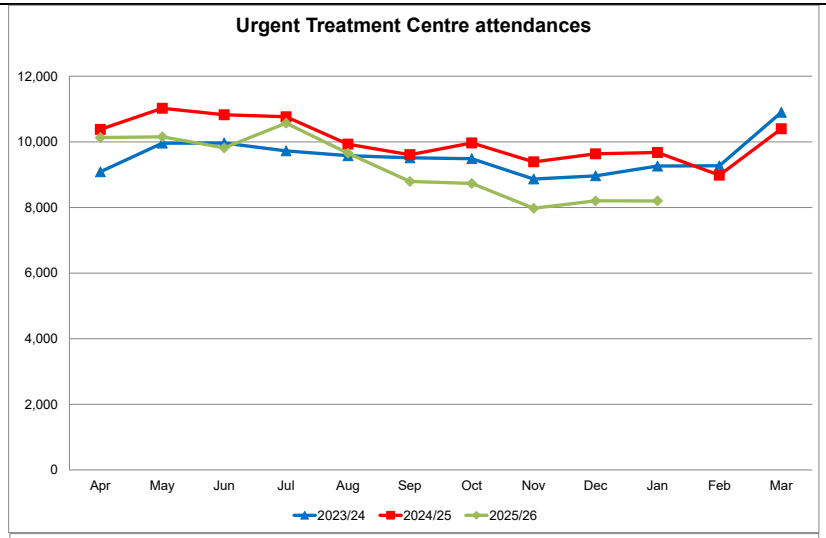
Summary:

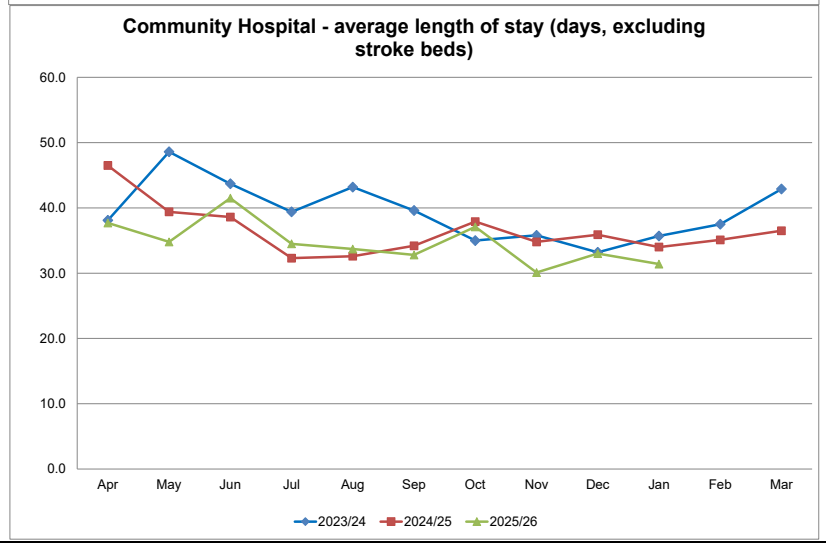
- Direct referrals to our community physical health services between 1 April 2025 and 31 January 2026 were 10.6% higher than the same months of 2024/25 and 22.6% higher than the same months of 2023/24. Services with the highest increases include Rapid Response, Diabetes Integrated Care and District Nursing.
- Attendances for the same reporting period were 5.6% higher the same months of 2024 and 12.1% higher than the same months of 2023.
- Community service caseload levels as at 31 January 2026 were 11.4% higher than as at 31 January 2025, and 3.8% higher than as at 31 January 2024.



Operational context

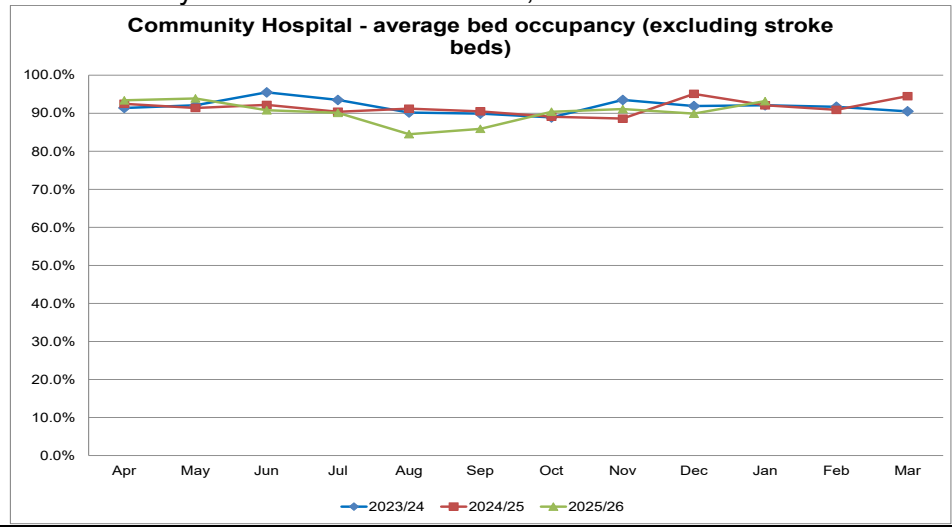
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





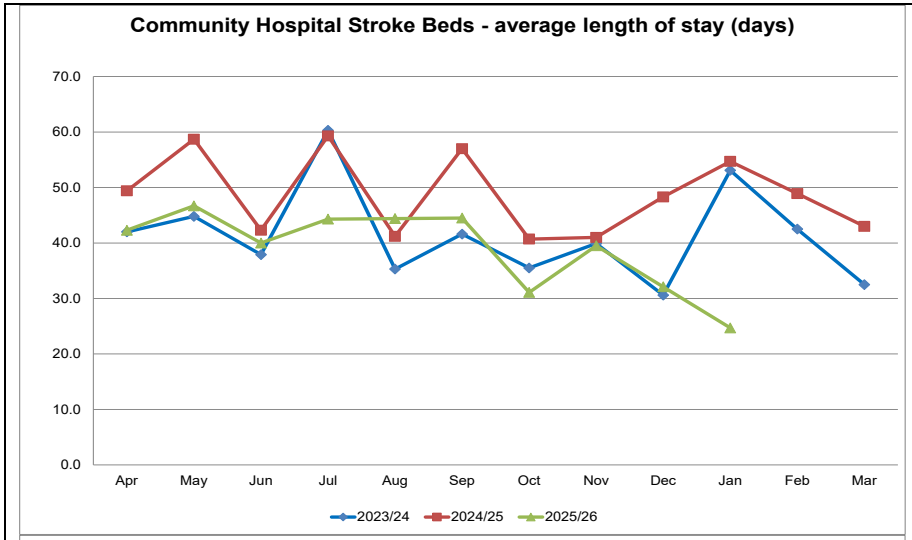
Summary:

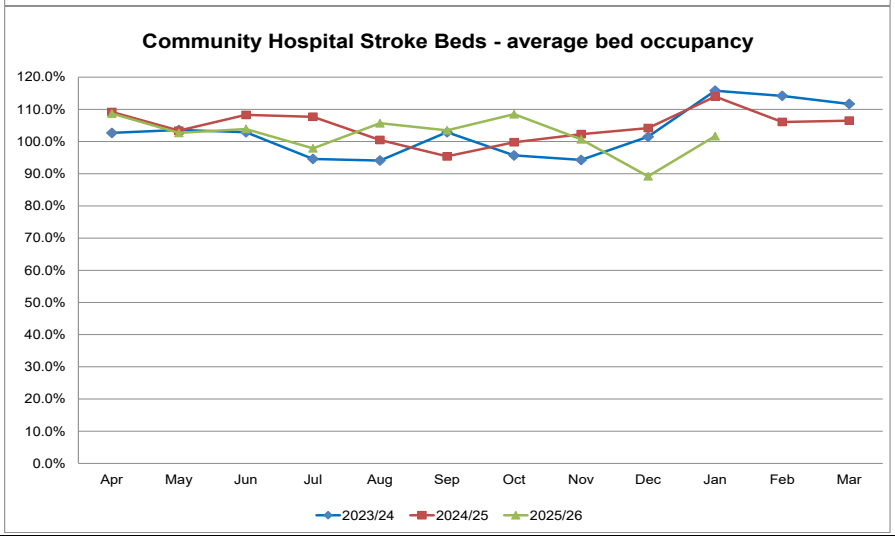
- Between 1 April 2025 and 31 January 2026, the number of Urgent Treatment Centre (UTC) attendances (excluding the YDH UTC) was 8.9% lower than the same months of 2024/25 and 2.3% lower than the same months of 2023/24. During January 2026, 97.3% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%.
- The average length of stay for non-stroke patients in our community hospitals in January 2026 was 31.4 days; a decrease compared to December 2025. During January 2026 one discharged patient 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 31 January 2026 was 35.2 days, compared to 37.2 days for the 12-month period ending 31 January 2025.
- The community hospital bed occupancy rate for non-stroke patients in January 2026 increased to 93.2%, from 89.9% in December 2025.



Operational context

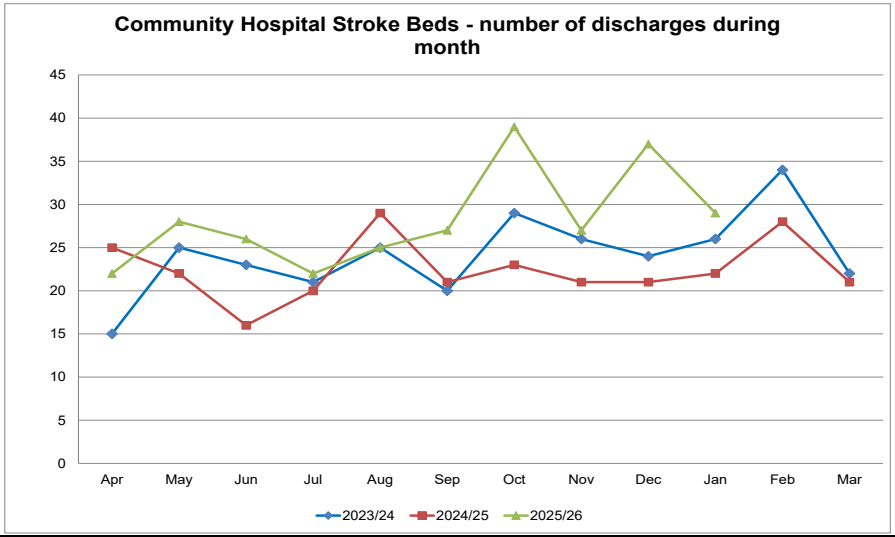
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay for stroke patients in our community hospitals in January 2026 significantly decreased to 24.7 days, from 32.1 days in December 2025. There were no patients discharged with a length of stay of 100 days or more. The rolling 12-month average length of stay in respect of stroke patients for the period ending 31 January 2026 was 39.3 days, compared to 46.9 days for the 12-month period ending 31 January 2025.
- Stroke bed occupancy in January 2026 increased compared to December 2025.
- During January 2026 there were 29 discharges of stroke patients, compared to 37 during December 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**
  The financial budget for 2025/26 and the Cost Improvement Programme are on plan.

What Requires Improvement and Planned Actions

- **Demetia Diagnosis Rates (S1)**
  The rate has reduced slightly. There are two focused improvement areas in place. The first is rural PCN being led by the complex care team being trained to diagnose rather than referring to specialists. Awaiting results on impact on these practices. Within Symphony North training for GPs is planned for April 2026 that will enable GPs with certain parameters make decisions on diagnosis. This is being led by Dr Tiff Earle from the mental health team.
- **Hypertension treatment (S2):**
  These scores are improving as we work towards the March 2026 reporting target. However, the new criteria for 2025/26 are significantly more challenging than in previous years, as they require demonstrable improvements in patient outcomes and active patient engagement. Nationally, this QOF target is consistently reported as being very difficult to achieve.
- **GP Vacancy (S4)**
  The rate has increased to 9%, and recruitment is currently underway. One area particularly affected by resignations is Symphony North, where the merger has brought changes to working expectations. New recruitment should help re-establish clarity around roles and the level of commitment required. Crewkerne has also seen turnover, although in this case it is largely due to an individual relocating abroad and another GP seeking a partnership opportunity, which is an unusual situation.
- **Average time for calls in the queue (S7):**
  High sickness levels and challenges with recruitment and retention continue to have an impact. There is a recovery plan in place.
- **Document Backlog:**

The document backlog is monitored against a recovery trajectory that we are currently ahead of, and weekly reporting to the CQC and ICB remains in place.

Other updates

Symphony South
The plan is to bring together the Symphony South contracts in June 2026. The property issues continue to be worked through.

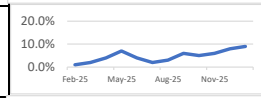
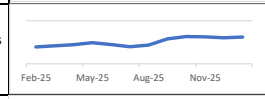
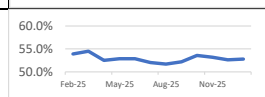
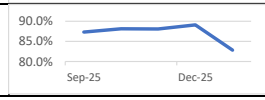
Neighbourhoods
Restructured the governance and additional programme management for SSW PCN. Diabetes pathway workshop with multiple stakeholders to be held in April Great feedback and success from the peri op clinics and liaising with patients to direct contact SFT for specific cancer symptoms.

Impact of Symphony on ED 2025

- Symphony shows a statistically significant **downward** trend in ED and MIU/UTC attendances
- Non symphony shows a statistically significant **upward** trend in ED and MIU/UTC attendances
- The estimated annual difference for 2025 will be 1617 fewer ED attendances

SOMERSET NHS FOUNDATION TRUST

SYMPHONY HEALTHCARE SERVICES

No.	Description	Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
S1	Dementia diagnosis rates for patients aged 65 years plus	OPG	1,3,4	52.3%	51.9%	52.5%	53.1%	54.0%	53.8%	54.1%	54.1%	54.6%	54.2%	54.1%	53.8%	>=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%	70.0%	72.0%	73.5%	73.3%	72.4%	73.1%	72.3%	72.7%	74.4%	75.2%	>=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%	65.0%	65.0%	55.0%	65.0%	61.0%	61.0%	62.3%	63.1%	63.9%	65.0%	>=50%= Green >=40% - <50% =Amber <40% =Red. Target to be achieved by year end		P
S4	GP Vacancy rate	SHS	6	1.0%	2.0%	4.0%	7.0%	4.0%	2.0%	3.0%	6.0%	5.0%	6.0%	8.0%	9.0%	=<5%= Green >5% - <10% =Amber >10% =Red		?
S5	Percentage of total Quality and Outcomes Framework (QOF) points	SHS	1,2,3	93.0%	95.0%	75.0%	75.0%	75.0%	75.3%	76.4%	77.4%	78.9%	81.5%	83.7%	86.8%	Profiled target: 95% by year end		P
S6	Patient satisfaction rate	SHS	2,3	94.3%	92.6%	92.1%	91.8%	89.7%	92.1%	90.4%	91.1%	93.8%	90.8%	92.7%	92.4%	>=85%= Green >=75% - <85% =Amber <75% =Red		P
S7	Average time for calls in the queue	SHS	2,3	04:42	05:01	05:20	05:52	05:23	04:45	05:12	06:58	07:36	07:30	07:15	07:27	=<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	53.9%	54.5%	52.5%	52.9%	52.9%	52.0%	51.7%	52.2%	53.6%	53.2%	52.6%	52.8%	>=50%= Green >=40% - <50% =Amber <40% =Red		P
S9	Seen within two weeks of request (acute team only)	SHS		New reporting		83.6%	86.8%	87.3%	88.1%	88.1%	89.1%	82.8%	87.0%	90.3%	88.6%	>=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, in January 2026, are as follows:

What is going well

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

All community mental health and community learning disabilities services continue to exceed their targets for access to services. 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 88.9% in January 2026, significantly above the 60% national standard. The number of women accessing our specialist community Perinatal mental health service remains better than the planned level. Home Treatment service and Psychiatric Liaison continue to exceed the expected standards for access.

Following review and recalculation of the Length of Stay metric, the service is now meeting the expected reduction for 2025/26.

In Talking Therapies, the service continues to perform well against most metrics. The percentage of people beginning treatment within six weeks of referral for January 2026 increased and was above the 75% reporting standard for the first time since January 2025.

The Service Group leadership have worked with the ICB to agree and submit compliant plans against the national mental health metrics for 2026/27 to 2028/29.

What is going less well

Bed demand and flow have become more challenged in month, with high numbers of patients awaiting social care input, which has been escalated within the Local Authority, with meetings to review and address individual patient needs. This has contributed to the need to use inappropriate Out of Area or Out of Trust admissions, with three at the month end; this is further contributed to by the temporary reduction in acute beds whilst the Rydon environmental improvement works are being completed.

The percentage of patients identified as clinically ready for discharge (CRFD) has increased, with social care challenges being a significant contributory factor. The lack of consistent social care input and capacity are two key challenges within this, but there also appears to be some underreporting of CRFD.

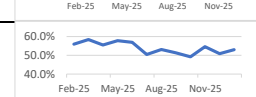
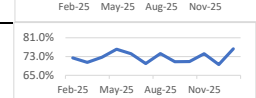
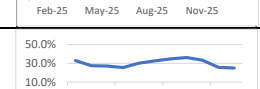
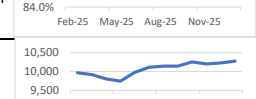
Focus of improvement work

A meeting chaired by the Service Group Director is taking place during the week commencing 2 March 2026, to review ward admission/discharge processes, as well as CRFD to identify areas for improvement which will address these issues, and also have a further positive impact on our length of stay.

Planning continues for the community mental health services transformation project, with engagement events for colleagues planned to take place in April 2026. The aims are to improve multi-disciplinary functioning within the service, streamline processes to improve productivity including clarification of clinical recording processes, and consider the overall model with Open Mental Health.

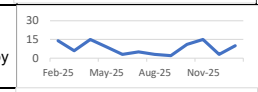
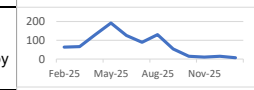
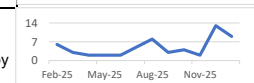
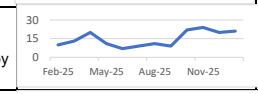
SOMERSET NHS FOUNDATION TRUST

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description		Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
MH1	Mental health referrals offered first appointments within 6 weeks	Adult mental health services	ICB	1,2,3	96.4%	91.0%	94.0%	92.6%	92.1%	97.1%	98.2%	91.9%	92.2%	93.8%	92.0%	90.7%	>=90%= Green >=80% - <90% =Amber <80% =Red		
MH2		Learning disabilities service	ICB		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%	100.0%			
MH3	Percentage of women accessing specialist community Perinatal Mental Health service - 12 month rolling reporting		LTP	1,2	706	713	689	690	657	655	642	658	658	653	668	702	>=640 = Green <640 = Red		
MH4	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		NHSC	1,2,3	93.8%	88.2%	80.0%	75.0%	83.3%	85.7%	100.0%	100.0%	100.0%	75.0%	80.0%	88.9%	>=60%= Green <60% =Red		
MH5	Talking Therapies RTT : percentage of people waiting under 6 weeks		NHSC	1,2,3	73.6%	69.6%	66.0%	58.8%	60.3%	63.6%	64.3%	73.1%	73.7%	73.1%	74.1%	77.7%	>=75%= Green <75% =Red		
MH6	Talking Therapies RTT: percentage of people waiting under 18 weeks		NHSC	1,2,3	98.4%	99.3%	98.7%	98.6%	100.0%	99.3%	99.2%	99.2%	99.3%	99.1%	99.2%	100.0%	>=95%= Green <95% =Red		
MH7	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates		NHSC	1,2,3	55.9%	58.4%	55.5%	57.8%	56.9%	50.4%	53.1%	51.3%	49.2%	54.6%	50.9%	53.0%	>=50%= Green <50% =Red		
MH8	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Improvement		NHSC	1,2,3	72.4%	70.5%	72.7%	76.1%	74.2%	70.0%	74.3%	70.8%	70.9%	74.2%	69.6%	76.3%	>=67%= Green <67% =Red 61% from April 2026		
MH9	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Recovery		NOF, NHSC	1,2,3	51.4%	54.2%	50.9%	56.7%	52.1%	47.4%	49.1%	48.3%	45.6%	50.8%	46.6%	50.2%	>=48%= Green <48% =Red 51% from April 2026		
MH10	Adult mental health inpatients receiving a follow up within 72 hours of discharge		NHSC	1,2	94.6%	97.5%	96.7%	96.2%	94.9%	100.0%	94.3%	100.0%	97.1%	100.0%	97.7%	96.6%	>=80%= Green <80% =Red		
MH11	Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end		LTP	1,2	6	3	2	2	4	3	3	2	1	0	0	3	1= Green >1 = Red		
MH12	Percentage of adult inpatients discharged with a length of stay exceeding 60 days		NOF, PAF	2,3	33.0%	27.5%	27.1%	25.5%	30.2%	32.6%	34.8%	36.2%	33.3%	25.8%	25.0%	30.6%	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	92.8%	90.0%	92.3%	90.8%	91.3%	90.2%	90.1%	91.2%	91.2%	91.0%	90.6%	91.1%	>=90%= Green >=80% - <90% =Amber <80% =Red		
MH15	Number of people accessing community mental health services with serious mental illness - rolling 12 month number.		NOF, PAF	1,2,3,4	9,965	9,916	9,805	9,744	9,977	10,113	10,141	10,143	10,255	10,202	10,227	10,276	No stated target		

SOMERSET NHS FOUNDATION TRUST

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
MH16	Number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission	PAF	2,3	0	0	1	0	1	1	2	1	2	0	0	0	No stated target		
MH17	Percentage of people with suspected autism awaiting contact for over 13 weeks (aged 18 or over)	NOF, PAF	2,3,4	97.0%	98.2%	97.0%	98.7%	98.0%	99.0%	98.2%	97.6%	97.6%	97.1%	97.0%	97.7%	To be confirmed		
MH18	Percentage of adults over the age of 65 with a length of stay beyond 90 days at discharge (Older Person wards only)	NOF, PAF	2,3	36.4%	43.5%	50.0%	52.0%	50.0%	44.0%	34.6%	37.0%	41.4%	39.3%	28.0%	21.4%	To be confirmed		
MH19	Total number of patient falls - mental health inpatient wards	NHSC	2	16	27	13	3	7	11	11	6	17	24	12	16	Monitored using Statistical Process Control rules. Report by exception.		
MH20	Rate of falls per 1,000 occupied bed days	NHSC	2	5.2	7.9	3.9	0.9	2.1	3.2	3.2	1.9	5.1	7.3	3.7	4.5	Monitored using Statistical Process Control rules. Report by exception.		
MH21	Restrictive Interventions - total number of incidents	NOF, NHSC	2	90	119	114	72	155	108	43	70	48	58	25	32	Monitored using Statistical Process Control rules. Report by exception.		
MH22	Restrictive Interventions per 1,000 occupied bed days	NHSC	2	29.2	34.7	34.3	20.9	45.7	31.2	12.3	21.8	14.4	17.6	7.8	9.0	Monitored using Statistical Process Control rules. Report by exception.		
MH23	Number of prone restraints	NHSC	2	14	6	15	9	3	5	3	2	11	15	3	10	Monitored using Statistical Process Control rules. Report by exception.		
MH24	Prone restraints per 1,000 occupied bed days	NHSC	2	4.5	1.7	4.5	2.6	0.9	1.4	0.9	0.6	3.3	4.5	0.9	2.8	Monitored using Statistical Process Control rules. Report by exception.		
MH25	Total number of medication incidents in a mental health setting	NHSC	2	11	5	11	13	19	16	21	15	3	8	9	11	Monitored using Statistical Process Control rules. Report by exception.		
MH26	Ligatures: Total number of incidents	NHSC	2	64	66	130	192	126	89	130	54	15	10	15	7	Monitored using Statistical Process Control rules. Report by exception.		
MH27	Number of ligature point incidents	NHSC	2	0	1	0	0	1	1	0	0	0	0	0	0	Monitored using Statistical Process Control rules. Report by exception.		
MH28	Violence and Aggression: Number of incidents patient on patient (inpatients only)	NHSC	2	6	3	2	2	2	5	8	3	4	2	13	9	Monitored using Statistical Process Control rules. Report by exception.		
MH29	Violence and Aggression: Number of incidents patient on staff	NHSC	2	25	12	23	19	29	31	66	57	32	48	36	31	Monitored using Statistical Process Control rules. Report by exception.		
MH30	Number of Type 1 -Traditional Seclusion	NHSC	2	10	13	20	11	7	9	11	9	22	24	20	21	Monitored using Statistical Process Control rules. Report by exception.		

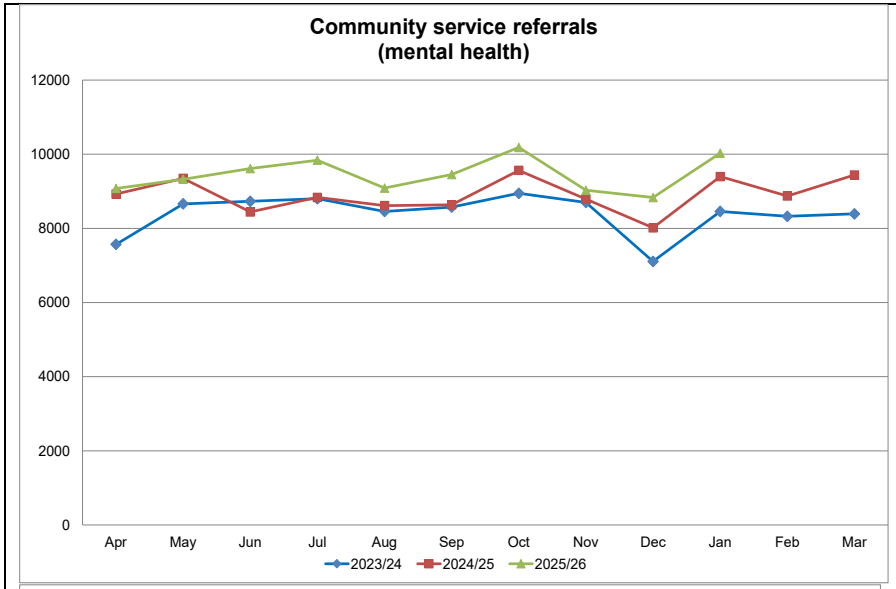
SOMERSET NHS FOUNDATION TRUST

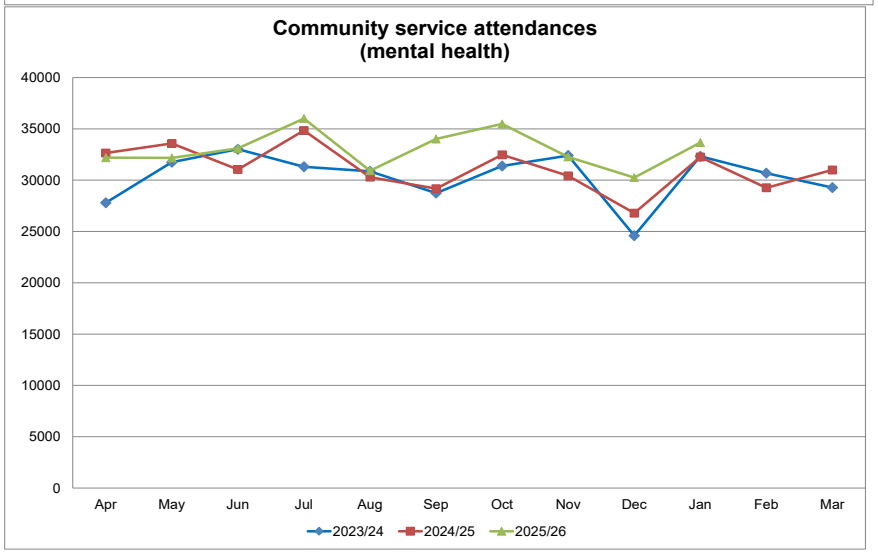
MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
MH31	Number of Type 2 -Short term Segregation	NHSC	2	0	2	1	0	1	0	0	1	0	1	2	7	Monitored using Statistical Process Control rules. Report by exception.		

