Public Board Meeting

Tue 12 May 2026, 09:30 - 12:45

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

Agenda

09:30 - 09:35 5 min

1. Welcome and Apologies for Absence

Note *Chair*

- 00 Programme for the Day - 12 May 2026 v1.3.pdf (1 pages)
- 120526 - Public Board Agenda v1.6.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 (4 pages)

09:35 - 09:35 0 min

3. Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 10 March 2026

Approve *Chair*

- Enclosure 02 - Minutes of the March 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 20 March 2026

Approve *Chair*

- Enclosure 03 - Minutes of the March 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:
    - Guardian of Safe Working Report

- Freedom to Speak Up Guardian Report
- NHS England Annual Self-Declaration: Continuity of services condition 7 – availability of resources (Approve)
- Risk of Changes to Visa and Settlement Entitlement – Workforce Impacts
- Use of the Corporate Seal
- Modern Slavery and Human Trafficking Act 2015 Policy Statement 2026-27 (Approve)

Enclosure 05 - Chief Executive and Executive Director Report - May 2026 v3.pdf (19 pages)

10:20 - 10:35
15 min

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

Receive *Mel Iles*

10:35 - 10:50
15 min

10. Q4 Board Assurance Framework and Corporate Risk Register Report

Receive *Mel Iles*

Enclosure 06 - 2025-26 Q4 Board Assurance Framework and Corporate Risk Register Report.pdf (83 pages)

10:50 - 11:00
10 min

11. Terms of Reference - Annual Review

Approve *Mel Iles*

Enclosure 07 - Terms of Reference - Annual Review.pdf (72 pages)

11:00 - 11:15
15 min

Refreshment Break

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

11:15 - 11:20
5 min

12. Assurance report from the People Committee meeting held on 4 March 2026

Receive *Graham Hughes*

Enclosure 08 - Assurance Report from People Committee - 4 March 2026.pdf (4 pages)

Aim 2 – Provide the best care and support to people

11:20 - 11:40
20 min

13. Integrated Performance Report

Receive *Pippa Moger*

Enclosure 09 - Integrated Performance Exception Report.pdf (120 pages)

11:40 - 11:45
5 min

14. Assurance report from the Quality and Governance Assurance Committee meeting held on 25 February 2026

Receive *Rosie Benneyworth*

Enclosure 10 - Assurance Report from the QGAC Committee - 25 February 2026.pdf (4 pages)

11:45 - 11:50
5 min

15. Assurance report from the Mental Health Legislation Committee meeting held on 17 March 2026

Receive *Alexander Priest*

Enclosure 11 - Assurance Report from the Mental Health Legislation Committee - 27 March 2026.pdf (4 pages)

11:50 - 12:00
10 min

16. Wellbeing Guardian Report

Receive *Graham Hughes*

Enclosure 12 - Wellbeing guardian report May 2026.pdf (35 pages)

12:00 - 12:15
15 min

17. Corridor Care Briefing

Receive *Deirdre Fowler*

Enclosure 13 - Corridor Care Report - May 2026.pdf (7 pages)

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

12:15 - 12:25
10 min

18. Finance Report (M12)

Receive *Pippa Moger*

Enclosure 14 - Board finance Report M12 FINAL.pdf (7 pages)

12:25 - 12:30
5 min

19. Assurance report from the Audit Committee meeting held on 22 April 2026

Receive *Paul Mapson*

Enclosure 15 - Assurance Report from the Audit Committee - 22 April 2026.pdf (4 pages)

12:30 - 12:35
5 min

20. Going Concern Statement

Approve *Pippa Moger*

Enclosure 16 - SFT 2025-26 Board Paper-Going concern assessment - FINAL for Board.pdf (8 pages)

For Information

12:35 - 12:40
5 min

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

Receive *Chair*

12:40 - 12:40
0 min

22. Any other business

All

12:40 - 12:40
0 min

23. Risks identified

All

12:40 - 12:45
5 min

24. Evaluation of the effectiveness of the Meeting

Chair

12:45 - 12:45
0 min

25. Items to be discussed at the Confidential Board Meeting

- Minutes of the Confidential Board meeting
- Notes of the Board Development session
- Minutes of the Extraordinary Confidential Board meeting
- Investigation and Disciplinary Procedure Review
- Healthset (Electronic Health Record)
- Minutes of the Finance Committee meetings

- People Services update

12:45 - 12:45
0 min

26. 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.

12:45 - 12:45
0 min

27. Close and Date of Next Meeting

14 July 2026

PROGRAMME FOR THE DAY

Board of Directors

Tuesday 12 May 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 – 12:45**
	Refreshment Break	11:00 – 11:15
3	**Lunch**	**12:45 – 13:15**
4	**Confidential Board of Directors**	**13:15 – 14:30**
5	**Refreshment Break**	**14:30 – 14:45**
6	**Seminar Session**	**14:45 – 15:55**
7	**Close**	**15:55**

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 12 May 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 10 March 2026**	Approve	Chair		Enclosure 02
4.	**Minutes of the Somerset NHS Foundation Trust's Extraordinary Public Board meeting held on 20 March 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:
	  • Guardian of Safe Working Report
	  • Freedom to Speak Up Guardian Report
			Peter Lewis	10:00	Enclosure 05

Kindness, Respect, Teamwork
Everyone, Every day

		Action	Presenter	Time	Enclosure
	• NHS England Annual Self-Declaration: Continuity of services condition 7 – availability of resources • Risk of Changes to Visa and Settlement Entitlement – Workforce Impacts • Use of the Corporate Seal • Modern Slavery and Human Trafficking Act 2015 Policy Statement 2026-27	Approve Approve			
9.	**Update on Paediatric and Maternity Services at Yeovil District Hospital**	Receive	Mel Iles	10:20	Verbal
10.	**Q4 Board Assurance Framework and Corporate Risk Register Report**	Receive	Mel Iles	10:35	Enclosure 06
11.	**Terms of Reference – Annual Review**	Approve	Mel Iles	10:50	Enclosure 07
	Refreshment Break: 11:00 – 11:15				
	Aim 5 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture				
12.	**Assurance report from the People Committee meeting held on 4 March 2026**	Receive	Graham Hughes	11:15	Enclosure 08
	Aim 2 – Provide the best care and support to people				
13.	**Integrated Performance Report**	Receive	Pippa Moger	11:20	Enclosure 09
14.	**Assurance report from the Quality and Governance Assurance Committee meeting held on 25 February 2026**	Receive	Inga Kennedy	11:40	Enclosure 10
15.	**Assurance report from the Mental Health Legislation Committee held on 17 March 2026**	Receive	Alexander Priest	11:45	Enclosure 11
16.	**Wellbeing Guardian Report**	Receive	Graham Hughes	11:50	Enclosure 12
17.	**Corridor Care Briefing**	Receive	Deirdre Fowler	12:00	Enclosure 13
	Aim 6: Live within our means and use our resources wisely				
18.	**Finance report (M12)**	Receive	Pippa Moger	12:15	Enclosure 14

		Action	Presenter	Time	Enclosure
19.	**Assurance Report from the Audit Committee meeting held on 22 April 2026**	Receive	Paul Mapson	12:25	Enclosure 15
20.	**Going Concern Statement**	Approve	Pippa Moger	11:30	Enclosure 16
For Information					
21.	**Follow-up questions from Members of the Public and Governors**	Receive	Chair	12:35	Verbal
22.	**Any other business**		All		Verbal
23.	**Risks identified**		All		Verbal
24.	**Evaluation of the effectiveness of the Meeting**		Chair	12:40	Verbal

25. 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 session
- Quarterly Investigation, Disciplinary and Employment Tribunal Oversight Report
- Healthset (Electronic Health Record)
- Minutes of the Finance Committee meetings
- Transforming People Services - update

26. 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.

27. Close and Date of Next Meeting 12:45

14 July 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:	12 May 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 6 May 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 6 May 2026

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Rosie	Benneyworth	Trust Board Member	Loyalty Interests	Member	Royal College of GPs	01/07/2025		03/12/2025
Rosie	Benneyworth	Trust Board Member	Outside Employment	Interim CEO	Health Services Safety Investigations Body	01/08/2022		03/12/2025
Rosie	Benneyworth	Trust Board Member	Loyalty Interests	Chair	Symphony Healthcare Services Ltd	01/03/2026		
Darshan	Chandarana	Trust Board Member	Outside Employment	Managing Director	Neopath Ltd	01/02/2025		
Darshan	Chandarana	Trust Board Member	Outside Employment	Senior Vice President of AI	ThoughtWorks	12/01/2026		
Isobel	Clements	Director of People	Outside Employment	Governor, Board member	Weston College	22/01/2025		18/03/2026
Isobel	Clements	Director of People	Loyalty Interests	Sister-in-Law employed as Technician, Pharmacy	Somerset NHS Foundation Trust	10/09/2004		
Isobel	Clements	Director of People	Loyalty Interests	Nephew employed as Physiotherapist Apprentice	Somerset NHS Foundation Trust	03/05/2023		
Olena	Doran	Trust Board Member	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	Nil Declaration			23/10/2025		
Tom	Frederick	Trust Board Member	Outside Employment	Director	Oliver Wyman	01/01/2025		
Andrew	Heron	Chief Operating Officer/Deputy Chief Executive	Loyalty Interests	Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust	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 Exec. Members	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 Exec. Members	Outside Employment	Director-Trustee	The White Ensign Association	01/04/2024		12/02/2026
Peter	Lewis	Chief Executive	Loyalty Interests	Director and Management Board Member, representing Somerset NHSFT	Somerset Strategic Estates Partnership Project Company Limited	01/04/2022		02/04/2025
Peter	Lewis	Chief Executive	Loyalty Interests	Management Board Member of the Somerset Estates Partnership (SEP) Board	Somerset Estates Partnership	01/04/2023		
Peter	Lewis	Chief Executive	Loyalty Interests	Director, Somerset Estates Partnership Project Co Limited	Somerset Estates Partnership Project Co Limited	01/04/2023		
Rima	Makarem	Trust Chairman Trust Board	Outside Employment	Lay member (remunerated) since 2019	General Pharmaceutical Council	01/01/2025	31/03/2026	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	Loyalty Interests	Chair (unremunerated) since 2021	Sue Ryder	01/01/2025		12/06/2025
Rima	Makarem	Trust Chairman Trust Board	Loyalty Interests	Visiting Professor	University of the West of England (UWE), Bristol	01/09/2025		
Rima	Makarem	Trust Chairman Trust Board	Loyalty Interests	Trustee	NHS Providers	01/06/2025		

(All Interests have been declared in line with the Code of Conduct and Managing Conflicts of Interest and Personal Conduct Policy)

REGISTER OF INTERESTS

Trust Board as at 6 May 2026

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Paul	Mapson	Non Exec. Members	Nil Declaration			31/03/2026		
Pippa	Moger	Chief Financial Officer	Outside Employment	NED SSL	Non Executive for Simply Serve Limited	04/04/2025		
Pippa	Moger	Chief Financial Officer	Outside Employment	SPS Board member	Member of 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 employed as Ward Manager	Somerset NHS Foundation Trust	04/04/2025		
Pippa	Moger	Chief Financial Officer	Loyalty Interests	Son employed as Payroll lead and technical support	Somerset NHS Foundation Trust	04/04/2025		
Pippa	Moger	Chief Financial Officer	Outside Employment	Director of JV - SEP	Director of SEP Project Co Ltd	04/04/2025		
Alexander	Priest	Trust Board Member	Outside Employment	Chief Executive	Mind in Somerset	01/04/2018		24/11/2025
Jade	Renville	Director of Corporate Services	Loyalty Interests	I am Joint Director of Corporate Affairs/Services across Somerset ICB as well as Somerset NHS Foundation Trust.	NHS Somerset ICB	06/07/2024		13/03/2026
Jade	Renville	Director of Corporate Services	Loyalty Interests	Richard Huish Multi Academy Trust Director (Chair of Trust from January 2023)	Richard Huish Multi Academy Trust	01/09/2019		13/03/2026
Jade	Renville	Director of Corporate Services	Loyalty Interests	Father is Director and Owner of Renvilles Costs Lawyers	Renvilles Costs Lawyers	01/08/2003		13/03/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	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	Loyalty Interests	Director of SHS - a subsidiary of YDH providing primary care services	Symphony Healthcare Services	01/03/2021		04/04/2025
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	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	Loyalty Interests	Board member of the Somerset Estates Partnership with Prime Plc	Somerset Estates Partnership	01/04/2023		04/04/2025
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Daughter is employed as a Healthcare assistant	Somerset NHS Foundation Trust	23/12/2020		04/04/2025
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Shareholder Director	Simply Serve Limited	01/07/2024		

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 10 MARCH 2026 IN MEETING ROOMS 1-3, WYNFORD HOUSE, LUFTON WAY, LUFTON, YEOVIL, BA22 8HR

PRESENT

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

IN ATTENDANCE

Sally Bryant	Director of Midwifery and Deputy to the Chief Nurse for Somerset [for items 15 & 16]
Emma Davey	Director of Patient Experience & Engagement [for items 9 & 16]
Mark Dott	Surgical Matron [for item 9]
Julie Hutchings	Board Secretary and Corporate Services Manager
Kelly Hutchins	Associate Director of Patient Care [for item 9]
Fiona Reid	Director of Communications

APOLOGIES

Darshan Chandarana	Non-Executive Director

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. The Chair 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 colleagues for their continued commitment during what she acknowledged had been an exceptionally busy period for the organisation. Apologies for absence were received as above.

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

2.1. The Board received and noted the Registers of Interests. The Chair invited members to declare any interests relating to items on the agenda. Rosie Benneyworth confirmed that she is now the Chair of Symphony Healthcare Services (SHS) and the Chair noted an additional declaration relating to her own interests and confirmed that this would be recorded outside the meeting.

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 13 JANUARY 2026

3.1. The minutes of the Public Board meeting held on 13 January 2026 were **approved** as a true and accurate record.

4. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S EXTRAORDINARY PUBLIC BOARD MEETING HELD ON 10 FEBRUARY 2026

4.1. The minutes of the Extraordinary Public Board meeting held on 10 February 2026 were **approved** as a true and accurate record.

5. ACTION LOG AND MATTERS ARISING

5.1. The Board reviewed the Action Log and noted progress on outstanding actions. In response to the Chair's challenge regarding the time taken since the matter was first raised in November, Mel Iles explained that the additional transition services role had been agreed with service groups following the November Board meeting, however that the job description was awaiting the approval/banding process.

5.2. Mel Iles reiterated that whilst there were two months when the Hospital Standardised Mortality Index (HSMR) was marginally higher, this was within the confidence limits and the HSMR has remained stable.

5.3. Tom Frederick sought clarification on the position regarding stroke performance data and the Freedom of Information request referenced at the previous meeting. David Shannon confirmed that the Freedom of Information request had been responded to the previous week and that two subsequent requests had since been received. He explained that the intention was to provide a dedicated area on the Trust's website to publish the relevant datasets once agreed by the Stroke Programme Board. He added that he would write individually to the member of the public who had originally raised the request.

5.4. No further matters arising were identified.

6. QUESTIONS FROM MEMBERS OF THE PUBLIC AND GOVERNORS

6.1. The Chair noted that no questions had been received from members of the public or Governors in advance of the meeting. She then invited any questions from those present. No questions were raised.

7. CHAIR'S REMARKS

7.1. The Chair reflected on what had been a particularly busy period and updated the Board on recent governance, strategic and engagement activities. She reported that she, Peter Lewis, David Shannon, Deirdre Fowler and Tom Frederick had met to consider digital and IT governance in preparation for the implementation of Epic, noting the new Epic Partnership Board with the three Dorset trusts and the need for each Board committee to take responsibility for different aspects of digital oversight. She added that the Digital Strategy Forum would be reviewed to ensure appropriate membership and focus.

7.2. The Chair confirmed that work on the Trust's refreshed strategy continued, supported by extensive engagement across the organisation. She highlighted recent meetings with Sarah Dyke MP and Rachel Gilmour MP, who raised concerns about dentistry provision, dementia service integration and public transport infrastructure. Visits to community sites, including Williton, Dene Barton, Bridgwater and Burnham on Sea, reinforced the importance of developing community hubs and ensuring services reflect local needs rather than applying a uniform model across all community hospitals.

7.3. The Chair noted ongoing ambassadorial work, reporting that she and Peter Lewis had received another webcast invitation, reflecting the increased external interest in the Trust's work and the value of sustained system-wide visibility. She provided feedback from the Chairs' Forum on strategic commissioning and the challenges of shifting activity from acute to community settings, as well as insights from the Nuffield Somerset Summit on misinformation, staff morale, social care reform and the practical constraints of expanding hospital-at-home models. She also reflected on learning from Lincolnshire regarding transport-related impacts on outcomes and the potential relevance for Somerset.

8. CHIEF EXECUTIVE AND EXECUTIVE DIRECTOR REPORT

8.1. Peter Lewis reported that an unannounced Care Quality Commission (CQC) inspection of maternity services at Musgrove Park Hospital and of community services had taken place during the week commencing 23 February. The inspection remained live, with the majority of information requests already submitted and the CQC continuing to follow up on interviews not completed during their visit. The inspection involved two days at Musgrove Park Hospital and two days within community services. Early feedback had been positive, with inspectors noting clear improvements since the last inspection. Peter Lewis confirmed that the Trust would receive a draft report once the inspection was concluded, with publication expected in due course.

8.2. Peter Lewis reflected on the wider national position as the financial year approached its end, observing that the NHS appeared likely to meet its collective financial plan. He noted improvements nationally in Referral to Treatment (RTT) performance and Emergency Department waiting times. Locally, he confirmed that there would be no further in-year financial discussions about additional funding.

8.3. Rosie Benneyworth queried whether issues referenced in the Integrated Performance Report relating to cleaning standards had increased infection risk.

David Shannon confirmed this had been discussed in several internal forums and at the Executive Committee, noting challenges with capacity, sickness absence and recruitment. While no additional clinical risk had been identified, he explained that during periods of higher sickness, resources were redirected from lower-risk areas, such as corporate sites, to higher-risk clinical areas.

8.4. Mel Iles provided an update on coronial activity, advising that the backlog of outstanding cases was being addressed, with some hearings continuing in real time. She also noted that the coroner was introducing a revised process to enable a more rapid "read-only" approach for certain matters. Peter Lewis confirmed that the coroner had increased local capacity to help reduce the backlog.

8.5. Graham Hughes highlighted previous discussions at the People Committee concerning retention difficulties among cleaning staff, noting increased competition from the private sector. The Chair asked about the transition to Patchwork and the concerns raised by resident doctors. Isobel Clements explained that the new system would provide long-needed stability and accuracy in pay processes, replacing a heavily manual system that had historically caused difficulties. Peter Lewis acknowledged the change involved but emphasised that it would ultimately improve the experience for doctors.

8.6. The Chair sought clarification regarding the noted increase in complaints. Deirdre Fowler explained that themes remained consistent, primarily relating to access to care and communication and that while the volume had risen, the quality of responses had improved. She agreed to take this back to the Quality and Governance Assurance Committee for a more detailed review. Peter Lewis added that complaints referenced in the report related to issues escalated through service group governance processes.

9. PATIENT STORY: ANDREW'S EXPERIENCE

9.1. Deirdre Fowler introduced Emma Davey, Kelly Hutchins and Mark Dott, who presented a patient story describing the experience of Andrew, aged 37, whose family had given permission for his story to be shared. The Board heard that Andrew, who had colorectal cancer, had been admitted to the surgical care ward at Musgrove Park Hospital despite no further surgical options being available. The family's experience had been deeply distressing. Although Andrew was initially advised he could have soft food, this was later denied, and he experienced persistent vomiting, with soiled sick bowls left by his bedside. The Board was told that when Andrew was informed he only had a few weeks left to live, this news was delivered to him while he was on his own and within earshot of another patient. A palliative care nurse had later told the family that Andrew had been "abandoned", and the family reported having to persistently seek information about his condition. His final days were described as traumatic and lacking the dignity he deserved. The family had requested a formal apology, a full investigation and assurance that learning would prevent similar experiences for others.

9.2. Emma Davey explained that the complaint had been received approximately a year ago, during a time when the Trust held a significant backlog of complaints. Contact with the family was made within three days, and a resolution meeting was arranged rather than a written response. She described the meeting as emotional but

constructive and the family later wrote to express their appreciation for the approach taken. She emphasised the importance of personalised engagement, noting that resolution meetings enabled better understanding and often reduced the likelihood of repeated correspondence.

9.3. Mark Dott reflected on the complexity of the issues raised, acknowledging that some decisions had aligned with Andrew's own wishes, such as remaining in a double room where he had built rapport with another patient. However, he also recognised that communication with the family had been inadequate, particularly regarding Andrew's care plan, nutritional decisions and his rapidly deteriorating condition. He explained that the ward had since introduced improved bedside handovers with families present, as well as measures to identify and support patients at the end of life. He noted that Martha's Rule was helping to empower patients and families to seek support when concerned.

9.4. Kelly Hutchins spoke about how impactful resolution meetings were for both families and staff, enabling meaningful learning and supporting a more compassionate culture. She explained that the complaints backlog had reduced considerably, with 17 formal complaints now reviewed weekly to ensure a patient-centred approach. Work was ongoing to share learning more consistently across wards and with families.

9.5. In discussion, Rosie Benneyworth reflected on the importance of fostering a learning culture and asked how teams were being supported through the emotional impact of such cases. Emma Davey stressed the need for compassionate engagement training and consistent leadership support. Graham Hughes highlighted the wider challenge that many clinicians, particularly the younger workforce, had limited exposure to death in their personal lives, making end-of-life care especially challenging. Deirdre Fowler added that cultural expectations around death varied significantly and that national work to improve end-of-life care was ongoing, including through the Chief Nursing Officer's strategy. Mark Dott emphasised the need for senior clinicians to lead sensitive conversations and reflected on the valuable non-clinical support often provided by palliative care teams.

9.6. The Chair thanked Emma Davey, Kelly Hutchins and Mark Dott for presenting the story and emphasised the importance of continuing to strengthen the Trust's approach to end-of-life care. She noted the need for the Board to return to this topic in a future meeting and indicated that she would ensure this was scheduled.
ACTION: Discussion on end-of-life care to be scheduled for future meeting, reflecting the learning from Andrew's experience and ensuring continued oversight of improvements (Lead: Deirdre Fowler).