Operational context

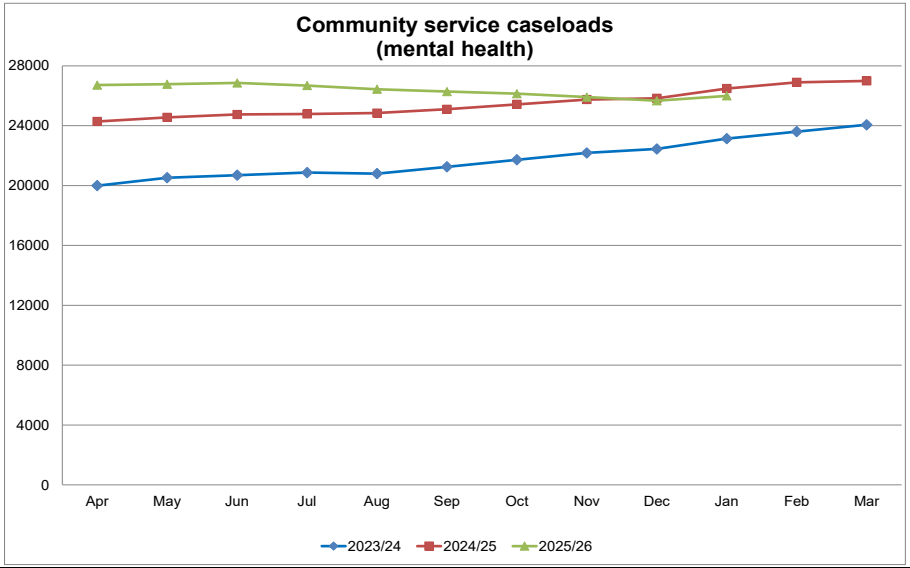
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





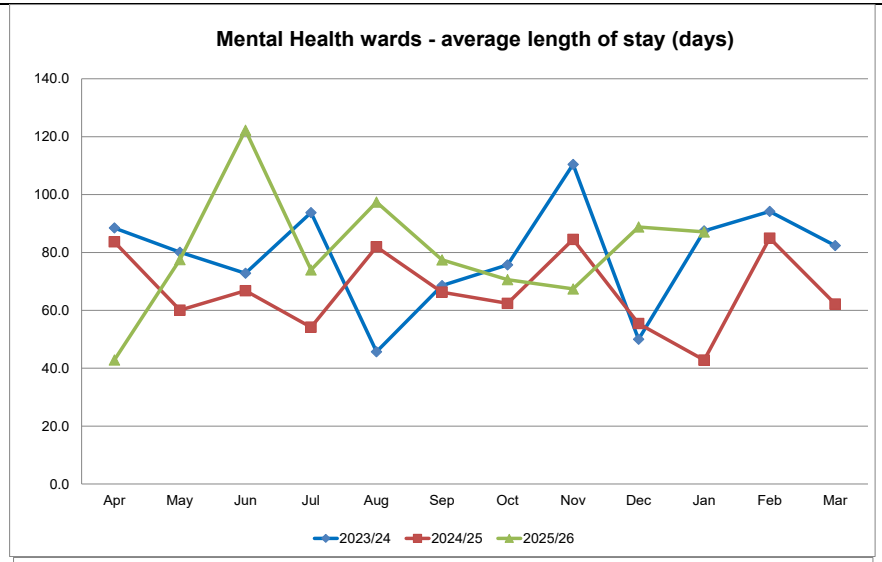
Summary:

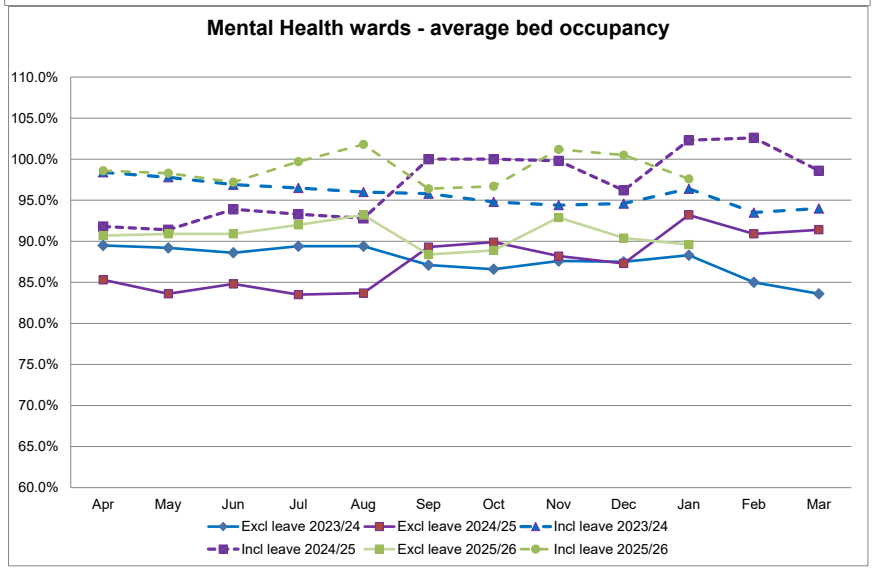
- Direct referrals to our community mental health services between 1 April 2025 and 31 January 2026 were 6.7% higher than the same months of 2024/25 and 12.5% higher than the same months of 2023/24.
- Attendances for the same reporting period were 5.3% higher than the same months of 2024/25 and 8.5% higher than the same months of 2023/24. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services.
- Community mental health service caseloads as at 31 January 2026 were 1.9% lower than as at 31 January 2025 but were 12.3% higher than as at 31 January 2024. It should be noted that investment has facilitated the expansion of some community mental health services.



Assurance and Leading Indicators

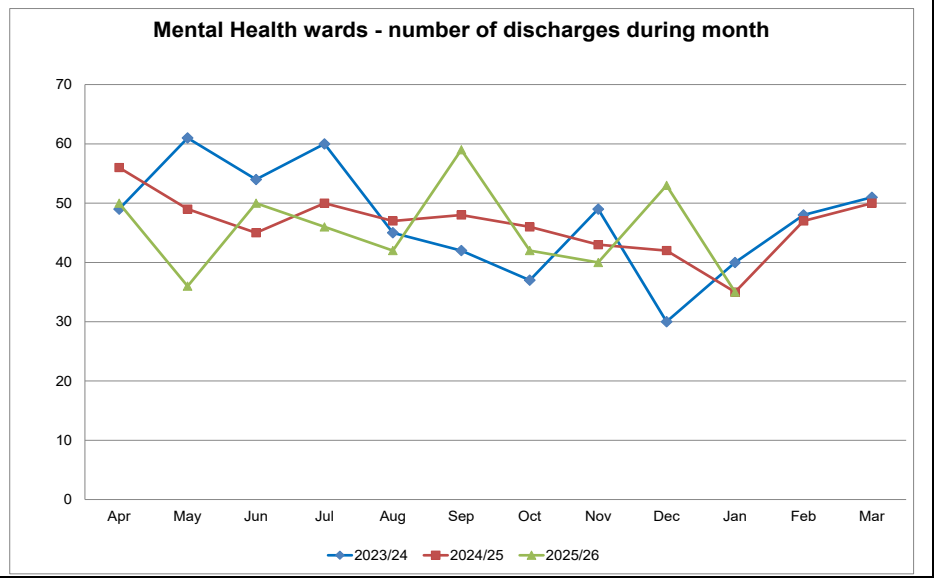
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay across all of our mental health wards in January 2026 was 87.1 days, down from 88.8 days in December 2025. During January 2026, nine 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 523 days. The rolling 12-month average length of stay for the period ending 31 January 2026 was 79.2 days, compared to 70.4 days for the 12-month period ending 31 December 2025.
- The mental health bed occupancy rates excluding leave and including leave both decreased compared to December 2025.
- A total of 35 patients were discharged in January 2026, down from 53 discharged in December 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 January 2026, performance for the handover within 30 minutes of patient arrivals by ambulance at MPH and YDH deteriorated at both acute sites, by 3.6% at MPH to 75.8% and by 2.9% at YDH to 64.0%.

January across both acute front doors saw exceptional increases in attendance with growth in January 2026 at MPH of 10.1% compared to the prior year, and a 21.3% growth at YDH compared to January 2025.

Average ambulance handover times in January 2026 were 19.7 minutes at MPH and 28.3 minutes at YDH. Somerset continues to see a higher level than the south west regional average of ambulance handover conveyances, by around 3.5%.

Focus of improvement work:

- The Trust continues to work with colleagues from SWAST to support a reduction to the regional average on Hear & Treat rates and See & Treat demand conveyed to hospital, in addition to supporting the ICB improve 'call before conveyance' rates.
- The YDH Urgent Treatment Centre (UTC) opened officially in November 2025; Average daily attendances increased during January 2026 compared to December 2025. There is work under way to support ENP colleagues and GPs to review the scope and upskill colleagues.
- As a result of increased demand, additional escalation beds were in use across both acute sites during January 2026.

No criteria to reside (NCTR) - During January 2026, the percentage of occupied bed days lost due to patients not meeting the criteria to reside Increased at both acute sites, to 21.9% at MPH and 20.4% at YDH. This remains significantly above the system plan ambition for NCTR.

The average Length of Stay at MPH increased, from 6.1 days to 6.5 days but decreased at YDH to 9.2 days.

Both indicators are having a significant impact on bed occupancy which in January 2026 reached 98.1%, the highest level reported during 2025/26. Coupled with the significant increase in front door ED demand, it has resulted in a challenged service.

Despite the challenges, SFT continues to perform well in discharging over 85% of our patients on a Pathway 0; for January 2026, this was 84.9% at MPH and 84.3% at YDH.

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 through the GIRFT work programme.

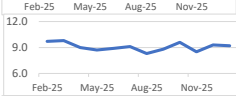
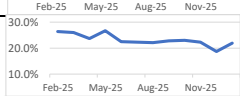
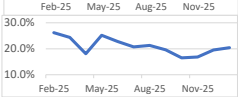
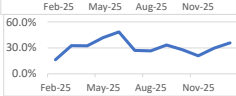
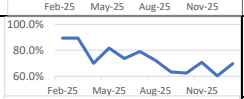
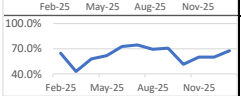
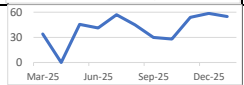
A focus on our capacity-related delays across pathways 1, 2 and 3, working with system partners to understand the reduction in flow. Discharges to Pathway 1 remain the most challenged against the 10% target, with attainment in January 2026 of 9.3% at MPH and 7.6% at YDH, reflective of challenges in capacity.

Stroke
Patients admitted to a stroke ward within four hours declined at MPH during January 2026, indicative of high operational pressures, with performance at 53.1% and improved at YDH with performance at 35.7%. The level of therapy minutes provided to stroke inpatients was 55 minutes at MPH, but only 34 minutes at YDH compared to a target of 42 minutes.

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 Sentinel Stroke National Audit Programme (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.

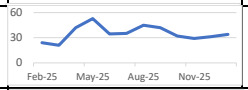
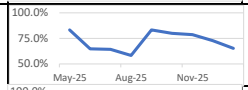
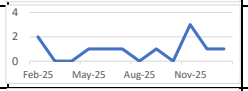
SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
UEC1	Ambulance handovers waiting less than 30 minutes	MPH	NHSC	2	62.4%	71.8%	64.6%	65.7%	79.6%	91.4%	88.2%	84.6%	83.2%	87.1%	79.4%	75.8%	>=95%= Green >=85% - <95% =Amber <85% =Red		
UEC2		YDH			57.1%	62.3%	51.0%	62.2%	65.4%	66.9%	68.7%	67.6%	67.9%	72.3%	66.9%	64.0%			
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	7.7	6.9	6.9	7.0	6.7	6.3	6.6	6.6	6.6	6.8	6.1	6.5	Monitored using Statistical Process Control rules. Report by exception.		
UEC4		YDH			9.7	9.8	9.0	8.7	8.9	9.1	8.3	8.8	9.6	8.5	9.3	9.2			
UEC5	Patients not meeting the criteria to reside: percentage of occupied bed days lost	MPH	SFT	2,6	26.4%	26.0%	23.7%	26.7%	22.5%	22.3%	22.1%	22.8%	23.0%	22.3%	18.7%	21.9%	<=9.8%= Green >15% =Red		
UEC6		YDH			26.2%	24.4%	18.1%	25.2%	22.8%	20.7%	21.3%	19.6%	16.5%	16.8%	19.5%	20.4%			
UEC7	Percentage of Stroke Patients directly admitted to a stroke ward within four hours	MPH	NSG	1,2,4	53.3%	72.7%	75.0%	62.3%	72.2%	70.8%	45.3%	53.3%	69.6%	60.7%	63.2%	53.1%	>=90%= Green >=75% - <90% =Amber <75% =Red		
UEC8		YDH			16.3%	32.5%	32.4%	41.9%	48.4%	27.0%	26.5%	33.3%	27.8%	20.8%	29.7%	35.7%			
UEC9	Percentage of patients spending >90% of time in stroke unit - acute services	MPH	NSG	1,2,4	89.4%	89.4%	70.0%	81.7%	73.6%	79.1%	72.3%	63.3%	62.5%	70.7%	60.3%	69.8%	>=80%= Green >=70% - <80% =Amber <70% =Red		
UEC10		YDH			76.2%	63.6%	67.5%	57.8%	63.8%	42.5%	62.5%	74.4%	61.0%	52.4%	52.9%	48.6%			
UEC11	Percentage of patients scanned within 20 minutes of clock start	MPH	NSG	1,2,4	50.0%	47.8%	70.0%	37.1%	52.7%	46.3%	46.2%	46.0%	44.7%	5.4%	60.9%	60.0%	>=32%= Green >=27% - <32% =Amber <27% =Red		
UEC12		YDH			17.6%	16.7%	21.1%	14.5%	33.3%	51.1%	19.4%	24.4%	21.6%	24.0%	17.8%	5.9%			
UEC13	Percentage of patients assessed by a Stroke Specialist Consultant within 14 hours of clock start	MPH	NSG	1,2,4	50.0%	39.1%	50.0%	48.4%	49.1%	50.7%	35.4%	46.0%	53.2%	62.1%	56.5%	62.0%	>=70%= Green >=60% - <70% =Amber <60% =Red		
UEC14		YDH			64.7%	42.9%	57.9%	61.8%	72.7%	74.5%	69.4%	70.7%	51.4%	60.0%	60.0%	67.6%			
UEC15	Stroke: Median number of minutes of total therapy received per inpatient day	MPH	NSG	1,2,4	No Data	34	No Data	46	41	57	45	30	28	54	59	55	>=42= Green >=32 - <42 =Amber <32 =Red		

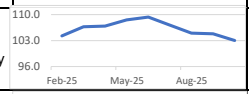
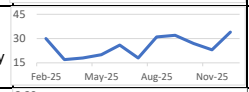
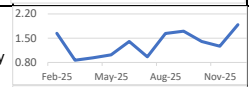
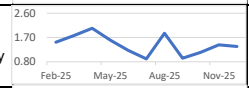
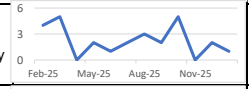
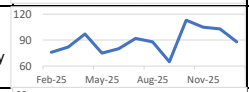
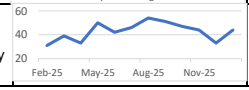
SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
UEC16	Stroke: Median number of minutes of total therapy received per inpatient day	YDH	NSG	1,2,4	24	21	42	53	35	35	45	42	32	29	31	34	>=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%	80.0%	78.6%	72.7%	65.2%	>=90%= Green >=80% - <90% =Amber <80% =Red		
UEC18	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	NHSC	1,2,4	84.2%	82.9%	96.9%	84.8%	90.0%	90.6%	92.0%	88.9%	100.0%	97.1%	Data awaited	Data not yet due			
UEC19	Percentage of emergency patients screened for sepsis - Emergency Departments				100.0%	88.9%	88.2%	90.0%	100.0%	100.0%	100.0%	66.7%	52.5%	69.7%	66.7%	79.3%			
UEC20	Percentage of patients admitted as an emergency within 30 days of discharge		NOF, PAF	2,3	8.3%	9.0%	8.8%	9.0%	9.0%	8.7%	9.6%	8.7%	7.3%	8.3%	9.1%	8.6%	To be confirmed.		
UEC21	Average number of days between planned and actual discharge date		NOF, PAF	2,3	2.8	3.1	3.1	2.7	2.6	2.6	2.5	2.3	2.4	2.2	1.7	1.3	To be confirmed.		
UEC22	Monthly number of inpatients to suffer a new hip fracture		PAF	2	2	0	0	1	1	1	0	1	0	3	1	1	To be confirmed.		
UEC23	Number of mental health patients spending under 12 hours in A&E		PAF	2,3	91.2%	90.7%	86.0%	89.9%	90.3%	90.3%	90.9%	90.7%	90.1%	90.9%	91.3%	91.0%	From April 2025 >=91.4% = Green <91.4% = Red		
UEC24	Percentage of over 65s attending emergency departments to be admitted		PAF	2,3	46.6%	45.9%	45.4%	45.1%	45.7%	44.2%	44.2%	44.3%	42.5%	45.1%	46.6%	44.7%	To be confirmed.		
UEC25	Percentage of under 18s attending emergency departments to be admitted		PAF	2,3	14.7%	13.5%	12.9%	11.3%	12.2%	12.2%	14.1%	13.9%	13.7%	16.5%	16.0%	15.5%	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	18	3	1	2	3	1	2	4	9	1	3	5	Monitored using Statistical Process Control rules. Report by exception.		
UEC28		YDH	NHSC	2	13	12	14	13	15	18	11	9	9	9	9	10	Monitored using Statistical Process Control rules. Report by exception.		
UEC29	Number of patients transferred between acute wards after 10pm	MPH	NHSC	2	117	99	85	96	75	83	82	103	61	67	78	143	Monitored using Statistical Process Control rules. Report by exception.		
UEC30		YDH	NHSC	2	92	149	126	85	98	109	133	92	137	104	175	138	Monitored using Statistical Process Control rules. Report by exception.		

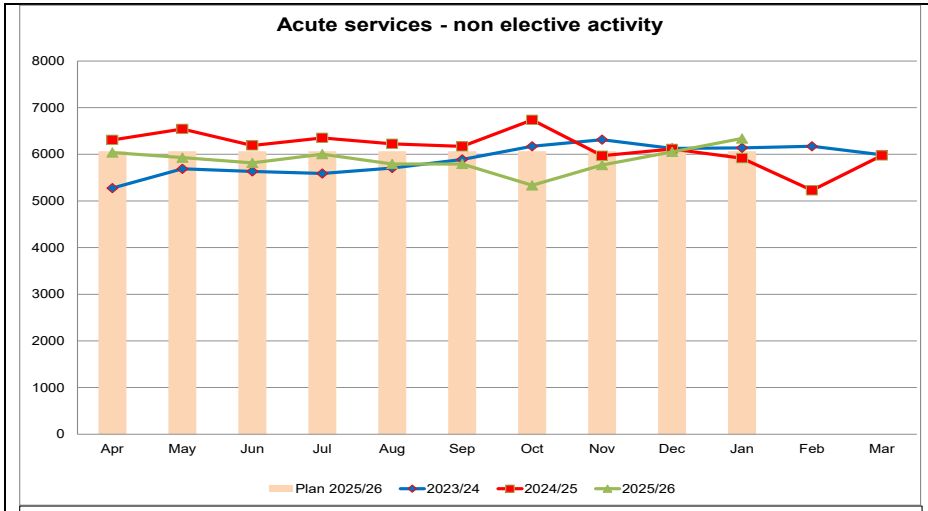
SOMERSET NHS FOUNDATION TRUST

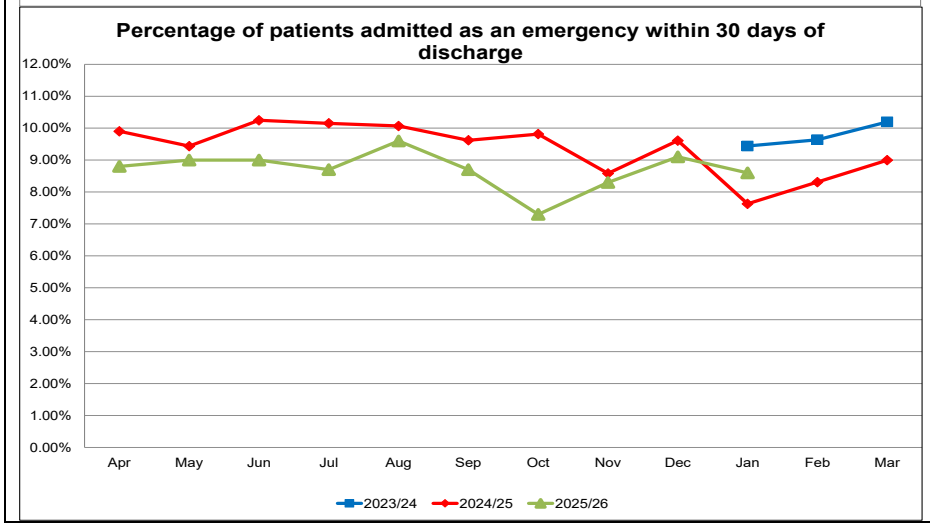
URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
UEC31	Summary Hospital-level Mortality Indicator (SHMI)		NOF, NHSC	2	104.3	106.7	106.9	108.6	109.3	107.2	105.0	104.8	103.0	Data not yet due - November 2025 to be reported after January 2026			Monitored using Statistical Process Control rules. Report by exception.		
UEC32	Total number of patient falls - acute services		NHSC	2	174	138	169	156	133	152	168	163	165	121	160	185	Monitored using Statistical Process Control rules. Report by exception.		
UEC33	Rate of falls per 1,000 occupied bed days - acute services		NHSC	2	6.05	4.46	5.62	5.20	4.70	5.32	5.86	5.72	5.56	4.29	5.66	6.05	Monitored using Statistical Process Control rules. Report by exception.		
UEC34	Number of pressure ulcers	MPH	NOF, NHSC	2	30	17	18	20	26	18	31	32	27	23	34	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	1.64	0.87	0.93	1.02	1.40	0.96	1.63	1.70	1.40	1.27	1.89	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC36	Number of pressure ulcers	YDH	NOF, NHSC	2	16	20	22	17	12	9	18	9	12	14	14	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	1.53	1.77	2.04	1.61	1.22	0.91	1.86	0.93	1.15	1.43	1.37	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC38	No. ward-based cardiac arrests - acute wards	MPH	NHSC	2	6	3	4	2	1	1	3	3	6	2	4	5	Monitored using Statistical Process Control rules. Report by exception.		
UEC39	No. ward-based cardiac arrests - acute wards	YDH	NHSC	2	4	5	0	2	1	2	3	2	5	0	2	1	Monitored using Statistical Process Control rules. Report by exception.		
UEC40	Total number of medication incidents	MPH	NHSC	2	76	82	97	75	80	92	88	65	113	105	103	88	Monitored using Statistical Process Control rules. Report by exception.		
UEC41	Total number of medication incidents	YDH	NHSC	2	31	39	33	50	42	46	54	51	47	44	33	44	Monitored using Statistical Process Control rules. Report by exception.		

Operational context

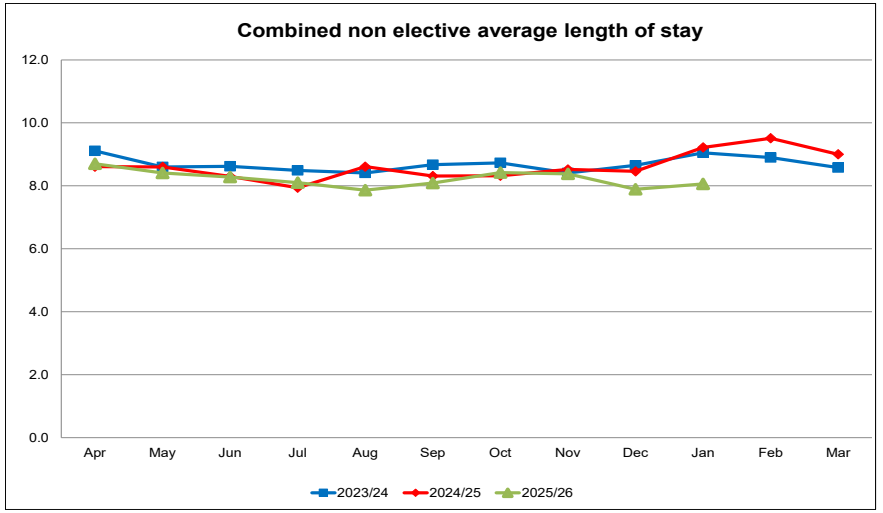
Acute services: This section of the report provides a summary of the levels of non-elective activity, emergency readmissions within 30 days, and non-elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- Between 1 April 2025 and 31 January 2026, non-elective admissions decreased by 5.8% compared to the same months of 2024/25 but increased by 0.6% compared to the same months of 2023/24. Activity for 1 April 2025 to 31 January 2026 was 3.0% below the planned level.
- Between 1 April 2025 and 31 January 2026, emergency readmissions totalled 11,337, 10.6% lower than the same period in 2024, when there were 12,675 readmissions.
- The trust-wide monthly non-elective average length of stay increased in January 2026 to 8.1 days, from 7.9 days in December 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 73.0% at the end of January 2026, compared with 72.5% at the end of December 2025. The number of patients waiting over six weeks for a diagnostic test increased in the period, from 3,181 to 3,244. The total waiting list size is significantly better than plan (12,020 versus a plan of 12,798). However, the number of over six-week waiters is worse than plan at 3,244 against a plan of 1,880. Performance deteriorated between the end of December 2025 and January 2026 positions, mainly due to an echo insourcing capacity shortfall and a general reduction in capacity due to the Christmas/bank holiday period, and patient choice to delay tests.

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

	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Trajectory (%)	93.8	95.0	76.0	75.7	77.4	78.2	79.2	81.0	83.0	85.1	83.0	85.3
Actual (%)	77.4	77.6	75.7	74.5	78.7	79.6	78.4	79.7	81.3	77.7	72.5	73.0
Total w/l	13622	13914	13914	13396	13426	12005	11057	11127	11385	11610	11554	12020

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 the newly-implemented scheduling system which has 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 in the past three months to increase capacity in these services:

- Opening of the Yeovil Community Diagnostic Centre – CT, including CT colon, MRI, ultrasound, endoscopy, audiology and echo.
- Six mid-county border GP practices have been asked to refer endoscopy patients to Yeovil, to make use of new Yeovil Community Diagnostic Centre capacity.

- A locum has commenced in post, supporting the DEXA service.
- Recruitment to endoscopy nursing vacancy gaps.
- Mutual aid has been explored for cardiac CT scans (this received a mixed response from patients, so proved not be a viable option).
- Piloting drugless cardiac CT protocol adoption (supported by University Hospitals Plymouth).

Additional actions being taken in the coming months include:

- Completion of the Bridgwater Diagnostic Centre (June 2026).
- Review of the echo insourcing contract, given the current delivery gap.
- Ongoing but reduced use of agency nurses to cover gaps in endoscopy because most appointed nurses are now post.
- Replacement of Bridgwater endoscopy scope washers being scheduled in (was planned for February/March 2026 but will be delayed, to support recovery).
- Additional DEXA locum being sought.
- Apprentice and trainee radiographer for the DEXA service in progress.
- Digital patient enabled booking solution is being progressed, to improve utilisation of radiology sessions and improve patient experience.

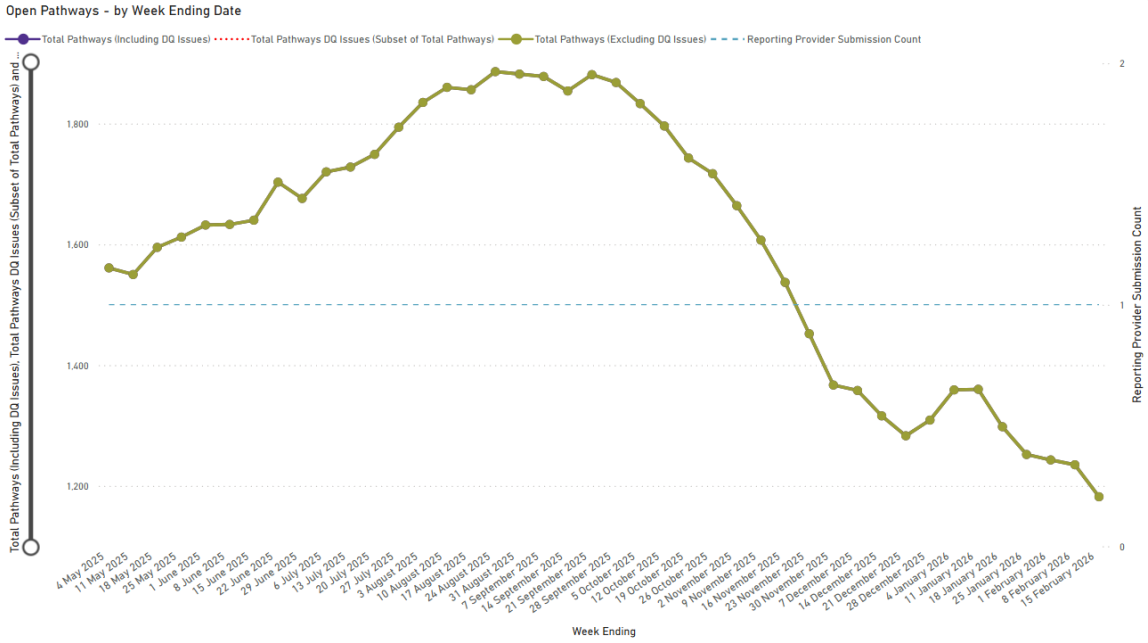
Table 2. The number of patients waiting over six weeks by diagnostic modality

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
MRI	691	499	461	335	260	148	130	96	136	88	105	143	262
CT	971	837	590	439	367	343	335	293	278	252	212	239	167
Ultrasound	583	251	429	849	1177	988	473	191	141	61	91	70	91
Barium Enema	44	44	71	71	61	30	23	21	21	12	19	10	4
DEXA	180	143	154	105	116	126	193	243	309	337	355	387	360
Audiology	157	148	167	176	90	92	163	111	120	79	117	239	161
Echo	750	606	570	526	327	254	256	328	142	130	296	564	757
Neurophysiology	51	24	19	25	41	46	25	28	62	26	35	50	33
Sleep studies	174	165	159	124	175	130	86	53	14	8	20	6	22
Urodynamics	53	43	66	38	48	35	36	24	26	30	25	58	65
Colonoscopy	118	105	179	304	302	258	326	447	442	465	520	618	628
Flexi sigmoid.	56	44	77	104	103	109	139	215	222	224	225	247	263
Cystoscopy	38	36	40	44	21	16	30	16	19	19	27	27	22
Gastroscopy	149	129	175	248	327	280	231	324	332	398	538	523	409

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

- 18-weeks RTT (plan 65.6%; actual 61.8%).
- First OPA within 18 weeks (plan 77.7%; actual 70.2%).
- 52-week waits (plan 1.8%; actual 2.2%) – forecast to be circa 1.0% by end of January 2026, with further investment from regional monies.
- 65-week waits (18 against a national requirement of zero) – the forecast for February 2026 is 18, and getting as close to zero as possible in March.