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

10.1. Mel Iles provided an update on the ongoing work to reopen paediatric and maternity services at Yeovil District Hospital. She reported that the past few weeks had been particularly busy, including briefings with local MPs and the Council, significant media interest, and a recent CQC visit. She also noted the publication of the interim national maternity report, which had generated further scrutiny. The BBC had broadcast the experiences of two women who had received less-than-optimal care at

the Trust, along with concerns raised by a member of the Healthcare Safety Investigation Branch (HSIB). Mel Iles explained that she had engaged directly with the BBC and encouraged the women involved to make contact so that further discussion could support learning and improvement.

10.2. She reiterated that the original decision to close the services had been a decisive response to concerns about fragility and extensive work had since taken place to ensure that reopening on 21 April remained achievable. Key elements included a Somerset-wide approach to workforce and governance, the recruitment of five paediatricians (three of which are now in post) and the introduction of a strengthened rota from 12 January to ensure paediatric cover during evenings and peak activity. The Board heard that staff previously redeployed to Musgrove Park Hospital and Dorset County Hospital were being supported to return, and that essential estate works such as fire safety improvements, enhanced security and redecoration had been completed during the closure.

10.3. Mel Iles highlighted the importance of developing leadership across paediatrics and obstetrics, noting that a clinical director was now regularly present at Yeovil District Hospital and working across both sites. Discussions were ongoing to determine how obstetric teams could similarly work across sites to support safety, sustainability and consistent practice. Recruitment of neonatal nurses had progressed, and work continued to define expected clinical behaviours and embed the changes required for sustained improvement.

10.4. The Chair asked about the communication plan for the local population and the potential destabilising effect on Musgrove Park Hospital and Dorset County Hospital once services reopened. Mel Iles confirmed that while reopening was set for 21 April, conversations with individual women about their planned place of birth would continue, recognising that some may choose to deliver where they had already received antenatal care. Fiona Reid was leading the communications plan with Sally Bryant and Gita Modgil, with a proposed three-week rollout. Mel Iles added that regular cross-site meetings were taking place with Dorset colleagues to coordinate the release of staff and manage the impact on activity at both sites. Deirdre Fowler highlighted that the midwifery workforce had been over-recruited intentionally to maintain safe staffing across all three sites throughout the transition.

10.5. Inga Kennedy emphasised the importance of avoiding the perception of a phased reopening and noted that once the unit was opened it must be fully able to operate. Rosie Benneyworth asked about the timing of the final review from Baroness Amos and whether the Trust would receive specific findings relevant to Somerset. Peter Lewis responded that the final report was expected by the end of June, though it remained unclear whether there would be a separate Somerset report or whether findings would be incorporated into the national summary. Mel Iles confirmed that she had asked the review team to flag any concerns that might affect reopening, and none had been raised.

11. Q3 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK MANAGEMENT REPORT

11.1. Mel Iles presented the Q3 report, noting that the overall risk profile remained high but stable. The Corporate Risk Register had been reviewed through committees and the

Executive Committee, with 22 risks recorded, six scoring 20 after one was reduced following validation. New risks had been added for agency market fragility, sharps compliance and data transformation. Nine risks had reduced and one had been archived, though several continued to sit outside appetite, including waiting times, Information Commissioner's Office (ICO) enforcement, subject access requests, capital and infrastructure pressures, SHS sustainability and unsafe staffing linked to agency market challenges. A risk relating to potential resident doctor strikes had also been reintroduced.

11.2. Board members provided challenge. The Chair queried an inconsistency in the scoring of risk 1494; Mel Iles confirmed the score had been reduced following review. Graham Hughes questioned why sharps compliance issues had resurfaced given previous Yeovil learning; Deirdre Fowler clarified the risk related specifically to procurement and rollout of safer sharps equipment. Inga Kennedy expressed concern about the archiving of a vacancies-related risk given ongoing discussions at the People Committee about the relationship between vacancies, bank and agency use, and she asked for this to be reviewed. **ACTION:** To review the archived vacancies related risk in light of ongoing concerns about the relationship between vacancies, bank and agency usage, and the potential impact on quality and safety (Lead: Isobel Clements).

11.3. David Shannon confirmed that ICO-related enforcement risk remained significant despite improvement and highlighted the importance of ensuring visibility of Healthset digital transformation work. Paul Mapson emphasised that the Corporate Risk Register would need reassessment in light of emerging Cost Improvement Programme (CIP) pressures. **ACTION:** Corporate Risk Register to be reassessed to reflect emerging CIP pressures and financial risk considerations raised by the Board (Lead: Pippa Moger).

11.4. Rosie Benneyworth sought clarity on the patient identification risk; Mel Iles confirmed it arose from a QI project that identified concerns with wristband use, with the score reduced after cross-organisational review.

11.5. Turning to the Board Assurance Framework (BAF), Mel Iles highlighted mixed progress against national priorities, with continued impact from Yeovil maternity and special care baby unit (SCBU) intervention but improvements in areas such as 65-week waits. She noted strong progress under Aim 1, driven by the new consultant in public health, including development of a population health management and inequalities framework and progress across serious mental illness, post-menopausal bleeding pathways, breast referrals and lung cancer diagnostics. Under Aim 7, she reported progress in digital medicines, ambient voice and Electronic Health Record (EHR) readiness, although risks remained around timeframe, funding and digital infrastructure. David Shannon noted that Q4 would reflect more rapid developments across digital projects.

11.6. Board members reflected on alignment between the BAF and strategy development. Paul Mapson suggested separating in-year financial pressures from longer-term structural deficit within the BAF. Inga Kennedy proposed addressing this through a Board development session once the strategy was finalised, which Graham Hughes supported. **ACTION:** Schedule a Board development session on BAF alignment once the strategy is finalised (Lead: David Shannon).

11.7. Alexander Priest queried delays in model-of-care work in Somerset West; Andy Heron advised that progress was now accelerating, although reporting may not fully reflect this. The Chair highlighted the need for greater visibility of mental health risks within future iterations of the BAF. **ACTION:** Strengthen visibility of mental health-related risks within future iterations of the Board Assurance Framework (Lead: Andy Heron/Ben Edgar-Attwell).

12. RESEARCH AND INNOVATION COMMITTEE TERMS OF REFERENCE

12.1. David Shannon presented the updated Terms of Reference for the Research and Innovation Committee, confirming that the revisions reflected discussions held at the Board development session in February. He noted that he and Mel Iles were meeting with the research team the following day to ensure alignment between the Terms of Reference and current operational priorities.

12.2. Olena Doran welcomed the inclusion of partnerships with emerging strategic initiatives but advised caution in being overly descriptive, recommending a slight amendment to refer instead to "other emerging strategic initiatives" to preserve flexibility. The Chair highlighted that the Committee's objectives should also encompass the development of the Trust's research infrastructure, training and workforce capability, and its ability to bid for external grants, noting that this was currently not explicit within the document.

12.3. The Board discussed the Committee's membership, with Jade Renville seeking clarification on whether it would be a formal Board committee, in which case amendments to the Trust's governance structure would be required. Olena Doran also suggested that while the Committee would focus primarily on regional priorities, the Terms of Reference should allow for ambition at regional, national and international levels. David Shannon agreed to incorporate the suggested amendments and confirmed they would be taken to the first formal meeting of the Committee.

12.4. The Board therefore **approved** the Terms of Reference, subject to amendments as detailed above.

13. INTEGRATED PERFORMANCE REPORT

13.1. Pippa Moger presented the Integrated Performance Report, confirming strong performance across community services, improved mental health length of stay, and progress in talking therapies. Cancer standards for faster diagnosis and 62-day pathways were above target, maternity smoking rates remained positive, and Symphony patient satisfaction continued to be high. Flu vaccination uptake had nearly doubled, and Care Opinion feedback remained strong.

13.2. Urgent and emergency care pressures persisted, with Accident and Emergency (A&E) performance below expectations at both acute sites. The opening of the Yeovil Urgent Treatment Centre (UTC) had shifted some activity from Type 1 to Type 3, reflected in the data. Twelve-hour waits and ambulance handover delays had improved but remained variable. No Criteria to Reside (NCTR) continued to be a challenge. Stroke performance had declined at Musgrove Park Hospital but improved

at Yeovil District Hospital. Diagnostics had strengthened, and elective activity was increasing, supported by Advice & Refer and higher outpatient volumes.

13.3. The Chair queried why A&E performance had deteriorated despite stable attendances. Peter Lewis explained that internal flow and hospital capacity were the key factors. Andy Heron highlighted that Yeovil attendances remained around 15% higher year-on-year, significantly impacting flow. Work was underway to improve front-door streaming and further benefits from the new UTC model were expected in the coming months. Deirdre Fowler noted seasonal pressures and staff sickness and highlighted the need for improved workforce resilience. Following a query from Graham Hughes, Andy Heron confirmed that Burnham Minor Injuries Unit (MIU) would remain at the hospital site for now, supported by GP input.

13.4. Rosie Benneyworth raised concerns about mental health patients spending extended periods in A&E. Mel Iles confirmed performance remained strong relative to national peers, with most long waits linked to external system factors. Peter Lewis added that integrated working had significantly reduced mental health breaches compared with other areas. Alexander Priest noted ongoing work with the Integrated Care Board (ICB) on appropriate local models for emergency mental health support.

13.5. The Board discussed RTT performance. Paul Mapson observed slow progress over two years, and Andy Heron confirmed that the impact of Advice & Refer would take time to materialise. Outpatient activity had risen by 4% in the past month, and Commissioning Support Unit (CSU) modelling was expected in April. In response to a question from Olena Doran, Peter Lewis clarified that dementia diagnosis rates reflected national prevalence-based measures and that work was underway to support primary care coding and pathways.

14. ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 28 JANUARY 2026

14.1. Rosie Benneyworth presented the assurance report from the Quality and Governance Assurance Committee meeting held on 28 January 2026. She highlighted a helpful presentation from Deirdre Fowler's team regarding the use of temporary environments and corridor care, noting the importance of continued scrutiny in this area. She also commended the significant progress made by the maternity team in developing the maternity incentive scheme, recognising the considerable effort involved.

14.2. Deirdre Fowler advised that further work remained on temporary environment use and confirmed that this would be brought back to the Board following additional discussion at a future Committee meeting.

15. MATERNITY & NEONATAL QUARTER 3 (2025/26) QUALITY & SAFETY REPORT

15.1. Sally Bryant presented the Quarter 3 Maternity and Neonatal Quality and Safety Report. She highlighted several achievements, including meeting the CQC requirement for 75% of maternity guidance to be in date and confirming that compliance had since increased towards a new trajectory of 90%. She reported positive feedback from the latest maternity experience survey and noted successful festive staff recognition activities. Recruitment progress continued, with an additional

obstetric consultant now in post and further interviews scheduled. The Amos investigation team had visited both Musgrove Park Hospital and Yeovil District Hospital as part of their national work, with constructive engagement observed during the visit. Interim findings had been published, and Trust-specific outputs were awaited.

15.2. Sally Bryant outlined ongoing work on the gold quality improvement projects, including improvements within triage and obstetric anal sphincter injury pathways and noted that the broader maternity and neonatal improvement programme was progressing under the Maternity and Neonatal Intensive Support Team (MNIST) framework. She reported that preparations for the reopening of services at Yeovil District Hospital had remained a major focus throughout Q3.

15.3. Key concerns for the quarter included pressures on planned elective activity and challenges in data completeness and health inequalities work. A new inequalities dashboard had been released nationally, which had been helpful, but local data extraction continued to rely heavily on manual processes. An increase in caesarean section requests in the absence of maternal risk factors had been noted, and work was underway to understand underlying drivers and implications for workforce capacity as well as to review information giving to service users and opportunity to discuss choices for birth.

15.4. In discussion, Inga Kennedy acknowledged the positive achievements but raised concerns about delays linked to flow and their impact on obstetric activity, noting these did not appear on the risk register. Sally Bryant confirmed that specific risks relating to activity pressures and postnatal bed capacity had been discussed and were being addressed through additional elective planning and strengthened booking processes. She also highlighted workforce constraints within postnatal services.
ACTION: Review how delays in flow and pressures on obstetric and postnatal activity are reflected on the risk register, ensuring that any related risks are clearly captured and monitored (Lead: Deidre Fowler/Sally Bryant)

15.5. Rosie Benneyworth asked how workforce models were being adapted to reflect the growing proportion of elective births. Sally Bryant confirmed that this was a key area of focus within workforce planning. Deirdre Fowler commented that heightened scrutiny and the wider national investigative landscape continued to generate anxiety within maternity teams and emphasised the importance of supporting colleagues through this period.

16. CQC MATERNITY SERVICE USER SURVEY

16.1. Sally Bryant and Emma Davey presented the CQC Maternity Service User Survey results. Of 300 eligible women, 154 responded (52%), with the respondent profile largely reflecting white, UK-born, English-speaking women; groups known to experience poorer outcomes were under-represented. Around 25% of respondents had received neonatal care.

16.2. Results showed a mixture of strong positive feedback and areas requiring improvement. Most indicators were “about the same” as other trusts, with three better than expected and four somewhat better than expected - particularly induction, discharge, community midwife support, postnatal care, feeding support and

confidence in raising concerns. Emma Davey noted that narrative comments often reached the Trust before survey benchmarks, enabling earlier learning through the Patient Experience and Engagement Committee.

16.3. Sally Bryant described next steps, including reviewing the findings against the existing improvement plan. She highlighted ongoing challenges with data completeness, as national dashboards remained high-level and local information required manual extraction; work with the Business Intelligence (BI) team continued to improve this. She also noted that women from minority backgrounds often reported poorer experiences that did not always translate into formal complaints and confirmed that only three such voices were currently represented on the maternity service user group, indicating the need for more targeted engagement.

16.4. In response to questions from the Chair, Sally Bryant clarified that antenatal-related survey questions focused mainly on information and clinic experiences. Work was underway to strengthen antenatal pathways and improve continuity of care, particularly for disadvantaged groups.

17. FINANCE REPORT (M10)

17.1. Pippa Moger presented the Month 10 financial position, confirming an in-month surplus of £0.75m, maintaining a breakeven position year-to-date. She reported that agency expenditure remained slightly lower than in December and continued to support the delivery of a 30-40% year-on-year reduction, equating to £9.4m less spent in 2025/26 than in 2024/25. The CIP was underperforming in month but remained on track to deliver in full by year-end. She noted that the capital programme continued to run behind plan by nearly £10m, largely due to specific scheme delays, including the Epic contract which was expected to be agreed imminently. The Trust's cash balance at the end of Month 10 stood at just under £35m, although delays in NHS England enacting Public Dividend Capital drawdown forms were noted.

17.2. Pippa Moger confirmed that the Trust remained below its whole-time equivalent workforce plan and reiterated the need for continued delivery against the CIP to sustain the forecast breakeven position. The Chair asked about the impact of vacancies on service delivery and what an optimal vacancy position should look like. Deirdre Fowler explained that some posts, particularly Band 7 ward leadership roles, were currently being counted as part of establishment despite not providing full leadership capacity, which required further review. She described recent increases in nursing numbers at the Yeovil front door and the associated risk of removing those posts without a full workforce review. Pippa Moger reminded the Board of the Trust-wide establishment review process in place, through which only a small proportion of vacancies had been declined. Isobel Clements noted that vacancy levels were routinely scrutinised at the People Committee, with further work underway to understand the optimal vacancy position at both Trust and service-level and to understand the relationship with agency use.

18. ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETING HELD ON 14 JANUARY 2026

18.1. Paul Mapson presented the assurance report from the Audit Committee meeting held on 14 January 2026. He noted that the Committee had undertaken substantial discussion on the Trust's risk profile, recognising that several risks remained above appetite and that some would require wider Board consideration, particularly where the Trust had limited ability to influence the underlying drivers. The Committee had reviewed reports from internal audit and counter-fraud and had approved the internal audit plan for the coming year.

18.2. Paul Mapson confirmed that discussions with external audit continued to be positive, including in relation to the Musgrove Park Hospital assessment and matters connected with the paediatric closure at Yeovil, which the external auditors hoped to incorporate into their value-for-money work. He also reported on an engagement visit from the national fraud team.

18.3. The Committee had discussed areas with limited assurance, including digital and associated controls, and noted that governance arrangements for the use of Artificial Intelligence (AI) were considered to be appropriate. He highlighted that the April Committee meeting would be a key session, as audit activity progresses towards issuing the annual audit opinion.

18.4. Pippa Moger clarified that the value-for-money consideration referred specifically to paediatrics at Yeovil District Hospital and Rosie Benneyworth sought assurance regarding progress on the limited assurance audit for paediatric early warning scores (PEWS). David Shannon confirmed improvements were progressing well. Rosie Benneyworth also noted the importance of linking this work to broader early deterioration themes. Inga Kennedy asked about delays in conducting and recording nursing observations, and Deirdre Fowler confirmed she had sought more detailed information on this and would bring further assurance back through the Quality and Governance Assurance Committee once analysis was complete.

19. ASSURANCE REPORT FROM THE CHARITABLE FUNDS COMMITTEE MEETING HELD ON 20 JANUARY 2026

19.1. Graham Hughes presented the assurance report from the Charitable Funds Committee meeting held on 20 January 2026. He highlighted that the quality of bids for charitable funding had continued to improve and that the Committee had approved several allocations, noting the increasing proportion of funding now supporting community and mental health services. He reflected that this demonstrated the breadth of engagement across the organisation and the impact of charitable support beyond acute hospital settings.

19.2. Graham Hughes also raised concerns regarding the performance of the Trust's charitable investments with Churches, Charities and Local Authorities (CCLA), noting that returns had been below expectations. The Committee had requested further review of the investment position and consideration of potential alternative options. The Chair echoed this concern, noting that other organisations had already taken similar steps to review or move their investments. Paul Mapson sought assurance that there was no suggestion of fraud, and Graham Hughes confirmed that this was

not the case. David Shannon added that performance had declined compared with previous years and that a refreshed review was therefore appropriate. **ACTION:** Undertake a review of CCLA investment performance and explore potential alternative investment options, reporting findings back to the Charitable Funds Committee (Lead: David Shannon/Charitable Funds Team).

20. APPROVAL OF 2026/27 REVENUE BUDGET

20.1. Pippa Moger presented the 2026/27 Revenue Budget, confirming that the proposals reflected the operational plan previously approved by the Board, now set out in greater detail at service-group and staffing-category level. She advised that there had been no material changes to the assumptions or financial allocations since the operational plan was agreed. The budget provided clarity on the distribution of both revenue and workforce resources and supported delivery of the Trust's financial commitments for the coming year.

20.2. No questions were raised by Board members, and the Board **approved** the 2026/27 Revenue Budget.

21. CAPITAL PROGRAMME 2026/7-2029/30

21.1. David Shannon presented the Capital Programme for 2026/27–2029/30, confirming that the plan remained substantively unchanged from the version previously discussed with the Board. He noted that this iteration provided a more consolidated overview of the programme while retaining alignment with priorities agreed in earlier financial planning discussions. The Board was informed that confirmation of a key element of national funding referenced in prior meetings was still awaited, with an update expected within the coming five weeks.

21.2. No further questions were raised, and the Board **approved** the Capital Programme for 2026/27–2029/30.

22. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

22.1. The Chair invited follow-up questions from members of the public and Governors. Jack Torr asked about ongoing challenges relating to the right to reside criteria and whether recent initiatives had begun to have an impact. Peter Lewis confirmed that improvements had been seen in internal processes, with delays attributable to internal flow now reduced. However, he noted that capacity-related delays within the system had more than doubled. He reported that the Council had confirmed the previous day that it would purchase additional capacity, particularly in Yeovil where the pressures were most acute, and that joint work was underway to address the remaining blockages.

23. ANY OTHER BUSINESS

23.1. The Chair invited any other business. It was noted that entries for this year's Health Service Journal (HSJ) Awards had now opened, with three new categories introduced: Neighbourhood and Community Care Innovation of the Year, Clinical Pathway Redesign, and Excellence in Narrowing the Health Inequalities Gap.

Colleagues were encouraged to consider and submit nominations where appropriate. No further items of business were raised.

24. RISKS IDENTIFIED

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

- Ongoing system pressures impacting right to reside and flow.
- Workforce capacity concerns, including vacancies and fragility within the agency market.
- Data quality challenges, particularly within maternity and health inequalities work.
- Delays and risks associated with digital transformation and readiness for the Electronic Health Record.
- Emerging concerns relating to mental health flow and sustained pressure within urgent and emergency care services.

25. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

25.1. The Board reflected on the effectiveness of the meeting and agreed that the agenda allowed for thorough discussion of key issues. Members felt that the balance between operational updates, strategic items and assurance reports supported clear scrutiny and constructive challenge. The focus on key areas such as maternity, urgent and emergency care, and digital transformation was regarded as timely and appropriate. Board members agreed that contributions from both Executive and Non-Executive Directors enabled effective debate and assurance, and no concerns were raised regarding the structure or conduct of the meeting.

26. 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.

27. 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.

28. CLOSE AND DATE OF NEXT MEETING

24.1. The meeting closed at 1.02 pm. The next meeting will take place on Tuesday 12 May 2026.

EXTRAORDINARY PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRAORDINARY PUBLIC BOARD MEETING HELD ON 20 MARCH 2026 VIA MS TEAMS

PRESENT

Dr Mima Makarem	Chair
Rosie Benneyworth	Non-Executive Director
Darshan Chandarana	Non-Executive Director [item 3.4 onwards]
Olena Doran	Non-Executive Director
Tom Frederick	Associate Non-Executive Director
Inga Kennedy	Non-Executive Director
Paul Mapson	Non-Executive Director
Alexander Priest	Non-Executive Director
Peter Lewis	Chief Executive
Isobel Clements	Chief People Officer
Deirdre Fowler	Chief Nurse and Midwife
Andy Heron	Chief Operating Officer/Deputy Chief Executive
Mel Iles	Chief Medical Officer
Pippa Moger	Chief Finance Officer

IN ATTENDANCE

Julie Hutchings	Board Secretary and Corporate Services Manager
Fiona Reid	Director of Communications

APOLOGIES

Graham Hughes	Non-Executive Director
Jade Renville	Director of Corporate Services
David Shannon	Director of Strategy & Digital Development

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 to receive a maternity update.

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 4.00 pm.

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETING

Minute	Action	By whom	Due date	Progress	Status
Public Board meeting held on 4 November 2025					
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)	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. Update: additional transition services role now agreed with service groups, with job description awaiting approval/banding process.	Complete
Public Board meeting held on 10 March 2026					
9.6 – Patient Story: Andrew's experience	Discussion on end-of-life care to be scheduled for future meeting, reflecting the learning from Andrew's experience and ensuring continued oversight of improvements.	Deirdre Fowler	June 2026	Session scheduled for June Board Development Day.	Complete

Minute	Action	By whom	Due date	Progress	Status
11.2 - Q3 Board Assurance Framework and Corporate Risk Management Report	To review the archived vacancies related risk in light of ongoing concerns about the relationship between vacancies, bank and agency usage, and the potential impact on quality and safety.	Isobel Clements	March 2026	Monitored through individual service group performance review meetings.	Complete
11.3 - Q3 Board Assurance Framework and Corporate Risk Management Report	Corporate Risk Register to be reassessed to reflect emerging CIP pressures and financial risk considerations raised by the Board.	Pippa Moger	May 2026	Risk register has been updated with financial risks for 2026/27.	Complete
11.3 - Q3 Board Assurance Framework and Corporate Risk Management Report	Schedule a Board development session on BAF alignment once the strategy is finalised	David Shannon	June 2026	Session scheduled for June Board Development Day.	Complete
11.6 - Q3 Board Assurance Framework and Corporate Risk Management Report	Strengthen visibility of mental health related risks within future iterations of the Board Assurance Framework	Andy Heron/ Ben Edgar-Attwell?	May 2026		Complete
15.4 - Maternity & Neonatal Quarter 3 (2025/26) Quality & Safety Report	Review how delays in flow and pressures on obstetric and postnatal activity are reflected on the risk register, ensuring that any related	Deirdre Fowler/ Sally Bryant	July 2026	The risk register clearly captures delays and sustained pressures across obstetric and postnatal services due to demand, capacity, workforce, theatre, and estate constraints. Risks are well documented across maternity, neonatal, and obstetric services.	Ongoing

Minute	Action	By whom	Due date	Progress	Status
	risks are clearly captured and monitored			Once YDH maternity services reopen, the cross-site pathway for antenatal, labour, and postnatal care during high-acuity periods will be reviewed, with potential to consolidate related issues into a single overarching risk to strengthen long-term oversight. Update: Maternity services have successfully re-opened in YDH. Following a month period of activity the service plans to review cross site pathway risks and consider need for potential consolidation of capacity and flow related risks to strengthen long term oversight.	
19.2 – Assurance Report from the Charitable Funds Committee meeting held on 20 January 2026	Undertake a review of CCLA investment performance and explore potential alternative investment options, reporting findings back to the Charitable Funds Committee	David Shannon/Charitable Funds Team	May 2026	The review of the current performance is currently underway and will be discussed at the April Committee. Update: April Committee reviewed the progress with investment advisor. The committee recommended maintaining the current relationship with the existing investment provider for the next 12 months based on the actions taken to improve the position. The performance will be monitored by the committee on a quarterly basis against the actions outlined by the investment provider.	Complete

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:	12 May 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 and to **approve** the NHS England Annual Self-Declaration: Continuity of services condition 7 – availability of resources and Modern Slavery and Human Trafficking Act 2015 Policy Statement 2026-27.

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

Kindness, Respect, Teamwork
Everyone, Every day

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1 BACKGROUND AND PURPOSE

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

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

1.3 The following items require Board approval:

- NHS England Annual Self-Declaration: Continuity of services condition 7 – availability of resources
- Modern Slavery and Human Trafficking Act 2015 Policy Statement 2026-27

2 NATIONAL AND REGIONAL DEVELOPMENTS / POLICY UPDATES

NATIONAL DEVELOPMENTS

National Planning, Performance and Financial Framework for 2026/27

2.1 NHS England has issued a national letter setting out next steps on planning and priorities for 2026/27, marking the transition into the new financial year and reinforcing expectations aligned to the NHS 10 Year Health Plan. The letter confirms continued national focus on elective recovery, urgent and emergency care performance, productivity and financial balance, alongside an increased emphasis on neighbourhood health models, strategic commissioning and multi-year planning. NHS England has also confirmed that regional teams will intensify support through the Intensive Recovery Programme for systems with the most persistent operational and financial challenges.

2.2 Alongside this, the Department of Health and Social Care has published the Financial Directions to NHS England for 2026/27, confirming the national revenue and capital resource limits that underpin all system and provider financial plans for the year ahead. These directions reinforce the constrained financial environment and the continued requirement for strong financial discipline across the NHS.

Primary Care, Neighbourhood Health and Workforce Flexibilities

2.3 NHS England has published variations to the Primary Care Network (PCN) Network Contract Directed Enhanced Service (DES), effective from 1 May

2026. These introduce new local variation arrangements, enabling Integrated Care Boards to make limited local amendments to support the development of neighbourhood-based services where existing contractual routes are insufficient. Additional flexibilities have also been introduced within the Additional Roles Reimbursement Scheme (ARRS), allowing certain GP and practice nurse roles previously funded through other national schemes to transition into ARRS, subject to funding availability. Collectively, these changes support the shift toward neighbourhood health models and greater local flexibility in workforce deployment.

Digital Transformation and Patient Access

2.4 Digital transformation continues to be a national priority, with NHS England confirming that patients at all NHS trusts can now view hospital referrals and appointments through the NHS App. This development supports national ambitions to improve patient access, reduce administrative burden and modernise outpatient pathways. NHS England has also continued to progress plans for the proposed NHS Online hospital, promoting virtual access to specialist care and contributing to wider elective recovery through digital and remote consultation models.

Public Health, Prevention and Patient Safety

2.5 The NHS Public Health Functions Agreement for 2026/27 has been published, confirming NHS England's delegated responsibility for the commissioning of key public health services including national immunisation and screening programmes. The agreement aligns explicitly with the three strategic shifts set out in the NHS 10 Year Health Plan: moving care closer to home, increasing digital enablement and strengthening prevention.
In parallel, national data published by NHS England highlights continued uptake and use of Martha's Rule escalation pathways, reinforcing the ongoing focus on patient safety, early recognition of deterioration and learning from concerns raised by patients, families and staff.

Southport Inquiry – Phase 1 Report

2.6 The Southport Inquiry was commissioned following the fatal knife attack at a children's dance class in Southport on 29 July 2024, in which three children were murdered and others seriously injured. Phase 1 of the Inquiry, published on 13 April 2026, examined how the attack was able to occur, whether it was foreseeable, and how public agencies managed risk in the years leading up to the incident. The Inquiry Chair concluded that the attack was foreseeable and avoidable, and that it resulted from systemic failures across multiple public agencies, rather than being an isolated or unpredictable act

2.7 Of all the findings in the Phase 1 report, the chair described the absence of clear risk ownership across multiple agencies as being the most important of his conclusions. The report describes how no single organisation accepted the responsibility for the escalating risk posed by the perpetrator. The report describes how the risk was repeatedly passed between agencies, with no one

body holding overall accountability. Closely allied to all this was the finding that multiple agencies held fragments of highly significant information, but this was poorly recorded, not shared, diluted or not acted upon. This resulted in critical warning signs being missed over a period of years, despite repeated agency contact.

2.8 The Inquiry found that the perpetrator's dangerous and violent behaviours were repeatedly excused or minimised on the basis of a diagnosis (or perceived diagnosis) of autism. The report describes how this was linked to harmful inaction rather than appropriate safeguarding responses. The report is also explicit that autism is not associated with an inherent risk of violence.

2.9 The Chair describes a lack of oversight of the perpetrator's online activity which could have provided some of the clearest indicators of violent intent, including obsession with weapons and extremist material. Despite this, there was no effective oversight, analysis or intervention by relevant agencies. Also described in the report are significant parental failures, including lack of boundaries and access to weapons. There was also a failure to share critical information with authorities in the period immediately before the attack.

2.10 The Inquiry remains ongoing with Phase 2 likely to examine policy, potential system-wide reform and future prevention. Ahead of this and any national policy response, we will be asking our young people's and adult mental health services to study and reflect carefully on these first phase findings ahead of any future national policy directives. As part of this we will be reviewing our own approach to risk assessment and management within the context of partnership working across multiple agencies.

REGIONAL DEVELOPMENTS – SOUTH WEST

Elective Recovery and Operational Performance

2.11 Across the South West, systems continue to report sustained operational pressure following winter, particularly within urgent and emergency care. Despite this, elective productivity across the region remains strong, with continued emphasis on increasing day-case activity, improving theatre utilisation and maximising capacity through pathway redesign. Regional teams continue to support delivery through targeted performance oversight and collaborative improvement arrangements.

Public Health, Screening and Prevention

2.12 Regional data indicates continued improvements in screening uptake across the South West, with breast screening participation increasing year on year and HPV vaccination coverage remaining above the national average. However, gaps in uptake persist within some population groups, and targeted work continues across the region to address inequalities in access to screening and vaccination services. Winter respiratory illness, including flu and norovirus, has continued to place pressure on acute services, reinforcing the importance of prevention and vaccination programmes.

Digital Innovation and Workforce Modernisation

2.13 The South West continues to advance its digital transformation agenda, including further deployment of digital and data-enabled workforce tools to improve rota management, reduce reliance on temporary staffing and enhance staff experience. Health Innovation South West has continued to support regional improvement through collaborative programmes, training events and shared learning networks, covering areas such as perinatal quality improvement, respiratory pathway redesign and integration between health and social care partners.

3 CORPORATE UPDATES

3.1 **Reopening of Maternity and Neonatal Services at Yeovil District Hospital**

In April, inpatient maternity services and the Special Care Baby Unit (SCBU) safely reopened at Yeovil District Hospital following a period of temporary closure. The reopening followed significant work to strengthen staffing, leadership, training, governance and safety oversight, and was supported by comprehensive engagement with service users, partners and local stakeholders. The reopening attracted extensive regional media coverage and marks an important milestone for local families, colleagues and the Trust, demonstrating sustained focus on quality improvement, patient safety and service resilience.

Supported Internship Programme – External Recognition and Media Coverage

3.2 The Trust's supported internship programme at Bridgwater Hospital, delivered through the Imagine the Possibilities Supported Employment Partnership, has received significant external recognition. The partnership was announced as the winner of the "Investing in Somerset" category at the Somerset Business Awards, recognising the collective contribution of employers, education providers, job coaches, families and young people across Somerset. The partnership has also progressed to the selection stage of the National Pearson Teaching Awards, with a panel assessment taking place on 24 April. In addition, the programme featured on BBC Points West in March, highlighting the positive impact of supported internships and inclusive employment opportunities within the Trust. This work reflects the Trust's continued commitment to inclusive workforce development and strong system partnership working.

NHS Excellence Awards – Regional Recognition

3.3 The Trust has been recognised as a South West regional champion in the inaugural NHS Excellence Awards, achieving two regional wins and one runner-up position. The Trust was named regional champion in the Digital Innovation category for the NHS 111 Online Self-Referral for Breast Cancer Diagnostics, and in the Sustainable Healthcare category for the Pee-in-Pot

initiative. In addition, the Digital Medicines team was awarded second place in the Digital Innovation category. Regional champions now progress to the national shortlist, with final winners announced at NHS ConfedExpo in June 2026. This recognition reflects the Trust's leadership in innovation, sustainability and patient-centred digital transformation.

Publication of Local Child Safeguarding Practice Review – Child C

3.4 In March, the Somerset Safeguarding Children Partnership published the independent Local Child Safeguarding Practice Review into the death of a baby (referred to as *Child C*) at Yeovil District Hospital in March 2024. The review concluded that, while there were areas for learning across agencies, the tragic events could not have been foreseen in a hospital setting. The Trust has welcomed the findings and is fully engaged with system partners to take forward the recommendations, alongside actions already implemented following the immediate post-incident reviews. The Trust has also commissioned a separate independent review of its own safeguarding practice to provide further assurance and identify any additional learning. The Trust is committed to strengthening safeguarding practice and multi-agency working.

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

Assurance Report from the Executive Committee meetings held on 7 April 2026 and 5 May 2026

4.1 The Executive Committee met on 7 April and 5 May 2026 and received updates across operational, financial, workforce, quality, safety and transformation programmes. The Committee noted that services continued to operate under sustained pressure, particularly across acute pathways, with ongoing challenges relating to patient flow, discharge performance and workforce availability. Notwithstanding these pressures, the Committee recognised the continued resilience of teams and noted progress in strengthening governance arrangements, improving financial delivery and maintaining oversight of key transformation programmes.

4.2 Across both meetings, the Committee considered the operational position in detail. In April, the impact of resident doctor industrial action, reduced discharge activity and system pressures were highlighted, contributing to increased bed occupancy across both acute sites. In May, pressures remained particularly evident at Yeovil District Hospital, including IPC-related constraints, reduced bed availability and sustained levels of patients with no criteria to reside. The Committee noted national expectations to eliminate corridor care by September 2026 and emphasised the importance of strengthening discharge processes, internal flow and alternative care pathways to support delivery.

4.3 The year-end financial position was reviewed, with the Trust reporting a surplus of £4.9m, reflecting receipt of national deficit support funding linked to

delivery of system plans. The Committee noted that the Trust had delivered its Cost Improvement Programme broadly in full, alongside reductions in agency expenditure and strong capital delivery, with minimal underspend. Whilst the overall position was positive, the Committee recognised ongoing risks associated with the sustainability of recurrent savings, workforce cost pressures and the financial challenges anticipated in the 2026/27 planning round.

4.4 The Committee reviewed the Corporate Risk Register and Board Assurance Framework, noting that the organisation continues to operate in a high-risk environment, with a number of risks remaining above appetite. Key themes included operational performance and patient flow, workforce sustainability, estate infrastructure, digital dependencies and system-wide pressures. The Committee noted improvements in risk articulation, governance processes and alignment between corporate, strategic and service-level risks, supported by development of the new Risk Management Strategy.

4.5 Quality and performance reports provided a mixed picture, with areas of improvement alongside continuing challenges. Progress was noted in urgent and emergency care performance, elective recovery and strengthening governance within service groups. However, concerns remained in relation to discharge delays, complaints handling, variation in performance across sites and ongoing workforce gaps in key service areas. The Committee also noted variability in data quality and the need to strengthen triangulation of performance, quality and workforce metrics to provide more robust assurance.

4.6 A key emerging risk relates to capacity to undertake Patient Safety Incident Investigations, with the Committee noting that current resource limitations have resulted in delays and a pause in some investigations. This presents a risk to timely learning and organisational assurance. The Committee supported further work to develop a more sustainable model, including consideration of a strengthened core investigator function and more consistent organisational approach. The Committee also received an update on dementia and delirium care following internal audit, which highlighted strong training compliance but ongoing challenges in admission screening, documentation and clinical engagement, with improvement actions now underway.

4.7 The Committee noted progress across key programmes, including the reopening of Yeovil District Hospital maternity and neonatal services in April 2026, with continued executive oversight of workforce, safety and culture considerations. Updates were also received on digital transformation and pharmacy services, including rollout of electronic prescribing and plans to develop longer-term aseptic pharmacy capacity. The Freedom to Speak Up report highlighted a reduction in overall concerns but increasing complexity, with themes relating to leadership, communication and staff wellbeing. The Committee was assured that appropriate oversight remains in place, whilst emphasising the need to maintain focus on patient flow, workforce pressures and patient safety capacity to support delivery against organisational priorities.

Guardian of Safe Working for Post Graduate Doctors Report

4.8 The quarterly Guardian of Safe Working report for the period January to March 2026 provides an overview of exception reporting activity across Somerset NHS Foundation Trust. Overall, exception reporting levels remain broadly consistent with recent quarters, although there has been an increase in reports recorded since the implementation of the Patchwork system, particularly during out-of-hours and weekend working. This increase is considered, in part, to reflect improved accessibility and awareness of reporting rather than a deterioration in working conditions.

4.9 Key points:

- Exception reporting during Quarter 4 (January–March 2026) was broadly consistent with recent quarters, with an increase noted following implementation of the Patchwork system, particularly for weekend and out-of-hours working.
- An increased number of Immediate Safety Concerns (ISCs) were submitted during the quarter; review indicates that most were misclassified and more appropriately attributed to overtime, although workload pressures relating to clerking at Yeovil District Hospital and activity on Eliot Ward at Musgrove Park Hospital were identified.
- No fines were issued and no work schedule reviews were required during the reporting period.
- Resident Doctor Forums were held at both hospital sites, with discussion focused on exception reporting, Patchwork implementation, and issues relating to payment and parking; no rota management concerns were escalated.
- Concerns were raised at Foundation Year 1 level regarding surgical on-call workload at Musgrove Park Hospital, including weekend and out-of-hours working, and these are being explored further.
- The Guardians note that some data irregularities are expected during early Patchwork implementation and will continue to monitor reporting trends through Resident Doctor Forums and targeted reviews.

4.10 The report also includes a breakdown of exception reports by specialty and trainee grade.

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

Freedom to Speak Up Guardian Report

4.12 The six-monthly Freedom to Speak Up (FTSU) Guardian report provides assurance on the operation and effectiveness of the Trust's speaking up arrangements.

4.13 During 2025/26, 351 concerns were raised, representing a reduction compared to the previous year, with 166 concerns raised in the most recent six-month period. The predominant themes continue to relate to worker safety and wellbeing, inappropriate behaviours, bullying and harassment, and patient

safety, with behavioural and leadership issues remaining consistent with previous reporting periods.

4.14 Colleague feedback remains positive, with high satisfaction reported for the support provided by the FTSU service. No formal cases of detriment were reported, although some ongoing fear of disadvantage was identified, reflecting national patterns. The report highlights continued organisational learning, alongside key developments including further expansion of the FTSU Ambassador programme, strengthened governance and assurance processes, and alignment with national changes to Freedom to Speak Up arrangements.

4.15 The full Freedom to Speak Up Guardian report is available in the Reading Room for Board members.

NHS England Annual Self-Declaration: Continuity of services condition 7 – availability of resources

4.16 As part of its Provider Licence, the Trust is required to confirm they have reasonable expectations of having sufficient financial, workforce, and operational resources to maintain commissioner requested services (CRS) for the next 12 months and to make one of the following statements:

EITHER

1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

4.17 It is proposed to declare compliance with statement 1a which is in line with the Going Concern statement as presented to this meeting.

4.18 The Board is also required to include a statement of main factors taken into account in making the above declaration and it is proposed to make the following statement:

"The Trust's Going Concern status is based upon the financial plan that was approved by the Board in February 2026, ensuring the Trust has suitable liquidity to pay suppliers and colleagues. In addition, the Trust has the support of Somerset Integrated Care Board, as indicated by the fact that services will continue to be commissioned to the Trust in 2026/27, with the contract signed. An outline cash flow plan suggests adequate liquidity to June 2027, based upon 2026/27 financial plan. The Trust's Finance Committee will oversee delivery of the Trust's financial plan, a robust governance structure maintains the internal controls, with risks to delivery of the plan and the strategic aim monitored and risk mitigation articulated through the Board Assurance Framework."

4.19 The Board is asked to **approve** this compliance statement and the statement of main factors taken into account in making the declaration.

Risk of Changes to Visa and Settlement Entitlement – Workforce Impacts

4.20 **Current position:** A 13-week rolling average was successfully used to support colleagues marginally below the salary threshold; 14/14 applications were approved. Other Trusts have approached SFT in recent months and have adopted the same approach. Following implementation of the new AfC pay scales (April), colleagues at the bottom of Band 3 now meet the £25,000 threshold, reducing the need for the rolling average approach for SOC 6131 (subject to any future threshold change).

4.21 **Settlement entitlement change (consultation closed 12 Feb):** The main risk is that entry-point roles (RQF5 and below) could move from a 5-year to a 10+ year route to settlement (ILR), increasing SFT's ongoing sponsorship and immigration cost exposure and potentially impacting retention.

4.22 **Workforce exposure and cost (based on length of service; see assumptions):** 125 sponsored colleagues at RQF5 and below are the most likely cohort to be affected. Worst-case additional cost is estimated at £0.89m (or £0.97m including visa renewals currently paid by SFT). A wider cohort of 886 colleagues at RQF6 and above are currently expected to remain on a 5-year route; if extended to 10 years, additional cost exposure could rise by £6.31m (or £6.87m including visa renewals).

4.23 **Service impact:** Roles most affected within the RQF5-and-below cohort are concentrated in Medicine (60 employees), Mental Health (18) and Surgical services (20).

4.24 **SOC 6131 / Immigration Salary List (ISL) phase-out risk:** SOC 6131 (nursing auxiliaries and assistants) was added to the ISL in July 2025. The ISL remains until December 2026. From Dec 2026 the code is expected to be unavailable for new sponsorship. Transitional arrangements for existing sponsored colleagues are unclear, creating risk to ongoing right to work and renewal eligibility for those not ILR-ready.

4.25 **Known at-risk population (subject to ongoing validation):** Potential impact on 107 HCAs not expected to have reached ILR by Dec 2026 (including 59 in the medical service group).

4.26 **Mitigations/next steps:** Continued engagement with NHS Employers and NHSE to influence and understand policy direction; close working with People Business Partners to ensure Service Groups have up-to-date information and understand the potential risk within their areas; ongoing internal data validation to refine at-risk numbers; and review of sponsorship/visa cost policy options to manage affordability while balancing retention and equality impacts.

4.27 **For information – options under consideration:** SFT is currently reviewing approaches to funding immigration costs: (1) continue the current position, (2) pay Certificate of Sponsorship (CoS) only, or (3) pay CoS and first visa only (no renewals). A further paper will be brought forward to explore these options in more detail and to make recommendations.