Graphs 1 - 52-week waiters as of 15 February 2026



The percentage of patients on an RTT pathway for a first outpatient appointment, waiting under 18 weeks, remained below plan in January 2026. 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, largely because of Advice & Refer implementation. We have also 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. In addition, there is 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 of patients waiting over 52 weeks decreased at the end of January 2026, as did the number of 65-week waiters. The main specialties making-up the current 52-week waiters are: Trauma & Orthopaedics, Urology, Upper GI, ENT and Gynaecology, making-up

76% of all current over 52-week waiters. There continue to be specialties which do not currently have significant volumes of 52-week waiters, 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. The Endocrinology (Weight Management Service) service 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. In agreement with the ICB, the service has temporarily closed to new referrals, and additional capacity has been established to help clear the backlog. The Pain Management service 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. Group clinics have been established which have mitigated the anticipated rise in 52-week waiters this quarter. Overall, the Trust's 52-week wait position has improved in the last four months, mainly due to additional capacity coming on line including more insourcing (T&O), the return of two urologists from maternity leave and the appointment of a further two, outsourcing of T&O patients to the Independent Sector, and increased scrutiny as part of waiting list management, on patients due to breach 52 weeks in the coming month. We have recently bid for funding for a 52-week wait 'Sprint'. Additional capacity is being established to support the clearance of 52-week waiters, through internal waiting list initiatives, weekend working and the purchasing of theatre capacity we can use at the Nuffield Hospital, Taunton.

The 65-week waiters have reduced significantly over the past three months, but largely in the same specialties as for the 52-week waiters. We have been monitoring individual patient pathways in the quarter 4 monthly cohorts, and pencilling in dates for appointment and surgery, to establish where we have gaps. This same approach will continue until all 65-week waiters are treated and the zero position has been maintained. Actions to get to zero 65-week waiters, 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 and continued very close tracking of progress of individual patient pathways. A shortfall in upper GI capacity presents the greatest risk to achieving this aim in the next two months. Plans are being revised following a low uptake of patients wanting to transfer to Yeovil for treatment, and a smaller than expected cohort of patients being appropriate for treatment in the Independent Sector, which includes additional lists being undertaken internally and making use of the theatre capacity at Nuffield Hospital that is being procured.

Refreshed plans to support the improvement in performance against all three RTT targets were 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 remain in place for

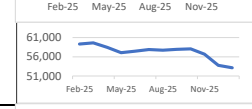
all specialties, and the plans continue to be updated with new actions identified. The themes for the main actions to improve RTT performance are as follows:

- Implementation of the Advice & Refer (Cinapsis) advice & guidance platform, which will enable enhanced referrals for all routine GP requests for secondary care opinion. In addition to ENT, Cardiology, Neurology and Urology having gone live, joining a number of other specialties already live including Dermatology, Gynaecology, Rheumatology, Vascular, Gastroenterology and Endocrinology, work will commence shortly on pathway design and onboarding process for Haematology, Respiratory and Colorectal. This will reduce the number of patients needing to have an outpatient appointment and being added to the waiting list. However, in the short term 18-week and First OPA within 18 weeks, performance will decline as a result of fewer shorter waiting patients being on 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 and gynaecology); additional theatre capacity being allocated to T&O at Yeovil, with a shift in job plans from outpatients to theatres.
- Ambient Voice Technology (AVT) utilisation in clinic, to replace dictation of letters and increase patient throughput of clinics (neurology, ENT, T&O, pain management, and gynaecology). We have re-visited the deployment process, to speed-up the establishment of AVT in a number of other specialties, with a seven-day implementation process now in place for fully engaged services.
- Group pain management clinics, to increase service capacity.
- Review and development with commissioners a new service delivery model for endocrinology weight management services.

Having moved into Tier 1 of national performance management for the Trust's 65-week wait position in October 2025, we have implemented a further level of governance, involving a weekly Chief Operating Officer-led review of the potential end of month 65-week wait breaches, with the Director of Elective Care and Service Group Directors, focusing on what mitigations are being put in place to avoid these breaches. We are no longer in Tier 1 but continue to manage RTT performance via this strengthened governance structure.

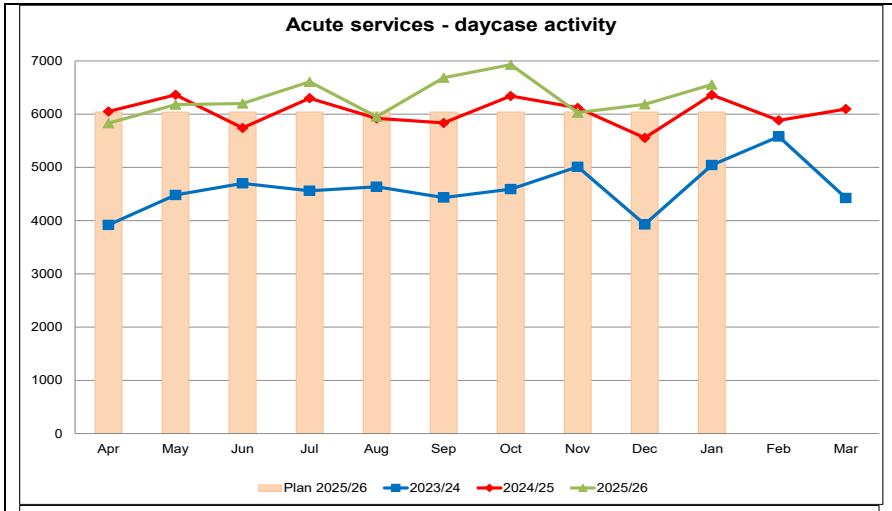
SOMERSET NHS FOUNDATION TRUST

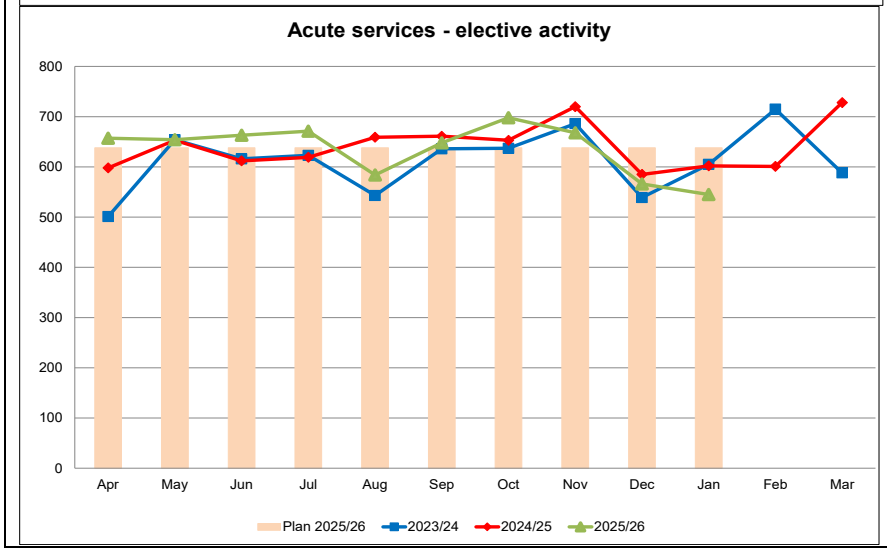
ELECTIVE CARE

No.	Description		Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
EC1	Diagnostic 6-week wait - acute services	MPH	NOF	1,2	77.4%	79.0%	79.7%	81.4%	83.6%	83.8%	80.3%	80.6%	82.0%	76.8%	71.7%	73.4%	From March 2024 At or above regional ambition 85% = Green Above trajectory = Amber Below trajectory = Red In 2026/27, the national requirement is performance of 80%, or an improvement of at least 3% compared to March 2026, whichever is higher.		
EC2		YDH			77.6%	73.6%	65.5%	64.3%	67.5%	68.1%	73.2%	76.6%	78.9%	80.9%	75.2%	71.9%			
EC3		Combined			77.4%	77.6%	75.7%	74.5%	78.7%	79.6%	78.4%	79.7%	81.3%	77.7%	72.5%	73.0%			
EC4	52 week RTT breaches - Patients of all ages		OPG	1,2	1,406	1,257	1,438	1,572	1,588	1,749	1,826	1,740	1,575	1,313	1,290	1,195	From April 2023 At or below trajectory = Green Above trajectory = Red		
EC5	52 week RTT breaches - Patients aged under 18		OPG		108	116	122	134	150	133	138	124	106	81	81	84			
EC6	65 week RTT breaches - Patients of all ages		NHSC		117	81	86	112	108	136	149	157	141	79	18	11			
EC7	Referral to Treatment (RTT) incomplete pathway waiting list size - all ages		NHSC		59,310	59,621	58,470	57,069	57,440	57,905	57,715	57,935	58,068	56,659	53,781	53,143			
EC8	Referral to Treatment (RTT) incomplete pathway waiting list size - under 18		NHSC		4,189	4,331	4,115	4,128	4,312	4,160	4,027	3,967	4,005	3,918	3,820	3,762	From April 2025 at or below trajectory = Green above = Red		
EC9	Rate of annual growth in under 18s elective activity - Rolling 12 months comparison of previous 12 months		NOF, PAF		5.3%	28.1%	-4.7%	-3.1%	-2.1%	-1.6%	-4.0%	-4.5%	-6.1%	-5.1%	-6.3%	-14.1%	To be confirmed		
EC10	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	SFT	2,6	3.0	2.7	3.0	3.5	3.1	2.9	2.4	2.7	2.4	2.3	2.7	2.2	Monitored using Statistical Process Control rules. Report by exception.		
EC11		YDH			2.9	2.2	2.6	2.3	2.6	3.2	2.1	2.3	2.1	2.2	2.4	2.1			

Operational context

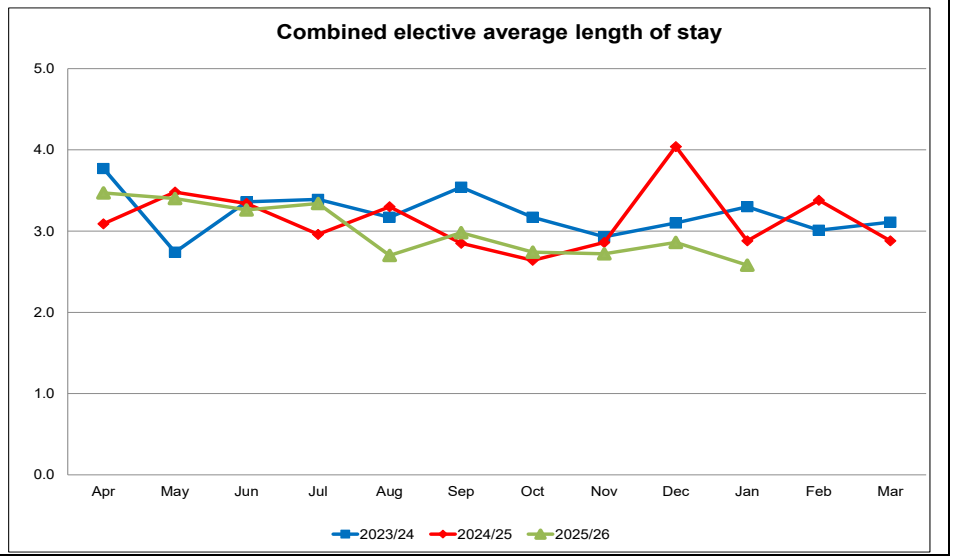
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





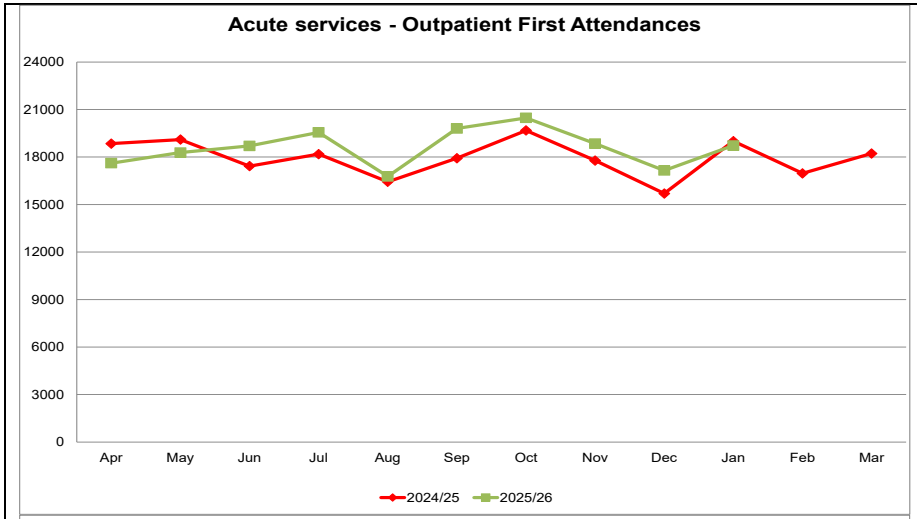
Summary:

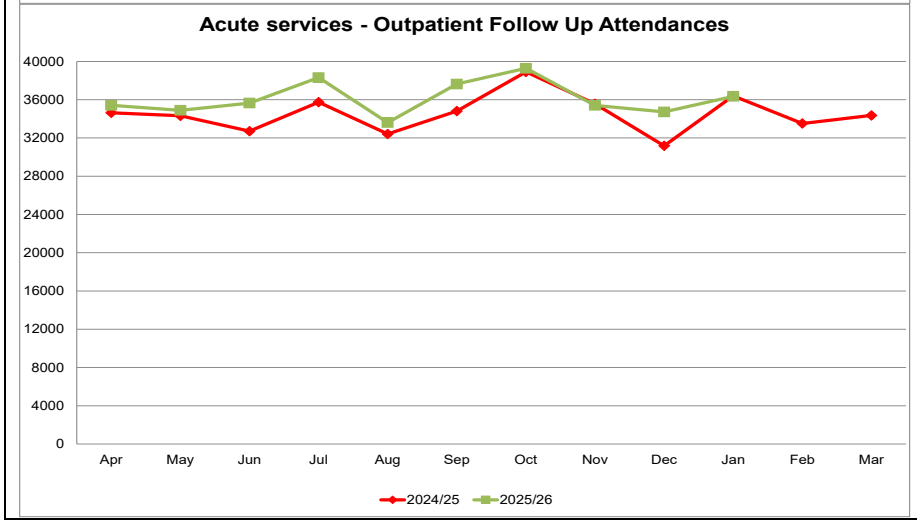
- The number of day cases undertaken by our acute services between 1 April 2025 and 31 January 2026 increased by 4.2% compared to the same months of 2024/25 and increased by 39.4% compared to the same months of 2023/24. Activity for the year to date was 4.5% above the current year plan.
- Over the same period, elective admissions were 0.1% lower than the corresponding months of 2024/25 but 5.2% higher compared to the same months of 2023/24. Activity for the year to date was 0.4% below the current year plan.
- The trust-wide monthly elective average length of stay was 2.6 days in January 2026, a decrease from 2.9 days in December 2025.



Operational context

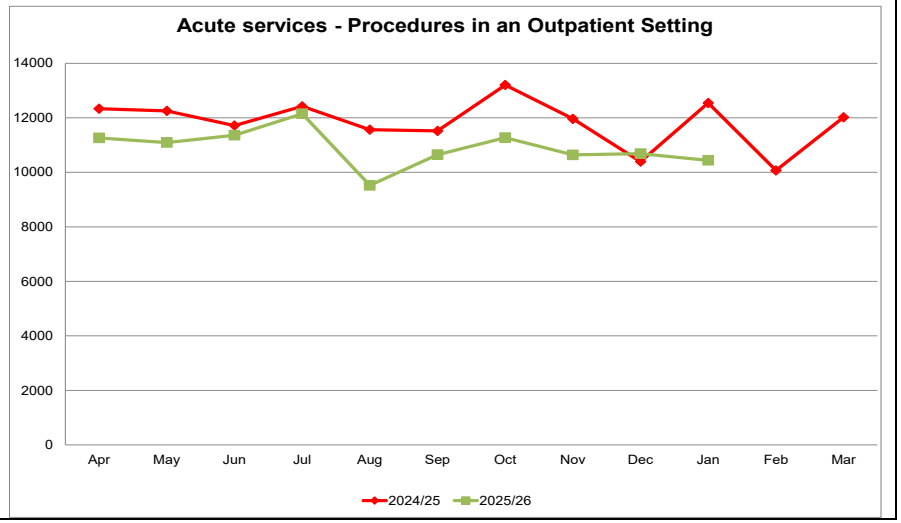
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- The number of first outpatient attendances undertaken by our acute services between 1 April 2025 and 31 January 2026 increased by 3.2% compared to the same months of 2024/25.
- Over the same period, follow up outpatient attendances were 4.2% higher than the corresponding months of 2024/25.
- Between 1 April 2025 and 31 January 2026, the reported number of procedures undertaken within an outpatient setting decreased by 9.0% compared to the same months of 2024/25. Due a backlog of coding, the reported numbers for April 2025 to January 2026 are 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 was 79.0% in December 2025, above the national standard (77.0%), and above our planning trajectory of 77.3% (Table 1). Like last month, two tumour sites, lower GI and gynaecology, were the main contributors to the breaches of the standard in December 2025 as shown in Table 2 below, together making up 55% of breaches. The only other tumour site not meeting the national standard was urology, with performance of 71%. Please note January's performance is draft, pre final validation.

Table 1. Faster Diagnosis Standard performance May 24 to December 25.

	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Trajectory (%)	78.0	78.0	79.4	78.8	77.1	77.0	78.3	78.3	77.1	80.3	81.2	78.7	81.5	78.1	77.6	78.7	81.7	81.8	80.3	77.3	75.1
Actual (%)	80.6	75.0	70.0	70.9	75.4	75.4	79.0	76.5	75.8	72.0	75.4	72.6	65.1	73.0	75.5	71.3	71.9	77.8	78.5	79.0	75.3

Table 2. Top five tumour sites contributing to current FDS performance in the previous month.

Tumour sites	Breaches (Nov 25)	Performance (Nov 25)	% of breaches (Nov 25)	Breaches (Dec 25)	Performance (Dec 25)	% of breaches (Dec 25)
Colorectal	184	60%	35%	202	55% ↓	39%
Gynaecology	77	67%	15%	80	67% =	16%
Urology	57	76%	13%	65	71% ↓	13%
Breast	69	87%	13%	51	90% ↑	10%
Skin	58	88%	11%	47	90% ↑	9%

2) The main actions colorectal and gynaecology are taking to improve performance are shown below:

Colorectal:

- Yeovil Community Diagnostic Centre opening (complete) to increase CT colon capacity (already reduced waits to below 14 days in Yeovil)
- Increase endoscopy capacity, through filling nurse vacancies – vacancies appointed to and most now in post; achieved 94% session utilisation in January, which is expected to be replicated in February.
- Review the high volume of patients needing general anaesthetic scopes is being reviewed as to whether appropriate.
- Restart internal 100-days challenge (underway).
- Job planning review for Musgrove and Yeovil (underway)
- Registrar clinics to be converted to two-week wait clinics to increase OPA capacity.

Gynaecology:

- WID-easy pilot of high vaginal swabs commences 1/3/26, which will provide a rule-out for endometrial cancers within 72 hours.
- Hysteroscopy and theatre capacity and demand being reviewed.
- Benign one-stop OP/diagnostics insourcing – working well, 349 patients seen so far since 8 Feb; this may release capacity for suspected cancer appointments in the borderline cases.
- Plan for community hysteroscopy being developed.
- Mapping of tracking and management of histology underway, to optimise results management.
- Transfer of patients across acute sites being streamlined (underway).

Between July and October 2025, the Trust participated in the GIRFT national 100 Days Matter challenge for colorectal and urology. This work, along with already planned increases in capacity have helped to, most notably, improve urology FDS performance (see Table 3). Some of the outcomes of the 100 Days Matter challenge have included:

- One-stop endoscopy and staging CT pathway implemented where a cancer is identified at colonoscopy.
- Faecal Immunochemistry Test (FIT) guidelines and resulting pathways have been reviewed.

- Colorectal Clinical Nurse Specialists have been given access to radiology imaging sharing system.
- One stop bladder cancer clinics have been established in Bridgwater.
- Urology clinic template and job plan reviews have been completed – which has liberated more capacity.
- Uro-Oncology Clinical Nurse Specialist has been appointed; Uro-Oncology band 6 posts x 1.6 WTE is being recruited.

Table 3. 100 Days Matter Challenge - FDS performance in colorectal and urology

Tumour site	Q4 24/25	Target Oct 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25
Colorectal	52%	57%	57%	40%	49%	62%	52%	53%	65%	60%	55%
Urology	52%	57%	53%	38%	50%	61%	67%	75%	68%	76%	71%

3) 62-day referral to cancer treatment performance was 76.4% in December 2025, above the current national standard of 70% and also the March 2026 target of 75%. Draft January 2026 performance represents a deterioration but forecast reduction in performance, largely related to reductions in capacity over the recent bank holiday period, combined with patient choice to delay tests and treatment (see Table 4). The step improvement seen in November and December is linked with the improvement in 28-day FDS performance two months prior. Colorectal and urology are the main tumour sites contributing to breaches, although the urology performance has improved with far fewer breaches of the standard.

Additional actions to improve 62-day performance, above those related to FDS are as follows:

- Urology capacity – two consultants back off maternity leave and two additional appointments (although one recent resignation and one consultant fully retiring this quarter); job plan review which has liberated more capacity.
- Lung – ring-fenced PET scan slots; one-stop echo slots for 2-week wait patients; EBUS scope resilience/capacity; AI for chest x-rays (Feb 27); streamlining MDT discussion effectiveness by ensuring only those patients with new results are discussed.
- Skin - Capacity & demand modelling for plastics, to determine whether we need to increase our Service Level Agreement with Royal Devon University Healthcare.

- Head & Neck – ENT insourcing for clinics and theatre sessions has commenced, which is aimed at reducing benign long-wait backlogs but in so doing will alleviate competing pressure on service capacity.
- Colorectal - demand and capacity review for theatre sessions; additional theatre lists to be identified.
- Weekend operating sessions – mainly for benign pathways but again alleviates pressure.

Table 4. 62-Day Cancer performance April 2024 to January 2026.

	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26 (draft)
Trajectory (%)	64.6	65.9	66.4	67.1	66.5	66.4	68.8	70.2	71.3	71.5	72.0	72.8	70.3	70.5	71.6	71.8	71.7	71.7	72.6	72.3	70.3
Actual (%)	64.2	68.0	67.8	72.0	64.4	65.6	68.2	71.0	66.9	68.9	75.2	70.2	69.2	68.1	68.4	70.0	70.4	69.1	76.5	76.4	70.0

SOMERSET NHS FOUNDATION TRUST

CANCER SERVICES

No.	Description	Source	Links to strategic aims	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-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%	97.1%	96.7%	95.4%	95.0%	95.2%	93.6%	94.1%	90.9%	91.6%	90.0%	92.1%	>=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	17	28	25	32	20	36	19	31	25	40	24	14	0= Green >0 = Red		
C3	Cancer: 62-day wait from referral to treatment for urgent referrals – Breast	OPG	1,2	77.8%	80.0%	87.5%	78.7%	62.2%	75.9%	74.6%	70.9%	67.3%	78.1%	73.1%	68.4%	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	50.0%	46.2%	58.1%	55.2%	50.0%	53.8%	60.0%	67.8%	65.6%	37.9%	48.5%	72.5%	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	80.0%	75.0%	77.8%	78.9%	100.0%	80.0%	62.5%	75.0%	72.7%	86.4%	57.1%	94.4%	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	77.8%	93.8%	78.9%	78.6%	100.0%	84.6%	75.0%	78.9%	63.4%	74.4%	100.0%	82.6%	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	69.0%	34.6%	77.8%	68.8%	72.7%	91.7%	52.6%	51.4%	68.8%	67.5%	77.8%	61.3%	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	54.2%	71.2%	73.1%	69.8%	75.5%	60.0%	57.6%	66.7%	68.1%	69.6%	100.0%	86.9%	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	83.3%	33.3%	88.9%	92.9%	100.0%	69.2%	92.3%	86.7%	77.8%	61.5%	58.8%	100.0%	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	75.0%	85.9%	92.8%	98.7%	91.6%	92.0%	81.4%	83.1%	82.3%	76.3%	89.7%	81.1%	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	72.6%	80.8%	91.1%	63.2%	82.1%	69.2%	66.7%	95.8%	63.8%	77.8%	86.2%	56.7%	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	56.2%	51.5%	52.8%	37.5%	39.9%	40.7%	58.3%	52.7%	64.8%	55.0%	68.3%	55.2%	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	68.4%	69.9%	72.4%	73.3%	71.8%	72.5%	70.8%	76.1%	72.8%	68.6%	72.5%	72.1%	>=60.1%= Green >=55.1% to <60.1% = Amber <55.1% =Red		

NARRATIVE REPORT

MATERNITY SERVICES

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

The service continues to monitor the impact of the temporary closure of YDH services on both activity and safety of services.
The service has continued to monitor reported incidents occurring due to the increase in activity on the MPH site in both maternity and neonates. Whilst there has been a reduction overall in reporting of incidents in relation to staffing, workload and capacity, incidents have shifted to community settings.
Themes of reported incidents for January are:

- Delay in transfer to Labour Ward for Induction of Labour continued care
- Staffing for transitional care and community
- Delay in Elective Caesarean pathways
- Delay in medical review following initial assessment in triage

The service continues to implement actions to mitigate delays in elective care including use of bank and agency staffing, active recruitment to Obstetric vacancy, improvements to flow and escalation processes.

The Children and Young People (CYP) and Families Leadership team continue to lead the work to re-launch YDH services on 21 April 2026. Good progress continues to be made in each of the five workstreams to support safe re-launching and colleagues have begun to return to YDH from re-deployment to attend team building and Simulation training sessions. The team continue to actively work to mitigate all identified risks to re-launch as identified to ensure the re-launch is achievable.

The service continues to make good progress with service transformation improvements under the Maternity & Neonatal Improvement Programme (MNIP). The MNIP comprises of eight programmes each with an assigned Executive Senior Responsible Officer:

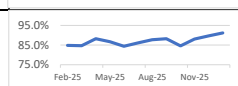
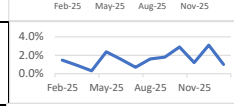
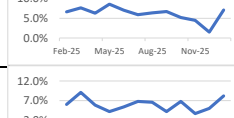
- Safety & Learning

- Workforce
- Culture & Leadership
- Clinical pathways
- Governance
- Collaboration
- Estates
- Equity, Diversity & Inclusion

The MNIP has its own dedicated Program Board which is chaired by the NED Safety Champion and attended by the Executive SRO (Chief Nurse & Midwife). The MNIP will provide assurance quarterly to the Q&GAC. Oversight of the MNIP will also be provide by the Safety Champions.

SOMERSET NHS FOUNDATION TRUST

MATERNITY SERVICES

No.	Description	Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
M1	Babies readmitted to hospital who were under 30 days	CQIM	2	3	7	4	2	0	0	0	0	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	32	17	13	15	26	13	15	16	24	26	9	20	Monitored using Statistical Process Control rules. Report by exception.		
M3	Percentage of babies where breast feeding was initiated	CQIM	1,2	84.8%	84.6%	88.3%	86.7%	84.4%	86.1%	87.7%	88.2%	84.6%	88.1%	89.7%	91.2%	>=80%= Green >=75% - <80% =Amber <75% =Red		
M4	Percentage of babies with an APGAR score between 0 and 6	CQIM	1,2	1.5%	0.9%	0.3%	2.4%	1.6%	0.7%	1.6%	1.8%	2.9%	1.2%	3.1%	1.0%	=<1%= Green >1% - =<2% =Amber >2% =Red		
M5	Women who had a 3rd or 4th degree tear at delivery	CQIM	2	5	9	8	5	3	8	4	10	9	4	4	8	To be confirmed, following benchmarking against regional performance.		
M6	Women who had a postpartum haemorrhage (PPH) of 1,500ml or more	CQIM	2	10	14	13	2	10	6	15	9	10	8	9	6	To be confirmed, following benchmarking against regional performance.		
M7	Women who were current smokers at booking appointment	CQIM	1,2	6.6%	7.6%	6.3%	8.6%	7.0%	5.9%	6.4%	6.7%	5.2%	4.5%	1.5%	7.1%	No target level.		
M8	Women who were current smokers at delivery	CQIM	1,2	6.0%	9.1%	5.8%	4.2%	5.4%	6.8%	6.6%	4.2%	6.8%	3.7%	5.0%	8.2%	=<10%= Green >10% - =<12% =Amber >12% =Red		
M9	No. of still births	CQIM	2	0	0	0	0	1	0	0	0	0	1	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	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.6	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	94.6%		98.1%			96.7%			Reported quarterly (Report due March 2026)			Reported quarterly	>=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	100.0%		93.3%			100.0%									

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

The Children and Young People's Eating Disorder Service (CEDS) workforce continues to stabilise, supported by improved staff retention and a significant reduction in agency nursing reliance. This strengthened position is reflected in improvements which have been made to routine referral performance. The three-month rolling performance for routine referrals was 90.8% in December 2025, followed by 91.8% in January 2026, against the national 95% standard.

Provider-level performance also remains strong overall. SFT reported 86.2% (25 out of 29 routine referrals seen within four weeks) in January 2026, while SWEDA reported 96.9% (31 out of 32). All breaches continue to be reviewed to understand causation and inform improvement plans. The Deputy Head of Service continues to work closely with SWEDA to support collaborative service development.

Urgent Referrals

Rolling three-month performance for urgent referrals to be seen within one week remains below the compliance standard. Following a decline to 80% in December 2025, performance improved to 85.7% in January 2026. This shift reflects the early impact of actions taken to address a known data recording error, which had resulted in some urgent appointments not being uploaded correctly to clinical systems. This system issue is now being urgently rectified.

Performance was further affected by difficulties in contacting some families by telephone, requiring letters to be issued, which reduces the ability to offer appointments within one week.

From April 2026, CEDS had planned to introduce urgent appointments at the point of referral, with availability within 24 hours at Intensive Treatment Houses in both east and west localities. This timescale may however be impacted by the recent flooding of the Swingbridge

Intensive Treatment House in the west of the county. Further improvement is expected through January 2026 data corrections, and Spring 2026 model changes.