4.28 **Key risks and mitigations – high-level overview**

Key risk	Potential workforce/service impact	Current / planned mitigations
Changes to settlement entitlement (e.g., 5-year route extended to 10+ years for some roles)	Reduced attractiveness of sponsored roles; increased churn/retention risk; extended period of sponsorship management and cost exposure for SFT.	Monitor policy outcomes and implementation timescales; scenario modelling using workforce cohorts; early engagement with affected cohorts and managers once confirmed; incorporate into workforce planning.
Salary threshold and eligibility criteria changes for sponsorship	Inability to recruit/retain into specific roles if thresholds increase; potential service gaps if renewals become non-viable for individuals close to thresholds.	Maintain oversight of pay alignment to thresholds (including AfC changes); continue use of permitted calculation methods where appropriate (e.g., rolling average) within rules; track upcoming policy announcements and update internal guidance promptly.
SOC 6131 / ISL phase-out (Dec 2026) and uncertainty over transitional arrangements	Risk that HCAs sponsored under SOC 6131 may be unable to extend sponsorship if not on ILR-ready, creating right-to-work/continuity risks and potential loss of experienced staff.	Continue engagement with NHS Employers/NHSE for clarity on transitional arrangements; validate the at-risk cohort list; develop local contingency plans (e.g., redeployment pathways, alternative eligible roles/codes where applicable, workforce plans for impacted services).
Affordability of immigration costs (visa, CoS, renewals) under extended sponsorship durations	Budget pressure and reduced ability to sponsor at scale; inconsistent application could affect retention and perceptions of fairness.	Review funding options and equality impacts; develop a clear, consistent policy and communications approach; ensure governance via a subsequent paper with recommendations on next steps.
Recruitment and retention impacts for roles concentrated in Medicine, Mental Health and Surgical services	Disproportionate impact on specific service areas; risk of reliance on temporary staffing and associated cost pressures.	Targeted workforce planning with affected Care Groups; strengthen domestic recruitment pipelines and retention initiatives; monitor vacancy, turnover and agency usage trends for early warning.
Data quality limitations (sponsorship start dates / prior sponsorship history)	Risk that impact and cost estimates are understated or overstated; difficulty targeting mitigations to the correct individuals.	Improve capture of sponsorship start dates and history; ongoing data validation and reconciliation with ESR and sponsorship records; standardised reports are now in place and under monthly review.

Key:
RQF - Regulated Qualifications Framework
ISL – Immigration Salary List
SoC – Standard Occupational Classification
CoS – Certificate of Sponsorship
ILR – Indefinite Leave to Remain

Use of the Corporate Seal

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

4.30 The seal register entries over the period 1 April 2025 to 30 April 2026 are set out in the attached Appendix A.

Modern Slavery and Human Trafficking Act 2015 Policy Statement 2026-27

4.31 Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps taken to ensure slavery and human trafficking is not taking place in any of its supply chains and in any part of its business.

4.32 The attached statement (Appendix B) sets out actions Somerset NHS Foundation Trust have taken, and continue to take, to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

4.33 The Trust continues to fully support the government's objective to eradicate modern slavery and human trafficking, and we acknowledge our role in both combating it and supporting victims. The Trust is committed to ensuring our supply chains and our business activities are free from ethical and labour standards abuse.

4.34 The Board is asked to **approve** the signing of the statement and for the statement to be upload onto the website.

Appendix A

SOMERSET NHS FOUNDATION TRUST - SEAL REGISTER

1 April 2025 – 30 April 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
26/03/2026	39	Quedam Car Park Licence Quedam Lease	Isobel Clements	Andy Heron
26/03/2026	40	Engrossment Deed of Surrender: Wells Priory – Ground Floor	Isobel Clements	Andy Heron
26/03/2026	41	Courtlands Lease Courtlands Deed of Variation	Isobel Clements	Andy Heron
26/03/2026	42	Canonsgrove Engrossment Lease	Isobel Clements	Andy Heron
30/03/2026	43	Millstream House Licence	Andy Heron	Peter Lewis
31/03/2026	44	The Bungalow, Abbey Manor Business Centre (counterpart)	David Shannon	Peter Lewis
31/03/2026	45	The Bungalow, Abbey Manor Business Centre (licence)	David Shannon	Peter Lewis
10/04/2026	01	MPH Generator Relocation	David Shannon	Isobel Clements
23/04/2026	02	West One Surgery Deed and Licence	Peter Lewis	Melanie Iles

Appendix B

Modern Slavery and Human Trafficking Act 2015 Policy Statement 2026-27

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps taken to ensure modern slavery and human trafficking is not taking place in any of its supply chains and in any part of its business.

This statement sets out actions taken by Somerset NHS Foundation Trust, and continue to take, to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

The Trust continues to fully support the government's objective to eradicate modern slavery and human trafficking and we acknowledge our role in both combating it and supporting victims. The Trust is committed to ensuring our supply chains and our business activities are free from ethical and labour standards abuse.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. Somerset NHS Foundation Trust has a zero-tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings, and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the Trust or our supply chain.

We are committed to improving our practices to combat slavery and human trafficking. We are fully aware of our responsibilities towards patients, employees and the local community. We have robust ethical values which we use as guidance for our commercial activities. We also expect all suppliers to the Trust to follow the same ethical principles.

Policy on Slavery and Human Trafficking

We are committed to ensuring there is no modern slavery or human trafficking in any part of our business and in addition, we require that our suppliers hold the same ethos.

Currently, all suppliers awarded a contract under the NHS Terms and Conditions for either supply of goods or provision of services are contracted under the relevant clause for modern slavery and human trafficking. Similar terms and conditions are also included by the national framework providers. For high-risk contracts, additional specific clauses can be included to strengthen contractual protection. Good Industry Practice including tackling modern slavery in supply chains ensures both Trust and suppliers commitment to anti-slavery and human trafficking, and that they conduct their businesses in a manner that is consistent with the Trust's stance on anti-slavery.

In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high-risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

We operate a number of internal polices which ensure we are conducting business in an ethical and transparent manner. These include:

Recruitment - we operate a robust recruitment policy for all directly employed colleagues and volunteers. This includes comprehensive employment checks and standards such as verifying

identify, confirming the right to work in the United Kingdom and obtaining appropriate references. We have rigorous vetting procedures in place to ensure compliance and all colleagues are paid above the National Living Wage, directly into their personal bank accounts.

Agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency colleagues, to safeguard against human trafficking or individuals being forced to work against their will.

Equal Opportunities - we have a range of controls to protect colleagues from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and fair access to training and development opportunities.

Safeguarding - we adhere to the principles inherent within both our safeguarding and protection of unborn babies and children policy and safeguarding adults policy. These are compliant with the relevant legislation, the Somerset Safeguarding Adult Board and Somerset Children's Safety Partnership multiagency agreements and provide clear guidance so that our colleagues are clear on how to raise safeguarding concerns.

Freedom to Speak Up - we operate a Freedom to Speak Up policy so that everyone in our employment knows they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals, and the various ways in which they can raise their concerns. This includes any circumstances that may give rise to an enhanced risk of slavery or human trafficking.

Standards of business conduct – the Trust's Code of Conduct and Managing Conflicts of Interest and Personal Conduct Policy clarifies the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

We are committed to social and environmental responsibility and have zero tolerance of modern slavery and human trafficking. Any identified concerns regarding modern slavery and human trafficking would be escalated as part of the organisational safeguarding processes in conjunction with partner agencies.

We will:

- comply with legislation and regulatory requirements.
- ensure suppliers and service providers are aware we promote the requirements of the legislation.
- develop awareness of modern slavery issues.
- include modern slavery conditions or criteria in specifications and tender documents within the supplementary terms and conditions.
- encourage suppliers and contractors to take their own action and understand their obligations about these new requirements.
- expect supply chain/framework providers to demonstrate compliance with their obligations in their processes.

Our approach to procurement and our supply chains

Trust colleagues must contact and work with the procurement departments when looking to work with new suppliers to ensure appropriate checks can be undertaken. Procurement colleagues will ensure due diligence by:

- checking draft specifications include a commitment from suppliers to support the requirements of the Act.
- not awarding contracts where suppliers do not demonstrate their commitment to ensuring slavery and human trafficking are not taking place in their own business or supply chains.
- communicating clear expectations to our suppliers through a supplier code of conduct.
- monitoring compliance by suppliers with the requirements of the Act.

Training

Advice and training about modern slavery and human trafficking is available to colleagues through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our corporate induction training which is mandatory for all our new starters. We are looking at ways to continuously increase awareness within our organisation, and to ensure a high level of understanding of the risks involved with modern slavery and human trafficking in our supply chains and in our business.

Our Performance Indicators

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if there are no reports from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2025.

To the best of my knowledge, the information in this document is accurate.

Signed

Chief Executive

01.04.2026

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2025/26 Q4 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:	12 May 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 presents the Q4 (year-end) 2025/26 Board Assurance Framework (BAF) to the Board of Directors. The BAF provides a consolidated and structured view of the Trust's risks, controls and assurance arrangements aligned to the Trust's seven strategic aims. This iteration reflects the full-year position, including: • Year-end performance against strategic aims and objectives; • Updated risk ratings and trajectories; • Progress against objectives and delivery of the Trust's strategy; • Areas where risks remain above appetite and require continued focus into 2026/27. Overall, the Trust continues to operate in a highly pressured environment, particularly across urgent and emergency care, workforce, and system flow. However, material progress has been achieved across a number of strategic programmes, notably in digital transformation, community services, workforce stability, and population health initiatives. While several risks remain above appetite, this is consistent with the operating context and reflects system-wide constraints, including primary care capacity, social care availability, and national financial pressures.
Recommendation	The Board is asked to: • Review and consider the Q4 2025/26 Board Assurance Framework; • Provide focused scrutiny of Aim 1 and Aim 7, which

	are reserved for Board oversight: ◦ Aim 1: Improving population health and reducing inequalities; ◦ Aim 7: Delivering transformation through research, innovation, and digital technologies; • Note areas where risks remain above appetite and the mitigating actions in place; • Provide feedback to inform development of the 2026/27 BAF and strategic planning cycle.

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

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

Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
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.

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

2025/26 Q4 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 Q4 BAF reflects a year-end position of sustained delivery alongside continued operational pressure. Key themes include:

- Operational performance and flow: Continued challenges in urgent and emergency care, discharge, and bed occupancy, with persistent reliance on system-wide improvement.

- Quality and safety: Targeted improvements in paediatrics and maternity, including reopening of services in Yeovil and strengthened medical workforce.

- Community and neighbourhood care: Continued expansion of Hospital at Home and urgent community response, although scale remains insufficient to offset demand fully.

- Workforce and culture: Stable retention and continued delivery of the People Strategy, alongside declining engagement indicators requiring sustained attention.

- Financial sustainability: Delivery of the financial plan with continued reliance on non-recurrent savings and ongoing productivity requirements.

- Digital transformation: Significant progress including completion of EHR procurement, expansion of digital medicines, and increased use of AI-enabled technologies.

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

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

2.3. Good progress has been made in establishing a coherent and mature population health programme, with strengthened governance and clearer prioritisation of workstreams. Early diagnosis initiatives continue to demonstrate strong impact, improving access and identifying disease earlier, particularly for underserved populations. The Stolen Years programme remains a key priority in addressing inequalities for people with severe mental illness.

2.4. The overall risk position remains within appetite; however, progress is limited by analytics capacity, data integration and system coordination, which continue to restrict pace. These dependencies will need to be addressed to enable further progress in 2026/27.

Aim 2: Provide the best care and support to people

2.5. Performance under this aim remains mixed at year-end, with progress in elective recovery and paediatric workforce stability, alongside the safe reopening of maternity services at Yeovil. However, significant operational pressures persist, particularly in patient flow, A&E performance, and discharge, with high levels of patients not meeting criteria to reside.

2.6. Risks remain above appetite, driven by workforce constraints, estate challenges, and system-wide pressures. Delivery continues to depend on external factors including primary and social care capacity, and sustained improvement will require ongoing system collaboration.

Aim 3: Strengthen care and support in local communities

2.7. Progress continues in expanding community-based services, with strong urgent community response performance and growth in Hospital at Home and neighbourhood models. The relaunch of integration programmes, particularly in South Somerset West, has strengthened governance and focus on delivery.

2.8. Despite this, risks have moved above appetite at year-end, reflecting workforce pressures, rising demand and system dependencies. The scale of transformation required to significantly impact acute demand has not yet been achieved and remains a key risk into 2026/27.

Aim 4: Respond well to complex needs

2.9. Progress has continued across this aim, particularly in the expansion and embedding of digital care planning through eSTEPs and the strengthening of paediatric services, including workforce improvements at Yeovil. The increase in completed eSTEPs represents a significant step forward in enabling more coordinated, person-centred care planning across services, with a growing focus on improving quality and consistency.

2.10. However, delivery has been variable across programmes. The CAMHS Tier 4 alternative programme has experienced delays following changes in regional scope, requiring the development of a revised business case and leaving an

unmet need for a small but high-risk cohort of young people. In addition, progress in improving transition pathways for young people with complex needs has been limited following workforce gaps, particularly the absence of a dedicated Transition Lead.

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

2.12. Delivery of the People Strategy has supported strong retention and improved organisational foundations, including progress in leadership development and people services transformation. These programmes are beginning to embed more consistent approaches across the Trust.

2.13. However, engagement and cultural indicators have declined, reflecting wider system pressures. Risks relating to burnout, discrimination and appraisal compliance remain, requiring continued focus to deliver sustained cultural improvement.

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

2.14. The Trust has delivered its financial plan, demonstrating strong financial control. However, a low proportion of recurrent savings presents an ongoing continued medium-term financial risk, with continued reliance on non-recurrent measures.

2.15. Financial risks remain above appetite, particularly around recurrent savings, elective delivery and system-wide pressures. While mitigation plans are in place, financial sustainability will remain a key focus into 2026/27.

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

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

2.17. Significant progress has been achieved under this aim over the course of the year, particularly in advancing the Trust's digital and transformation agenda. The procurement and contract award of the Electronic Health Record (EHR) represents a major milestone. Alongside this, the Trust has successfully completed the rollout of digital medicines across all service areas and expanded the use of AI-enabled technologies, including ambient voice tools and wider digital innovations, which are beginning to support improvements in productivity and clinical workflow.

2.18. The overall risk position remains above appetite, reflecting the scale and complexity of the transformation required. The implementation of the EHR programme presents significant delivery, financial, and operational risks, particularly given the pace required and the dependency on national approvals and capital funding. In addition, underlying digital infrastructure limitations and

estate constraints continue to pose challenges to delivery. These risks will require continue oversight and focus.

3. CONCLUSION

3.1. The Q4 Board Assurance Framework outlines meaningful progress against its strategic aims over the course of 2025/26, despite operating in a sustained period of organisational and system pressure.

3.2. There have been notable achievements in digital transformation, workforce stability, community service expansion and the development of a more structured population health approach. However, risk exposure remains elevated across several domains, particularly in relation to operational flow, workforce capacity and financial sustainability, with many factors driven by wider system dependencies.

3.3. While the overall position reflects a stable but pressured operating context, the BAF highlights that further progress will depend on continued system-wide collaboration and sustained organisational focus, particularly in areas where risks remain above appetite.

3.4. Aims 1 and 7 continue to require focused Board oversight, given their strategic importance, scale of delivery, and level of interdependency.

4. RECOMMENDATION

4.1. The Board is asked to:

- Review and note the Q4 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.

DIRECTOR OF GOVERNANCE

Board Assurance Framework 2025/26 – Q4 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**	**Finance**	⇔
		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		
7	DS	**Deliver the vision of the Trust by transforming our services through innovation, research and digital transformation**	**Board**	⇔
		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 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 vision for the programme is to improve healthy life expectancy and reduce the inequality in healthy life expectancy in Somerset. 5 priority workstreams have been agreed which are based upon local data. These are:

- Cardiometabolic health and preventable vascular disease
- Mental health, substance misuse and inclusion health
- Children, young people and life-course inequality
- Anchor institution
- Enabling population health work at service level

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 – 1044 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. 596 patients have referred themselves with 14% 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 – 1044 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 145 patients have	

	so far completed a referral form for the service with 3 patients being diagnosed with cancer, and one having a lung nodule which is now under surveillance. 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 3,000 with 128 cancers identified to date and the equivalent of 102 days of GP time saved. 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 has been approved in principle by the ICB, with an agreement for 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				
April 2025	**July 2025**	**October 2025**	**January 2026**	**April 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**	**12**

Risks to Objectives

		Radar Ref.	Score
Obj1	Reduced temporary workforce impacting mental health wards	**R3624**	**16**
	Primary care capacity/resilience constraints across Somerset	**R0673**	**16**
	Failure to meet psychological needs	**R2777**	**16**
	GP collective action may stop physical health monitoring for patients on antipsychotic/ADHD meds/eating disorders	**R2884**	**10**
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		
	Insufficient capacity to meet waiting times	**R0012**	**20**

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

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	3	15	9	Data not yet due
Diabetes: pats on hybrid closed loops	192 in Year 1	Data not available											
Smoking status: acute inpatients	Green: >=60% Red: <55%	41%	43%	45%	46%	46%	48%	46%	51%	51%	51%	54%	55%
Smoking quit rates: Mental health inpatients	Green: >=55% Red: <50%	100%	100%	100%	100%	0%	100%	75%	50%	0%	-	-	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%	72.5%	72.1%	82.2%	86.0%	Data not yet due
Years in good health (females)	Green: National best quartile: 63.9 years Red: National worst quartile: 58.4 years (National average: 61.9 years) 2021-2023 data	63.2	63.2	63.2	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: 63.7 years Red: National worst quartile: 57.9 years (National av.: 61.5 years) 2021-2023 data	63.2	63.2	63.2	63.2	63.2	63.2	63.2	63.2	63.2	63.2	63.2	63.2

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 risk environment, with steady numbers of patient who have no criteria to reside across both acutes, community hospitals and mental health inpatient areas. Additional capacity has been a significant challenge with escalation beds open 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. This will also include benchmarked recommendations against the recent NHSE letter on elimination of corridor care by Sept 1st 2026 sent to all NHS acute Trusts in March 2026. Self-assessment submitted to NHSE week commencing 27/04/26.

YDH maternity and neonatal unit reopened on April 21st and in general has been uneventful and welcomed by staff and local families alike. Ongoing actions and associated assurances with clear criteria to for safe staffing of 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. A working group is in development to expedite actions in relation to development of a PAU in YDH.

	CQC conducted an unannounced inspection of MPH maternity services week commencing February 23, they visited the inpatient service and community over 4 days. Areas for improvement in safeguarding and triage as well as celebration regarding notable improvements from last inspection were shared with executives and mat/neo PLT on Monday March 2nd, the formal inspection report has not yet been received.

SFT Objectives / Programmes

1	**Delivery of 2025/26 national priorities and success measures**	**Behind Schedule**
	The Trust continued 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 remains in Tier 2 of national performance management for its diagnostic and cancer waiting times delivery. Performance against the diagnostic 6-week wait standard remains below plan but has improved in the last two months, ending the year on 80.7%. Performance against the 28-day Faster Diagnosis Standard (FDS) cancer standard dipped slightly in January, reflecting a reduction in capacity over the Christmas and New Year periods together with high levels of patient choice to defer tests and appointments, but recovered strongly in February to 80.8%, meeting both the national standard (77%) and our planning trajectory. 62-day cancer (referral to treatment) performance decreased in January and February, mirroring FDS performance impacts, but remained above the current national target. Referral to Treatment Time (RTT) performance improved across quarter 4, following an initial deterioration in performance due to a reduction in referrals related with our implementation of Advice & Refer in four high volume specialties at the end of November. Performance against the 18-week RTT standard improved from 61.8% in January to 65.4% in March but remained below our planning trajectory of 67.3%. The number of 52-week waiters decreased across quarter 4, but we remained above plan in terms of the percentage of the RTT waiting list waiting over 52 weeks at 2.0% against a plan of 1.5%.	
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 continues work to strengthen our review processes for patients with No Criteria to Reside (NCTR), supporting timely discharge and improving patient flow. This programme complements the longer-term Every Minute Matters approach, which focuses on culture change and refreshed MDT discharge practices. Length of stay remains challenged, particularly on our acute wards, with complexity of need and infection control measures contributing to pressures. Recent reviews continue to generate actionable themes, which will be taken forward through the EMM Steering Group. To maintain safety and support unscheduled care flow at YDH, additional capacity was opened with active plans to de-escalate as soon as clinically appropriate. Performance remains significantly challenged against the ≤15% target. The most recent data (March 2026) shows the proportion of occupied bed days lost to patients not meeting criteria to reside has increased to 25.4% at MPH and 22.8% at YDH, with the overall NCTR position also deteriorating to approximately 25.9% of acute beds. This continues a pattern of sustained underperformance across the year, with levels consistently above 20%. Length of stay remains a contributory factor, particularly at YDH where it has increased to 8.7 days, reflecting ongoing acuity, complexity, and the impact of infection prevention measures.	

	Progress is also being made in developing out-of-hospital models of care. Hospital at Home and urgent community response services continue to expand, with strong performance in rapid response (consistently above 90%), supporting admission avoidance and earlier discharge. However, the scale of these services is not yet sufficient to offset the current level of demand and discharge delay. A range of actions, including enhanced discharge planning, improved domiciliary care collaboration, and expansion of alternative-to-admission pathways, continues to focus on improving flow, enabling care at home where appropriate and facilitating timely discharge.