Children and Young People's Community Mental Health service

Somerset CAMHS continues to demonstrate strong performance nationally in relation to waiting times and timely access to community mental health support. In January 2026, 90.0% of children and young people were seen within six weeks for their first appointment. For the whole of the 12-month reporting period from February 2025 to January 2026, the service has achieved or exceed the 90% reporting standard reflecting the service's robust triage, referral management processes, and effective system flow.

In addition to waiting time performance, the service continues to make progress towards the national ambition for increasing the number of children and young people (aged 0–25) accessing mental health services. This month's data demonstrates a steady and sustained increase in access throughout the reporting period, with activity rising from 5,010 in February 2025 to 5,822 in January 2026. This upward trend indicates improving reach, strong system engagement, and continued expansion of early intervention and community-based mental health support pathways

These results reinforce the position of Somerset CAMHS as a high-performing and responsive service, maintaining timely access while supporting an increasing number of children and young people to receive mental health care in line with national trajectories.

Primary care dental service

Community Dental Services across Dorset and Somerset continue to demonstrate strong and sustained progress in addressing operational challenges, particularly around workforce stability, clinical capacity, and waiting list reduction.

The Productive Care Initiative focuses on optimising appointment allocation, improving demand-capacity matching, and reducing excessive waits across Somerset. The programme is now firmly embedded, with positive engagement across all localities.

Waiting List Improvements – 18-Week Standard

The Somerset service has delivered consistent reductions in the number of patients waiting 18 weeks or more for General, Domiciliary or Minor Oral Surgery procedures. Between February 2025 and January 2026, the number of patients waiting over 18 weeks reduced by 37% from 2,629 to 1,645, reflecting steady month-on-month improvement (with a sustained plateau in November–December 2025 at 1,747, followed by continued reduction into January 2026). This places the service below the monitoring target and demonstrates effective delivery of recovery plans.

Improvement Against Long-Wait Backlogs – 52 Weeks

There has been a substantial reduction in very long waits. Numbers waiting over 52 weeks have fallen from 571 in February 2025 to 81 in January 2026, representing an 86% reduction over the 12-month period. This sustained improvement aligns with the service's targeted work to prioritise the longest waiters and improve scheduling efficiency.

Child GA Waiters – 18-Week Standard

Waiting times have also improved for children requiring a General Anaesthetic. The number waiting more than 18 weeks fell by 37%, from 626 in February 2025 to 397 in January 2026, including consistent reductions through spring and summer, and stabilisation during autumn and winter. This demonstrates strong progress despite known constraints on GA capacity.

General Anaesthetic Pressures and Mitigations

The General Anaesthetic waiting list for young people exceeding 18 weeks did not reduce further during December 2025 due to annual leave, bank holidays and theatre refurbishment delays. Nevertheless, the service was able to maintain the overall improved position at 1,747, and subsequent activity in January 2026 improved this further to 1,645. The service remains confident that the ambition of no patients waiting over 18 weeks by June 2026 is achievable.

To support this trajectory, Dorset ICB approved additional theatre capacity through to August 2025. While refurbishments extended beyond planned timelines and productivity was affected by dentist availability, theatre staff sickness and industrial action, recovery actions have mitigated these impacts.

Workforce Strengthening and System Collaboration

Recruitment across both counties has been highly successful, and the service is now operating close to full establishment with a strong, multi-disciplinary skill mix. This represents the most positive workforce position in several years.

The newly appointed Consultant in Special Care Dentistry continues to lead collaborative work with paediatric and anaesthetic colleagues to strengthen clinical pathways, expand the pool of dentists able to contribute to the GA rota, and enhance service resilience and patient safety.

RTT Data and National Dataset Readiness

The service has submitted its full RTT dataset ahead of community dental services joining a nationally mandated dataset. As national guidance on expected outcomes and timelines has not yet been published, the service continues to supply commissioners with full datasets while working closely with the Trust's Performance and Information Teams to ensure ongoing accuracy and future readiness.

Acute Paediatric service

National Paediatric Early Warning System (PEWS)

The National PEWS audit continues to show improving compliance across both acute paediatric sites, with focused education and strengthened clinical oversight supporting sustained progress.

MPH

MPH has demonstrated a marked and sustained improvement in medium-risk PEWS compliance. Performance rose significantly through the autumn, increasing from 58.3% in November 2025 to 81.0% in December 2025, before falling slightly to 76.9% in January 2026. This improvement follows targeted teaching sessions and enhanced oversight by the nurse in charge. Continued focused education remains a priority to consolidate these gains.

YDH

YDH continues to perform strongly, maintaining consistently high levels of PEWS compliance. Medium-risk review rates reached 93.3% in December 2025 following the delivery of bitesize teaching sessions and increased further to 100% in January 2026. This demonstrates strong clinical engagement with the PEWS process and robust local governance.

Digital Enhancements

Implementation work for ePEWS in the YDH Emergency Department has been completed, and the system went live during the week commencing 19 January 2026. Early feedback indicates improved visibility of observations and enhanced escalation support for clinical teams.

CYP Neurodevelopmental Partnership (CYPNP) service

Referrals and Service Demand

Demand for the CYPNP service continues to exceed available capacity, with referral volumes remaining significantly higher than the service can sustainably manage.

- Triage activity increased in December 2025, exceeding the previous three-month average and reflecting sustained upward pressure.

- First appointment activity decreased in December 2025, largely due to staff annual leave and reduced clinic availability over the holiday period.

Waiting List Pressures

Waiting list pressures remain a critical concern.

- The total waiting list increased from 4,177 to 4,209, driven by high levels of incoming referrals.
- The number of children waiting 104+ weeks increased from 1,054 to 1,179, continuing the upward trend in longest waits.
- The longest recorded wait is now 197 weeks, linked to an inherited referral from North Somerset.
- The number of children waiting over 52 weeks is 2,873, above the previously submitted NHSE trajectory, highlighting the scale of system pressure.

ADHD Pathway

ADHD Reviews

- Although some delays persist, the overall position is improving, with an increasing proportion of young people now being seen within expected review timeframes.
- High DNA rates continue to affect clinic productivity and contribute to waiting list stagnation.

ADHD Nursing

- The Understanding ADHD course was delivered ten times during 2025, both online and in-person, with strong attendance.
- Clinics are now running more consistently across Wells, Minehead and Yeovil, improving equity of access.
- IT system issues continue to disrupt appointment bookings and communication, and further technical support is required.

Key Updates, Successes and Areas Requiring Support

Operational Improvements

- The half-day assessment model is now fully implemented, supporting high-quality assessments while protecting clinic capacity and offering valuable development opportunities for clinicians.
- Most clinicians have now cleared their historic assessment caseloads, enabling greater focus on new assessment bookings (with room availability now the main limiting factor).

Active Caseload

- Only 88 children remain on the active “in-progress” assessment caseload, a significant reduction demonstrating progress in clearing overdue activity.

Partnership and System Engagement

- CYPNP clinicians delivered multiple WISE Up and PINS (Partnerships for Inclusion of Neurodiversity in Schools) workshops, all receiving positive feedback.
- Preparations are under way to review the referral form at the next National Autism Foundation meeting.
- Collaborative work with the ICB is progressing around Right to Choose (RTC) guidance to better support GPs and improve consistency of information provided to families.

Performance Trends, Variations and Concerns

- Administrative capacity remains fragile, with multiple vacancies, maternity leave, sickness and a recent retirement. A Band 2 vacancy has proven particularly difficult to recruit to.
- Rising demand for Right to Choose assessments continues to generate operational pressure, particularly around shared care and follow-up responsibilities.

- Joint work is ongoing with GPs, the NAF group and the ICB to address challenges relating to referral quality, shared care expectations and communication pathways.

Improving Emergency Department Waiting Times

Reducing waiting times for children and young people (CYP) in the Emergency Departments (ED) at Yeovil District Hospital (YDH) and Musgrove Park Hospital (MPH) remains a critical operational priority. The Trust is working towards the national requirement that at least 76% of patients are admitted, discharged, or transferred within four hours by March 2026, rising to 95% by September 2026.

Current Performance

Trust-wide performance for CYP in December 2025 improved slightly to 72.4%, reflecting the impact of early improvement actions already underway. Performance improved further to 76.2% in January 2026, meeting the Trust's target of 76% by March 2026 two months ahead of trajectory.

Weekly improvement meetings have now been established to drive operational focus and accelerate change. These sessions have strengthened cross-team working and enabled quicker adoption of process improvements. In addition, Ward 10 at YDH has continued to provide paediatric staff to support the ED during periods of pressure, improving flow and patient experience where capacity allows.

Paediatric Assessment Unit (PAU) Requirements

Establishing a dedicated Paediatric Assessment Unit (PAU) footprint at YDH remains essential to achieving sustained improvements in CYP ED waiting times. A well-defined PAU will:

- Enhance early assessment and streaming
- Improve patient flow
- Reduce ED congestion
- Provide a more age-appropriate environment for children and young people

However, two major challenges remain:

1. Workforce Model

Three of the five newly appointed Paediatricians have started in post, however there is a shortfall in paediatric nursing numbers required to safely operate a PAU model. This gap continues to affect CYP flow in ED, especially during peak winter demand. A review of paediatric nursing establishment is underway as part of this work.

2. Estate and evacuation Constraints

Safe evacuation restrictions within the current YDH building significantly limit viable locations for a PAU.
Ward 10 has been assessed with a risk score of 15, with simulation training highlighting:

- Extended time required to evacuate a child on oxygen
- The need to navigate a staircase during evacuation
- Increased risk profile for staff and patients

A Quality Impact Assessment (QIA) has been completed, and further mitigations are being implemented. Nonetheless, the environment remains a substantial safety concern.

Potential Relocation

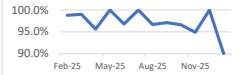
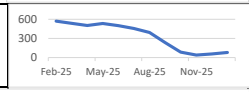
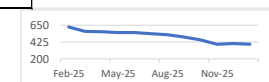
A proposal is being developed to relocate Paediatrics into the Women's Building, with space allocated for a PAU. This would require:

- Significant capital investment
- Re-provision of Paediatric Outpatients (potentially off-site)

Until a long-term solution is confirmed, fire safety and capacity constraints will continue to limit progress.

SOMERSET NHS FOUNDATION TRUST

CHILDREN AND YOUNG PEOPLE'S SERVICES

No.	Description		Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
CYP1	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		NHSC	1,2,3,4	-	-	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	85.7%	>=95%= Green >=85% - <95% =Amber <85% =Red		?
CYP2	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)		NHSC	1,2,3,4	94.1%	92.3%	93.9%	92.7%	98.2%	97.0%	98.2%	89.8%	90.9%	90.8%	90.8%	91.8%	>=95%= Green >=85% - <95% =Amber <85% =Red		F
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	5,010	5,216	5,246	5,315	5,408	5,524	5,451	5,610	5,676	5,691	5,751	5,822	From April 2025 >=5,400 = Green <5,400 = Red		P
CYP4	Mental health referrals offered first appointments within 6 weeks	Children and young people's mental health services	ICB	1,2,3	98.8%	99.0%	95.6%	100.0%	96.8%	100.0%	96.7%	97.1%	96.6%	94.9%	100.0%	90.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
CYP5	Improve A&E waiting times, with a minimum of 76% of patients admitted, discharged and transferred from ED within 4 hours in March 2026: Trust-wide performance - Under 18 years old		PAF	2	74.5%	70.6%	73.7%	76.8%	78.1%	80.6%	77.6%	77.1%	77.2%	70.5%	72.4%	76.2%	From April 2025 >=76%= Green >=66% - <76% =Amber <66% =Red (the standard will rise to 78% in March 2026, and 95% in September 2026)		?
CYP7	Community dental services - General, Domiciliary or Minor Oral surgery waiting 18 weeks or more		SFT	1,2,3	2,629	2,544	2,516	2,532	2,523	2,495	2,420	2,252	1,956	1,747	1,747	1,645	From April 2024 <1,979 = Green >=1,979 = Red		?
CYP8	Community dental services - General, Domiciliary or Minor Oral surgery waiting 52 weeks or more		SFT		571	538	502	535	501	456	393	234	84	39	55	81	From April 2024 <574 = Green >=574 = Red		P
CYP9	Community dental services - Child GA waiters waiting 18 weeks or more		SFT	1,2,3	626	567	563	552	551	537	522	491	454	395	405	397	From April 2023 <463 = Green >=463 = Red		?
CYP10	National paediatric early warning system (PEWS) - Medium risk: percentage reviewed by the nurse in charge	MPH	SFT	1,2,4	57.1%	46.2%	70.0%	43.8%	62.5%	100.0%	57.1%	66.7%	73.3%	58.3%	81.0%	76.9%	>=90%= Green >=80% - <90% =Amber <80% =Red		F
CYP11		YDH	SFT	1,2,4	66.7%	76.9%	100.0%	100.0%	100.0%	100.0%	71.4%	88.9%	66.7%	100.0%	93.3%	100.0%			?

NARRATIVE REPORT

PEOPLE

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

Areas of Success / Celebration

- Mandatory training - compliance increased slightly to 94.2% in January 2026. Of 689 teams, a total of 593 achieved the 90%+ compliance benchmark. For January 2026, five service groups have seen an increase in compliance.

- Vacancy levels – this increased slightly in January 2026 but remained within the Trust's expected parameters. Leaver numbers (83.32) were consistent with the usual monthly pattern; however, starter numbers (53.74) were lower than previous years, although this was expected, due to the ongoing vacancy exception process. This process is slowing the flow of posts entering the recruitment pipeline, contributing to the upward movement in the overall vacancy percentage. This effect was anticipated and is expected to create short-term fluctuations in vacancy levels while the new controls continue to embed.

- Retention – whilst retention remains within the expected parameters, some groups are experiencing higher than Trust average turnover rates; this includes additional clinical, admin and clerical and estates and facilities colleagues. The retention of Medical and Dental colleagues has improved during the last 12 months. The top reason for leaving is 'unknown', resulting in a gap in understanding the reasons for leaving and potentially concerns not being addressed. Actions following the release of the 2025 Staff Survey will contribute to improved retention.

Areas of Concern

- Job Planning – the number of fully signed-off job plans continues to rise, but overall compliance remains below the target level, and achieving 95% by March 2026 continues to be challenging. The Job Planning Steering Group remains focused on progressing the remaining outstanding plans, with specialties continuing to work through sign-off for individuals whose plans are currently in draft or under review. Work on the 2026/27 planning cycle is also progressing, with early engagement now underway to support prospective agreement of next year's job plans and reduce the usual year-end spike in activity. Development of a structured approach to team job planning continues, which is essential for the strategy to achieve alignment between individual activity and

both Trust-wide and national priorities. In addition, the Steering Group is continuing to shape the proposed consistency panels, which will provide a mechanism for strengthening the quality, equity and standardisation of job plans, ensuring that key elements are captured appropriately and that policy expectations are met. A new area of focus this month is the planned introduction of a small pool of trained mediators to support resolution where job plans have become stuck due to disagreements between individuals and specialty or divisional leadership. This approach is intended to unblock long-standing cases, support constructive dialogue, and help ensure job plans can progress to timely sign-off.

- Sickness Absence – the rolling average remained static in January 2026 with a 0.1% decrease in the monthly percentage of days lost due to sickness, which remains above planned levels. Short term absence increased, largely due to seasonal illness, while long term absence decreased. A focus on improving absence levels is a key element of the employee relations improvement programme; while actions are in place, it is too early to evidence improvement from this work. Estates and Ancillary and Additional Clinical colleague groups have the highest absence levels; this is reflected in the service group absence rates, with SSL and Estates and Facilities having the highest rates of absence. Other areas of concern include maternity (6.8% rolling absence) and the Mental Health and Learning Disability Service group (6.2%).

Focus Areas

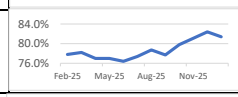
- Appraisal compliance saw a decline in month of 1%. This decline is likely due to the knock-on impact of a reduced workforce within the month of December 2025 due to higher-than-normal sickness absence levels, planned leave and critical incidents. The Appraisal Deliverable Workstream will explore the experience and needs of the appraiser and appraisees to ensure the revamped appraisal is fit for purpose. This will be arranged in the coming months. The other key area identified as critical to the success of any appraisal scheme is manager capability in this area: to ensure clear expectations/goals are agreed, regularly reviewed throughout the year during management supervisions / 1-2-1s, and ensuring there are clear links to the team/service/Trust objectives which helps foster a sense of belonging.

- Demographics – Proposed measures for workforce, patient and community inequalities will be presented to the Trust Board for discussion in February 2026. These proposed measures will help track progress towards inclusion at Board level, sub-committee level, and within service groups. The measures once agreed will flow into the scorecard and replace the current measures. Currently, focus on the measures is not happening at service level in the way anticipated and a reset in this space is required. Improvements in understanding the right measures will help improve controls to reduce the systemic discrimination risk on the risk register.

- Formal HR cases – the pressure created from the number of formal case numbers is significant and numbers continue to increase over the course of the year. The Employee Relations Improvement Programme is currently reviewing effectiveness, and while planned actions have been put in place, the impact is not yet evidenced in either the number of cases or the time taken to manage cases. A significant issue in overseeing this level of activity is the lack of case management software which results in burdensome manual processes and a risk that cases are not actively managed. The working group will be reviewing actions and identifying next steps.

SOMERSET NHS FOUNDATION TRUST

PEOPLE

No.	Description		Source	Links to strategic aims	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Thresholds	Trend	Variation / Assurance
P1	Mandatory training: percentage completed	Combined	SFT	5	92.8%	92.8%	93.0%	93.0%	93.2%	93.2%	93.5%	93.9%	94.0%	94.0%	94.1%	94.2%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber		
P2	Monthly percentage of days lost due to sickness absence		NOF	5	5.3%	4.8%	4.6%	4.8%	5.1%	5.2%	5.1%	5.2%	5.6%	5.4%	5.7%	5.6%	SPC (Upper Control Limit 5.4%)		
P3	Sickness absence levels - rolling 12 month average (Trust-wide)		NOF	5	5.2%	5.2%	5.2%	5.2%	5.2%	5.1%	5.2%	5.2%	5.2%	5.1%	5.2%	5.2%	SPC (Upper Control Limit 5.2%)		
P4	Career conversations (12 months)		SFT	5	77.8%	78.2%	77.0%	77.0%	76.4%	77.4%	78.7%	77.7%	79.8%	81.1%	82.4%	81.4%	>=90%= Green >=80% - <90% =Amber <80% =Red		
P5	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		SFT	5	7.8%	7.8%	8.4%	8.3%	8.4%	8.3%	6.7%	7.8%	7.8%	7.4%	7.9%	8.2%	<=8.5%= Green >8.5% to <=9.0% =Amber >9.0% =Red		
P6	Retention rate – rolling 12 months percentage of colleagues in post		SFT	5	89.0%	89.1%	89.1%	89.4%	89.5%	89.6%	89.4%	89.7%	89.8%	89.8%	89.9%	90.0%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red		
P7	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	SFT	1,5	22.5%		23.2%			24.4%			24.7%			Reported quarterly	>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red		
P8		Who are female	SFT	1,5	58.2%		57.9%			58.7%			59.0%						
P9		With a recorded disability	SFT	1,5	4.0%		4.2%			4.8%			4.8%						
P10	Job planning: Percentage of Consultant and SAS doctor job plans signed off		SFT	5	New reporting	21.5%	6.6%	10.2%	12.8%	20.2%	31.6%	60.4%	76.4%	80.6%	83.7%	84.1%	>=95%= Green >=85% to <95% =Amber <85% =Red		
P11	Percentage of patient-facing staff receiving a 'flu vaccination		PAF	1,5	Reporting to run from October 2025 to January 2026.								35.4%	45.3%	50.7%	50.2%	By February 2025 >=33.1% = Green <33.1% = Red		
P12	Number of formal HR case works (disciplinary, grievance and capability).		SFT	5	50	63	58	69	55	68	86	88	128	105	95	124	SPC (Upper Control Limit 78		

NARRATIVE REPORT

PATIENT EXPERIENCE AND INVOLVEMENT

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

What is going well

There has been an increase in the number of Care Opinion stories received, with over 97% of stories being responded to during January 2026. The improvements we put in for last month are showing as being sustainable. Overall, the stories were positive, expressing deep gratitude for staff who were calm, reassuring and attentive.

What is going less well

Some of the feedback we received via Care Opinion was regarding communication failures and lack of follow up, with patients being discharged without being informed and referrals not being followed through.

In January 2026 the Trust received six second letters. Five related to the medical service group and one related to the surgical service group. The reasons for the requests for second letters continue to be analysed, and included:

- **Incomplete or insufficiently detailed responses:** Two complainants were not satisfied with their initial response, so requested a further response.
- **Lack of clarity or unresolved questions:** One complainant was unhappy that some of their concerns were not answered.
- **Further concerns raised:** One complainant raised further concerns following receipt of their initial response letter.
- **Requests for a meeting or further dialogue:** One complainant was unhappy with the response received so requested a meeting, and one complainant requested a meeting with the consultant as they found some of the responses in the initial letter difficult to process.

In January 2026, the response rate for formal complaints responded to within agreed time frame was 55.8%.

Delays were attributable to the following factors:

- Intensified focus on the quality of responses, with a focus on the accuracy of information and comprehensive responses to all questions within the initial response.
- Ongoing operational and workforce challenges across all areas to be able to review, prioritise and respond to complaints.
- Continued challenges with ownership and accountability of formal complaints within some service areas and individual clinicians. This is being addressed through proactive support and engagement of the patient experience leadership team alongside service group governance leads and Associate Directors of Patient Care.
- 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.
- Sickness within the complaints team and increased leave across the Trust during the festive season.

In January 2026 the percentage of complaints fully upheld fell to 7.0% and the number of formal complaints partially upheld rose to 76.7%. Work is underway to formalise the process for categorising complaints by developing a set of principles aligned with the Parliamentary and Health Service Ombudsman (PHSO) process, to ensure consistency and accuracy of reporting.

Focus of improvement work

- To continue with Patient Voice, engaging with patients, carers and visitors.
- The Care Opinion service tree is now complete for Musgrove and work continues to complete this for the rest of the trust.
- Recruitment has taken place into the 1.8 WTE patient engagement assistant roles – one person was successful who already works in the team, and there was a new appointment so we will review the new vacancy as a team.
- Recruit into the 1.0 WTE complaints vacancy - interviews are planned for early February 2026.
- A weekly sit rep outlining each service group's position on formal complaints is submitted to the Director of Patient Experience and Engagement. Its purpose is to provide senior leaders with clear oversight - particularly of complaints that are approaching risk status (30 - 40 days) - to support timely and effective escalation.
- Tailored escalation pathways have been established for each service group (Families, Neighbourhoods, and Surgical), including escalation to Associate Medical Directors and Associate Directors of Patient Care before complaints reach the breach point.
- Regular tracker meetings are held between complaints coordinators and Service Groups to identify emerging delays and raise any concerns promptly.
- Development of a set of principles to assist in the categorisation of complaints (i.e. fully upheld, partially upheld, not upheld).

- A review of performance targets has been undertaken to ensure they remain aligned with national standards.
- The NHS Complaint Standards action plan has been completed and is subject to ongoing review.
- Work is in progress to develop an interactive dashboard designed to improve visibility of complaint timelines and overall performance.

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	Oct-25	Nov-25	Dec-25	Jan-26	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	25	37	30	36	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%	92.0%	81.0%	100.0%	97.2%	>=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%	52.8%	73.0%	50.0%	55.8%	>=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	3	8	2	6	Monitored using Statistical Process Control rules. Report by exception.		
PE5	Percentage of formal complaints fully upheld	SFT	2	7.7%			9.0%			13.6%			17.6%			14.8%			10.7%			7.0%	Compare to national average		
PE6	Percentage of formal complaints partially upheld	SFT	2	78.8%			73.1%			75.8%			63.7%			62.3%			72.8%			76.7%	Compare to national average		

Appendix 1 – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in January 2026, including the number of patients waiting over 18 weeks, the number of patients waiting over 52 weeks, and the average (mean) number of weeks patients have waited on the Trust's waiting list.

RTT specialty	Over 18-week waiters	Over 52-week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	648	49	2394	72.9%
Urology	1442	136	3105	53.6%
Trauma & Orthopaedics	3310	390	8147	59.4%
Ear, Nose & Throat (ENT)	2509	147	5074	50.6%
Ophthalmology	937	26	3236	71.0%
Oral Surgery	1576	76	3286	52.0%
Plastic Surgery	24		114	78.9%
Cardiothoracic Surgery	2		20	90.0%
General Medicine	10	1	43	76.7%
Gastroenterology	542	3	2062	73.7%
Cardiology	1318		3448	61.8%
Dermatology	747	5	2951	74.7%
Thoracic Medicine	282	2	1328	78.8%
Neurology	826	5	1738	52.5%
Rheumatology	274	1	765	64.2%
Geriatric Medicine	138	6	512	73.0%
Gynaecology	1791	114	3788	52.7%
Other – Medical Services	1225	26	4126	70.3%
Other - Paediatric Services	261	10	906	71.2%
Other - Surgical Services	2399	198	5838	58.9%
Other – Other Services	18		262	93.1%
Total	**20279**	**1195**	**53143**	**61.8%**

Table 2 – RTT validation progress

The national target is to reach a level of 90% validation of patients waiting 12 weeks and over from Referral to Treatment (RTT) by 31 October 2023. Validation includes both the administrative/technical validation and also contacting the patient to confirm they still wish to be seen.

RTT waiting times bands	Week ending 11th May	Week ending 8th Jun	Week ending 20th Jul	Week ending 17th Aug	Week ending 14th Sep	Week ending 12th Oct	Week ending 9th Nov	Week ending 7th Dec	Week ending 11th Jan	Week ending 15th Feb
12 weeks and over	79%	83%	81%	81%	80%	78%	77%	76%	77%	79%
26 weeks and over	84%	89%	90%	91%	89%	87%	86%	84%	83%	85%
52 weeks and over	98%	96%	99%	99%	98%	97%	99%	97%	96%	95%

Table 3 – Performance against the 62-day GP cancer standard in December 2025.

Tumour site	No of breaches	Trust performance
Breast	12.0	68.4%
Colorectal	9.5	72.5%
Gynaecology	1.0	94.4%
Haematology	4.0	82.6%
Head & Neck	6.0	61.3%
Lung	4.0	86.9%
Other	0.0	100.0%
Skin	16.0	81.1%
Upper GI	13.0	56.7%
Urology	21.5	75.7%
Total	**87.0**	**76.4%**

Eighteen patients were treated in December on or after day 104 (the national 'backstop' for GP pathways). A breakdown of the breaches is as follows:

- Nine patient pathways had internal delays mainly related to a lack of capacity. Most of these pathways also had elements of unavoidable delays, due to additional investigations, medical complexity, waiting times at other organisations and periods of patient choice.
- Five patients had a complex pathway, including patients requiring additional or repeat diagnostics, transferring from a different cancer pathway and being treated at the same time for another cancer.
- Four pathways were delayed due to a range of factors, including elements outside of our control.

Appendix 2 – Infection Control and Prevention – January 2026

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 = 6**	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. There has been one case of MRSA in January, a review of the case could not identify the source. Over this financial year case numbers have increased, and we have the fifth highest rates in the region. The reasons for this rise are unclear, sources are varied and no clear trends have been identified. Case numbers for MSSA remain stable and as a Trust we are under our internal trajectory. Regionally we have one of the lowest rates. This does not change our focus for improvement which is still peripheral cannulae.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 4 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Internal Threshold = 64** **Total year to date = 47**	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 9 Yeovil District Hospital = 6 Community Hospitals / Mental Health = 0 **Threshold = 100** **Total year to date = 109**	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 above trajectory. However, we still have one of the lowest rates in the region. **Klebsiella** Case numbers for Klebsiella are double where they were at the same point last year and the annual threshold has been breached. As a trust we still have some of the lowest rates in the region. Nationally, rates have been increasing since surveillance began in 2017. **Pseudomonas** Case numbers for Pseudomonas are higher than the same period last year and the annual threshold has been breached. As a Trust we are in the upper half regionally with rates of 7.06 per 100,000 occupied bed days (range 1.13 to 12.03).
Klebsiella bloodstream infections	
Musgrove Park Hospital = 2 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0 **Threshold = 36** **Total year to date = 44**	
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 3 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 0 **Threshold = 12** **Total year to date = 28**	

C. difficile	Commentary on C. difficile
Musgrove Park Hospital = 7 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0 **Threshold = 91** **Total year to date = 77**	Despite rising case numbers, regionally we have the lowest rates of infection (21.68 per 100,00 occupied bed days). Nationally case numbers are increasing, and the drivers are not clear. National experts have not identified any clear drivers to date. There have been no significant changes in overall antibiotic use, and there are no particular antibiotics being used that are implicated. Previously, certain strains of C diff such as 027 were linked to higher levels of disease and transmission but this does not seem to be the case currently.
Respiratory Viral Infections - inpatients	**Commentary on Respiratory Viral Infections**
COVID (Trust Cases) = 49 Musgrove Park Hospital = 32 Yeovil District Hospital = 14 Community / Mental Health = 3 **Influenza = 162 (Inpatients)** Musgrove Park Hospital = 104 Yeovil District Hospital = 49 Community Hospitals / Mental Health = 9 **Respiratory Syncytial Virus (RSV) = 98 (Inpatients)** Musgrove Park Hospital = 60 Yeovil District Hospital = 29 Community / Mental Health = 9	**Respiratory Viruses** • Cases of COVID-19 increased slightly in January which might indicate the beginning of a second wave. Since the beginning of April, there have been 775 inpatients with COVID-19. This is about half the number of cases we had during the same period last year (April 2024 to January 2025). • Cases of influenza have decreased significantly through January which is in line with the earlier start to the year. • RSV cases increased through January, which is in line with the usual season. The number of children with RSV significantly reduced in January and almost all cases were adults, mostly over 65yrs old.
Outbreaks	**Commentary on outbreaks**
COVID = 3 Musgrove Park Hospital = 2 Community Hospital = 1 **Influenza = 7** Musgrove Park Hospital = 2 Yeovil District Hospital = 2 Community Hospital = 2 Mental Health = 1	Outbreaks due to respiratory viruses decreased during January and as Flu levels decreased the Flu cohort ward was successfully de-cohorted and the ward returned to normal operations during January.