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

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

Risks to Aim

		Radar Ref.	Score
1	Access to primary care / increasing ED demand	**R0673**	**16**
2	Shortfalls in system capacity to enable timely discharge		**16**
3	Age of acute and community estates	**R1789**	**20**
4	Workforce shortages	**R2044**	**6**

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

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%	7.9%	7.9%	8.0%	8.2%
Clostridium difficile cases in inpatient settings: cumulative year to date number		Green: <91 annually Red: >96 annually	12	16	20	32	45	55	59	64	69	77	82	83
Clostridium difficile cases in inpatient settings: monthly number			12	4	4	12	13	10	4	5	5	8	5	1
Falls per 1000 bed days: YTD		SPC Upper limit: 5.50	5.38	5.20	5.00	5.10	5.25	5.27	5.31	5.28	5.31	5.38	5.47	5.49
Pressure ulcers per 1000 bed days: YTD		SPC Upper limit: 1.35	1.31	1.2	1.16	1.08	1.17	1.18	1.18	1.18	1.24	1.29	1.29	Data not yet due
Acute Home Treatment caseload		Green: >=134 Red: <120	92	77	77	74	85	100	107	98	99	100	89	77
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%	21.1%	24.8%	25.9%
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	6.7	6.0
	YDH		8.2	7.9	8.1	8.4	7.5	7.8	8.5	7.6	8.4	8.6	8.1	8.7
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%	21.9%	24.0%	25.4%
	YDH		18.1%	25.2%	22.8%	20.7%	21.3%	19.6%	16.5%	16.8%	19.5%	20.4%	26.2%	22.8%
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%	60.7%	58.3%	46.2%	57.4%	62.5%
	YDH		32.4%	41.9%	48.4%	27.0%	26.5%	33.3%	27.8%	20.8%	24.3%	32.3%	34.6%	22.2%

Metric	Site	Target												
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%	70.7%	60.3%	63.3%	69.4%	70.6%
	YDH		67.5%	57.8%	63.8%	42.5%	62.5%	74.4%	61.0%	52.4%	50.9%	48.6%	39.5%	47.1%
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%	61.8%	63.1%	65.4%
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%	70.2%	72.4%	73.9%
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%	2.2%	2.1%	2.0%
Improve performance against the headline 62-day cancer standard to 75% by March 2026		Trajectory: Green: >=75% by March 2026 Red: <75% by March 2026	70.2%	69.2%	68.1%	68.4%	70.0%	70.4%	69.6%	76.5%	76.4%	73.7%	73.1%	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%	79.0%	76.2%	80.8%	Data not yet due
Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED		Green: >=76% Red: <66%	71.3%	73.0%	75.7%	77.5%	73.5%	70.8%	71.0%	70.0%	70.7%	67.2%	70.1%	72.8%

within 4 hours in March 2026: Trust-wide performance														
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: >=97.3% Red: <97.3%	95.9%	96.5%	97.1%	97.4%	97.5%	97.4%	97.2%	97.2%	97.1%	96.8%	96.7%	96.7%
Reduce average length of stay in adult acute mental health beds		Trajectory: Green: =<53.1 days by March 2026 Red: >58.1 days by March 2026	61.1	59.1	61.9	68.7	70.5	76.3	74.2	66.3	60.6	67.1	73.0	73.1
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 - The 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%	65.2%	73.3%	80.0%
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%	76.9%	91.7%	80.0%
	YDH		100.0%	100.0%	100.0%	100.0%	71.4%	88.9%	66.7%	100.0%	93.3%	100.0%	100.0%	50.0%

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

SFT Objectives / Programmes

1	**Community response including care-coordination, virtual ward and Call before Convey**	**Behind Schedule**
	The Trust continues to deliver a strong community-based urgent care offer, with KPIs showing consistently high performance across rapid response, virtual ward activity and wider care-coordination programmes. Urgent Community Response (UCR) 2-hour performance remains significantly above the ≥70% national standard, consistently delivering over 90% (91–94%) across the year, indicating a reliable and responsive service with effective triage and deployment models. Activity within community-based admission-avoidance pathways is mixed at the moment with strong performance from respiratory elements of the service. However the frailty element of this service is now subject to a root and branch review by the new Service Group Director and Triumvirate leadership team. This work will conclude with a complete refresh of this aspect of the service including operational and clinical leadership arrangements. A recruit campaign will also run over the summer to address the current high number of vacancies within the frailty service.	
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 launched and 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**
	Good progress is being made on offering an enhanced range of formally acute based services across a range of community sites and especially at community hospitals. Recent temporary bed closures have afforded greater space for these new services and a comprehensive list of services signed up so far was presented to the Trust Board Development Day on 14 April 2026. Closely allied to this work the building works for a community diagnostic centre at Bridgwater Community Hospital remain on plan and will be completed in July 2026. Amongst the new services offered will be urology investigation unit offering a broad range of diagnostic and treatment services that up until now have only been available on acute hospital sites.

Risks - Scoring and Appetite

Risk Appetite over Time - Aim

Seek – 15-16				
April 2025	**July 2025**	**October 2025**	**January 2026**	**April 2026**
Within appetite	Within appetite	Within Appetite	Within Appetite	Above 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	15
	Symphony not becoming self-sustaining	R2192	20
Obj3	Poor condition of Shepton Mallet CH portakabins	R0534	20

Controls and Assurance

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

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	501	572	517	577	559	609	654	534	536	634	533	499
Patients admitted to Acute Home Treatment	Green: >=419 Red: <350	265	258	242	289	288	308	364	304	342	342	254	251
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	21,396	21,591	21,512	21,464	21,357
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	15,127	17,759	20,195	22,587	25,538	28,271	31,168
Urgent Community response <2hrs	Green: >=70% Red: <60%	91.9%	93.0%	92.6%	93.5%	92.0%	92.7%	91.2%	93.9%	91.9%	91.6%	93.0%	93.6%
Treatment Escalation Plans – patient/family involvement	Green: >=90% Red: <80%	62.0%	68.0%	No audits run - awaiting the development of a dashboard.								80%	Data awaited

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. Recruitment processes have commenced with a new JD draft and awaiting approval/banding confirmation.

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. Recruitment processes have commenced with a new JD draft and awaiting approval/banding confirmation. 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				
April 2025	**July 2025**	**October 2025**	**January 2026**	**April 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	LOS > 21 days due to insufficient intermediate care capacity	**R2273**	**12**

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		
	YDH Paediatric Acute quality/safety concerns	**R2839**	**12**
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	

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

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%	93.9%	92.7%	98.2%	97.0%	98.2%	89.8%	90.9%	90.8%	90.8%	91.8%	91.0%	Data not yet due
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	83,197	Data awaited	Data awaited
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	93.3	108.2	117.0
Av wait for assessment: adults w/ASD (weeks)	TBC	79	81	83	84	86	88	90	90	91	93	94	98
Homeless service: annual referrals	Green: >696 Red: <696	802	788	817	774	761	782	798	816	823	830	840	844
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%	53.8%	53.6%	Data awaited
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%	21.1%	24.8%	25.9%

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				
April 2025	**July 2025**	**October 2025**	**January 2026**	**April 2026**
Above appetite	Within 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
	  ○ Internal audit

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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

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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

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<td>
Oversight Arrangements for Governance and Engagement

Reports to Exec Committee
Chief of People report to People Committee
People Committee
People Services Governance Committee

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<td>
Oversight Arrangements for Governance and Engagement

Quality Assurance Group Topic Reporting

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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%	90.0%	89.9%	90.0%
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			Data awaited				
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			Data awaited				
Inclusion: % of colleagues in a senior role (Band 8a+ and consultants) who are female. The ambition is to represent the overall Trust position by 2028 with a trajectory for March 2026 of 69.8%.	Trajectory: Green: >=69.8% by March 2026 Red: <64.8% by March 2026		58.1%			58.7%			59.0%			59.1%	
Learning Education and Training (LET): A reduction in the cost of mandatory and role essential training.	Green: Maintain or reduce spend 25/26 Red: Increase in spend 25/26												
Disciplinary Investigations to take no more than 4 weeks.	Green<4 weeks Red: >6 weeks	New reporting		13	12		9.2	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%	81.4%	80.1%	80.2%
Sickness absence: over rolling 12 months maintain levels within the upper control limit of 5.2%	Green 5.2=< Red >5.2	5.2%	5.2%	5.2%	5.1%	5.2%	5.2%	5.2%	5.1%	5.2%	5.2%	5.2%	5.2%

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 has been submitted which shows a 6.5% CIP for 2026/27, 5.0% 2027/28 and 4.5% 2028/29. The plan assumes 65% CIP delivered recurrently which will result in a reduction in the recurrent deficit across the 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				
April 2025	July 2025	October 2025	January 2026	April 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	6
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	6
	Unplanned cost pressure from operational activities and activity levels not being delivered	R3059	12
Obj2	Failure to deliver elective activity trajectory	R3060	12
Obj3	Insufficient investment to reduce backlog maintenance	R0003	16

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

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	B/E	£4,933k surplus
% of CIP identified as recurrent	Green: >=70% Red: <40%	8%	12%	17%	23%	31%	29%	32%	32%	31%	30%	30%	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	£236k adv	£39k 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%	21.7%	21.7%	24.8%	25.9%
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	12,886	12,943

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 end 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 with our preferred supplier and the full business case and contract were concluded and EPIC awarded the contract. . 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 was completed in 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**	**Complete**
	The procurement of the new Electronic Health Record (EHR) solution concluded with Epic as our preferred supplier. The contract was signed in March 2026. Alongside the contract, an Inter-Trust Agreement (ITA) has been drafted to ensure SFT, as the lead authority on the contract, has the necessary legal agreements in place with the Dorset Trusts..	
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				
April 2025	**July 2025**	**October 2025**	**January 2026**	**April 2026**
Above Appetite	**Above Appetite**	**Above Appetite**	**Above Appetite**	**Above Appetite**

Risks to Aim

		Radar Ref.	**Score**
1	Failure to secure/implement necessary digital/data/technology	**R1611**	**20**
2	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			
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 • Research and Innovation Committee

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	228	228
Quality Improvement: training packages	Trajectory: Green: >=750 annually Red: <675	63	105	167	256	271	313	338	408	424	446	524	562
Data Delivery Strategy on track	-	On plan	On plan	On plan	On plan	On plan	Behind plan	Behind plan	Behind plan	Behind plan	Programme paused	Programme paused	Programme paused
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	6,242	9,178	11,210	14,284
Electronic Health Record on track	-	On plan	On plan	On plan	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	85	98	85
Number of Services live with Ambient Voice Technology (cumulative)										16	16	16	16
Number of Users live with Ambient Voice Technology (cumulative)										38	38	38	38
Number of Services live with EPS (cumulative)		6	6	6	7	10	23	25	37	40	40	40	40
Number of Prescriptions processed through EPS (per month)		853	998	1138	1205	1323	2948	4045	4059	4712	4712	4149	4807
Number of Licensed Users live with M365 Copilot (cumulative)					175	198	219	242	242	260	292	314	367

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Chief Medical Officer
REPORT BY:	Trust Risk Manager
PRESENTED BY:	Chief Medical Officer
DATE:	20 April 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.* 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. Of particular note under the remit of the Board of Directors since the last report: **Corporate Risk Register Highlights:** There are twenty risks on the April 2026 Corporate Risk Register compared to 22 as of the previous report to the Board. In addition, there have been several updates in this reporting period: • One new risk has been identified as the overarching fire safety risk following a full review of fire safety related risks. • One corporate risk increased in current risk score since the previous report. • One risk has been closed since the previous report. • Three risks have been reduced in score since the previous report.
Recommendation	The report covers those risks detailed on the Somerset Foundation Trust CRR on 20 April 2026. The report focuses on the high risks scoring 15+ on the risk matrix and includes corporate risks and service group risks. The Committee is asked to note the report and the risks identified. The Committee should highlight any risks that they would expect to see on the CRR or any changes that are required following the discussions within the Committee meeting.

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 20 APRIL 2026

1. INTRODUCTION

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 20 April 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 will either be shown as additional corporate risks for SFT or mapped into existing SFT corporate risks.

3. CORPORATE RISK REGISTER

3.1 There are currently twenty risks on the Corporate Risk Register detailed within the circle heat map. The highest rated risks sorted by Current then Target scores (highest to lowest) are:

Ref	Description	Original score	Current score	Target score
RSK-000012	Waiting Times	20	20	15
RSK-003775	Risk of degradation of the safety of patient and service user care, for example increased likelihood of clinical errors, delayed interventions, or unsafe skills mix. This would be due to the hazard that is a care environment where safer staffing standards cannot maintained in one or more areas across the trust.	20	20	15
RSK-001789	Unsafe Premises and environment. The trust is required to manage and maintain its premises and infrastructure such that it complies with the Health and Social Care Act 2008 (Regulated Activities) Regulations	15	20	8

	2014: Regulation 12 (Safe Care and Treatment and Regulation 15 (premises and equipment) as well as other Health and Safety legislation. Failure to meet these standards could lead to significant harm/injury being caused to patients, staff and visitors using our premises and services			
RSK-001611	Risk of: Failure to secure the necessary infrastructure to meet the current and future demands of the population and the clinical strategy. Due to: Assurance of availability capital funding either locally or through national programmes (New Hospital programme or other sources). Impacted by availability of estate and supplier capacity.	16	20	8
RSK-002192	Risk of: SHS not becoming self-sustaining. Due to: costs exceeding its contract income	20	20	6
RSK-001517	Non-compliance with subject access requests	12	20	4

New Risks

3.2 There is one new risk included in the Corporate Risk Register since the last report on 13 February 2026:

- **RSK-002677** – Corporate Risk - Passive fire protection breaches, dampers & non-compliant fire doors across inpatient services (15)
  Fire Safety risks have been reviewed and are to be managed under this overarching risk.

Increased Risks

3.3 There was one risk which increased in scoring since the last report on 13 February 2026:

- **RSK-001936** – Corporate Risk - If delays in reviewing controlled documents continue and overdue documents cannot be reduced, then inconsistent practice may occur, affecting care quality, regulatory ratings, and inquest outcomes (16)

Risks which have Reduced

3.4 There have been three risks which has reduced since the last report on 13 February 2026.

- **RSK-000009** - Diagnostic Waiting Times Performance. The current risk score was changed from 16 to 12 on the 09-Apr-2026.

- **RSK-003059** - 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 outcome. The current risk score was changed from 16 to 12 on the 10 March 2026.

- **RSK-003660** - If patient identification processes remain inconsistent across the Trust, then patients are at increased risk of harm due to misidentification. The current risk score was changed from 20 to 10 on the 8 April 2026 as part of the review and validation process.

Risks which have been Archived (Closed)

3.5 The following corporate risks have been archived in the reporting period:

- **RSK-000673** – Corporate Risk - Issues with the current capacity and future resilience of primary care in Somerset.

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 Simply Serve Limited 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.

Service Group & Corporate Function Risks

3.8 94 risks scoring 15 or more continue to be identified at Service Group and departmental levels. These risks have been linked to risks on the Corporate Risk Register as shown in Appendix 1. The movement of these risks since the last report has also been included within Appendix 1.

Compound Risks

3.11 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.

3.12 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.

3.13 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.

3.14 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

3.15 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

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

3.17 A more detailed explanation, including a visual representation of the compound risks, is included within Appendix 5.

Positive Risk Taking

3.21 A positive risk is an uncertain event or condition that, if it occurs, would have a beneficial impact on a service / organisation / system. Like negative risks, positive risks are not guaranteed to happen. They represent possibilities and opportunities, not certainties. The defining feature for positive risks, is that unlike negative risks, which are potential problems, positive risks if they occur, would lead to positive outcomes such as improved outcomes for our patients; improved wellbeing for our colleagues; increased efficiency; cost savings; achievement of strategic aims.

3.22 The Trust's central risk team are developing a risk matrix for positive risks and working with Radar to understand whether Radar has the functionality for the Trust to be able to record both positive and negative risks within the risk register.

3.23 Despite the fact the Trust does not currently have a system in place that provides the ability to record positive and negative risks differently within the same system, a positive risk has been added to the risk register. This risk, risk 3239, relates to the Bridgwater MIU test and learn which if the opportunities are realised, may lead to triage and booked appointments meeting urgent treatment centre standards; improved flow, colleague health and wellbeing and retention rates; and improved patient care.

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 On 17 April 2025, approval was formally granted by the Learning Committee to mandate the Level 1 Risk Management training for all colleagues. The training was mandated for colleagues from 28 April 2025. Overall compliance with Level 1 Risk Management training continues to show steady progress, with the latest data showing Trust-wide completion rising to 83.5% in February - a 1.2% improvement since February.

4.5 The risk approval training on Radar took place during June and early July with the approval step live from 15 July 2025. Any risks which await approval on Radar will be included within this report marked with an asterisk. The risk approval step only applies to new risks added to the risk register after 15 July 2025. It is hoped adding this additional validation step within Radar will support the improvement of risks meeting the minimum standard as specified within the Risk Management Policy.

4.6 Progress has been made with the development of the Risk Management Strategy 2026–2029. The strategy was circulated for consultation across relevant stakeholders and was presented to the Audit Committee in April 2026, where it was approved. It will now be disseminated across the Trust to support implementation and embed a consistent approach to risk management.

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 20 April 2026

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

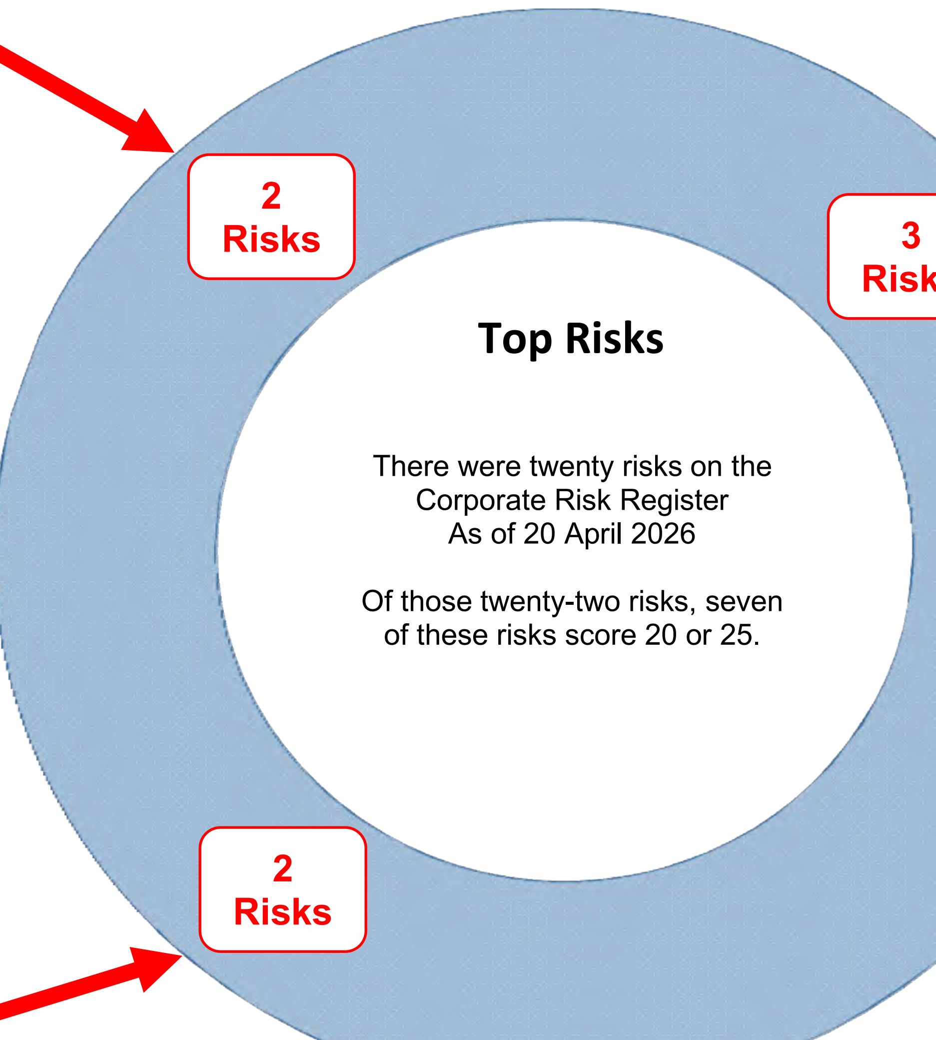
***NEW* 20 R3775** Risk of degradation of the safety of patient and service user care, for example increased likelihood of clinical errors, delayed interventions, or unsafe skills mix.

16 R2770 Inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients due to systemic discrimination

16 R3222 Inconsistent provision of rest/wellbeing spaces across SFT impacting on colleague health and wellbeing

16 R3563 Inability to deliver robust claims and inquest provision

***NEW* 15 R1815** - Workforce metrics such as vacancies, retention & sickness affecting delivery of care



Financial Committee

20 R1611 Failure to secure necessary infrastructure due to the assurance of availability of capital funding either locally or through national programmes

20 R2192 SHS not becoming self-sustaining ***(SHS Risk)***

Quality & Governance Committee

20 R0012 Waiting Times

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

20 R1789 Unsafe premises and environment

16 R1936 If delays in reviewing controlled documents continue and overdue documents cannot be reduced, then inconsistent practice may occur, affecting care quality, regulatory ratings, and inquest outcomes.