Norovirus = 15 Musgrove Park Hospital = 5 Yeovil District Hospital = 9 Community Hospital = 1 **Carbapenemase Producing Organism (CPO)** • **YDH -** Since January 2022 there have been 105 cases of CPO identified on the YDH site.	Outbreaks due to norovirus remained challenging in January and the biggest impact was seen on the Yeovil District Hospital site. **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. A screening strategy is being costed to try to determine the status of the outbreak.
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 (January 2025 to December 2025) a total of 349 operations were undertaken with no infections identified. • **Knee Replacement** Within the last year (January 2025 to December 2025) a total of 234 operations were undertaken and 2 infections identified giving an infection rate of 0.85% which overall remains in line with the national benchmark of 0.4%. • **Spinal Surgery** Within the last year (January 2025 to December 2025) a total of 339 operations were undertaken and 4 infections identified giving an infection rate of 1.18%. The infection rate is in line the national benchmark of 1.1%. • **Caesarean Section** Surveillance started in June 2025 as one of the assurance controls to support the use of the procedure room as a second operating space. The clinical teams were unable to support surveillance after June and therefore there is a gap in data

	however this has recommenced from November. Infections are monitored in two ways, firstly by monitoring for any patients readmitted to hospital with a surgical site infection these are medically confirmed infections. Secondly, patients are asked to submit a post discharge questionnaire and report any infections. These are not medically confirmed infections but are noted as self-reported. December data is being reviewed.
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.	**<u>Yeovil District Hospital Site</u>** • **Hip Replacement** Within the last year (January 2025 to December 2025) a total of 339 operations were undertaken with no infections identified. • **Knee Replacement** Within the last year (January 2025 to December 2025) a total of 459 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.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 28 January 2026
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Rosie Benneyworth, Acting Chair of the Quality and Governance Assurance Committee
DATE:	10 March 2026

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 28 January 2026 and reviewed temporary care environments, Strategic Aim 3 priorities, maternity and neonatal safety, and the Every Minute Matters programme. Assurance was noted in relation to improvements in escalation processes, community-based service developments, and continued compliance with maternity safety actions. Key risks remain around staffing pressures within neonatal services, the use of temporary care environments, and digital readiness ahead of the EPIC implementation. This report is presented to provide the Board with assurance on these areas and to highlight the principal risks identified by the Committee.
Recommendation	That the Board notes the assurance provided and the key risks highlighted, particularly those relating to temporary care environments, maternity and neonatal workforce pressures, digital readiness ahead of the EPIC implementation, and the ongoing delivery of Strategic Aim 3.

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)

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 – e.g. 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 QUALITY AND GOVERNANCE ASSURANCE COMMITTEE HELD ON 28 JANUARY 2026

1. PURPOSE

1.1 This report provides a summary of key items discussed at the Quality and Governance Assurance Committee (QGAC) focus meeting held on 28 January 2026, including assurance received, areas of concern, and risks/issues to be escalated to the Board. It is presented to provide assurance regarding the Trust's governance, oversight of quality and safety and management of associated risks.

2. ASSURANCE RECEIVED

2.1 The Committee received updates on the Board Assurance Framework and the Corporate Risk Register. It was noted that there were no material changes to the BAF this quarter, with risks relating to urgent and emergency care, workforce and system capacity continuing to sit above appetite due to sustained operational pressures since the Christmas period. The Committee also received an update on the Corporate Risk Register, including a new governance risk relating to sharp safety which had been scheduled for review by the Quality Assurance Group but postponed due to staff absence. Assurance processes for this risk are ongoing, and the Committee noted that discussions during the meeting may inform future updates to the BAF.

2.2 The Committee received an extensive update on patient care in temporary care environments. Operational pressures, particularly surges in ambulance conveyances linked to the Timely Handover Programme, continue to require the use of escalation spaces. A review identified inconsistent understanding of escalation terminology, incomplete SOPs and risk assessments, gaps in equipment such as call bells and privacy screens, and unreliable data capture. A rapid improvement project is underway including SOP revision, education, digital reporting improvements, and safety checks.

2.3 A detailed review of Aim 3 highlighted continued progress in community-based urgent and planned care. Hospital at Home activity is increasing, with improvements in urgent community response performance. MDT working across South Somerset West PCN has strengthened, with emerging evidence of reduced non-ambulance ED attendances. Community hospital test-and-learn changes are progressing at Burnham-on-Sea and Crewkerne.

2.4 The Committee received strong assurance regarding compliance with Safety Action One of the Maternity Incentive Scheme Year 7. All 2025 reviews met the requirement for external clinical involvement. Guideline compliance has exceeded the 75% CQC threshold and is progressing towards 90%. Despite pressures, the service remains safe and well led with notable achievements including improved survey results and strengthened governance. A neonatal workforce development plan is being prepared to address ongoing nursing shortages.

2.5 Assurance was received on the governance and implementation of the Every Minute Matters programme. The framework aims to improve discharge processes, embed personalised discharge planning, and strengthen

fundamental care through enhanced MDT board rounds, increased early-day discharges, improved weekend discharge activity, and better discharge lounge use.

3. AREAS OF CONCERN OR FOLLOW UP

3.1 Although improvements are underway, risks remain significant due to inconsistent SOP compliance, insufficient staffing during escalation, increased use of spaces outside policy, and the impact on patient and staff experience. Digital data capture is unreliable, and concerns were raised regarding increased numbers of undifferentiated patients in temporary spaces.

3.2 The Committee noted substantial risks associated with the EPIC EHR programme planned for 2028. The transition is expected to generate new risks during rollout, place demands on clinical staffing, and require significant planning to ensure digital safety and workforce resilience.

3.3 Workforce pressures remain a concern, particularly neonatal nursing vacancies and long-term sickness rates. Triage delays require sustained improvement despite dedicated leadership and consultant oversight.

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

4.1 The Committee agreed that risks relating to temporary care environments remain above the Trust's risk appetite, driven by ongoing operational pressures, variability in compliance with escalation processes, and limitations in data quality and digital reporting. The Committee noted that these risks continue to impact patient experience, staff wellbeing, and the reliability of assurance mechanisms.

4.2 The Committee noted that significant risks remain around digital readiness, particularly in relation to the future implementation of the EPIC Electronic Health Record. The potential diversion of senior clinical staff, combined with known interoperability and design risks, presents a compound risk across workforce, digital safety and quality assurance during the transition period.

4.3 The Committee agreed that maternity and neonatal workforce pressures, especially neonatal nursing shortages, long-term sickness, and pressures within triage, continue to pose safety and resilience challenges. Although improvement work is underway, the Committee emphasised the need for strengthened governance and clear oversight of the criteria and assurance required for the reopening of Yeovil maternity services.

4.4 The Committee highlighted that Strategic Aim 3 risks remain above appetite, as challenges persist in evaluating outcomes, demonstrating impact, and determining which community-based interventions can be sustained and scaled. The Committee agreed that clearer outcome measurement frameworks will be required to support future decision-making.

Rosie Benneyworth
ACTING CHAIR OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Maternity & Neonatal Quarter 3 (2025/26) Quality & Safety Report
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and 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:	10 March 2026

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 and quality of maternity and neonatal services
Recommendation	That the report be noted.

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

- ☐ Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
- ☒ Aim 2 Provide the best care and support to people
- ☐ Aim 3 Strengthen care and support in local communities
- ☒ Aim 4 Respond well to complex needs
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- ☐ 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)
Maternity and Neonatal Voices Partnership (MNVP) provide service user feedback and work with SFT colleagues as quorate members of all quality and 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 – e.g. 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

MATERNITY AND NEONATAL QUALITY AND SAEFTY REPORT QUARTER 3, 2025/26

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 Q3 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:**

- Achieving CQC target of 75% for maternity guidance
- CQC maternity experience survey very positive – best results in South West
- Festive celebrations including MatNeo Star Awards
- Recruited additional obstetric consultant, more interviews planned in January
- Completed two days visit by Amos Review team – data request complete and submitted on time
- Maternity Incentive Scheme, final evidence submission for Year 7 – anticipating full compliance

2. THE PLANNED FOCUS FOR Q3

- Gold QI projects in Triage and OASI (Obstetric Anal Sphincter Injury (otherwise known as 3rd and 4th degree tears))
- MNIP (Maternity and Neonatal Improvement Plan) now fully scoped, continuing to work to establish programme boards and workstream meetings
- NHSE MSSP support to drive key improvement including culture
- Planning for YDH re-opening

3. AREAS OF CONCERN

- YDH – work required to achieve safety criteria for re-opening
- Delays to IOL and flow pressures, due to staffing, capacity and estate issues
- Continued challenge to capture and report data related to health inequalities.
- Noted increase in primigravida women requesting elective caesarean section without medical indication (maternal choice)
- Challenge with lack of engagement from services outside of MatNeo re trust guidance development

4. MITIGATIONS IN PLACE

- Stakeholder meetings commenced to develop action plan for safe YDH re-opening

- Estates challenges including as workstream in MNIP, as are staffing
- Soft and hard intelligence triangulated to identify themes
- SW Cliunical Support Unit developing regional dashboard, draft shared Jan 26
- Continued challenge to access usable data via BI dashboards within SFT, unable to report meaningfully by ethnicity or deprivation
- Working party meeting to agree set of actions to understand service user choices and inform improvement

5. MIS SAFETY ACTION BRIEFING REPORTS

- A report detailing all deaths in quarter 3, including those supported for review using the Perinatal Mortality Review Tool (PMRT), has been written and was also discussed at the Safety Champion Board in January 2026. 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 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 Gold QI working group has been set up in response to this. A copy of the report is available for review in the Admin Control.

- The twice yearly Safer Staffing Report available in Admin Control demonstrates assurance to the Trust Board on the safety, effectiveness and sustainability of Midwifery and Neonatal staffing across the Trust for July – December 2025. Despite significant operational pressures, including the continued temporary closure of inpatient maternity and neonatal services ay Yeovil District Hospital (YDH) services remained safe, well-led and responsive, with robust oversight mechanisms in place.

  Birth activity increased by 13% compared with the previous reporting period, largely due to the relocation of intrapartum care from YDH. Musgrove Park Hospital (MPH) absorbed resulting increases in antenatal, postnatal and neonatal demand, supported by substantial reconfiguration of the MPH maternity footprint and introduction of a designated Transitional care area. The Somerset Neonatal Intensive Care Unit delivered 2,943 care days during the period, with increased activity linked to the YDH closure.

  Midwifery staffing remained largely stable, with high compliance in supernumerary labour ward coordinator cover and one-to-one care in labour. Funded vacancy levels were minimal, though an additional 6.31 WTE midwives above the current funded establishment are required to maintain safe staffing in light of increased MPH activity and amended footprint. Neonatal nursing continues to face significant Band 6 (QIS) vacancies, continuing to a reliance on bank and agency staffing and pressure on maintaining safe skill mix across all shifts. A business case is being developed to strengthen neonatal staffing and support compliance with national standards.

Sickness absence, particularly long term absence continues to impact both midwifery and neonatal teams., Targeted wellbeing, PMA/PNA support, and strengthened sickness management processes are being implemented to improve resilience and retention.

The Trust continues to meet the requirements of the Maternity Incentive Scheme (MIS) Safety Actions 4 and 5, with strong compliance demonstrated across midwifery oversight, obstetric consultant attendance, anaesthetic cover, and neonatal medical staffing standards.

- The quarterly meeting in the series of quarterly quality review meetings to monitor implementation of version 3 of the Saving Babies Lives Care Bundle took place on 28th October. The LMNS confirmed they approved the required amount of progress had been made against previously set targets. Whilst the targets were not increased for Quarter 3, progress continued and a further quarterly sign off meeting is scheduled.

- Compliance has been achieved with regard to mandatory training for fetal monitoring, Neonatal Life Support and MDT emergency training (PROMPT) as per the briefing report is available in the Admin Control. A minimum of 90% was achieved across all staff groups, except rotational resident doctors. For this staff group an action plan demonstrating the plan (attached to briefing paper) to achieve full compliance within six months of rotation to the Trust is accepted as evidence of compliance.

- The briefing report in Admin Control for Safety Action 9 demonstrates full compliance for perinatal quality and safety processes including the appointment of Non- Executive and Executive safety champions, implementation of the Perinatal Quality Surveillance Model (PQSM) and planned implementation of the Perinatal Quality Oversight Model (PQOM). Discussion of safety intelligence take place regularly at the nominated Board Committee (QGAJ) and at Safety Champions Board, both of which fora report to Trust Board.

- Finally with regard to Safety Action 10, the briefing paper in Admin Control, provides assurance that with regard to mandatory reporting of relevant cases to the Early Notification Scheme and the Maternity and Newborn Safety Investigations (MNSI) SFT are fully compliant. This reporting has become more streamlined with the implementation of a national reporting portal (SPEN) which negates the requirement to report the same case to multiple external organisations. Statutory requirements for Duty of Candour have been achieved.

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

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

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	CQC Maternity Service User Survey
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and Midwife
REPORT BY:	Alison Dennett/Stephanie Larcombe
PRESENTED BY:	Sally Bryant/Emma Davey
DATE:	10 March 2026

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 CQC Maternity Survey 2025 Action Plan has been developed in response to the national findings and IQVIA recommendations. The plan is structured around the key domains of Labour and Birth, Antenatal Care and Postnatal Care, with additional sections addressing Communication, Estates and Facilities, and Clinical Safety. This structure reflects both the maternity pathway and the wider system factors influencing women's experience. There is a strong emphasis on strengthening governance and assurance arrangements to ensure these actions are delivered effectively and translate into measurable and sustained improvements in women's experience and outcomes. **Co-production with MNVP** Design and delivery of the action plan has been co-produced with the Maternity and Neonatal Voices Partnership (MNVP) ensuring that lived experience is embedded throughout improvement activity. The MNVP team have been actively involved in the development of actions, particularly those relating to communication, personalised care and listening to women's concerns. **Thematic review and alignment to the Maternity & Neonatal Improvement Plan (MNIP)** A thematic review of the Maternity Survey 2025 findings and actions is currently underway against the Maternity and Neonatal Improvement Plan (MNIP). This review will:

	• Map actions to existing MNIP priorities, including communication, continuity, triage, postnatal care and workforce. • Identify where actions are already being progressed through the MNIP and where additional or distinct actions are required. • Avoid duplication and ensure a single improvement narrative. Where actions are already embedded within the MNIP, this will be clearly documented to provide clarity and assurance on ownership and delivery. **Governance Assurance and Reporting** Oversight of the Maternity Survey 2025 Action Plan is maintained through the maternity governance framework. The plan is reviewed and updated quarterly by the Perinatal Experience and Engagement Committee as well as oversight via the Trust Patient Experience and Engagement Committee. Progress is formally reported to the Perinatal Leadership Team (PLT) to ensure strategic scrutiny and alignment with service priorities, and is further monitored through Maternity and Neonatal Governance, which feeds into wider Trust governance structures. Governance and assurance arrangements include: • Regular review of progress, risks and RAG status of actions • Escalation of issues, slippage or risks requiring senior intervention through agreed governance routes • Triangulation of survey findings with PALS, complaints, safety intelligence and staff feedback This structured reporting route will provide clear accountability and line of sight from patient experience through to Trust-level governance, supporting clear accountability for delivery of agreed actions, which aligned to national and local priorities.
Recommendation	The Board is asked to discuss and note the report

Links to Joint Strategic Aims (Please select any which are impacted on / relevant to this paper)
☐ Aim 1 Contribute to improving the 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)
The views of service users and the public have been central to the issues covered in this report. The Maternity Survey 2025 itself provides a primary source of service-user feedback and has directly informed the development and prioritisation of actions within the action plan. In addition, the action plan has been developed and reviewed through ongoing engagement with the Maternity and Neonatal Voices Partnership (MNVP), ensuring that lived experience and the perspectives of women and families are embedded throughout.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – e.g. in Part B]
The report is presented to the Board following sharing of the survey results with the Patient Experience and Involvement Committee.

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

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

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NHS Maternity Services Survey 2025 Benchmark Report

Kindness, Respect, Teamwork
Everyone, Every day

Sally Bryant & Emma Davey

10/03/2026

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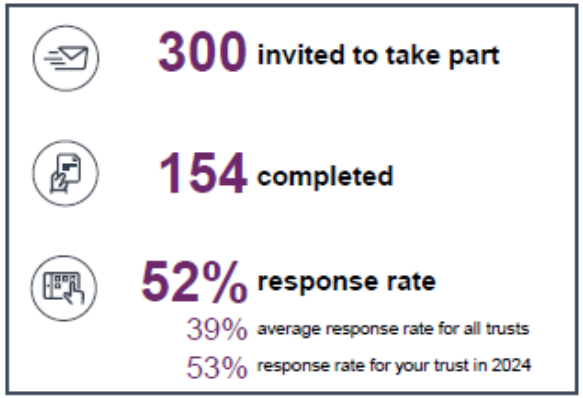
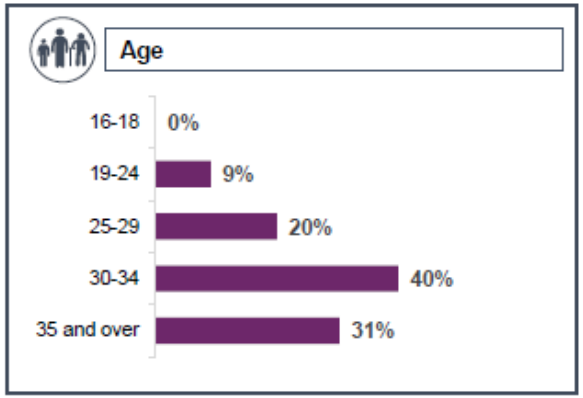
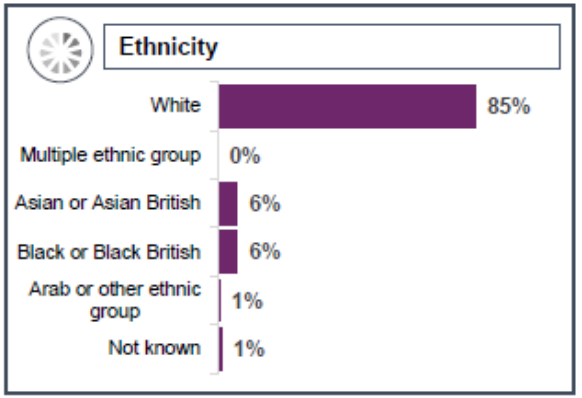
Headline Results

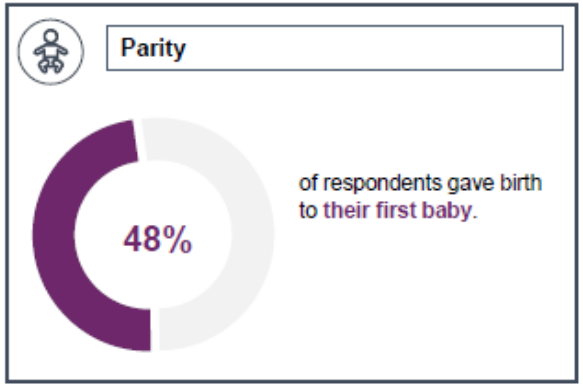
Disclaimer: The following charts are taken from the CQC reports.

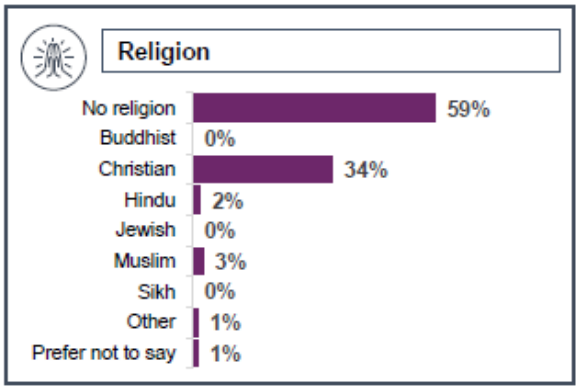
Who took part in the survey?











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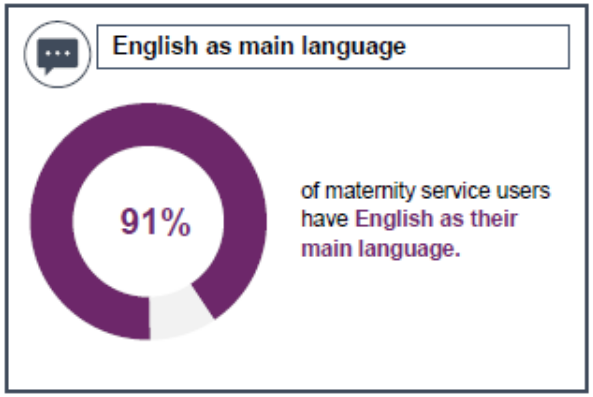

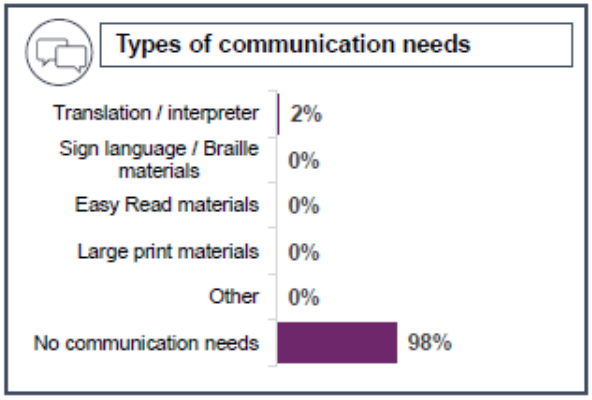

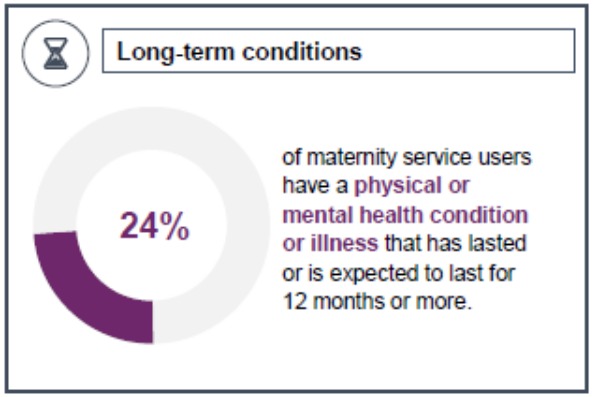

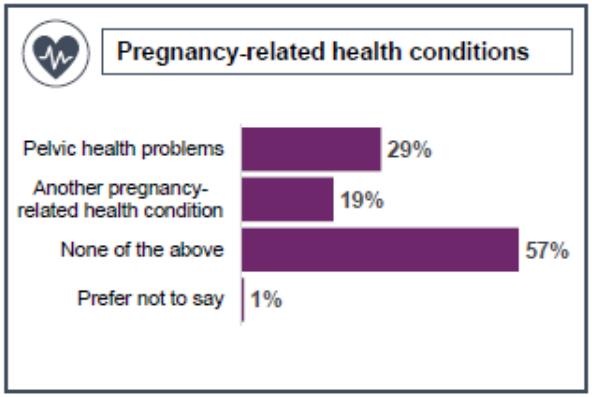

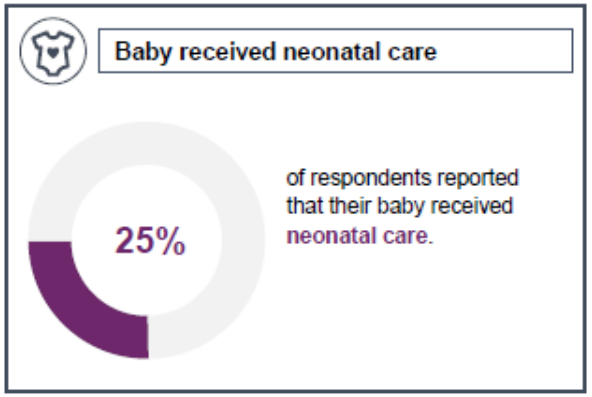

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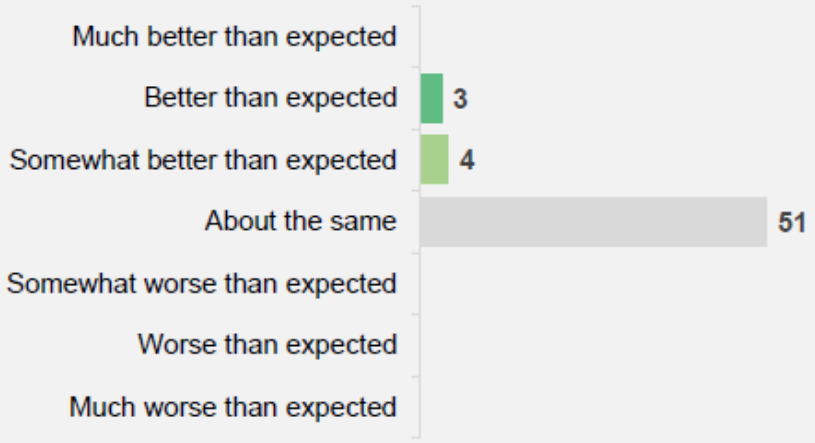
Comparison to Other Trusts

Summary of findings for Somerset NHS Foundation Trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2025 vs 2024.

Comparison to other trusts

Better than expected

- C4. Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?
- D2. On the day you left hospital, was your discharge delayed for any reason?
- G16. In the four weeks after the birth of your baby, did you receive help and advice from midwives about your baby's health and progress?

Somewhat better than expected

- G1. Thinking about your postnatal care, were you involved in decisions about your care?
- G14. In the four weeks after the birth of your baby, did you receive help and advice from a midwife about feeding your baby?
- G15. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?
- G19. At any point during your maternity care journey, did you consider making a complaint about the care you received?