16 R0007 Referral to Treatment Times

***NEW* 15 R2677** Passive fire protection breaches, dampers & non compliant fire doors across inpatient services

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

16 R2923 Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas

16 R3616 Risk of regulatory action due to non-compliance with Health & Safety (Sharps Instruments in Healthcare) Regulations 2013

15 R0004 Demand

15 R0862 Use of escalation beds across SFT

15 R2462 Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for decontamination.

Key: Risk Score = 15-25 R = Risk 01 = Unique Risk Reference **Risk awaits approval on the risk register*

Appendix 1

Board of Directors

Corporate Risks 15+

R0012	20	If we are unable to provide sufficient capacity to enable us to meet clinically acceptable waiting times for patients for non-admitted and admitted care, including follow up internals, then this has the potential to impact on the clinical outcomes for patients
SA2	↔	

R1517	20	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	↔	

Service Group / Corporate Function Risks 15+

Ref	Score	Trend	Description
R0009	16	↔	Diagnostic Waiting Times Performance
R2123	16	↔	Increased wait time for Corneal ophthalmology patients due to increased referrals and limited clinical consultant resource
R2615	16	↔	Inability to meet Ambulance handovers trajectories at YDH due to lack of throughput (flow through ED) and output in ED (flow out of ED)
R2697	16	↔	Inability to meet waiting times for Young Adult Diabetes Service (MPH)
R3631	16	↔	Risk of prioritising long waiting patients over clinically urgent patients due to operational pressures and external pressures to deliver national targets
R1504	15	↔	Risk to patients and their families as a result of long waiting times for neurodevelopmental assessments as the accepted referrals to the service are double the number of assessments that are commissioned
R2063	15	↔	Increased wait time for category 2 (P2) Urology patients due to lack of theatre capacity
R3716	20	↔	Medical Service Group - Dermatology Advice & Guidance (Cinapsis)

Key: Risk Score = 15-25 R = Risk 01 = Unique Risk Reference * = Risk Awaiting Approval on Radar
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External Risks – Risks which are predominately outside of the control of the organisation to mitigate

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Appendix 1

Board of Directors

Corporate Risks 15+

R1789	20	The Trust is required to manage and maintain its premises and infrastructure such that it complies with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Regulation 12 (Safe Care and Treatment) and Regulation 15 (Premises and Equipment) as well as other Health and Safety legislation. Failure to meet these standards could lead to significant harm/injury being caused to patients, staff and visitors using our premises and services
SA2	⬌	

Service Group / Corporate Function Risks 15+

R0534	20	⬌	Poor condition of Shepton Mallet Community Hospital Portakabin Units
R1907	20	⬌	Potential closure of the obstetric service due to insufficient maintenance programme to maintain the integrity of the estate
R3032	20	⬌	Increased risk of morbidity/mortality for mothers, birthing people and their babies due to significantly limited theatre capacity in Maternity (MPH) requiring the use of non-theatre environment being used to perform surgical procedures leading to increased risk of surgical site infections and poor experience for families
R3403	20	⬌	In the event of a HAZMAT/CBRN incident at MPH, there would be a failure in the delivery of safe and timely emergency department services as decontamination area is situated outside the main entrance to ED which would lead to delayed or denied emergency care
R1256	16	⬌	Contamination due to water droplets/aerosols from toilets/macerators/drains due to poor ventilation
R1297	16	⬌	Lack of safe access to steam control valves serving the heating & hot water heat exchangers for the day surgery building
R1562	16	⬌	Non-compliance of statutory maintenance of thermostatic mixing values
R1648	16	⬌	Poor water quality and potentially unsafe water systems at project handovers
R1849	16	⬌	Outbreak of Carbapenemase-producing organisms (CPO) due to an environmental reservoir of CPO
R2259	16	⬌	Condition and security of Shepton Mallet Community hospital site
R2264	16	⬌	Inadequate environment to provide inpatient Colposcopy services resulting in the Trust being non-compliance with standards
R2519	16	⬌	Loss of orthopaedic restroom and preparation room due to leaks in roof (MPH)
R2692	16	⬌	Loss of power to the YDH site due to ageing and failure of electrical equipment and infrastructure
R3088	16	⬌	Risk to meeting contractual obligations to deliver vaccination service due to high staff attrition rate as a result of working conditions
R3112	16	⬌	Sheppard Ward Unsecured Entrance Door

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Board of Directors

Corporate Risks 15+

Service Group / Corporate Function Risks 15+

Risk Ref	Score	Trend	Description
R3260	16	↔	Patient flow and financial risks as projects such as UTC, requiring electrical loads at YDH site, will not be able to be connected to the existing electrical infrastructure under after the higher and lower voltage systems are energised as the current infrastructure is insufficient to connect additional loads safely
R3262	16	↔	Risk of failures in the nurse call systems at YDH due to old and obsolete system which could impact on patient care and treatment
R3263	16	↔	Non compliance with British Standards and HTMs as a result of failures of the internal electrical system due to hard wear and tear and age and damage to the systems impacting lighting, power and critical equipment (YDH)
R3375	16	↔	Increased risk of infection from lack of air changes due to the lack of ventilation within the recovery area of the main theatres which could result in the closure of recovery
R3392	16	↔	Risk to colleague/patient wellbeing due to failures in heating, ventilation and air conditioning as a result of poor maintenance of services by the Landlords (Oaklands Surgery)
R3533*	16	↔	If the airborne contamination from mould spores in the Old Building corridor (MPH) is not rectified, patients, visitors and staff with severe immunosuppression or significant underlying respiratory conditions may experience adverse health effects following prolonged exposure
R3580	16	↔	Families and vulnerable children being put in unfit environments and clinic rooms being needed for non-clinical purposes due to building works on Summerlands site
R3613	16	↔	Spore forming pathogenic mould identified during routine monitoring in chemotherapy isolator hatches has the potential to be tracked through to the chemotherapy product creating a risk to patient safety
R0332	15	↔	Inadequate estate and care provision facilities for the EPAC service for patients and colleagues leading to poor patient and colleague experience and lack of privacy leading to potential data breaches
R1294	15	↔	Risk of injury from falling metal ceiling grid access panels (Queens & Duchess Buildings)
R1300	15	↔	Air conditioning maintenance not undertaken to the correct legislative standards
R1346	15	↔	Inability to develop support site development due to electrical supplier unable to increase our maximum demand for a long period of time

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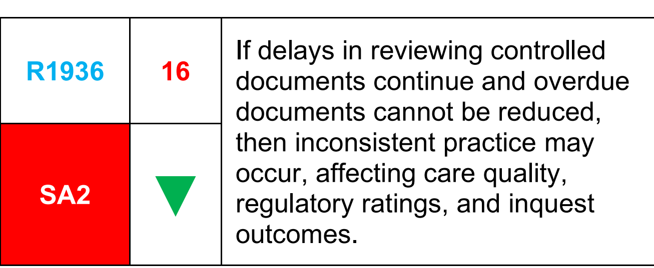
Board of Directors

Corporate Risks 15+



R1936	16	If delays in reviewing controlled documents continue and overdue documents cannot be reduced, then inconsistent practice may occur, affecting care quality, regulatory ratings, and inquest outcomes.
SA2		

Service Group / Corporate Function Risks 15+

R1686	15		Treatment room on Blake Ward is no longer fit for purpose for ENT emergencies
R2054	15		Risk of injury from deterioration of Boiler House
R2381	15		Lack of assurance provided by the Beacon Centre that there is a robust water safety regime in place
R2388	15		Closure of boiler house and loss of services due to eroded structural beam - MPH
R2969	15		Risk of structural degradation and potential collapse due to number of services placed on the roof and overall poor condition due to water ingress (Old Building Corridor, MPH)
R2971	15		Risk of legionella growth in water coolers (MPH)
R3011	15		Asbestos containing materials (ACMs) could be released into the environment leading to asbestos related health issues if we do not remove degrading ACMs due to limited funding
R3168	15		Non compliance with legislation if Trust does not maintain and replace fault emergency lighting (MPH)
R3485*	15		Increased risk of confused and wandering patients leaving the ward unsupervised which could compromise patient safety and dignity following recent Elliot move to Shepherd Ward as there is no locked door for the care of the elderly patients
R3518*	15		If power at Poole Dental fails, there is currently no UPS system meaning medical equipment will fail immediately and clinical staff would be unable to commence or complete procedures

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Board of Directors

Corporate Risks 15+

Ref	Score	Description
R2923 / SA2	16 / ↔	Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas which could lead to increased infection transmission with cross transmission of infectious agents among patients, staff and visitors particularly for airborne, droplet, or contact-based infections

Ref	Score	Description
R0007 / SA2	16 / ↔	If we do not have sufficient capacity and resource currently allocated to meet demand for non-admitted and admitted care then waiting times will continue to lengthen. Over time, this will takes us to a position where patient safety is compromised and regulatory action will be taken against the Trust as a Provider

Service Group / Corporate Function Risks 15+

Ref	Score	Trend	Description
R3785	20	↔	Symphony Healthcare Services - Clinical vaccancies in workforce - Symphony North Healthcare
R3702	16	↔	Risk of the team being unable to provide safe, effective clinical advice and support for A&G and Virtual Clinic activity due to the removal of EMIS access from March 2026
R1815	16	↔	Workforce metrics such as vacancies, retention & sickness affecting delivery of care
R2411	16	↔	Neighbourhoods Service Group - UTC Non-clinical Triage Risk
R3764	15	↔	Surgical Service Group - YDH T&O If the plaster room service does not return to full staffing compliment

Ref	Score	Trend	Description
R2077	16	↔	Non-compliance with national Early Inflammatory Arthritis Audit
R3354	16	↔	Risk to patient safety, staff wellbeing and continuity of service due to the demand for maternity services (MPH)
R3599	16	↔	Delays to patient care and treatment due to increase in demand, capacity and backlogs (SHS)
R3750	16	↔	Children & Young People & Families Service Group - Absence of a Paediatric High Dependency Unit (PHDU) at YDH

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Board of Directors

Corporate Risks 15+

R0673	16	Issues with the current capacity and future resilience of primary care in Somerset are significantly impacting on capacity across the Trust in areas already under pressure (EDs, MIUs, District Nursing etc). One Practice has already closed and an increasing number are registering difficulty, including one Practice only treating emergencies
SA3	↔	

R1878	16	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. Risk to patient safety due to potential for missing key information
SA7	↔	

Service Group / Corporate Function Risks 15+

R2683	15	↔	Backlog of patient records being updated across a number of SHS Practices

R3684	16	↔	Risk that safeguarding responsibilities within maternity and neonatal services are not consistently or effectively fulfilled due to workforce capacity pressures, variable safeguarding confidence, system interoperability issues and environmental constraints leading to delays, omissions, inconsistent safeguarding practices and increasing the potential for harm to unborn and newborn babies

Key: **Risk Score = 15-25** **R = Risk 01 = Unique Risk Reference** *** = Risk Awaiting Approval on Radar**
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Board of Directors

Corporate Risks 15+

R2677	15	Passive fire protection breaches, dampers & non compliant fire doors across inpatient services
SA2	⬌	

R3616	16	Risk of regulatory action due to non-compliance with Health & Safety (Sharps Instruments in Healthcare) Regulations 2013
SA2	⬌	

Service Group / Corporate Function Risks 15+

Ref	Score	Trend	Risk
R1897	20	⬌	Patient outcomes potentially compromised due to current evacuation plan for Neonatal Unit
R1746	15	⬌	Evacuation of patients – lack of appropriate equipment to support vertical evacuation in community hospitals
R2094	15	⬌	Evacuation of patients – Wards 6 to 9
R2102	15	⬌	Loss of storage and logistics areas due to open fire barriers in ceiling voids (YDH)
R2500	15	⬌	Fire and smoke damper failures (MPH)
R2677	15	⬌	Fire Compartmentation breaches (Summerlands)
R2822	15	⬌	Inappropriate storage, charging and use of Li-ion Batteries causing batteries rupturing and creating thermal explosions resulting in fires and exhaust of flammable and toxic gases
R3090	15	⬌	Due to the lack of robust fire compartmentation and non-compliant escape routes, there could be significant loss of life due to the inability to safely evacuate patients, visitors and colleagues (Level 10 YDH)
R3377	15	⬌	In the event of a fire on level 5, due to the lack of fire compartmentation and suitable evacuation for very high dependency patients, this could result in significant casualties and prolonged disruption of essential healthcare services
R3507	15	⬌	If there is a fire on ward 10 (YDH) due to the lack of robust compartmentation and non-compliant escape routes, there could be a significant loss of life due to the inability to safety evacuate patients, visitors and staff

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Board of Directors

Corporate Risks 15+

R0004	15	If demand for services continues to increase in line with demographic trends, then the Trust will not have sufficient capacity to keep pace and the quality of services will be affected which could result in poor outcomes, increase the risk of the number of medical outliers and impact on achievement of key targets, leading to regulatory action
SA2	↔	

Service Group / Corporate Function Risks 15+

R2229	20	↔	Insufficient capacity to meet demand in the Rheumatology service
R2450	20	↔	Inability to maintain service delivery due to demand on the epilepsy service and workforce issues
R2866	20	↔	Poor outward flow and exit blocks leading to patient harm and poor experience (ED)
R0372	16	↔	Inability to respond in a timely responsive and safe manner due to difficulties in coordination; ability to escalate; demand in services and lack of continuous low leading to overcrowding; delays for patients and patient safety compromised (MPH ED)
R2035	16	↔	Inability to meet demand for virtual macular reviews within the Ophthalmology service
R2864	16	↔	Inability to meet increasing demand in Emergency Department due to lack of physical space and supporting staffing establishment
R3705	16	↔	Lack of space to clinically review patients and no regular theatre sessions at MPH for dermatology
R0562	15	↔	Insufficient capacity to meet demand in diabetes specialist podiatry service
R1362	15	↔	Insufficient theatre capacity for Urology cases to meet demand
R2316	15	↔	Inability to see new and existing patients within acceptable timeframes due to demand and staffing issues within Orthotics
R2905	15	↔	Inability to meet the requirements of the paediatric transition service
R2917	15	↔	Inability to deliver a quality and safe paediatric dietetic outpatient service due to insufficient capacity to meet the increasing demand resulting in increased waiting times, reduced quality of patient care and negative effect on colleague wellbeing

Key: Risk Score = 15-25 R = Risk 01 = Unique Risk Reference * = Risk Awaiting Approval on Radar
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Board of Directors

Corporate Risks 15+

R0862	15	Risks to patient safety and patient experience from increased need for escalation beds across SFT due to the increasing demand, acuity of patients, increased level of no criteria to reside. This could result in; the quality of care and safety being compromised; impact of colleague experience leading to reduced morale, increased absence and inability to achieve safe staffing levels.
SA2	⬌	

R2462	15	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 which will result in poor decontamination practice; inability to demonstrate compliance with national guidance and legislation; and increased patient harm due to inadequate decontamination of critical and non critical medical devices
SA2	⬌	

Service Group / Corporate Function Risks 15+

R2267	16	⬌	Use of escalation areas and cancellation of elective activity on YDH site
R3505	16	⬌	Use of POAC as escalation beds
R1322	15	⬌	Escalation bed open in dining room in acute frailty unit resulting in a privacy of patients being affected and patient safety being compromised
R2782	15	⬌	Inappropriate space against a wall used for escalation bed impacting on the ability to deliver patient care (Acute Frailty Ward)
R3476	15	⬌	Risk of increased patient harm whilst onboarding patients due to an increased workloads and patients staying on the unit in non-assigned bedspaces (Triscombe older persons unit, MPH) resulting in patient safety risks, failure to meet care standards, reduced colleague morale
R3511	15	⬌	If an escalation ward is opened to alleviate emergency department overcrowding without adequate staffing; clinical safeguards; funding and governance arrangements; then patient may experience delayed or suboptimal care; colleagues may face burnout; and the organisation may be exposed to regulatory, reputational, safety and financial risks (Freya Escalation Ward)

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Board of Directors

Corporate Risks 15+

R3536	15	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
SA7	↔	

Service Group / Corporate Function Risks 15+

R3093	16	↔	Risk of an administration error for patients having systemic anti-cancer therapy as the prescription is on Mosaiq and EPMA and an error could occur where treatment is delivered twice or not at all either under treating the patient or increasing the toxicities
R3724*	16	↔	Multiple IT systems – Risk of missing important clinical information, potentially detrimentally affecting patient care due to need to access at least six IT systems per clinical consultation
R3537	15	↔	Multiple digital systems required for care of a single patient which may lead to delays in treatment, duplication of information, missed information as no one clear location to find all associated patient information
R3548*	15	↔	Risk of harm to patients in perinatal services due to automated blood product tracking not being implemented and incorrect blood product could be given

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Appendix 1

QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Service Group / Corporate Function Risks 15+

Not Mapped to a Risk on the Corporate Risk Register

Ref	Score	Trend	Risk
R3178	16		
R3514	15	▼	Women may experience delays in receiving timely triage assessments when phoning in with acute concerns during the perinatal period as a result of system inefficiencies; lack of staff availability; or unclear pathways for accessing triage services; leading to missed or late identification of clinical deterioration, increasing risk of maternal and neonatal morbidity and mortality
R3709*	20	⇔	If flow from AMU to wards remains poor, causing ED queues and post-take backlogs, then AMU capacity will be compromised, delaying assessment and increasing patient safety risks.
R23838	16	⇔	Without an overarching transition service there will be no unified approach to transition across all services for young people with complex needs post March 2025 due to the project funding ceasing which could result in increased gaps in care; higher risk of patient harm; disruption in support networks; and reduced long term outcomes
R2211	16	⇔	Ward medicine storage on MPH site non-compliant with CQC standards
R2231	16	⇔	Lack of sub-specialty service provision for patients on biologics and disease modifying antirheumatic drugs (DMARDS)
R2812	16	⇔	Risk of remedial notice being served by ICB due to significant backlog of documentation which could compromise patient safety (SHS)
R2839	16	⇔	Quality and safety concerns associated with Paediatric Acute service at YDH impacting on patients, wellbeing of clinical staff and ability to recruit
R3043	16	⇔	Inability to introduce knee ankle foot orthoses (KAFO) safety programme within MPH Orthotics services due to demand in service, limitations in resources and training needs, which increases the risk of injury and harm to service users and risk of litigation to the Trust for non-adherence to guidelines
R3045	16	⇔	Lack of a commissioned and fully funded, equitable countywide paediatric respiratory service

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Ref	Score	Trend	Risk
R3500	16	↔	Risk that the current MRI sedation pathway at YDH may led to patient harm and service disruption as the pathway relies on paediatric doctors administering sedation without anaesthetic support which is considered unsafe by anaesthetic colleagues and does not align with best practice standards
R3586	16	↔	Risk of collars and spinal braces being incorrectly fitted or there being a delay in provision due to a lack of pathway in place within either acute site
R3589	16	↔	Risk of patients being discharged without the education required to manage their collar/brace at home as there is no pathway for patients discharged from acute sites
R3725*	16	↔	If reference lab reports continue to be manually transcribed without adequate checks, then inaccurate results may be authorised, posing risks to patient safety.
R3740	16	↔	If CNS capacity remains insufficient to deliver timely genetic counselling and testing, then patients may miss optimal treatment and families may lose access to appropriate surveillance or risk-reduction options.
R0363	15	↔	Patient outcomes and treatments not recorded in a timely and accurate way whilst in Emergency Department
R2075	15	↔	Substandard multi-disciplinary team working due to poor organisational culture (maternity services)
R2768	15	↔	If the C-mac video laryngoscope blades fail during intubation then the patient's airway may not be secured in a timely fashion resulting in prolonged hypoxaemia that will cause permanent brain or vital organ damage or death
R2932	15	↔	VUE issues with new digital system which delays reports being completed (Histopathology)
R3749	15	↔	Children & Young People & Families Service Group - Delayed App C Reports for EHCP Applications (YDH)

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Ref	Score	Trend	Risk
R3091	15	↔	Reduction in service due to moving to digital triage system which will limit number of patients who can be seen (Bridgwater MIU)
R3686*	15	↔	If the Windows/Adobe interface continues to fail, preventing access to scanned clinical documents, then delays in vetting and reporting may occur within radiology, increasing the risk of compromised patient safety and scan turnaround times.
R3692*	15	↔	Risk of delays to patient treatment, staff burn out and reputational harm as a result of delays in x rays being carried out in ED and UTCs due to the level of requests, radiology staffing levels and porters not available
R3715	15	↔	If the Trust continues without a dedicated MHA Lead to provide specialist legal advice and oversight, then there may be an increased risk of regulatory action and legal challenge.

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PEOPLE COMMITTEE

Corporate Risks 15+

R3673*	20	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
SA5	↔	

R2770	16	Inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients if having systems, policies and processes that have not been designed to be inclusive and therefore create inequitable outcomes are in place. This could result in an inequality across our workforce; no reduction in health inequalities across Somerset; an inability to identify and make systemic changes in our systems, policies and processes
SA5	↔	

Service Group / Corporate Function Risks 15+

R3775	20	NEW	Safer Staffing - Risk of degradation of the safety of patient and service user care, for example increased likelihood of clinical errors, delayed interventions, or unsafe skills mix.