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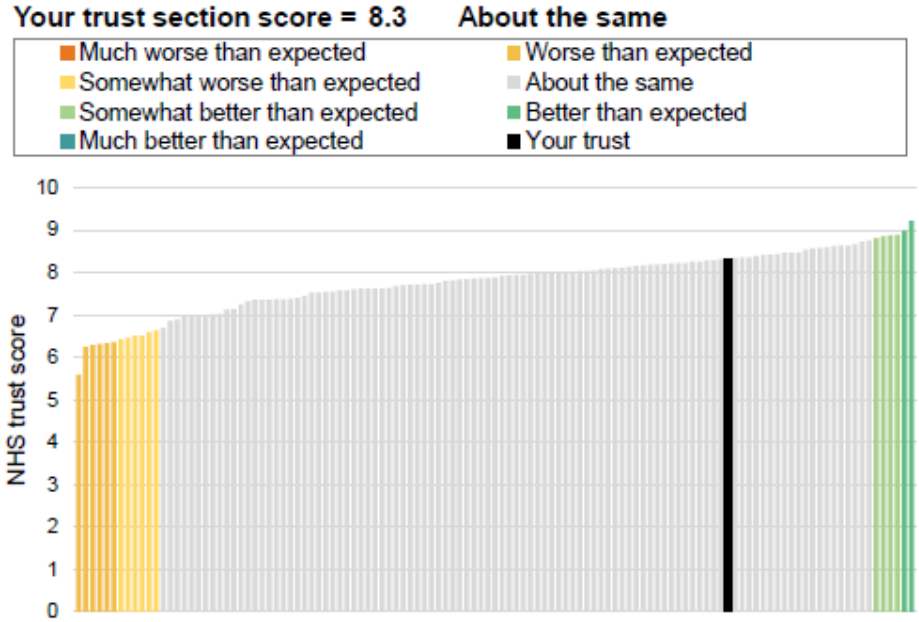
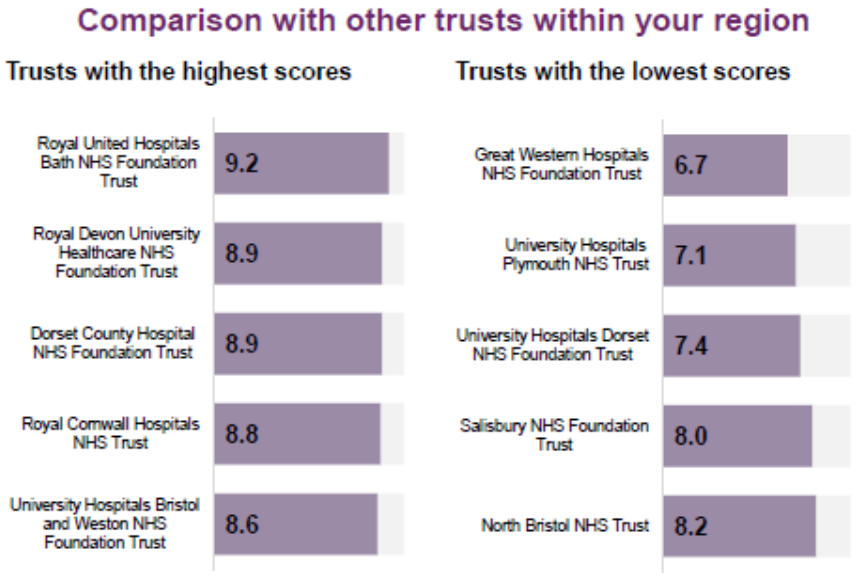
Benchmarking – nationally and regionally

The start of your care in pregnancy

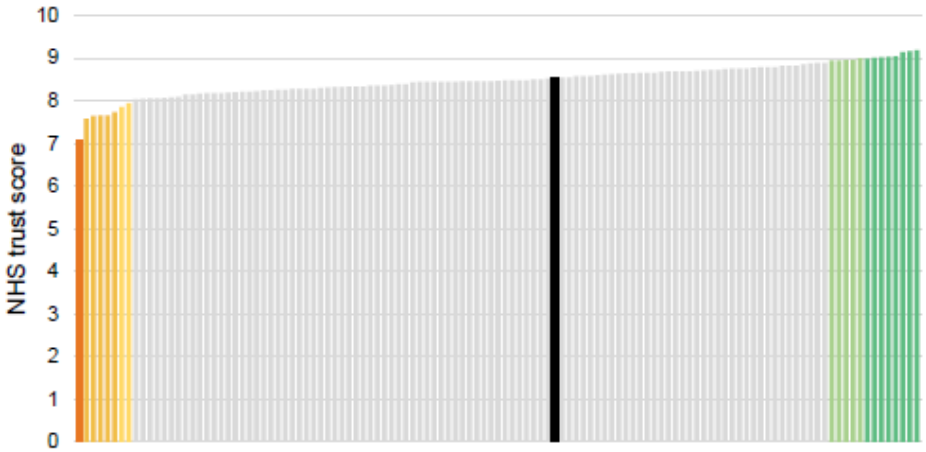




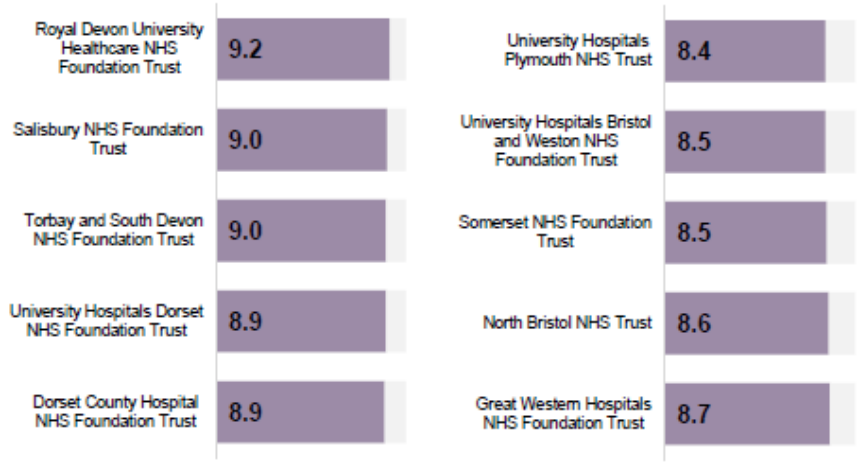
Antenatal check-ups

Your trust section score = 8.5 **About the same**

- Much worse than expected
- Somewhat worse than expected
- Somewhat better than expected
- Much better than expected
- Worse than expected
- About the same
- Better than expected
- Your trust

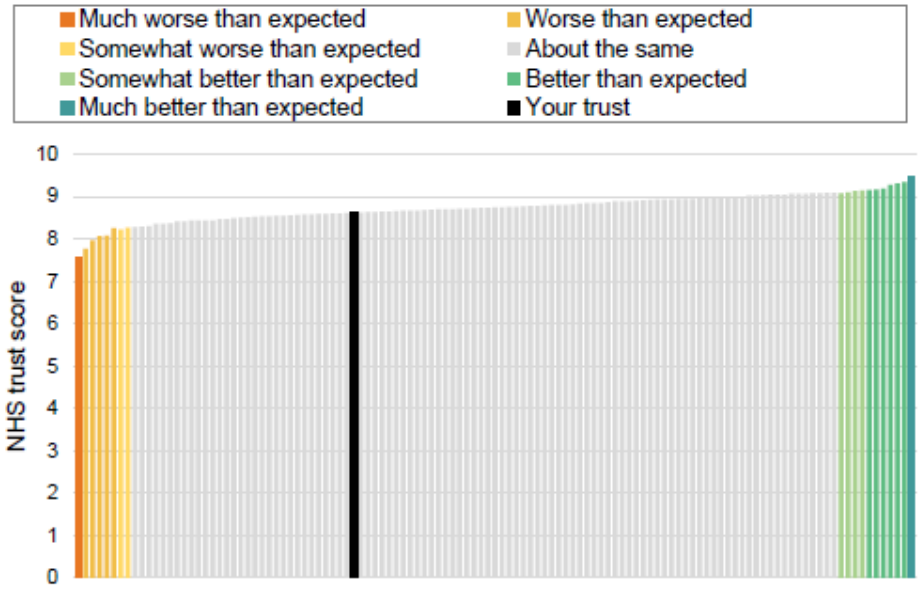


Comparison with other trusts within your region

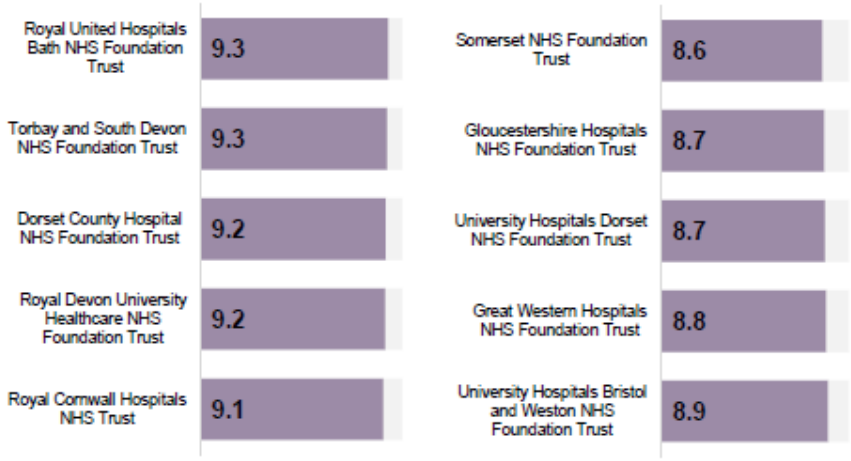


During your pregnancy

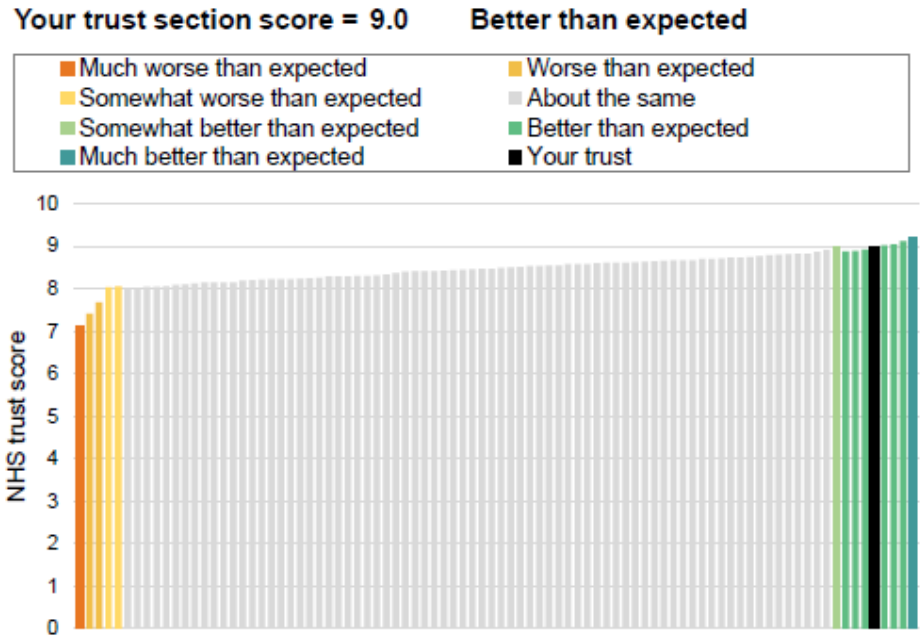
Your trust section score = 8.6 **About the same**

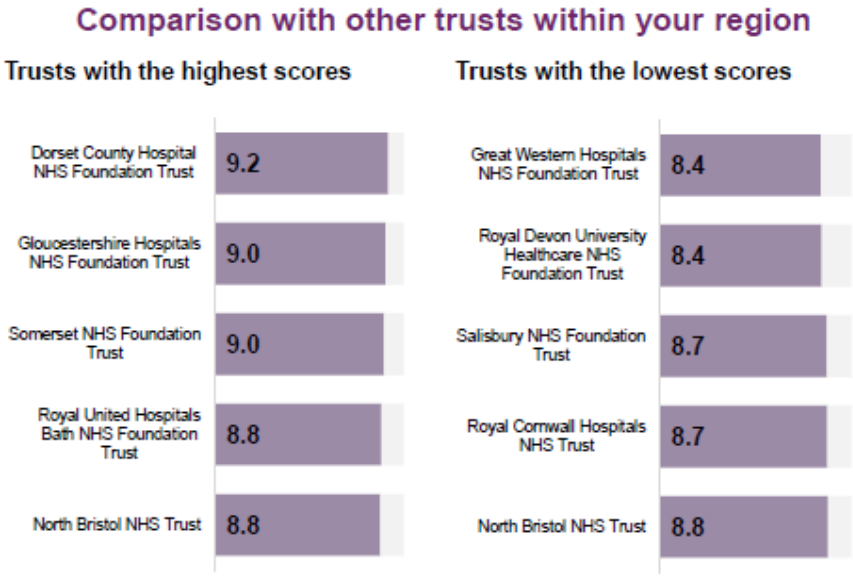


Comparison with other trusts within your region



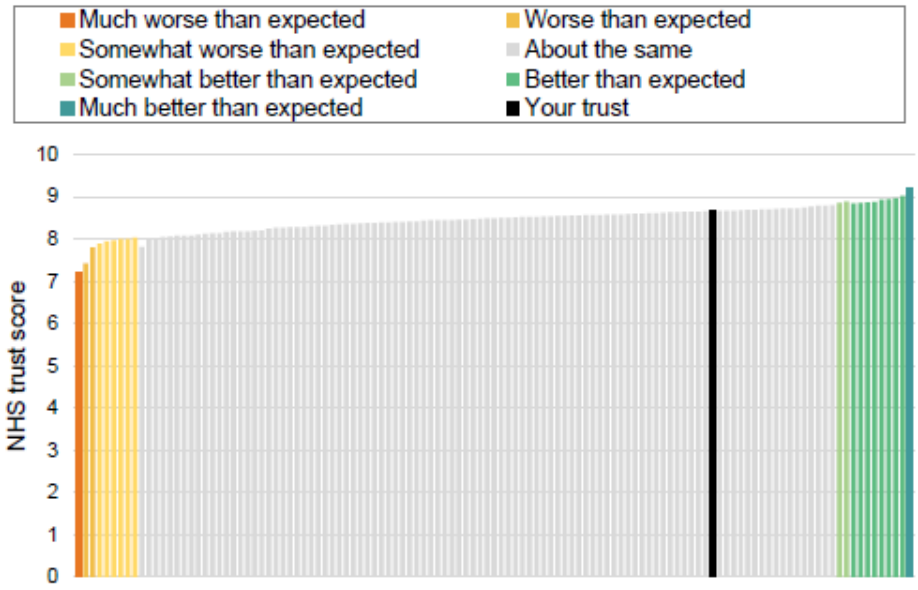
Your labour and birth



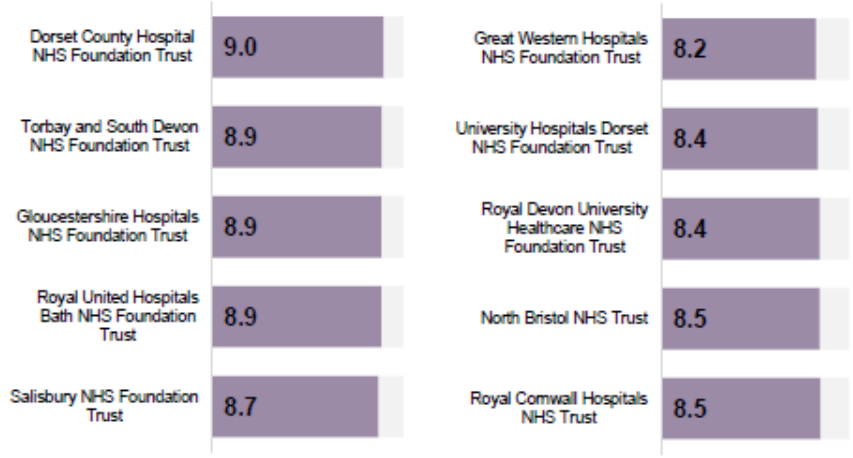


Staff caring for you

Your trust section score = 8.7 **About the same**

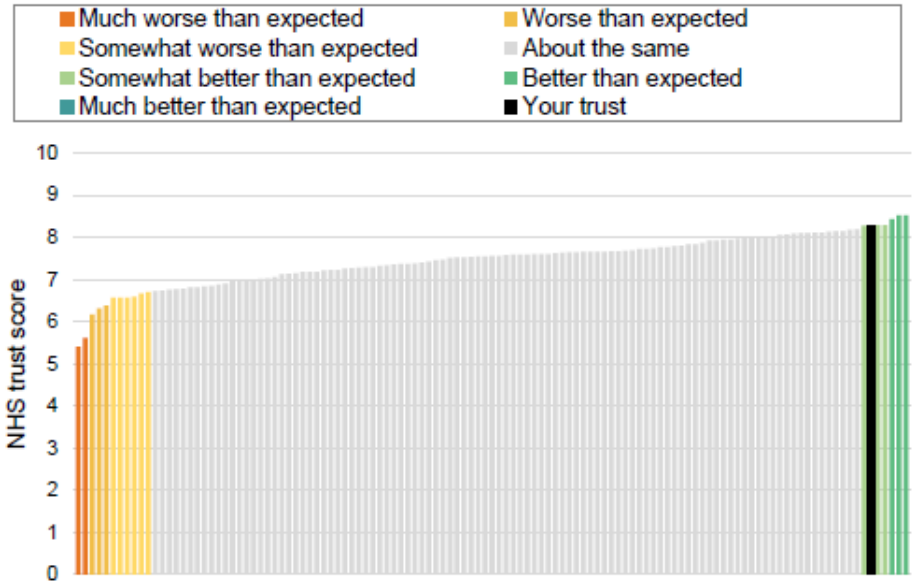


Comparison with other trusts within your region

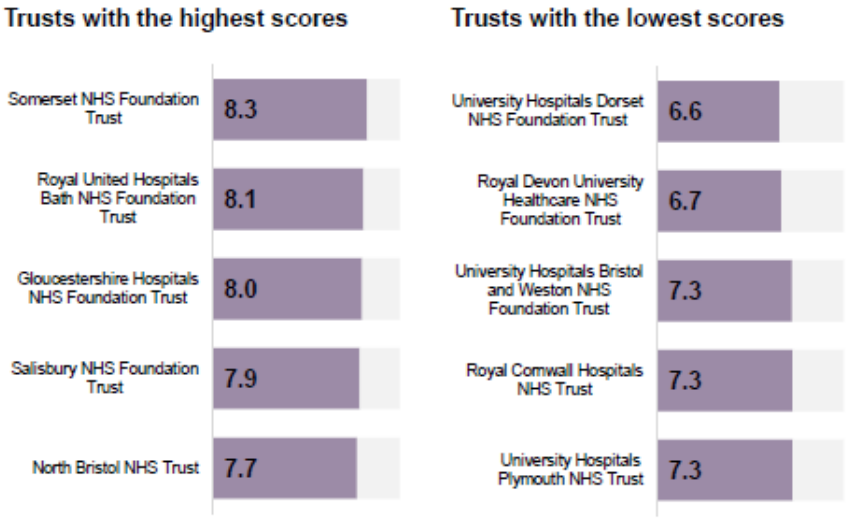


Care in the ward after birth

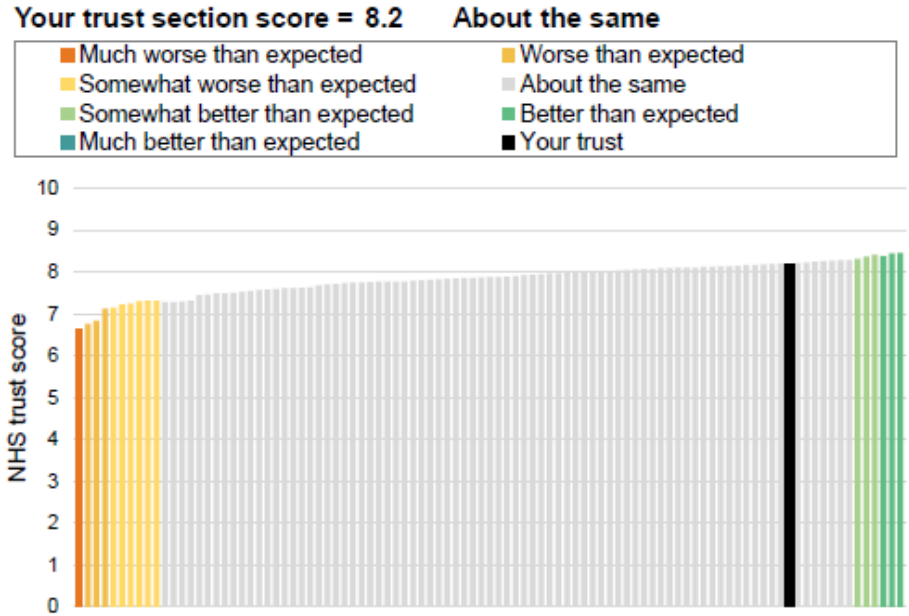
Your trust section score = 8.3 **Somewhat better than expected**

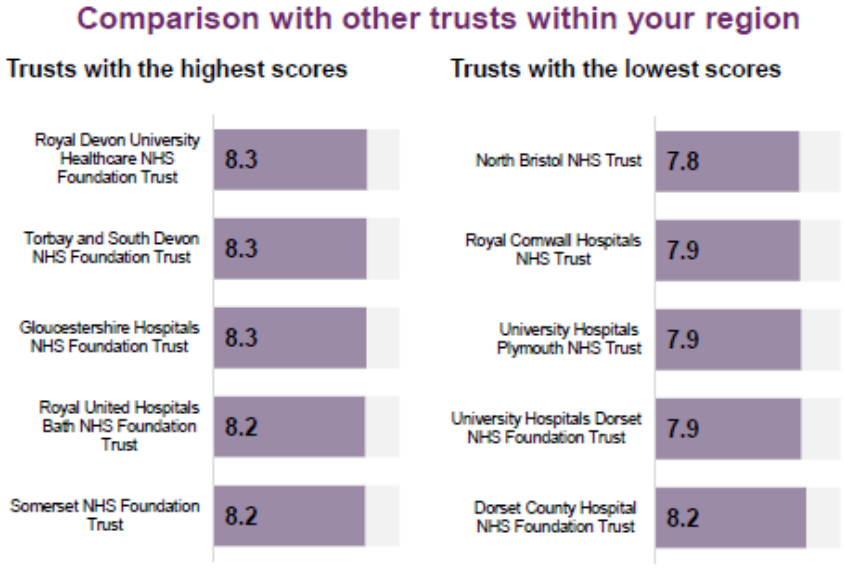


Comparison with other trusts within your region



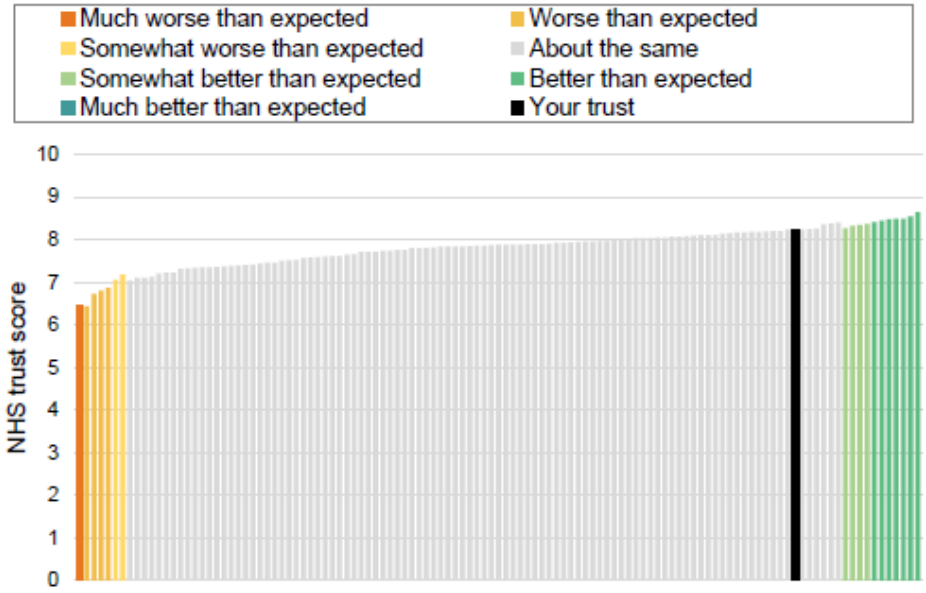
Care at home after birth



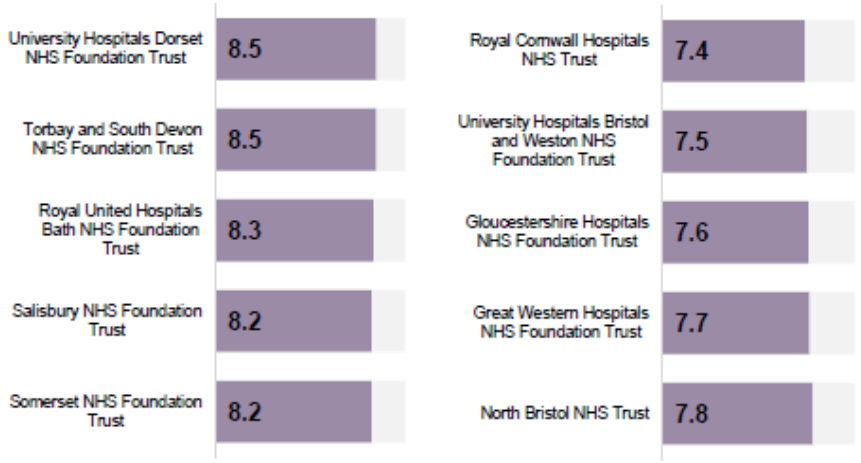


Triage: Assessment and Evaluation

Your trust section score = 8.2 **About the same**



Comparison with other trusts within your region



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Summary and Next steps

Overall Narrative

Key Messages from the Narrative Comments

- Strong blend of highly positive experiences alongside areas requiring improvement.
- Many women reported excellent care from midwives, doctors, neonatal teams and home-birth teams.
- Staff described as kind, professional and compassionate; individual staff frequently praised.
- Supportive communication had a clear positive impact on confidence and emotional wellbeing.
- Positive birth experiences often linked to feeling listened to, supported, and having continuity of care.

Positive Themes

What women valued (thematic analysis taken from the free text comments)

- Kindness, professionalism, and compassion.
- Clear explanations and involvement in decisions.
- Supportive communication that builds confidence.
- Positive labour and birth experiences.
- Impact of continuity of care.

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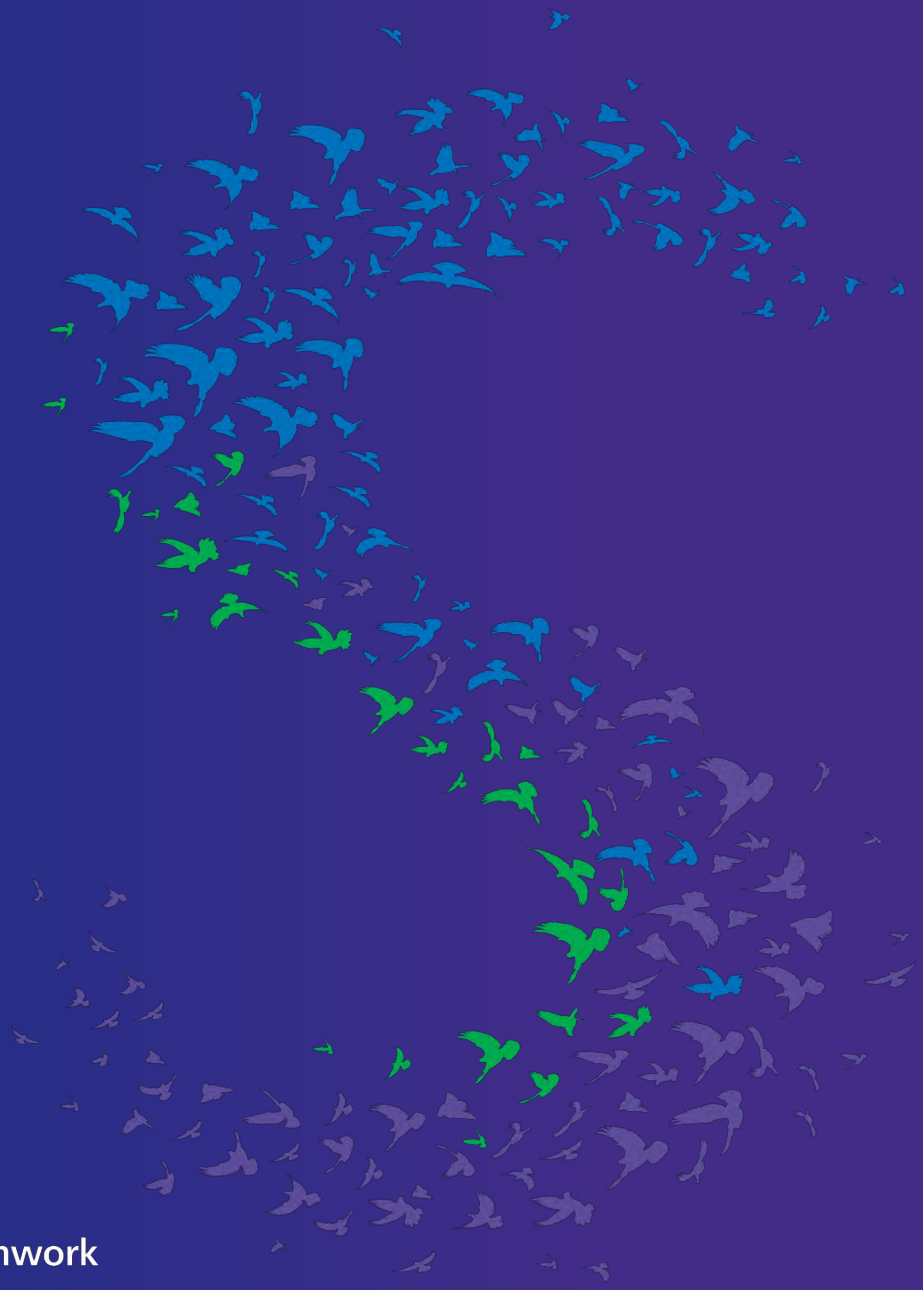
Next Steps

- Review survey themes against the existing CQC maternity service user survey improvement plan.
- Identify where new or adapted actions are needed (e.g., postnatal support, continuity of care, communication).
- Co-produce action plan with the MNVP
- Produce an updated action plan to bring back to the perinatal and experience and engagement committees, including how improvements will be measured.
- Begin to map change over time to enable comparisons and track improvement trajectory

Thank you for listening

Any questions?



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Everyone, Every day

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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Group Finance report
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	10 March 2026

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

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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – 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 January, the Trust reported a £1.746m surplus, which was on plan for the month. Year to date, the Trust remains on plan with a cumulative deficit of £5.048m.

1.2 The January headlines were:-

- Agency expenditure in January totalled £1.386m, representing a £0.071m reduction from December. On a comparable, this was £0.833m lower than January 2025, and cumulative spending is £9.495m below the equivalent period in 2024/25. The Trust has been able to successfully sustain its reduction in agency usage, a significant achievement given the heightened operational pressures experienced during winter.
- CIP delivery in month was £4.894m, £1.080m below plan. The recovery of retrospective VAT on agency expenditure has fully closed the gap, and we continue to forecast full delivery of the £50m efficiency programme. However, £35.182m (70%) of this is non-recurrent.
- The Trust continues to face significant operational pressures associated with winter, creating additional strain on both services and finances as we approach year end. To maintain our planned breakeven position, it will be essential to mitigate any unfunded pressures and sustain delivery of the remaining efficiencies within our programme.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the Group summary income and expenditure account to 31 January 2026:

Table 1: Income and Expenditure Summary January

Statement of Comprehensive Income	Annual Budget	Current Month 10			Year to date		
	£000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	1,040,254	87,967	87,542	(424)	867,845	871,815	3,970
Other Operating Income	78,973	6,183	16,324	10,141	64,841	77,146	12,304
Total operating income	1,119,227	94,150	103,867	9,716	932,686	948,960	16,274
Operating expenses							
Employee Operating Expenses	(771,114)	(62,745)	(64,668)	(1,923)	(645,436)	(656,122)	(10,686)
Drugs Cost: Consumed/Purchased	(81,313)	(7,449)	(7,649)	(201)	(69,446)	(71,631)	(2,185)
Clinical Supp & Serv Exc-Drugs	(74,642)	(6,022)	(7,298)	(1,276)	(63,503)	(69,078)	(5,575)
Supplies & Services - General	(32,144)	(2,884)	(3,511)	(627)	(26,640)	(31,665)	(5,025)
Other Operating Expenses	(151,737)	(12,705)	(17,868)	(5,163)	(125,987)	(118,247)	7,740
Total operating expenses	(1,110,950)	(91,803)	(100,993)	(9,190)	(931,012)	(946,743)	(15,731)
Operating Surplus/Deficit	8,277	2,347	2,873	526	1,675	2,217	543
Finance Expense	(14,177)	(1,201)	(1,247)	(45)	(11,774)	(10,639)	1,135
Finance Income	3,518	285	435	149	2,947	2,196	(751)
Other	0	(1)	(1)	(0)	0	(12)	(13)
Overall Surplus/(Deficit)	(2,383)	1,430	2,061	630	(7,152)	(6,238)	915
Depr On Donated Assets	1,216	101	93	(8)	1,013	1,194	181
Donated Assets Income	(1,412)	0	0	0	(1,059)	(156)	903
Amortisation	0	0	3	3	0	30	30
PFI UK GAAP Adjustments	2,579	215	(411)	(626)	2,150	122	(2,028)
Impairments	0	0	0	0	0	0	0
Adjustments to control total	2,383	316	(315)	(631)	2,104	1,190	(914)
Adjusted Financial Performance	(0)	1,746	1,746	0	(5,048)	(5,048)	0

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

- In January, our total staffing was 12,879 WTE, 212 WTE under the planned establishment for the month of 13,091 WTE with the following variances: -
  - Substantive staff were 190 WTE under the establishment plan.
  - Bank 13 WTE over plan.
  - Agency 15 WTE under &
  - Locums 19 WTE under the plan

2.3 Further information 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	Oct-25 £000	Nov-25 £000	Dec-25 £000	Jan-26 £000	2025/26 In Month Budget	F/(A) Variance £000	2025/26 Total £000	2025/26 YTD Budget	F/(A) Variance £000
Temporary staff															
Bank Staff	2,083	2,224	2,055	2,127	2,253	2,072	2,061	2,108	1,985	2,126	1,796	(330)	21,095	17,928	(3,167)
Medical Agency	1,251	1,178	1,175	1,167	1,082	1,107	1,128	922	1,117	1,013	722	(291)	11,141	9,424	(1,716)
Medical Locums	846	800	816	808	963	755	797	849	1,533	658	898	240	8,827	9,503	677
Nursing Agency	406	317	315	364	321	285	79	307	252	349	247	(101)	2,995	2,443	(551)
Other Agency	170	168	118	119	97	92	102	72	88	24	139	114	1,049	1,652	602
Total Temporary Staff	**4,756**	**4,687**	**4,480**	**4,585**	**4,716**	**4,311**	**4,167**	**4,258**	**4,975**	**4,171**	**3,802**	**(368)**	**45,106**	**40,951**	**(4,155)**
Nursing	16,525	16,473	16,437	16,715	15,960	16,565	16,307	16,772	16,692	16,871	17,022	151	165,316	172,573	7,256
Support to Nursing	6,368	6,342	6,372	6,020	6,486	6,153	5,939	5,890	5,924	5,947	5,556	(391)	61,442	57,017	(4,425)
Medical	13,858	13,752	13,742	14,734	14,699	14,710	14,444	14,640	14,165	14,166	13,364	(801)	142,909	132,317	(10,592)
AHP's	9,526	9,523	9,533	9,691	9,919	9,787	9,696	9,761	9,702	9,758	9,722	(36)	96,896	97,631	735
Infrastructure Support	10,548	10,483	10,698	10,604	10,749	10,484	10,934	10,912	10,554	10,037	9,205	(832)	106,002	104,149	(1,853)
Other	4,011	4,184	4,113	4,635	4,231	3,319	3,678	2,779	3,782	3,718	4,073	355	38,451	40,798	2,347
Substantive Staff	**60,835**	**60,756**	**60,896**	**62,398**	**62,044**	**61,019**	**60,997**	**60,755**	**60,819**	**60,497**	**58,942**	**(1,555)**	**611,016**	**604,485**	**(6,531)**
Total All Staff	**65,592**	**65,443**	**65,376**	**66,983**	**66,760**	**65,331**	**65,164**	**65,013**	**65,794**	**64,668**	**62,745**	**(1,923)**	**656,122**	**645,436**	**(10,686)**
% Temporary	7.25%	7.16%	6.85%	6.84%	7.06%	6.60%	6.39%	6.55%	7.56%	6.45%	6.06%		6.87%	6.34%	

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	Oct-25 WTE	Nov-25 WTE	Dec-25 WTE	Jan-26 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	489.04	489.45	461.36	491.54	478.85	(12.69)
Medical Agency	57.89	55.77	55.19	56.24	50.27	50.74	48.00	48.69	49.73	45.28	38.07	(7.21)
Medical Locums	48.91	45.94	47.85	47.33	45.45	43.49	49.88	44.29	47.60	58.59	77.73	19.14
Nursing Agency	58.76	56.94	41.37	54.17	47.42	41.23	49.60	41.04	41.94	45.84	44.01	(1.83)
Other Agency	42.53	35.57	29.31	23.27	19.17	21.36	15.98	9.83	13.52	6.27	31.28	25.01
Total Temporary Staff	**780.91**	**697.90**	**634.92**	**715.78**	**678.09**	**652.78**	**652.50**	**633.30**	**614.15**	**647.52**	**669.94**	**22.42**
Nursing	3,515.03	3,505.84	3,502.40	3,475.99	3,485.50	3,518.73	3,527.99	3,537.51	3,534.52	3,516.68	3,448.52	(68.16)
Support to Nursing	2,008.96	1,990.93	1,995.47	1,989.30	1,984.46	1,910.43	1,881.38	1,867.88	1,860.25	1,854.45	1,795.34	(59.11)
Medical	1,215.27	1,218.17	1,210.91	1,215.12	1,268.22	1,274.89	1,274.20	1,276.42	1,265.71	1,264.41	1,291.14	26.73
AHP's	1,623.27	1,617.72	1,625.00	1,612.73	1,634.40	1,650.36	1,648.79	1,641.49	1,651.48	1,653.52	1,738.99	85.47
Infrastructure Support	2,743.25	2,766.59	2,767.95	2,771.36	2,758.36	2,760.38	2,764.96	2,768.71	2,736.51	2,737.58	2,842.17	104.59
Other	1,231.31	1,234.14	1,227.20	1,234.78	1,222.60	1,206.86	1,215.86	1,218.54	1,210.23	1,204.79	1,305.06	100.27
Substantive Staff	**12,337.09**	**12,333.38**	**12,328.93**	**12,299.28**	**12,353.55**	**12,321.65**	**12,313.18**	**12,310.54**	**12,258.69**	**12,231.42**	**12,421.22**	**189.80**
Total All Staff	**13,118.00**	**13,031.28**	**12,963.85**	**13,015.06**	**13,031.64**	**12,974.43**	**12,965.68**	**12,943.84**	**12,872.84**	**12,878.94**	**13,091.16**	**212.22**
% Temporary	5.95%	5.36%	4.90%	5.50%	5.20%	5.03%	5.03%	4.89%	4.77%	5.03%	5.12%	

2.4 Total agency and locum costs in month were £2.045m, a decrease of £0.946m compared with December. This is largely due to the industrial action locum backfill costs in December. Agency costs were £0.071m lower than in December at £1.386m. There was a decrease of £0.104m in medical agency, a £0.097m increase in nursing agency.

2.5 The sustained reduction in agency usage is highly positive. The Trust is now outperforming the national target of a 30% reduction and is within 1% of achieving our stretch goal of a 40% reduction. This represents a significant achievement, demonstrating strong operational control and the success of efforts to recruit to historically hard-to-fill roles.

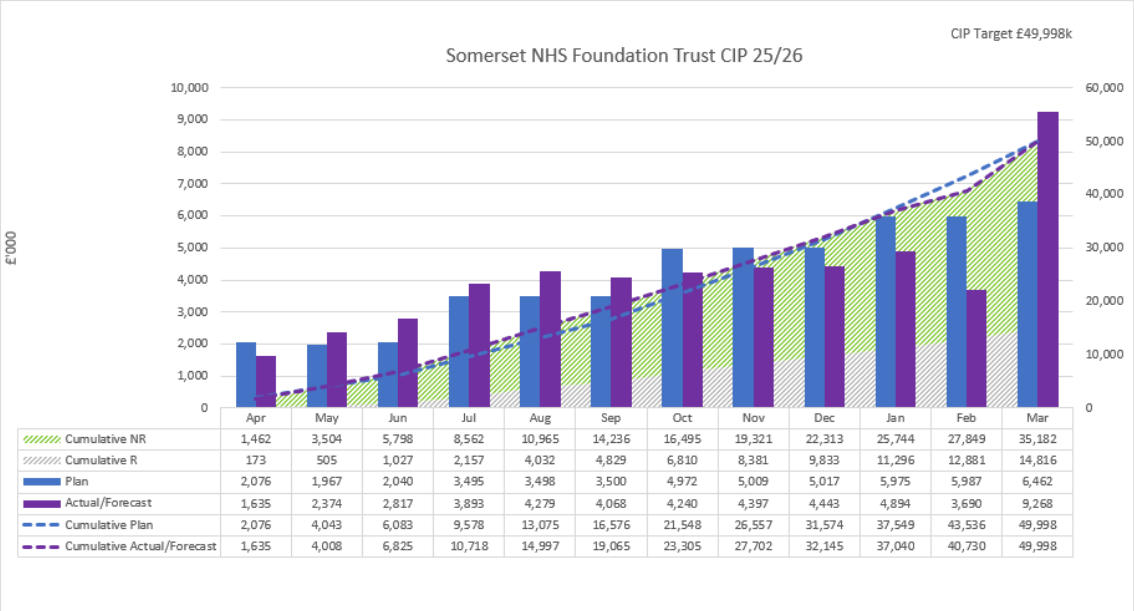
3. COST IMPROVEMENT PROGRAMME

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

3.2 In January, total savings of £4.894m were delivered, this was £1.080m under plan for the month. Recurrent savings were £1.463m (30% of total) and savings of £37.040m have been delivered to date, this is £0.509m adverse to the planned position. However, of the total delivery to date, only £11.296m (30%) is recurrent and full year forecast also indicates we will deliver c70% of savings non-recurrently. The Board will be aware of the impact this has had on our plans for 2026/27 and the intention to significantly improve our recurrent delivery next year.

3.3 Further analysis is shown in the chart below: -

Chart 1: CIP Plan 2025/26



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative NR	1,462	3,504	5,798	8,562	10,965	14,236	16,495	19,321	22,313	25,744	27,849	35,182
Cumulative R	173	505	1,027	2,157	4,032	4,829	6,810	8,381	9,833	11,296	12,881	14,816
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	2,817	3,893	4,279	4,068	4,240	4,397	4,443	4,894	3,690	9,268
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	6,825	10,718	14,997	19,065	23,305	27,702	32,145	37,040	40,730	49,998

3.4 The Trust has no unidentified as a result of the inclusion of the vat recovery on agency expenditure. Work has already commenced on recovery and this is being undertaken by EY as our VAT advisors on our behalf. We have included a prudent net value of the amount recoverable.

3.5 We must focus on continuing to deliver our service cip plans as forecast, these are expected to deliver c£8m in the remaining two months. The ongoing operational pressures increase the risk that planned schemes may slip and we do not have the headroom in our position to mitigate this.

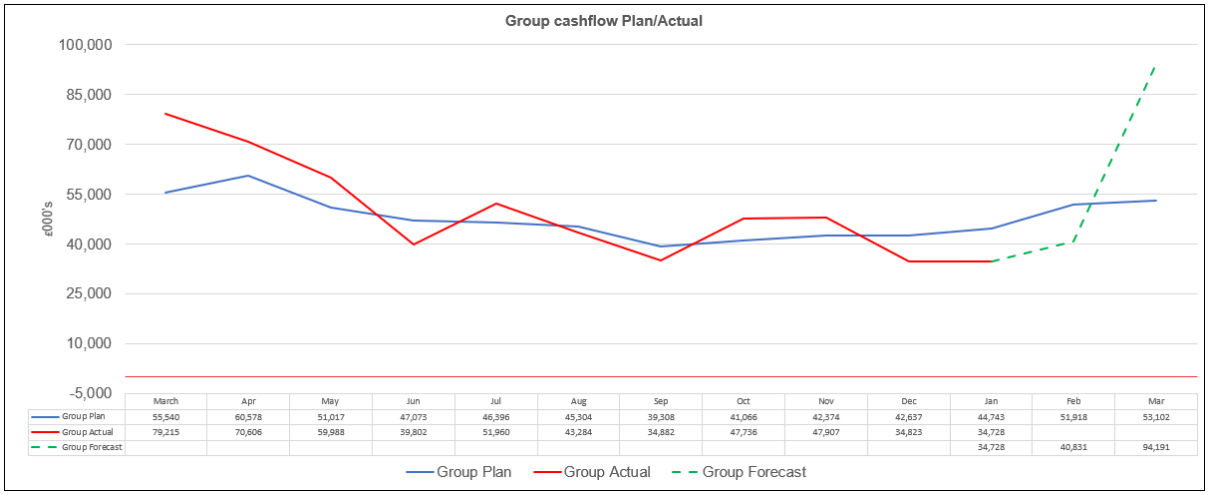
4. CASH

4.1 Cash balances at 31 January were £34.7m; £10m lower than plan, largely due to capital expenditure incurred in advance of PDC drawdown (£26.5m drawn down in February to be received in March with a further £17.4m expected to

be drawn down for EHR). The group cashflow position including the updated forecast is shown below.

4.2 The forecast cashflow position in March refers to monies received for Capital PDC draw-downs (EHR) that will remain as capital creditors at year-end with the payment of invoices expected Q1 2026-27.

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	47,736	47,907	34,823	34,728		
Group Forecast											34,728	40,831	94,191

4.3 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.

5. STATEMENT OF FINANCIAL POSITION

Dec-25	Jan-26	Movement		Mar-25	Jan-26	Movement in Year
£000	£000	£'000		£000	£000	£000
45,006	45,919	913	Intangible Assets	35,549	45,919	10,370
415,576	418,337	2,761	Property, plant and equipment, other	408,864	418,337	9,474
27,251	27,409	158	On SoFP PFI assets	29,141	27,409	(1,731)
86,228	85,464	(763)	Right of use assets	89,834	85,464	(4,370)
(76)	14	89	Investments	14	14	0
14	14	0	Other investments/financial assets	14	14	0
3,178	3,335	157	Trade & other receivables > 1yr	3,063	3,335	271
577,177	**580,493**	**3,316**	**Non-current assets**	**566,479**	**580,493**	**14,014**
13,890	13,084	(806)	Inventories	11,281	13,084	1,803
16,762	14,686	(2,077)	Trade and other receivables: NHS receivables	5,338	14,686	9,348
27,333	38,389	11,056	Trade and other receivables: non-NHS receivables	18,796	38,389	19,593
0	0	0	Non current assets held for sale	496	0	(496)
34,823	34,728	(95)	Cash	79,215	34,728	(44,487)
92,808	**100,886**	**8,078**	**Total current assets**	**115,126**	**100,886**	**(14,240)**
(104,788)	(106,736)	(1,948)	Trade and other payables: non-capital	(102,078)	(106,736)	(4,659)
(5,555)	(7,733)	(2,178)	Trade and other payables: capital	(18,183)	(7,733)	10,450
(29,792)	(21,865)	7,927	Other liabilities	(18,455)	(21,865)	(3,410)
(12,957)	(12,173)	784	Borrowings	(16,046)	(12,173)	3,873
(3,191)	(4,666)	(1,475)	Provisions < 1yr	(9,440)	(4,666)	4,774
(156,284)	**(153,173)**	**3,111**	**Current liabilities**	**(164,203)**	**(153,173)**	**11,029**
(63,476)	**(52,287)**	**11,189**	**Net current assets**	**(49,077)**	**(52,287)**	**(3,212)**
(109,838)	(109,779)	59	Borrowings > 1yr	(112,989)	(109,779)	3,210
(2,725)	(2,677)	48	Provisions > 1yr	(2,871)	(2,677)	194
(1,229)	(1,208)	22	Other liabilities > 1Yr	(1,423)	(1,208)	216
(113,792)	**(113,663)**	**129**	**Total long-term liabilities**	**(117,282)**	**(113,663)**	**3,619**
399,909	**414,542**	**14,633**	**Net assets employed**	**400,120**	**414,542**	**14,422**
			Financed by:			
407,823	420,284	12,461	Public dividend capital	399,414	420,284	20,870
73,581	71,459	(2,121)	Revaluation reserve	73,581	71,459	(2,121)
(3,702)	(3,702)	0	Other reserves	(354)	(3,702)	(3,349)
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(75,908)	(71,725)	4,183	I&E reserve	(70,733)	(71,725)	(992)
			Other's equity			
587	697	111	Non-controlling interest	683	697	14
399,909	**414,542**	**14,633**	**Total financed**	**400,120**	**414,542**	**14,422**

6. CAPITAL

6.1 Year to date, capital expenditure is £51.7m compared with the plan of £61.8m, resulting in an underspend of £10.1m. There are several timing differences within the internal programme on our 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. We are expecting to fully spend the programme by 31 March.

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	4,961	3,978	(983)
Essential Facilities Improvement Works	1,885	1,585	1,413	1,427	14
Service Redesign Enabling Works	4,243	7,046	3,676	4,734	1,058
Service Redesign Enabling Works - Major	13,400	9,800	12,966	13,559	593
Infrastructure	350	433	267	83	(184)
Rolling IT & Digital Development	7,230	7,350	5,714	5,879	164
Equipment Replacement	5,126	6,026	4,046	2,358	(1,688)
Subsidiary Companies	260	260	195	236	41
Transfers	1,844	0	0	0	0
Leases	5,668	10,797	4,801	2,330	(2,471)
Total Internal Capital Envelope	46,653	50,008	38,040	34,584	(3,455)
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	66,638	23,754	17,080	(6,673)
TOTAL TRUST PROGRAMME	105,034	116,646	61,793	51,665	(10,129)
Overplan Reduction	(2,134)				
TOTAL TRUST PROGRAMME	102,900	116,646	61,793	51,665	(10,129)

7. CONCLUSION & RECOMMENDATION

7.1 The financial position within many of our clinical services continues to be extremely challenging, particularly within the Children, Young People & Families, Surgery and Medical service groups. Operational pressures in these areas combined with shortfalls in their cip delivery are being offset by the release of non-recurrent sums held for year provisions and underspends in other clinical and non-clinical areas.

7.2 Escalation pressures continue to have a material impact on many of our services with increased pressure through higher patient numbers and increased colleague sickness due to winter bugs and sickness.

7.3 We are continuing to forecast breakeven and will continue to monitor the impact of escalation pressures on our financial performance. We may need to identify further actions to offset any unplanned increased in expenditure beyond those already included within our forecast but this is considered to be a relatively low risk

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 meeting held on 14 January 2026
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer Jade Renville, Director of Corporate Services
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Paul Mapson, Chair of the Audit Committee
DATE:	10 March 2026

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 Audit Committee met on 14 January 2026 and reviewed the Quarter 3 BAF and Corporate Risk Register, internal and external audit updates, counter fraud activity, limited assurance reviews, and a range of governance reports including AI governance and financial control items. Assurance was received on progress across risk management, internal audit delivery, fraud prevention, and audit planning, and this report provides assurance to the Board and highlights key risks requiring Board oversight.
Recommendation	The Board is asked to note the assurance provided and the key risks identified, including those relating to strategic risks above appetite, digital transformation and cyber assurance, governance effectiveness, and fraud prevention activity, and to support ongoing work to strengthen internal control, risk management and oversight across the Trust.

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)
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 – e.g. 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 14 JANUARY 2026

1. PURPOSE

1.1 The Audit Committee met on 14 January 2026 to review the effectiveness of internal control, risk management, governance and assurance arrangements 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 Quarter 3 Board Assurance Framework. It was noted that a number of strategic aims remained above the Trust's risk appetite, particularly those relating to the Electronic Health Record implementation, digital transformation, estates condition, workforce shortages, and discharge capacity pressures over the Christmas and New Year period. Improvements since Quarter 2 were highlighted, including strengthened Hospital at Home capacity, progress on digital programmes, rollout of self-referral cancer pathways, and positive developments on the ADHD service model.

2.2 The Committee reviewed the Quarter 3 Corporate Risk Register, noting 26 corporate risks with a continued high proportion of high-rated risks. Changes since the previous quarter included the reopening of an industrial action risk, new risks relating to claims and data strategy, and an increased risk concerning Information Commissioner's Office enforcement linked to Subject Access Request backlogs. Improvements in risk articulation and culture were noted, with mandatory risk management training compliance increasing to 79.6%. A revised Risk Management Strategy is in development for April.

2.3 The Committee received the Internal Audit Progress Report, noting good progress against the 2025/26 Internal Audit Plan and several audits receiving moderate assurance. Findings from audits relating to Third-Party Supplier Management, Symphony Complaints, Service Group Governance and Infection Prevention and Control were reviewed. The Committee also received the Culture Framework Maturity Assessment and the Follow-Up Report, noting the importance of ensuring timely completion of actions ahead of the Head of Internal Audit Opinion. The draft 2026/27 Internal Audit Plan was supported, with the final plan due for approval in April

2.4 KPMG provided assurance on completion of the 2024/25 Group and Trust accounts and confirmed preparation for the 2025/26 audit cycle. Materiality levels and key audit risks—valuation of land and buildings, understatement of expenditure, and management override—were outlined. No emerging concerns were identified.

2.5 The Committee received the Quarter 3 Counter Fraud Progress Report. The NHS Counter Fraud Authority engagement visit was positive, identifying only minor housekeeping actions. The National Fraud Initiative identified 17 duplicate payments (£58k), all successfully recovered. Updates were provided on active fraud investigations and the associated staff support processes. The updated Anti-Fraud, Bribery and Corruption Policy was approved,

reflecting new legislative requirements relating to failure to prevent fraud.

2.6 The Committee received assurance that Limited Assurance audits—including PEWS, rostering and temporary staffing, and agency identity checks—are being monitored through Executive and Committee routes, with improvements progressing in policy compliance, training, and digital verification processes.

2.7 The Committee reviewed losses and special payments, and single tender/quotation waivers. Assurance was received that all waivers had followed governance processes, with a peer-to-peer review scheduled for April. An overview of the Trust's AI Governance Framework was received, confirming robust arrangements for ethical oversight, cyber assurance, and information governance when implementing AI systems. The Committee also reviewed progress against its Terms of Reference and forward plan.

3. AREAS OF CONCERN OR FOLLOW UP

3.1 The Committee noted recurring themes within limited assurance reviews, including inconsistent application of processes, gaps in local oversight, and the need to ensure that improvements are embedded in practice rather than procedural alone. Concerns were raised regarding the articulation of the industrial action risk and the need for clearer classification. Risks linked to Information Commissioner's Office enforcement and Subject Access Request backlogs were discussed, with the Committee emphasising the importance of addressing underlying process and data infrastructure weaknesses. Strengthened oversight of digital transformation, cyber security and AI governance was identified as an emerging priority.

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

4.1 The Committee agreed that several strategic aims within the Board Assurance Framework remain above the Trust's risk appetite, including workforce sustainability, digital transformation, estates condition and urgent care pressures. The Committee highlighted the potential for compound risks across workforce, digital systems, estates and demand/capacity to exacerbate operational challenges if not effectively managed. The Committee also noted implications arising from the new "failure to prevent fraud" offence and confirmed the importance of maintaining strong fraud prevention arrangements. Limited assurance audit findings will be referred to the relevant Committees for further oversight.

Paul Mapson
CHAIR OF THE AUDIT COMMITTEE

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:	Katie Fry, Executive Assistant to Director of Strategy & Digital Development
PRESENTED BY:	Graham Hughes, Chairman of the Charity Committee
DATE:	10 March 2026

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 20 January 2026 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

This report was produced with the assistance of AI

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 20 JANUARY 2026

1. PURPOSE

1.1. The Charitable Funds Committee met on 20th January 2026 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 fundraising report from James Kirton. Highlights include:

- The Charity has been selected as one of only six NHS charities nationally to deliver a new Young People's Mental Health Project, securing £152,000 in external funding. [Enc 1a Min...2026 DRAFT | Word]
- Significant community fundraising results were reported, including:
- £14,000 raised at the Round Table Annual Ball.
- Ongoing partnership building with the Round Table to encourage recurring donations.
- Successful delivery of two Fire Walk events targeting new audiences and carrying low financial risk.
- Continued, though reduced, engagement with Glastonbury Festival and proactive relationship maintenance during their fallow period.
- Launch of a new fundraising toolkit and introduction of online direct debit functionality, improving supporter experience and modernising income processing.
- Upcoming major events include the annual golf day and a sold out wing walk at the end of May.
- Positive community relationships continue to grow, including partnerships with funeral directors and civic charity supporters such as the Mayor of Yeovil.

2.2. The Committee noted that the Charity's activity now more visibly supports both acute and mental health/community services, aligning well with the organisation's integrated identity.

2.3. The Committee received the Q3 finance report which highlighted the total income year-to-date is £968,000 including £75,000 in legacies and £46,000 in events income.

2.4. Major expenditure included £32,000 on point-of-care viral testing equipment and £99,000 delivered via the Open Mental Health grant scheme.

2.5. The Charity holds approximately £5 million in cash, with £4.3 million generating a favourable 3.8% return via COIF.

2.6. Five business cases were formally ratified collectively by the Committee, reflecting careful governance and prior email scrutiny.

2.7. The committee discussed ongoing concerns about the underperformance of the CCLA investment portfolio. Evidences shows that two years of sub-benchmark performance, with the CCLA 25 fund down in value during 2025 and approximately 5% below benchmark.

2.8. The committee agreed that a full investment options paper will be brought to the April 2026 meeting by Chris Upham.

2.9. The committee received assurance that preparations for the annual accounts and audit are on track, with auditors scheduled to conduct their main review in May. Positive case studies will be collated for inclusion in the report.

2.10. A detailed briefing on population health was delivered by Florence Lock and identified a strong alignment between charitable activity and preventative health priorities. Opportunities include green social prescribing, community capacity building, early-years interventions and supporting voluntary sector partners.

2.11. The committee received emerging proposals for future fundraising appeals including

- Paediatric and Emergency Department improvements,
- Youth support and community wellbeing initiatives,
- Interactive nursing technology,
- Improving “difficult conversation” spaces across clinical areas,
- Supporting major clinical developments (e.g., LINAC).

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The sustained and significant shortfall in investment returns represents a material concern. Committee members emphasised the importance of completing the investment review rapidly, considering alternative providers and safeguarding charitable resources during market volatility.

3.2. Due to delays in the Surgical Centre handover, previously committed funds cannot be spent in year. The committee highlighted the operational and reputational need to progress capital-dependent charitable projects in a timely manner.

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

4.1. The Committee noted that despite strong operational performance, there are risks that require escalation to the Board. Ongoing underperformance of the investment portfolio continues to limit potential income growth, reinforcing the urgency of completing the investment strategy review. In addition, delays to key capital projects, such as the urology relocation, are preventing timely use of committed charitable funds, with potential implications for donor confidence and delivery of planned improvements. Income patterns also remain unpredictable, with reliance on variable community fundraising and one-off events creating exposure to year-on-year volatility.

Graham Hughes
CHAIR OF THE CHARITABLE FUNDS COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Approval of 2026/27 Revenue Budget
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	10 March 2026

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

Executive Summary and Reason for presentation to Committee/Board	This report presents the Board with the 2026/27 annual revenue budget including information on the cost improvement programme, forecast cashflow and statement of financial position.
Recommendation	The Board is requested to approve the 2026/27 annual revenue budget.

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

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

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

Equality 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]
Draft plan presented to and approved by the Finance Committee on 15 December 2025. The Final plan was approved by the Board on 10 February 2026.

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

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

SOMERSET NHS FOUNDATION TRUST

APPROVAL OF 2026/27 REVENUE BUDGET

1. INTRODUCTION

1.1 The Board approved the final operational plans at its meeting on 10 February 2026. The plan was subsequently submitted to NHS England on 12 February 2026, in line with the mandated national timetable. The submission comprised the following elements:

1) **Financial Plan** – detailed, profiled plans for income and expenditure, capital, cash, and efficiency requirements, together with high-level projections for 2027/28 and 2028/29.
2) **Workforce Plans** – outlining anticipated workforce demand, supply, efficiency assumptions, and skill-mix requirements.
3) **Activity Plans** – setting out trajectories for key operational and performance metrics.

2. SUMMARY

2.1 The financial plan has been developed with reference to the national planning guidance and is aligned with our locally determined strategic priorities. A thorough internal business planning process underpinned the development of the plan, ensuring that services are allocated the resources necessary to deliver safe, high-quality and effective care, while supporting the achievement of key organisational priorities.

2.2 The Trust (and ICB) plan is breakeven. There is a clear expectation that all organisations will live within their means and therefore set plans that are affordable but will also ensure there is continued progress on the delivery of a core set of targets.

2.3 Our patient care income assumptions are based on realistic activity and delivery plans and informed by the NHS payment scheme framework which has been significantly changed for 2026/27. Our plans align with our principal commissioners. Non patient care income is based on service specific knowledge of expected income levels.

2.4 The Finance Committee and Board have been regularly updated on the development of our operational plans. This paper sets out how the revenue funding is allocated within the Trust, together with information on how the plan impacts cashflow and the Statement of Financial Position. There is also more granular detail on planned workforce levels.