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Corporate Risks 15+

R3222	16	Inconsistent provision of rest/wellbeing spaces across SFT could lead to a risk of higher absence under stress and burnout leaving a shortage of colleagues to cover care and potentially compromising skill mix in areas. This could also impact on the achieving the People strategic aim
SA5	↔	

R3563	16	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
SA5	↔	

Service Group / Corporate Function Risks 15+

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PEOPLE COMMITTEE

Service Group / Corporate Function Risks 15+

Not Mapped to a Risk on the Corporate Risk Register

Ref	Score	Trend	Risk
R3643	20	↔	Risk of routine referral delays due to workload outweighing staff hours which could impact on patient care and treatment – Burnham Medical Centre (SHS)
R0343	20	↔	Reduced ability to deliver service to meet demand due to consultant vacancies within neurology service at both MPH & YDH sites
R2090	20	↔	Inability to meet key national standards in Facing the Future: Standards for Acute General Paediatric Services (RCPCH, 2015) due to insufficient consultant level cover for YDH Paediatrics
R3033	20	↔	Reduced availability of obstetric medical staffing leading to irregular elective caesarean section list in MPH leading to delayed or cancelled cases
R3532	20	↔	Risk to the safe provision obstetrics and gynaecology services at YDH & MPH due to Insufficient obstetrics and gynaecology medical workforce to support all rota activity resulting in potential standing down of elective activity or preventable risk to women, birthing people and babies
R3636	15	▼	Depleted administration covers across sites due to vacancies leading to backlog in administration tasks
R3690	20	▲	Risk to patient care and treatment due to GP capacity at Crewkerne Health Centre as a result of absence and vacancies (SHS)
R2217	16	↔	Dermatology staffing vacancies including nursing teams and HCA support within the GPWeR clinics which may delay appointments and treatments for patients
R2467	16	↔	Risk delays in patient treatment and medical records being updated due to backlog of unprocessed documents as a result of staff sickness and vacancies (SHS)
R2606	16	↔	Reduced capacity for fetal medicine appointments and follow ups due to lack of fetal medicine consultant based at SFT and reduced capacity regionally to support the service

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Ref	Score	Trend	Risk
R2776	16	↔	Inability to meet the demand on the Gastroenterology service due to vacancies
R2777	16	↔	Risk of not meeting patients' psychological needs, or not doing so in a timely way coincident with the delivery of other aspects of the patient's rehabilitation due to insufficient neuropsychology staffing, which could result in misdiagnosis, delayed discharges, service inequality and failure to meet national standards
R2892	16	↔	Reduced ability to meet national service delivery targets due to staff shortages (Acute Occupational Therapy service)
R3067	16	↔	If diabetes specialist nurse who is employed within the diabetes intermediate care team to provide service to type 1 diabetic patients leaves or is absence, then there is no provision within the existing team and skillset to backfill which will impact patients in the Frome area
R3086	16	↔	Breast radiology staffing shortages leading to reduced service provision and breaches in RTT
R3329	16	↔	If the service continues to face the occupational therapy staffing challenges (absenteeism and vacancies), this could impact service delivery resulting in patients receiving delays in therapy provision and risk to staff retention
R3355	16	↔	Risk to service provision with patients being cancelled on the day of their operations due to shortfall within staffing and skill mix of colleagues (Ophthalmology MPH)
R3444*	16	↔	Cleaning service staff shortages due to long term and short team absence rates which has been further compounded by vacancies which are no longer being approved to recruit to as a result of the Trust's financial position, will impact on the cleaning standards across wards and departments, cleaning audits will not be undertaken leading to the Trust lacking accurate data to prioritise interventions, which could result in an increase in infection control risks
R3480	16	↔	If neonatal medical staffing at Tier 1 (SHO) and Tier 2 (Middle Grade) levels remain non-compliant with BAPM/MIS standards and continue to rely on shared cover with paediatrics, then there is a risk of rota gaps requiring consultants to act down or Advanced Neonatal Nurse Practitioners (ANNPs) to act up with associated financial costs; safety could be compromised during neonatal emergencies; and reduced capacity to support YDH with the reopening of maternity and neonatal services
R3482	16	↔	If experienced ANNPs at MPH continue to work below their level of expertise without recognition, progression or appropriately remunerated at Band 8B in line with BAPMs 4 Pillars Framework, there is a risk they will leave the organisation, leading to staffing shortages; the neonatal

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PEOPLE COMMITTEE

			service will not be fully supported, junior staff (tier 1) will receive less supervision, training and support; and ANNPs will not be available to help with cross site development and training which is crucial to support the reopening of YDH maternity and neonatal services
R3489	16	↔	Risk to neonatal care quality due to non-compliance with BAPM staffing standards on SNICU posing a risk to the quality and safety of neonatal care
R3496*	16	↔	If the team remain understaffed, then there is a risk of significant stress and burnout (patient engagement team)
R3525	16	↔	Risk of increased patient safety incidents and impact on the quality of care to patients due to increase in capacity and demand, and reduced funding to cover GP leave and sickness (SHS)
R3538	16	↔	If we don't upskill our workforce and continue with an underdeveloped skill mix, we cannot run our high risk procedures due to large gaps within the workforce, with new staff unfamiliar with processes with skill mix risks, which could lead to endoscopy activity being stood down and diagnostic breaches leading to poorer patient outcomes
R3559	16	↔	Risk of unsafe nursing care provided for patients on non-invasive ventilation who are acutely unwell due to their respiratory condition. Staff are unable to perform required monitoring and assessment which could lead to patients deterioration, prolong recovery and longer hospital stay due to inappropriate staffing levels on night shifts
R3561	16	↔	Insufficient consultant staffing for critical care resulting in the inability to provide 7 day per week intensivist delivered patient care which compromises patient safety, delays in care and increases clinical risk
R3585	16	↔	Risk results will be delayed, or could be inaccurately reported, which will impact on patient management, morbidity and mortality due to staffing numbers and skill mix within Mycobacterial service
R3624	16	↔	If changes in the additional internal restrictions on band 3 agency workers comes into effect from 31 January 2026, there could be a reduction in the available temporary workforce for Mental Health inpatient wards which could further impact staff shortages, decrease colleague wellbeing, impact delivery on services and increase patient safety risk
R3682	16	↔	High turnover of staff due to Crewkerne community hospital transformation proposal resulting in a reduced ability to maintain safer staffing with substantive staffing which could impact on patient safety; colleague wellbeing; and finances

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Ref	Score	Trend	Risk
R2374	15	↔	Insufficient staffing to meet national guidelines in Stroke
R2803	15	↔	Reduced ability to deliver the nurse advice line at MPH for patients on biologic drugs due to insufficient staffing within the rheumatology nursing team
R3315	15	↔	Risk of compromising patient care due to GP shortages as a result of annual leave being taken by GPs (Crewkerne Health Centre)
R3394	15	↔	Risk of harm to colleagues due to current employee relation processes being managed in a way that is time consuming, doesn't identify or address discrimination and results in increased numbers of employment tribunals
R3397	15	↔	Inability to provide clarify and understanding on regulatory standards and essential provision on learning due to lack of robust processes to review current training arrangements on a regular basis
R3633	15	↔	Inadequate resources (staffing and training) to adequately manage the demand for dual energy x ray absorptiometry (DEXA) scans across Somerset leading to patients experiencing an unacceptable wait for scans and reports
R3637	15	↔	Patient services advisor vacancies impacting on the timeliness of services and impact on existing members of the team – Crewkerne Health Centre (SHS)
R3720*	20	▲	Workforce limitations for Biochemistry team at SFT and risk of burnout

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FINANCE COMMITTEE

Corporate Risks 15+

R2192	20	SHS not becoming self-sustaining due to costs exceeding its contract income which could result in a deficit or loss making performance which is adverse to the long term plan
SA6	⬌	

R1611	20	Failure to secure necessary infrastructure to meet current and future demands of the population and the clinical strategy due to the assurance of availability of capital funding either locally or through national programmes. This will result in not achieving the Trust's strategic aims; failure to improve services for the population for the workforce; and failure to meet the populations expectations in relation to the delivery of healthcare
SA6	⬌	

Service Group / Corporate Function Risks 15+

R1343	20	⬌	Quality of Discharge Summaries
R3398	20	⬌	Risk of reduction in Radiotherapy capacity of 33% for at least 18 months from end of 2028 due to the replacement of linear accelerators (Linacs) without a spare bunker into which activity can be decanted leading to delays in patients being seen and operational disruption
R0003	16	⬌	Insufficient investment to reduce levels of backlog maintenance
R2409	16	⬌	Insufficient investment from main contractor to reduce levels of backlog maintenance
R0532	15	NEW	Shepton Mallet Community Hospital - Structural Roof/Ceilings Deflections

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Service Group / Corporate Function Risks 15+

Not Mapped to a Risk on the Corporate Risk Register

Risk Ref	Score	Trend	Description
R3604	20	↔	Risk to income generation from coroners case if the leaking roof in the Nissen hut, which contains the mortuaries additional storage fridges, has to be shut due to leaks or repair works
R3336	16	↔	Risk of significant financial loss to the private patient income target together with the possibility of being unable to grow the private patient business due to the temporary closure of Parkside Ward and the relocation to Tor Ward to accommodate the temporary relocation of YDH maternity unit
R3704	16	↔	Failure for the CYP&F Service Group to achieve the NHS Cost Improvement Programme (CIP) and control overspend
R3718*	16	↔	Risk of not receiving appropriate payment for results within Same day emergency care YDH, due to lack of coding treatment and investigations on TrakCare
R3683	16	↔	Inability to maintain safer staffing levels due to ongoing financial pressures of the Trust which had lead to the decision to stop the authorisation to use agency HCAs within community hospitals from 1 February 2026
R2531	16	↔	Inability to deliver the requirements of the NICE technology appraisal as unable to provide access to hybrid closed loop systems due to lack of available funding
R3528	16	↔	If recurrent funding for the dementia and delirium training team cannot be agreed, the significant improvements in managing challenging behaviours and patient care and reduction in agency usage for observation and support will be lost/reverse
R3600	16	↔	Risk of patient harm, staff morale and burnout and unnecessary financial expenditure due to GP trainees being allocated to Emergency Departments within a combination of inadequate training or knowledge of NHS processes and pathways and inadequate patient assessment and management skills which results in the department requiring to rota these staff members as supernumerary or only on specific shifts with supported supervision
R3819	16	↔	Clinical Support & Cancer Services - Effect of medicines/radiopharmaceutical supply chain on radiology business continuity

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R3630	16	↔	Risk of achieving the CIP savings required for the surgical service group due to increased clinical demand and activity pressures, workforce constraints and external factors which could lead to overspend, reduced ability to invest in service improvements and impact on patient care
R2633	15	↔	Risk to commercial income stream, increase in business costs and reputational damage if Somerset Cancer Register is removed and included as sub-module of the EHR system that is procured
R2800	15	↔	Loss of £17million Frontline Digitisation (FD) funding in 2025/26 due to delays in the business case approval process leading to a contract aware outside of the FD timescales

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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)**

9. COMPOUND RISKS

9.1 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.

9.2 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.

9.3 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.

9.4 The compound risks the organisation should be aware of are:

Demand, Capacity & Flow Constraints Across Services

Risks Involved	• Insufficient capacity and resource (R0007, R3643) • Demand on services (R0012, R3043, R3599, R3633) • ED throughput/output blockages (R0372, R2615, R2866, R3709) • Waiting time breaches in multiple specialties (e.g., diagnostics R0009, diabetes R2697, urology R2063, ophthalmology R2123, ophthalmology R2035, physiotherapy R1037) • Specialty service capacity issues (e.g. Rheumatology R2229, Orthotics R2316, Epilepsy R2450, Dermatology R3705) • Reduced primary care capacity (R0673) • Escalation (R862, R2267, R2782, R3476, R3511)
Compound Risk	The Trust's ability to meet patient demand across multiple services is compromised due to capacity constraints, workforce shortages, and infrastructure limitations. These risks can amplify each other — for example, ED exit block leads to ambulance handover delays, which also worsens elective backlogs, increasing patient acuity and mortality risk. System-wide gridlock could trigger regulatory action and reputational damage.

Clinical Safety and Continuity of Services

Risks Involved	• ED delays and documentation issues (R0363, R0372, R3725) • Radiotherapy service disruptions (R3398) • Lack of clinical pathways (R3586, R3589) • Claims and inquest provision (R3563) • Prioritisation of national targets over clinically urgent patients (R3631)
Compound Risk	Delays in diagnostics, treatment, and care coordination are increasing the risk of patient harm and poor outcomes.

Workforce Sustainability & Wellbeing

Risks Involved	• Consultant and specialist vacancies across multiple services (paediatrics R2090, gastroenterology R2776, neurology R0343) • GP shortages (R3315, R3525, R3690)

	• High stress and reduced resilience (R3222) • Unsafe staffing in high-acuity areas (R3355) • Staffing levels (R2302, R2374, R2467, R2777, R2892, R2920, R3067, R3086, R3329, R3405, R3496, R3532, R3538, R3559, R3561, R3585, R3624) • Non-medical vacancies (R3636, R3637) • Employee relations and discrimination concerns (R3394) • Administration vacancies (R2467, R3636)
Compound Risk	Chronic staffing shortages, high attrition, and poor working conditions are leading to reduced service quality, increased burnout, compromised patient safety by reducing quality of care, and increasing sickness absence — leading to a reinforcing negative cycle.

Maternity & Neonatal Service Pressures

Risks Involved	• Reduced obstetric medical staffing (R3033) • Staffing levels/shortages (R3480, R3482, R3489) • Triage assessments (R3514) • Limited theatre capacity (R3032) • Demand on services (R3354) • Safeguarding responsibilities (R3684)
Compound Risk	Service relocation + workforce shortages + higher case complexity could produce unsafe care environments, increase adverse outcomes, and heighten media/regulatory scrutiny.

Infrastructure & Estate Failures

Risks Involved	• Estate condition and maintenance (R0534, R1789, R1907) • Power/electrical system fragility (R1346, R2692, R3260, R3263, R3518) • Ventilation issues (R3375, R3392) • Water quality and legionella risks (R1648, R2971) • Asbestos degradation (R3011) • Fire safety and compartmentation breaches (R1238, R1897, R2500, R3090, R3377, R3507) • Space constraints (R0332, R3580)
Compound Risk	Ageing, poorly maintained, or non-compliant infrastructure is creating safety hazards, service disruptions, and regulatory risks. Multiple failures could overlap (e.g., electrical outage during a heatwave causing IT and clinical equipment shutdown in a poorly fire-compartmented building) — creating life safety hazards and major operational disruption.

Infection Prevention & Control Risk

Risks Involved	• Lack of isolation capacity (R2923) • Environmental reservoirs of resistant organisms (R1849, R2971, R3613) • Poor water systems (R1648) • Delayed decontamination processes (R2462) • Poor ventilation in theatre recovery area (R3375) • Cleaning service staffing shortages (R3444) • Regulatory action – safer sharps (R3616)

Compound Risk	Environmental and operational factors are increasing the risk of infection transmission within Trust facilities. An outbreak could spread rapidly if coupled with capacity shortages, affecting multiple sites and specialties, especially in the absence of rapid isolation and adequate staffing.

Digital and Information Governance Risk

Risks Involved	• Delivery of data strategy (R3093, R3536, R3537, R3548, R3734) • Frontline Digitisation funding risk (R2800) • Roll out of digital systems (R3452) • Subject access request volume and compliance (R1517) • MHA specialist advice (R3715)
Compound Risk	Inadequate digital infrastructure and data governance are impacting clinical decision-making, patient safety, and regulatory compliance. If an IT outage coincides with already high demand, lack of access to records and safety alerts could severely compromise clinical decision-making and delay treatment.

Financial Sustainability & Strategic Delivery Risks

Risks Involved	• CIP and financial plan delivery risks (R3059, R3600, R3630, R3632) • Capital funding shortfalls (R1611) • SHS contract sustainability (R2192) • Loss of digitisation finding (R2800) • Shortfalls in equipment required (R3398) • Recruitment freeze/workforce funding (R3528, R3683) • Contract delivery (R2812) • Income generation (R3604)
Compound Risk	Operational pressures, delayed efficiencies, and infrastructure investment gaps are threatening the Trust's financial viability. Financial deficits can lead to delayed capital investment in critical estates and IT, worsening infrastructure risks, while also forcing staff reductions that increase operational pressures.

9.5 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

Compound Risks	Combined Effect
Capacity and flow constraints → Longer waits in emergency, delayed discharges, increased bed occupancy, higher risk of harm from delays	Delayed treatment + infection spread + service pressure could push mortality and avoidable harm rates higher increasing the harm to patients due to delayed or disrupted care
Maternity & neonatal pressures → Increased maternal and infant morbidity/mortality, reduced ability to meet national safety standards	
IPC failures → Outbreaks of healthcare-associated infections, compounding already stretched capacity	

Reduced service resilience and ability to continue to deliver services

Compound Risks	Combined Effect
Infrastructure/estate failures → Loss of critical clinical areas (e.g., theatres, wards), forcing service relocation or closure	Even well-staffed teams may be unable to deliver safe care if physical and digital infrastructure is unreliable. Harm to patients will increase as care will be compromised
IT/digital failures → Disruption to patient records, diagnostics, prescribing, scheduling — magnifying operational delays	

Reduced workforce wellbeing and ability to retain colleagues and recruit

Compound Risks	Combined Effect
Shortages & burnout → Higher sickness absence, reduced productivity, increased turnover	Vicious cycle where staff loss worsens capacity issues, further driving burnout. Absenteeism and retention challenges will increase
Service pressures → Further stress on remaining staff, risk of moral injury from being unable to provide adequate care	

Financial pressures and inability to achieve strategic aims

Compound Risks	Combined Effect
Financial pressures → Inability to invest in urgent repairs, technology upgrades, or recruitment incentives	Escalating inefficiencies and higher costs from crisis management instead of prevention leading to cuts in staffing, infrastructure and innovation which will lead to a failure to deliver strategic aims
Strategic delivery risks → Long-term transformation plans stall, locking the organisation into reactive firefighting	

Increased regulatory interest and reputational concerns

Compound Risks	Combined Effect
Regulatory breaches (CQC, NHS England, HSE) from quality, safety, environmental and access failures	Harder to recruit, retain, and secure funding, creating a downward spiral. Loss of public trust
Public trust erosion through negative media coverage and patient complaints	

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

9.7 The detail within Appendix 5 has, in part, been created with the use of AI technology.

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Terms of Reference – Annual Review
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Mel Iles, Chief Medical Officer
DATE:	12 May 2026

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

<table>
<tr>
<td>Executive Summary and Reason for presentation to Committee/Board</td>
<td>
The Trust’s Board and Committee Terms of Reference have been reviewed and updated as part of a Trust-wide programme of work to standardise the format, structure and wording of governance documentation, in line with the agreed model template. This work is intended to improve clarity, consistency and alignment across the Trust’s governance framework.

The updated Terms of Reference brought forward for approval relate to the following:

• Board of Directors
• Audit Committee
• Finance Committee
• Quality and Governance Assurance Committee
• People Committee
• Mental Health Legislation Committee
• Charity Committee
• Executive Committee
• Research and Innovation Committee
• Nomination and Remuneration Committee

Across the terms of reference for the Board of Directors and the nine committees, the majority of changes are presentational or minor wording amendments, with no change to core purpose or delegated authority.

In addition:

• Audit Committee
The Terms of Reference have been reviewed to ensure alignment with Healthcare Financial
</td>
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Management Association (HFMA) guidance, reflecting good practice for NHS audit and assurance committees.

- **Finance Committee**
  The revisions clarify and strengthen the Committee's assurance role in relation to financial performance, financial risk and the oversight of major transformation programmes, including explicit reference to assurance on the Healthset programme (financial exposure, affordability, benefits realisation and delivery risk).

- **Quality and Governance Assurance Committee**
  The updates reflect current membership and meeting arrangements and reinforce the Committee's assurance role in relation to quality, patient safety, governance and risk. The Terms of Reference also clarify the Committee's assurance responsibilities in respect of the Healthset programme, including clinical safety, people impact and inclusion, information governance, clinical pathways, quantitative quality outcomes and associated quality-related risks.

- **People Committee**
  The revisions clarify the Committee's assurance role, streamline membership and quorum arrangements, update language to reflect delivery of the People Plan, and strengthen assurance over workforce risks, culture, inclusion, wellbeing and major transformation programmes, including Healthset.

- **Executive Committee**
  The revisions confirm the Committee as the primary forum for operational oversight of the Healthset programme, with responsibility for monitoring delivery progress, service group readiness, performance, data impacts and programme-level risks.

- **Charity Committee**
  The revisions strengthen clarity, assurance and compliance, particularly around the discharge of trustee responsibilities, financial controls, and alignment with Standing Financial Instructions (SFIs).

Collectively, these updates strengthen the Trust's governance framework while maintaining clear separation of responsibilities and assurance across Board Committees.

Recommendation	The Trust Board is asked to **approve** the updated Terms of Reference.

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)
No public, patient or staff involvement was required for this paper, as it relates to governance documentation and committee arrangements.

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 updated Terms of Reference for each respective committee have been approved at their most recent committee meeting wherever possible. This paper forms part of routine

governance review arrangements and follows the Trust-wide standardisation of Board and Committee Terms of Reference.

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 (THE 'TRUST')

BOARD OF DIRECTORS
TERMS OF REFERENCE

1. Strategic Statement

1.1 In accordance with its Constitution, the Trust has a Board of Directors (which comprises both Executive Directors and Non-Executive Directors, one of whom is the Chair) acting as a unitary board.

1.2 The "Healthy NHS Board" report published by the Leadership Academy identifies the key roles of a board as follows:

- formulating strategy for the organisation;
- ensuring accountability by:
    - holding the organisation to account for the delivery of the strategy;
    - being accountable for ensuring the organisation operates effectively and with openness, transparency and candour;
    - seeking assurance that systems of control are robust and reliable.
- shaping a healthy culture for the board and the organisation.

1.3 As set out in the Constitution, the Trust has Standing Orders for the practice and procedure of the Board of Directors. For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

2. Objectives

2.1 The Board of Directors' objectives are to govern the organisation effectively and to ensure that the Trust is providing safe, high quality, patient-centred care.

3. Duties

3.1 The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

3.2 The Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee or by a Director or an Officer in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

3.3 The duties to be retained by the Board of Directors are set out in the "Scheme of Delegation" and the key duties are to:

- provide leadership to the Trust to promote achievement of the Trust's principal purpose as set out in its constitution, ensuring that all times it operates in accordance with the Constitution and relevant operating licences;

- set the values and strategic direction of the Trust and any relevant strategies;

- agree the Trust's financial and strategic objectives, including approval of the operational plan, workforce plan, financial plan and budgets;

- oversee the implementation of the Trust's strategic aims and objectives;

- monitor the performance of the Trust and ensure that the Executive Directors manage the Trust within the resources available in such a way as to:

  - ensure the safety of patients and the delivery of a high quality of care;

  - protect the health and safety of Trust colleagues and all others to whom the Trust owes a duty of care;

  - make effective and efficient use of Trust resources;

  - promote the prevention and control of Healthcare Associated infection;

  - comply with all relevant regulatory, legal and code of conduct requirements;

  - maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust and promote an open and honest culture where Trust colleagues feel safe to speak up;

  - maintain the high reputation of the Trust both with reference to local stakeholders and the wider community.

- ensure that the Trust has adequate and effective governance and risk management systems in place;

- review and approve the Trust's Annual report and Accounts, including the Trust's Quality Report and Quality Accounts;

- approve financial business cases for capital investment and approve any other expenditure as required by the financial limits set out in the Standing Financial Instructions;

- approve proposals for merger, acquisition, dissolution in terms of the Trust's organisational form as well as relating to the use of land and buildings;

- ensure ongoing compliance with the Care Quality Commission's requirements for all regulated activities;

- ensure the Trust promotes and safeguards the health and wellbeing of its colleagues;
- promote training, teaching, research and innovation in healthcare in line with the Trust's values and strategic direction;
- promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction;
- engage as appropriate with the Trust's membership and the Council of Governors;
- act as corporate trustee for the Somerset NHS Foundation Trust registered charities.
- approve the incorporation of new subsidiaries, to include the terms of articles of association and standing financial instructions; maintain oversight and review regular reports by the wholly owned subsidiaries.
- approve the dissolution of existing subsidiaries.

3.4 The above overview of duties is not an exhaustive list of duties and a detailed overview of the Board of Directors' duties is set out in the "Scheme of Delegation".

Discharge of Duties

3.5 The process for the discharge of these duties is set out in the "Overview of Regular Items to be Presented to the Board" and include:

- receiving and considering high level reports on quality of care, patient experience, colleague/staffing, operational, financial and clinical performance;
- receiving patient stories at Board meetings as well as presentations on clinical topics to identify any lessons learned and areas for improvement;
- receiving quarterly Board Assurance Framework progress reports on the achievement of the strategic objectives and the mitigation of high level corporate risks and review the strategic objectives and strategic risks on an annual basis as part of the business planning process;
- receiving assurance reports from Committees concerning work undertaken within their Terms of Reference;
- receiving an annual self declaration to show compliance with the Trust's Provider Licence;
- reviewing the Constitution, Standing Orders and Standing Financial Instructions on an annual basis;

- reviewing and approving any declarations/compliance statements to regulatory bodies prior to their submission.