3. INCOME AND EXPENDITURE

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

Group Statement of comprehensive income	Annual Budget £000
Operating income from patient care activities	1,079,862
Other operating income	71,484
Employee expenses	(769,538)
Operating expenses excluding employee expenses	(369,228)
Operating Surplus/(Deficit)	12,580
Finance Costs	(13,450)
Corporation Tax	(572)
Surplus/(Deficit) 2026/27	**(1,442)**
Adjustments to Financial Performance	1,442
Adjusted Financial Performance Surplus/(Deficit)	**0**

3.2 Service group, corporate services and other budgets are set out below. These are net of the agreed cost improvement targets. Corporate includes the corporate support service departments and other central budgets such as CNST, capital charges and depreciation is shown in the table below: -

SERVICE	EMPLOYEE BENEFITS £000	NON CLINICAL SUPPLIES £000	OTHER INCOME £000	CLINICAL SUPPLIES £000	DRUGS £000	FINANCING COSTS £000	NHS CLINICAL INCOME £000	NON NHS CLINICAL INCOME £000	TOTAL PLAN £000
SURGICAL SERVICES	(151,853)	(2,866)	2,175	(22,113)	(18,230)	0	0	20,806	**(172,081)**
MEDICAL SERVICES	(136,903)	(2,056)	241	(12,707)	(20,403)	0	0	15,112	**(156,717)**
CLIN SUPP & CANCER SERVS	(56,583)	(9,492)	2,353	(8,423)	(43,144)	(1,067)	0	40,873	**(75,483)**
NEIGHBOURHOOD SERVICES	(118,201)	(8,747)	674	(5,128)	(970)	0	589	3,178	**(128,605)**
MENTAL HEALTH AND LD	(72,860)	(12,108)	932	399	(834)	0	0	0	**(84,470)**
CYP & FAMILIES SERVICES	(78,319)	(3,125)	705	(3,442)	(3,370)	0	131	3,601	**(83,819)**
Total Clinical Service Groups	**(614,720)**	**(38,394)**	**7,079**	**(51,414)**	**(86,951)**	**(1,067)**	**720**	**83,570**	**(701,175)**
Corporate & Other Services									
OPERATIONAL MANAGEMENT	(9,821)	(4,152)	13	(59)	(41)	0	0	4	**(14,056)**
RESERVES	15,346	2,452	3,740	4,130	0	386	(2,800)	(4,800)	**18,453**
CHIEF OF PEOPLE & OD	(10,235)	(4,156)	1,995	77	(176)	0	0	38	**(12,457)**
CHIEF FINANCE OFFICER	(10,537)	(2,552)	5,800	(420)	0	(98)	0	0	**(7,808)**
CHIEF MEDICAL OFFICER	(3,497)	(55)	0	13	0	0	0	0	**(3,539)**
CHIEF NURSE	(4,151)	(137)	7	(6)	0	0	0	0	**(4,286)**
DIRECTOR OF CORPORATE SERVICES	(6,747)	(26,709)	0	75	0	0	0	0	**(33,381)**
DIRECTOR OF STRATEGY & DIGITAL	(22,023)	(25,841)	6,184	287	0	0	0	0	**(41,393)**
ESTATES AND FACILITIES	(34,906)	(29,812)	33,680	(3,341)	0	(148)	381	38	**(34,108)**
FINANCIAL ACCOUNTING	0	(295)	0	0	0	(60,122)	0	1,304	**(59,113)**
EDUCATION	(34,218)	(2,946)	39,670	(70)	0	0	0	0	**2,436**
CLINICAL INCOME	0	(7,963)	0	0	0	0	1,036,607	(69,869)	**958,776**
CENTRAL BUDGETS	(7,305)	(3,205)	14,251	44	0	(681)	0	0	**3,105**
Total Corporate & Other	**(128,095)**	**(105,371)**	**105,341**	**730**	**(217)**	**(60,663)**	**1,034,188**	**(73,285)**	**772,629**
Subsidaries									
SIMPLY SERVE LIMITED	0	(2,246)	(40,937)	0	0	(167)	0	0	**(43,350)**
SHS	(26,724)	(3,295)	0	(265)	(1,999)	(2,266)	34,391	278	**120**
SPS	0	(7,137)	0	(8,052)	0	0	0	0	**(15,188)**
SPSF	0	(6,261)	0	(8,217)	0	0	0	0	**(14,477)**
Total Subsidaries	**(26,724)**	**(18,939)**	**(40,937)**	**(16,533)**	**(1,999)**	**(2,434)**	**34,391**	**278**	**(72,896)**
Group Total	**(769,538)**	**(162,704)**	**71,484**	**(67,216)**	**(89,167)**	**(64,163)**	**1,069,300**	**10,563**	**(1,442)**
Less Control Total Adjustment	**0**	**0**	**0**	**0**	**0**	**1,442**	**0**	**0**	**1,442**
Adjusted Financial Performance	**(769,538)**	**(162,704)**	**71,484**	**(67,216)**	**(89,167)**	**(62,721)**	**1,069,300**	**10,563**	**-**

Inter-company transactions have been excluded

3.3 A more granular income and expenditure position is set out in the table below. This is also net of the £80m efficiency programme.

Statement of comprehensive income	Annual Budget £000	2025/26 Outturn £000
Income from patient care activities		
Integrated Care Boards	944,638	903,051
NHS England	116,746	110,808
Local Authorities	2,126	4,000
NHS Trusts//overseas/other/non NHS	9,717	14,824
Private patients	6,636	8,085
sub-total	**1,079,862**	**1,040,768**
Other operating income		
Research & Development	3,968	4,537
Education & Training	28,191	50,541
Car Parking, catering & staff accommodation	4,852	4,841
Donations	810	2,233
Other Income	33,664	21,943
sub-total	**71,484**	**84,095**
Total operating income	**1,151,347**	**1,124,863**
Operating expenditure		
Staff costs – substantive	(727,294)	(737,088)
Staff costs – agency	(12,552)	(17,510)
Staff costs – bank/locum	(29,692)	(34,808)
Supplies & services - clinical	(67,216)	(65,315)
Supplies & services - general	(38,210)	(27,990)
Drug costs	(89,167)	(84,847)
Establishment & premises costs	(38,686)	(37,426)
Purchase of healthcare	(16,984)	(13,864)
Depreciation & amortisation	(50,097)	(44,895)
Impairments	(45)	0
Clinical negligence	(24,056)	(22,460)
Other	(44,769)	(27,618)
sub-total	**(1,138,767)**	**(1,113,821)**
Operating Surplus/(Deficit)	**12,580**	**11,042**
Finance Costs		
Interest receivable	2,510	2,252
Finance Expense	(4,739)	(3,197)
PDC dividends payable	(11,221)	(8,784)
Losses from disposal of assets	0	(13)
Corporation Tax	(572)	(869)
Surplus/(Deficit) 2026/27	**(1,442)**	**431**
Remove capital donations	1,296	(889)
Remove PFI revenue costs on an IFRS 16 basis	10,588	10,279
Add back PFI revenue costs on a UK GAAP basis	(10,442)	(9,821)
Adjusted Financial Performance Surplus/(Deficit)	**0**	**0**

3.4 Total staff costs are £769.538m and represent c68% of the Group operating expenses. The agency budget is c1.6% of total pay expenditure and reflects the ongoing requirement to drive down temporary staffing use.

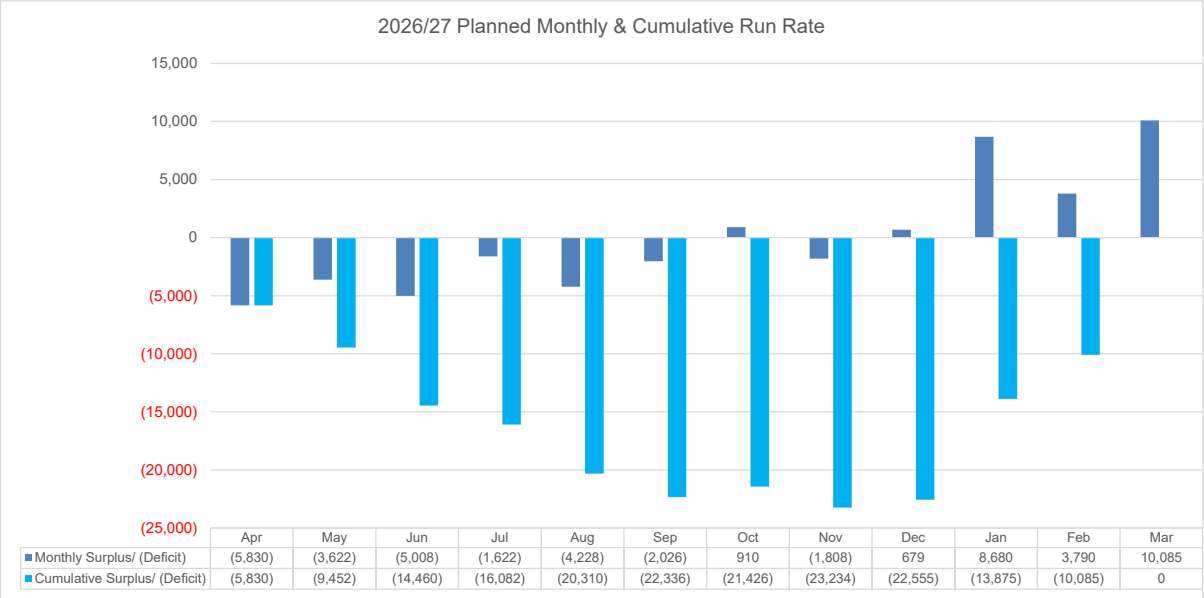
3.5 A breakdown of the total staffing budget by staff type including whole time equivalent information (planned as 31 March 2026) is shown in the table below: -

Staff costs detail	Annual Budget £000	WTE (SIP)
Clinical substantive staff (non-medical)		
Registered nursing & midwifery staff	(218,326)	3,672.35
Registered/ Qualified Scientific, Therapeutic and Technical Staff	(114,093)	1,729.42
Support to nursing, AHP & clinical staff	(117,487)	2,571.46
	(449,907)	**7,973.22**
Medical & dental substantive staff		
Consultants	(93,632)	453.23
Career/Staff grades/Trainees	(82,892)	791.17
	(176,524)	**1,244.40**
Non-medical/non-clinical substantive staff		
NHS infrastructure support & others	(100,864)	**2,856.12**
Total substantive staff costs	**(727,294)**	**12,073.75**
Bank/Locum staff		
Registered nursing & midwifery staff	(7,387)	133.45
Registered/ Qualified Scientific, Therapeutic and Technical Staff	(1,404)	25.90
Support to nursing, AHP & clinical staff	(8,921)	176.51
Consultants	(5,796)	35.78
Career/Staff grades/Trainees	(4,437)	48.81
NHS infrastructure support & others	(1,747)	104.87
Total bank staff costs	**(29,692)**	**525.31**
Agency staff		
Registered nursing & midwifery staff	(2,257)	30.19
Registered/ Qualified Scientific, Therapeutic and Technical Staff	(391)	7.85
Support to nursing, AHP & clinical staff	(281)	6.44
Consultants	(8,964)	29.21
Career/Staff grades/Trainees	(590)	3.20
NHS infrastructure support & others	(69)	3.95
Total agency staff costs	**(12,552)**	**80.84**
Total staff costs	**(769,538)**	**12,679.91**

3.6 All budgets are profiled according to the expected pattern of monthly income, expenditure and efficiency savings delivery. Due primarily to the way that the efficiency programme is phased (i.e. a greater level of savings in the third and fourth quarters) the Group will accumulate a deficit and recover this through increase efficiency savings in the second six months. Note: the October

surplus position is driven by a higher number of working days (and therefore more activity generating higher levels of income).

3.7 The monthly and cumulative phased budget is shown below :-



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Surplus/ (Deficit)	(5,830)	(3,622)	(5,008)	(1,622)	(4,228)	(2,026)	910	(1,808)	679	8,680	3,790	10,085
Cumulative Surplus/ (Deficit)	(5,830)	(9,452)	(14,460)	(16,082)	(20,310)	(22,336)	(21,426)	(23,234)	(22,555)	(13,875)	(10,085)	0

4. CIP

4.1 The total savings programme is £80m in 2026/27. This represents c6.5% of operating expenditure and has been modelled on the basis that recurrent delivery will be a minimum of 65% or £51.8m. Savings have been categorised into broad areas:

	Recurrent £m	Non Recurrent £m	Total £m
Pay	33.4	6.6	40.0
Non pay	18.4	1.6	20.0
Income	-	20.0	20.0
Total	**51.8**	**28.2**	**80.0**

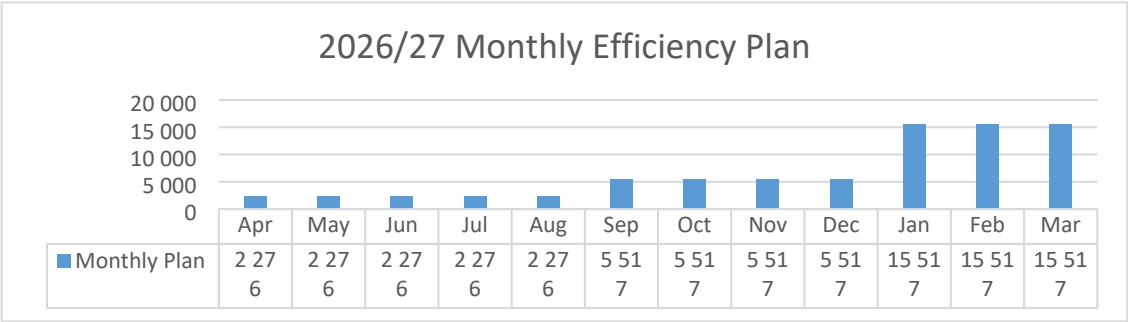
4.2 An element (c34% or £27.3m) of the programme has been allocated to clinical and non-clinical services on an agreed methodology that means their cip target equates to the value of the pay and non-pay inflationary uplifts to their 2026/27 budgets – in effect they are being asked to offset the inflationary impact through efficiency (this broadly mirrors the national approach where funding uplifts to prices and pay are net of a 2% productivity assumption).

4.3 In addition, the programme will include a small number of transformational strategic schemes. These will focus on scalable opportunities that span multiple services or operate at a trust-wide level — for example, outpatients, patient flow, and similar cross-cutting areas. Work to scope and define the potential opportunities is currently underway.

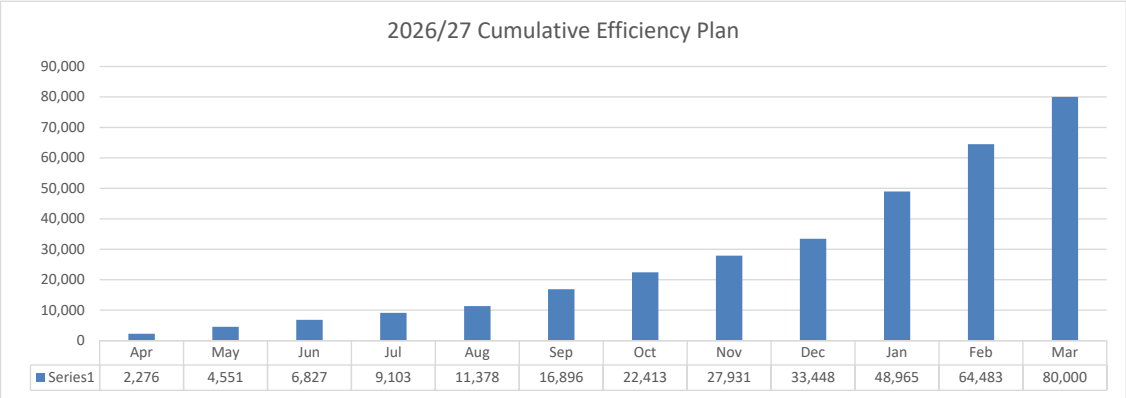
4.4 The breakdown by service specific efficiency targets is shown in the table below:

Service Group/Corporate Team/Area	2026/27 CIP Target £m	% of Total Operational expenditure Budget
Clinical Support & Cancer Services Group	2.5	3.2%
Medical Services Group	4.5	2.8%
Surgical Services Group	5.1	2.9%
Mental Health & LD Services Group	2.4	2.8%
CYP & Families Services Group	2.4	2.7%
Neighbourhood Services Group	3.9	2.9%
Operational Management	0.4	2.7%
Estates	1.1	3.0%
Director of Corporate Services	0.4	1.1%
Chief Finance Officer	0.4	5.1%
Chief Nurse	0.1	3.1%
Chief of People and OD	0.4	3.3%
Chief Medical Officer	0.1	1.8%
Director of Strategy and Digital	1.4	3.4%
SSL	0.6	1.4%
SHS	1.5	4.8%
Transformation	22.7	
Central	30.0	
TOTAL	**80.0**	

4.5 We have phased the efficiency plan based on a realistic assessment of when each benefit can be delivered, this approach, however, results in a substantial back-loading of the programme, as illustrated below:



4.6 Planned savings are £6.8m in Q1 increasing to £46.6m in Q4:



5. CASH

5.1 The Cash Flow Statement provides a high-level view of how we generate and use cash over the financial year. It explains the actual movement in cash is driven by the planned operating surplus/(deficit), the impact of non-cash transactions such as depreciation and movements in working capital and the impact of investment activities, namely the Group capital programme expenditure both in terms of capital expenditure and capital funding (PDC) received.

5.2 Delivery of the efficiency programme as planned and with genuine cash releasing savings is critical to maintaining the level of cash set out below. Balances reduce principally due to operating deficits in the first six months with cash reaching a low point of £20.3m in December 2026. The cash position then improves in the remaining three months as the impact of the stepped increase in efficiencies takes effect.

5.3 The level of cash retained by month is shown in the table below. The year-end balance is projected to be c£61m, this a net reduction of £7.3m from the cash position forecast for the year ending 31 March 2026.

	YE Mar 2026	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Cash	68,436	82,371	68,202	42,196	57,573	39,861	28,374	45,503	31,826	20,260	41,443	45,015	61,119

5.4 The Group cash flow statement is set out in the table below and is based on the final income and expenditure plan and capital programme for the year.

Statement of Cash flows	Plan for y/e 31/03/27 £'000
Operating surplus/(deficit)	**12,574**
Non-cash income & expense	
Depreciation/amortisation	50,084
Income in respect of capital donations	(812)
Amortisation of PFI credit	(264)
Increase/(decrease) in trade/other payables/liabilities	(9,680)
Net cash generated/(used in) operations	**51,902**
Cash flows from investing activities	
Interest received	2,124
Purchase of property, plant & equipment	(55,874)
Net cash used in investing activities	**(53,750)**
Cash flows from financing activities	
Public dividend capital received	21,728
Loans from DH/Other repaid	(708)
Capital element of lease payments & PFI	(12,314)
Interest paid/ Interest element of lease payments/PFI	(2,621)
PDC dividend (paid)/refunded	(11,554)
Net cash generated from/(used in) financing activities	(5,469)
Increase/(decrease) in cash & cash equivalents	**(7,317)**
Cash & cash equivalents at start of period	**68,436**
Cash & cash equivalents at end of period	**61,119**

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

6. STATEMENT OF FINANCIAL POSITION

6.1 The statement of financial position (balance sheet) is derived principally from the final revenue plans set out above and planned capital expenditure programme. The SOFP sets out the assets owned by the Group and liabilities which it owes. These sum to the total net assets of the organisation and in the case of NHS bodies, are funded by the taxpayers' equity. The movement in current assets and liabilities and other working capital are based on the business as usual activities of the Group. The SOFP complies with the relevant International Financial Reporting Standards(IFRS), HM Treasury Financial Reporting Manual (FreM) and NHS Group Accounting Manual (GAM)

6.2 The Trust has net assets of £503.1m, funded primarily through Public Dividend Capital (£481.5m) and the Revaluation Reserve (£78.0m). The SOFP reflects a stable asset base, strong liquidity, and a manageable liability position.

6.3 The SOFP as at the 31 March 2027 is set out below:

Statement of Financial Position	Plan for y/e 31/03/27 £'000
Non-current assets	
Intangible assets	65,595
On-SoFP IFRIC 12 assets	24,688
Other property, plant and equipment (excludes leases)	491,734
Right of use assets - leased assets for lessee (excl PFI/LIFT)	81,890
Other investments/financial assets	28
Receivables: due from NHS/DHSC & non-NHS/DHSC bodies	3,950
Credit loss allowance	(725)
Total non-current assets	**667,160**
Current assets	
Inventories	13,021
Receivables: due from NHS and DHSC group bodies	13,021
Receivables: due from non-NHS/DHSC Group bodies	8,350
Credit loss allowance	(640)
Cash and cash equivalents	61,119
Total current assets	**98,608**
Current liabilities	
Trade and other payables: capital	(19,207)
Trade and other payables: non-capital	(103,067)
Borrowings	(13,300)
Provisions	(385)
Other liabilities: other	(15,259)
Total current liabilities	**(151,218)**
Total assets less current liabilities	**614,550**
Non-current liabilities	
Trade and other payables: non-capital	(107,390)
Other liabilities: deferred income/other	(4,027)
Total non-current liabilities	**(111,417)**
Total net assets employed	**503,133**
Financed by:	
Public dividend capital	481,499
Revaluation reserve	77,987
Other reserves	(2,871)
Income and expenditure reserve	(54,022)
Non-controlling interest	540
Total taxpayers' and others' equity	**503,133**

7. PRODUCTIVITY

7.1 The 2025 Spending Review settlement requires the NHS to deliver annual productivity improvements of 2%, representing the minimum level of efficiency growth needed to meet national activity and performance expectations within the agreed financial envelope. NHS England has confirmed this requirement as central to ensuring the service can sustainably increase output, recover performance, and operate within available resources.

7.2 This productivity expectation forms a core assumption underpinning financial planning for 2026/27 and beyond, and systems are expected to embed credible delivery plans aligned to this national requirement.

7.3 Productivity is measured by comparing the relative change in activity and cost from year to year with data from our final financial and activity plans. The output from this is as follows:-

Cost weighted Activity growth %	Real term cost growth %	Implied Productivity %
2.6%	0.5%	2.1%

The financial plan shows a 0.5% inflated increase in expenditure (compared with 2025/26 forecast outturn) and 2.6% change in cost weighted activity (CWA). The CWA growth is set out in more detail below:

Total activity	25/26 FOT Activity Count	25/26 FOT Activity adj for calendar/working days	26/27 plan Activty Count	Activity count growth	25/26 FOT Costed Activity £000	26/27 FOT Costed Activity £000	CWA growth
Consultant-led first outpatient attendances (Spec acute)	213,258	211,572	224,020	5.9%	46,197	48,915	5.9%
Consultant-led follow-up outpatient attendances (Spec acute)	407,976	404,751	402,307	-0.6%	73,322	72,879	-0.6%
Total number of specific acute elective day case spells in the period	73,295	72,716	75,586	3.9%	83,206	86,490	3.9%
Total number of specific acute elective ordinary spells in the period	6,529	6,477	7,491	15.6%	38,894	44,980	15.6%
Total number of attendances at Type 1, 2, 3 A&E departments.	264,687	264,687	267,334	1.0%	71,899	72,618	1.0%
No of specific acute non-elective spells in the period with a LOS of zero days	16,698	16,698	16,866	1.0%	21,996	22,217	1.0%
No of specific acute non-elective spells in the period with a LOS of one or more days	42,919	42,919	43,348	1.0%	231,194	233,505	1.0%
Total	**1,025,362**	**1,019,820**	**1,036,952**		**566,709**	**581,606**	**2.6%**

The 2.1% implied improvement in productivity is the minimum we would expect to achieve by delivering our financial and activity plans in 2026/27. Through our efficiency work, we will seek to maximise productivity gains with digital and pathway transformation.

8. RECOMMENDATION

8.1 The Finance Committee reviewed the 2026/27 revenue budget at its meeting held on 23 February 2026 and recommended that it be approved by the Board.

8.2 The Board is asked to note and approve the Trust's 2026/27 annual revenue budget as set out above.

CHIEF FINANCE OFFICER

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Capital Programme 2026/7-2029/30
SPONSORING EXEC:	David Shannon (Director of Strategy and Digital)
REPORT BY:	Ian Boswall (Director of Redevelopment), Neil Murray (Strategic Accountant)
PRESENTED BY:	David Shannon
DATE:	10 March 2026

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

Executive Summary and Reason for presentation to Committee/Board	This paper sets out capital programme for the 2026/27 financial year and the 4 year capital programme.
Recommendation	To approve the capital programme for 2026/27 and the outline programme for the period 2027/8 to 2029/30.

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

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

CAPITAL PROGRAMME 2026/7 – 2029/30

1. INTRODUCTION

This report sets out the proposed draft capital programme for 2026/27 and the subsequent 3 financial years. The available capital for the year totals £64.543m with a planned level of expenditure of £66.630m reflecting an over commitment of £2.087m. This level of over commitment reflects the approach of previous years to ensure that the overall programme is achieved and to compensate for any delay in schemes.

2. LOCAL CAPITAL ALLOCATIONS

2.1 The Somerset Foundation Trust capital programme is included within the table below. The programme has been developed following discussions with budget managers within the Trust, Capital Finance Monitoring Group and Strategic Estates Group.

2.2 The local capital envelope for 2026/27 of £41.735m set by NHSE includes a £7.727m fair shares allocation based on the assumption that the system will deliver a balanced 25/26 revenue position.

2.3 The programme has been set with an overcommitment of £2.087m (5% of allocated local capital allocation including the fair shares allocation). This is within budget setting guidance issued by NHSE and follows the Trust practice of previous years in slightly oversetting budgets in anticipation of slippage on some schemes.

2.4 The plan includes setting aside some significant amounts to cover some of the higher risks faced by the Trust:

- Progress towards completion of the Elective Recovery Development on the Yeovil District Hospital site. The development has incurred cost pressures and delays associated with the Building Safety Act (BSA) and wider fire safety requirements. £2.500m has been included within the plan to cover further costs that will likely be incurred within the next financial year. This figure is on top of an anticipated £3.500m further additional PDC funding that has been provisionally set aside by NHSE as part of the elective recovery constitutional standards allocation for next year.

- Stroke service reconfiguration costs on the MPH site of £1.373m and YDH £1.314m have been budgeted. The allocated sum is to complete previously agreed works as part of the stroke service reconfiguration business case. There remains uncertainty regarding the programme, cost and profile of expenditure for the YDH works due to application to the building safety regulator and adoption of wider fire strategy recommendations.

- The Electronic Health Record plans include £9.837m of trust capital investment during the coming financial year. This matches the Full Business Case commitment for this project for 2026/27 and future financial years.

2.5 The local capital allocations for the years 2027/28 to 2029/30 have also been issued and are also included in the summary table below. Indicative allocation of the funding to spend areas are shown but will require further refinement over time. The Healthset Electronic Health Record project places limitations on other areas of investment over the next 3 financial years. This has been mitigated by significant investment over the last 3 years in the estate and into other digital infrastructure. The significant investment in the integrated health record will put a strong infrastructure in place for over 10 years and reduce the need for capital system replacement during this period. This allows the capital programme to continue to be allocated into the estate and other developments in later years.

3. EXTERNAL CAPITAL FUNDING

3.1 Several capital budgets have been held by the regional team to support the requirements of the medium term operational plan and the NHS 10 year plan. The Trust has submitted bids against these funds, the final allocation of funds is detailed below

Regional Programme Funding	**2026/27 Allocation £'m**	**Total 4 Year Allocation £'m**
Diagnostics	0.315	0.788
Urgent and Emergency Care – Urgent Treatment Centre and Same Day Emergency Care	14.696	17.696
Mental Health, Learning Disability and Autism	0.272	3.821
Community	1.250	3.500
Elective – YDH Theatre 5	4.000	4.000
Total Capital to Support 10 Year Plan	**20.533**	**29.805**

3.2 In addition to the items detailed above there is an Estates Safety fund which has been established to support ongoing investment into managing backlog maintenance, with a specific focus on critical infrastructure including fire protection works, electrical and water infrastructure. This fund consists of two elements, an annual allocation for Trust wide infrastructure and a targeted strategic allocation. These funding sources are still to be confirmed, however it is anticipated that an annual allocation of £6.5m will be received for Trust wide schemes and a strategic allocation of £49m across the 5-year period will be made available to address the infrastructure issues within Yeovil District Hospital. This specifically will address the compliance of the building with the High-Risk Buildings Act and will allow for some refurbishment of the ward and department areas. These allocations have not yet been included within the programme as the final confirmation and allocation across financial years has

not been confirmed. Business cases will be presented where relevant for these schemes for approval by the Trust Board.

3.3 The capital programme will be managed through the year to ensure any emergent risks are managed and the opportunity to bid and secure additional capital from underspends where appropriate.

3.4 Whilst there are significant allocations for all areas of the capital programme, the infrastructure risk remains at a score of 20 on the corporate risk register. The additional £49m identified for the YDH site over the next 5 years is a positive step there remains significant risk and need specifically for the old buildings and maternity at the MPH site. These buildings are expected to be replaced as part of the New Hospital Programme, however the current timetable for the scheme is outside of this current planning period and expected to commence after 2030.

4 RECOMMENDATIONS

4.1 The Trust Board is asked to approve the capital programme for 2026/27 to 2029/30

Capital Programme	2026/2027	2027/2028	2028/2029	2029/2030
	£000	£000	£000	£000
Allocated CDEL Internal Capital Envelope	34,008	35,464	36,129	36,794
Additional Fair Shares Expected Allocation	7,727	0	0	0
Total Internal Capital Envelope Available to Trust	**41,735**	**35,464**	**36,129**	**36,794**
Internal Capital Programme				
Backlog Maintenance	6,090	5,600	6,890	6,890
Digital & Electronic Health Record	12,810	18,192	4,725	4,312
Essential Facilities Improvement Works	1,865	1,789	1,989	2,289
Infrastructure	885	0	500	3,500
Replacement Medical Equipment	4,250	3,800	4,500	4,500
Rolling IT Programme	5,355	2,755	6,500	6,000
Service Redesign Enabling Works	7,799	525	7,763	6,075
SHS	180	180	180	180
SSL	80	80	80	80
Sundry Equipment	250	100	250	250
Lease Equipment Additions	300	300	300	300
Lease Rent Review	2,708	2,508	2,508	2,508
Lease Vehicle Additions	250	250	250	250
Leased Premises Renewals	1,000	1,158	1,500	1,500
Internal Envelope CDEL	**43,822**	**37,237**	**37,935**	**38,634**
Target 5% Overcommitment on Internal Programme	**-2,087**	**-1,773**	**-1,806**	**-1,840**
Externally Funded Schemes				
Managed Equipment Service	270	0	0	0
Donated Assets	810	810	810	210
National Programme Theatre Expansion	4,000	0	0	0
National Programme Urgent Treatment Centre	14,696	3,000	0	0
Digital EHR PDC	1,195	831	84	1,134
Other National Programme Biddable Monies	1,837	1,523	2,766	1,983
Total Externally Funded Schemes	**22,808**	**6,164**	**3,660**	**3,327**
Total Capital Programme	**66,630**	**43,401**	**41,595**	**41,961**