3.6 A detailed overview of how duties will be discharged is set out in the “Overview of Regular Items to be Presented to the Board”.

4. Membership

4.1 This section refers to paragraph 31 of the Constitution and Annex 2 - paragraph 2.7 – of the Trust’s Standing Orders.

4.2 The membership of the Board of Directors shall comprise both Executive and Non-Executive Directors.

4.3 Board membership shall be as follows:

- a Non-Executive Chair;
- up to a maximum of nine other non-executive directors;
- up to a maximum of eight executive directors, which as a minimum will need to include:
  - Chief Executive (voting right). The Chief Executive also acts as the Accountable Officer);
  - Chief Finance Officer (voting right);
  - Chief Medical Officer (voting right);
  - Chief Nurse (voting right).

  In addition to the above executive directors, the Board of Directors currently includes:

  - Chief Operating Officer (voting right);
  - Chief of People and Organisational Development (voting right);
  - Director of Strategy and Digital Development (voting right);.
  - Director of Corporate Services.

4.4 In the event that the number of Non-Executive Directors (including the Chair) at a meeting is equal to the number of Executive Directors, the Chair (and in their absence, the Deputy Chair), shall have a second or casting vote at meetings of the Board of Directors in accordance with the Standing Orders for the Board of Directors.

4.5 If, in spite of the Chair’s casting or second vote, there remains an imbalance at Board meetings between the number of Executive and Non-Executive Directors, if a formal vote is required, the maximum number of Executive votes to be counted will be equivalent to the number of Non-Executive Directors present at the meeting of the Board of Directors in accordance with the Standing Orders for the Board of Directors.

4.6 An Officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the

Executive Director. An Officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director

5. Meetings

5.1 This section refers to Annex 2 - paragraph 3 - of the Trust's Standing Orders.

5.2 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons, to be determined by the Board of Directors. Members of the public will not be able to contribute to the meeting unless specifically asked so by the Chair.

5.3 At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and they are present, shall preside. If the Chair and Deputy Chair are absent such Non-Executive Director as the members of the Board of Directors present shall choose, shall preside.

5.4 The Constitution allows for meetings to be conducted fully or partially by electronic means.

5.5 The minutes of the proceedings of a meeting shall be drawn up by the Secretary to the Trust and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.

6. Attendance

6.1 Board members are expected to attend all formal Board meetings unless in the case of exceptional circumstances. Any non-attendance is to be agreed with the Chair or Chief Executive in advance of the meeting.

6.2 Any Executive Director unable to attend a formal Board meeting will be required to arrange for their Deputy to attend the meeting on their behalf.

6.3 The names of the Directors present at the meeting shall be recorded in the minutes.

6.4 Senior managers may, at the invitation of the Chair or Executive Director, be invited to the meeting to present specific reports to the Board.

6.5 Members of the public, including Governors, have an open invitation to attend the public Board meetings.

7. Quorum

7.1 This section refers to Annex 2 - paragraph 3.18 - of the Trust's Standing Orders.

7.2 No business shall be transacted, where a vote is required, at a meeting of the Board of Directors unless at least two Executive Directors, two Non-Executive Directors and the Chair, or nominated Deputy Chair for the purpose of this meeting, are present and to be properly constituted the number of Non-Executive

Directors (including the Chair) voting must exceed the number of Executive Directors.

7.3 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

7.4 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (Annex 2– paragraph 3.18.3 of the Standing Orders) they shall no longer count towards the quorum.

8. Frequency of Meetings

8.1 Routine meetings of the Board shall be held in public, on dates agreed with the Chair. Dates of forthcoming meetings of the Board of Directors to be held in public, and meeting papers, shall be posted on the Trust's website.

9. Authority

9.1 The powers of the Trust are set out in the 2006 Act (as may be amended by the Health and Social Care Act 2012) subject to any restrictions in the Terms of its Licence.

9.2 In the exercise of its powers, the Trust shall have regard to the principles of the NHS and the Trust.

9.3 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

10. Accountability and Reporting Responsibilities

10.1 The Board of Directors is accountable to its regulators, commissioners and members of the public through its Council of Governors.

10.2 The Board of Directors reports on the discharge of its duties through regular meetings with its relevant stakeholders, including to the Council of Governors.

11. Subgroups

11.1 This section refers to Annex 2 - paragraph 5 - of the Trust's Standing Orders.

11.2 Subject to its Standing Orders and such guidance as may be issued by NHS England/Improvement (Monitor), the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee or by a Director or an Officer in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

11.3 The Committees established by the Board are:

- Audit Committee;
- Nomination and Remuneration Committee;
- Charity Committee;

- Finance Committee;
- Quality and Governance Assurance Committee;
- People Committee;
- Mental Health Legislation Committee;
- Executive Committee;
- Research and Innovation Committee.

11.4 When the Board is not meeting as the Trust in formal session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in formal session.

11.5 All Committees are required to present an assurance report to the Board of Directors meetings following each formal Committee meeting to ensure that the Board of Directors receives comprehensive assurances on the Trust's business and activities.

12. Monitoring of Effectiveness

12.1 The Board of Directors will review its work and effectiveness annually and will take account of the findings of any external Well-Led or effectiveness reviews.

13. Review

13.1 The Board of Directors will review these Terms of Reference at least annually.

Approval Date: TBC
Review Date: TBC

SOMERSET NHS FOUNDATION TRUST (THE ‘TRUST’)

AUDIT COMMITTEE
TERMS OF REFERENCE

1. Strategic Statement

1.1 The Board hereby resolves to establish a sub-committee to be known as the Audit Committee (the ‘Committee’). The Committee is accountable to the Trust Board (the ‘Board’) and has delegated authority as set out in these Terms of Reference.

1.2 The role of the Committee is to provide assurance to the Board, along with the Quality and Governance Assurance Committee, that the Trust is governed appropriately and well managed across the full range of its clinical and non-clinical activities in accordance with the Trust’s strategic aims, using its authority delegated by the Trust Board.

2. Authority

2.1 The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

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

2.5 The Committee is authorised to make requests to any Trust Committee to undertake detailed review of specific risks on the corporate risk register or board assurance framework.

3. Membership

3.1 The Committee will be established by the Board, in accordance with the Constitution, the core membership of the Committee will comprise:

A minimum of four non-executive directors. In attendance: The following participants are expected to attend meetings of the Committee:

- Chief Finance Officer
- Director of Corporate Services
- Representative(s) from External Audit
- Representative(s) from Internal Audit
- Representative(s) from Counter Fraud
- Head of Risk and Health and Safety
- Director of Governance

3.2 The Chair of the Trust will appoint the Chair of the Committee.

3.3 The Chair of the Committee will nominate a Deputy Chair to act in their absence.

3.4 The Chairman of the Trust will not be a member of the Committee.

3.5 Executive directors may appoint an appropriate deputy to attend meetings in their absence.

3.6 The minute taker will be appointed by the Director of Governance.

4. Attendance

4.1 All other Non-Executive Directors also have a standing invitation to attend the Committee meetings. They will be able to contribute to the discussions but will not be able to vote.

4.2 All members should attend all meetings either in person or via electronic means and Executive Directors may send a nominated deputy. In addition, other directors, senior managers and advisers will be invited to attend as and when required.

4.3 The Chair and Chief Executive, as Accountable Officer, should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement and the Annual Report and Accounts.

4.4 At least once a year the committee should meet privately with the internal auditors, external auditors and Local Counter Fraud Specialist either separately or together. Additional meetings may be scheduled to discuss specific issues if required.

4.5 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.

4.6 The Committee reserves the right to exclude some or all attendees, including executive director attendees, for part of the meeting.

4.7 Attendance will be recorded within the minutes of each meeting and monitored annually.

5. Quorum

5.1 The quorum will be at least three members who will include:

- the Chair or Deputy Chair of the Committee.

5.2 All non-executive directors (including the Trust Chair), regardless of whether or not they are a member of the Committee, will be deemed eligible for the purposes of establishing a quorum.

5.3 In the absence of a quorum, the meeting may proceed for discussion, but no decisions may be taken.

6. Frequency of Meetings

6.1 The Committee will meet at least four times a year. Additional meetings may be convened at the request of the Chair of the Committee, the External Auditor or Head of Internal Audit. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1 The Committee's objective is to provide assurance to the Board that the Trust has effective systems of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's aims including approval of the Trust's policies and procedures for the management of risk.

8. Duties

Governance, Internal Control and Risk Management

8.1 The Committee, on behalf of the Trust Board, will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives to gain assurance about the robustness of the system and controls.

8.2 In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board/governing body.

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, including risk appetite and maturity, and the appropriateness of the above disclosure statements.

- The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.

- The policies and procedures for all work related to counter fraud, bribery and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (NHSCFA).

8.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

8.4 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

8.5 The Audit Committee will escalate any areas on which it is unable to obtain sufficient assurance to the Trust Board.

8.6 The Committee will review the Annual Accounts and make recommendations on the approval of the Annual Accounts to the Board.

Internal Audit

8.7 The Committee will ensure that there is an effective internal audit function established by management that meets the mandatory NHS Internal Audit Standards, the Public Sector Internal Audit Standards, and provides appropriate independent assurance to the Audit Committee, to the Chief Executive as Accountable Officer, and to the Board of Directors. The Committee will monitor and review the effectiveness of the internal audit function.

8.8 This will be achieved by:

- Consideration of the provision of the internal audit service, including advising on the appointment of internal auditors; the audit fee and any questions of resignation or dismissal; reviewing the performance, remuneration and any proposal for changing the internal auditors.

- Review and approval of the Internal Audit Strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.

- Receiving and considering the major findings of internal audit investigations, their implications and management's response and monitoring progress on the implementation of recommendations.

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

- Annual review of the effectiveness of internal audit.

- Ensuring internal reports are received, whenever relevant, by the other committees of the Board for appropriate investigation.

External Audit

8.9 The Audit Committee will make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approval of the terms of engagement of the external auditor.

8.10 The Committee will review the work and findings of the External Auditor and consider the implications and management's responses to their work. The Committee will also monitor and review the External Auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

This will be achieved by:

- Consideration of the performance of the External Auditor.

- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with Internal Audit.

- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

- Considering and reviewing external audit reports, including the annual audit letter, together with the management response, and monitoring progress on the implementation of recommendations, advising the Board as appropriate.

- Discussing problems and reservations arising from the external auditor's work and any matters the external auditor may wish to discuss (in the absence of executive directors and other managers where necessary).

- Referring such reports to other committees of the Board, as appropriate, for their consideration and review.

- Consider the non-audit services provided by external audit in accordance with the requirements of the NAO Audit Code and Audit Guidance and ensure that a policy on the Engagement of the External Auditor is in place.

Counter Fraud Service

8.11 The Committee will review the work and findings of the Counter Fraud Manager and consider the implications and management's responses to their work. The Committee shall satisfy itself that the organisation has adequate controls, management mechanisms and arrangements in place for counter fraud, bribery and corruption that meet the NHSCFA's Functional Standards (and as required by service condition 24.1 and 24.2 of the NHS Service Contract) and shall review the outcomes of work in these areas. The Committee will refer any suspicions of fraud, bribery and corruption to the NHSCFA (via the case management system). In accordance with the NHSCFA's Functional Standards for NHS Providers, the Audit Committee is committed to protecting NHS resources by using intelligence to understand the nature of fraud risks, investigate serious and complex fraud, reduce its impact and drive improvements.

8.12 The Committee shall seek assurance in relation to the actions taken by the Local Counter Fraud Manager (LCFM) to meet the requirements of the Government Functional Standard 013: Counter Fraud, otherwise known as the 12 'Functional Standards'.

8.13 This will be achieved by:

- Reviewing and considering the annual work plan to ensure that the Trust has a provision that is proportionate to the level of risk and that the local counter fraud services has sufficient resource to deliver work in accordance with the Functional Standards issued by the NHS Counter Fraud Authority.

- Evaluating and documenting an effectiveness review of the counter fraud provision and reporting outcomes to the Board.

- Obtaining assurance that there is clear, demonstrable proactive support and strategic direction for anti-fraud, bribery and corruption work from directors and senior management within the organisation.

- Considering the major findings of reports; receiving and considering the recommendations made by the Local Counter Fraud Manager (LCFM), following local proactive work and investigations, and the associated management responses and monitor the implementation of these recommendations.

- Reviewing the annual counter fraud report on how the Trust has met the standards set by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work.

- Reviewing and approving the annual Counter Fraud Functional Standard (CFFSR) submission as required by the NHS Counter Fraud Authority.

Other Assurance Functions

8.14 The Audit Committee will, where appropriate and not within the remit of the Quality and Governance Assurance Committee, review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the integrated governance of the organisation.

8.15 These will include, but will not be limited to:

- Reviewing and approving schedules of losses, compensation and special payments and making any recommendations to the Board as required.
- Reviewing accounting policies and any changes in accounting practice.
- Regularly scrutinising the trust's cyber security arrangements and ensuring that the trust has robust and rapid responses in place in line with national guidance.
- Considering the outcomes of significant reviews carried out by other bodies that fall within the remit of the Audit Committee, including, but not limited to, regulators and inspectors.

8.16 In addition, the Committee will review the work of other committees and groups within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This may include other Board assurance committees.

8.17 Receiving and noting and/or approving any annual reports or procedural documents that fall within the Committee's remit.

8.18 Examining any matter referred to the Committee by the Trust Board.

Management

8.19 The Committee will request and review reports and positive and negative assurances from directors and managers on the overall arrangements for governance, risk management and internal control. This will be achieved by:

- Reviewing the scope of internal control and advising the Board on the effectiveness of the Trust's internal control systems.
- Reviewing the establishment and maintenance of an effective system of internal control and risk management through use of the assurance framework.

- Considering risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, prior to endorsement by the Board.

- Having oversight of risk management across the Trust's activities, including clinical and non-clinical risk, supported by the Governance and Quality Assurance Committee.

- On behalf of the Board, overseeing any proposed changes made by subject level experts to the Standards of Business Conduct, Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.

- Obtaining reports from the Head of Procurement or other relevant officer on probity in connection with the purchase of goods and services by the Trust and reviewing the arrangements as necessary.

- Reviewing the effectiveness of the Audit Committee.

8.20 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.

Annual Accounts and Annual Reports

8.21 The Audit Committee will review the Annual Report, Financial Statements, and external audit opinion on the Financial Statements and Quality Accounts (if required) before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.

- The integrity of the financial statements.

- Changes in, and compliance with, accounting policies and practices and estimation techniques.

- Unadjusted mis-statements in the financial statements.

- Significant judgements in preparation of the financial statements.

- Significant financial reporting adjustments resulting from the audit.

- Letters of representation.

- Explanations of significant variance.

In addition, the Committee will also receive the annual financial statements of the wholly owned subsidiary companies of the Trust.

8.22 The Committee will also ensure that the systems for financial reporting to the Board, including those of budgetary control, and formal announcements relating to the Trust's financial performance are subject to review as to completeness and accuracy of the information provided to the Board.

9. Accountability and Reporting Responsibilities

9.1 The Committee will function as a sub-committee of the Board and be accountable to the Board.

9.2 The minutes of each Committee meeting will be formally recorded and the Chair of the Committee will provide a written report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or that require executive action.

9.3 The Committee will be administratively supported by the Board Secretary and Corporate Services Manager or a nominated deputy, who will be solely responsible to the Chair of the Committee when undertaking work for the Committee.

9.4 The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible. In agreement with the Chair or Deputy Chair of the Committee, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

9.5 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements.

9.6 To support the Audit Committee in this function, the Chairs of the Quality and Governance Assurance Committee and People Committee will provide a report to the Audit Committee every six months on the activities of the Committees.

10 Relationships with other committees

10.1 This Committee and other Board Committees have a shared responsibility to provide assurances to the Board. As such, all committees need to work collaboratively, to ensure that all aspects of governance and risk management are covered, and that the Board receives comprehensive assurances on the Trust's business and activities.

10.2 As part of its integrated approach, the Committee will have effective relationships with the Finance Committee to ensure delivery of its assurance functions as part of the overall internal control mechanisms for the trust and the oversight of the delegated Board Assurance Framework objective.

11 Monitoring of Effectiveness

11.1 The Committee will develop and agree an annual workplan and will review its work and effectiveness annually.

11.2 The effectiveness of the Committee will be monitored by the Board through its regular reporting.

11.3 The Board will also evaluate the effectiveness of the Committee through its internal audit programme and Annual Governance Statement.

12 Review

12.1 The Committee will review these Terms of Reference at least annually or more frequently in the event of significant political, organisational, staff or policy changes.

12.2 The Committee will present the Terms of Reference to the Board for approval.

Approval Date: TBC
Review Date: TBC

SOMERSET NHS FOUNDATION TRUST (THE 'TRUST')

FINANCE COMMITTEE
TERMS OF REFERENCE

1. Strategic Statement

1.1 The Board hereby resolves to establish a sub-committee to be known as the Finance Committee (the 'Committee'). The Committee is accountable to the Trust Board (the 'Board') and has delegated authority as set out in these Terms of Reference

1.1 The role of the Committee is to provide assurance to the Board that the Trust is governed appropriately and well managed across the full range of its financial activities in support of the Trust's strategic aims, using its authority delegated by the Trust Board.

1.2 The Committee will provide objective review and assurance to the Board that financial management processes are effective and support the delivery of the Trust's operational and long-term financial plans.

2. Authority

2.1 The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

2.4 The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.5 The Committee is authorised to make requests that the Audit Committee commissions internal audit reviews relevant to its remit.

3. Membership

3.1 The Committee will be established by the Board, in accordance with the Constitution, the core membership of the Committee will comprise:

- Three Non-Executive Directors one of whom will act as Chair and one of which will act as Deputy Chair
- Chief Finance Officer
- Chief Operating Officer
- Director of Strategy and Digital Development
- Deputy Chief Finance Officer

In attendance: The following participants are invited to attend meetings of the Committee:

- Chief Information Officer (quarterly)
- Director of Redevelopment (bi-monthly)
- Director of Commercial Development (quarterly)
- A Governor member of the Strategy and Planning Group
- Other executive directors or other colleagues invited as required

3.2 The Chair of the Trust will appoint the Chair of the Committee.

3.3 The Chair of the Committee will nominate a Deputy Chair to act in their absence.

3.4 Executive directors may appoint an appropriate deputy to attend meetings in their absence.

3.5 The minute taker will be appointed by the Chief Finance Officer.

4. Attendance

4.1 There is a standing invitation for the Chief Executive, Chair and Trust Governors to attend the Committee meetings as observers. All other Non-Executive Directors also have a standing invitation to attend the Committee meetings. They will be able to contribute to the discussions but will not be able to vote.

4.2 All members should attend all meetings either in person or via electronic means and Executive Directors may send a nominated deputy. In addition, other directors, senior managers and advisers will be invited to attend as and when required.

4.3 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.

4.4 Attendance will be recorded within the minutes of each meeting and monitored annually.

5. Quorum

5.1 A quorum will be at least three members who will include:

- the Chair or Deputy Chair of the Committee

- one other Non-Executive Director
- the Chief Finance Officer or the Deputy Chief Finance Officer

5.2 All non-executive directors (including the Trust Chair), regardless of whether or not they are a member of the Committee, will be deemed eligible for the purposes of establishing a quorum.

5.3 In the absence of a quorum, the meeting may proceed for discussion, but no decisions may be taken.

6. Frequency of Meetings

6.1 The Committee will meet at least ten times a year. Additional meetings may be convened at the request of the Chair of the Committee. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1 The Committee's objective is to provide assurance to the Board that the Trust is delivering its agreed financial plans and related strategies.

8. Duties

8.1 **Delegated Responsibility**

The duties of the Committee as defined in the Trust Board Scheme of Delegation are to ensure that:

- Financial performance is delivered in accordance with the agreed strategy, plans and trajectories;

- The Trust's cost improvement and productivity programme is delivered in accordance with agreed plans;

- The Trust's capital investments, including IT, are in line with its strategic objectives and that benefits set out in the business cases for investment are realised;

- It will provide overview and scrutiny in any area of financial planning and financial performance as well as Risk Management of Board Assurance Framework and Trust Level Risks relevant to the committee's remit, and those referred to it by the Board.

8.2 **Discharge of Duties**

The Committee's duties will be discharged, though not exclusively, by the following:

Financial Planning and Financial Performance Management

- Examine the key principles and assumptions for the Trust’s business planning and budget setting processes.

- Receive assurance that the Trust’s financial, activity, capacity and workforce plans are fully aligned.

- Recommend to the Board approval of the Trust’s annual operational plan, capital investment plan and revenue budgets.

- Monitor the Trust’s performance against its annual financial plan and budgets.

- Receive and monitor reports on financial performance including forecasts, cost improvement / productivity programmes and use of resources, noting any trends, exceptions and variances against plans on a Trust-wide and directorate basis and reviewing in detail any major performance variations.

- Maintain an overview of the activity models to ensure consistency and to provide assurance on critical assumptions.

- Monitor workforce and agency spend, linking with the Audit Committee, People Committee and Quality and Governance Assurance Committee as required.

- Consider the adequacy of forecasting models used in relation to financial performance.

- Review income line and service line reporting to support investment and disinvestment decision making in relation to profitable and unprofitable services.

- Consider changes to the Trust reporting requirements under new regulatory arrangements.

- Seek assurance on mitigations for financial risks from contracting and planning with commissioners.

Capital Management

- Review and monitor the strategic five-year capital programme and the annual capital budgets and recommend actions or mitigations to the Trust Board.

- Consider proposals for investment in the estate and technology to ensure alignment with Trust strategy.

- Review and approve capital business cases in accordance with the Trust’s Standing Financial Instructions and Scheme of Delegation.

- Review those capital business cases above the Committee's authority limits as set out within the Trust's Standing Financial Instructions and Scheme of Delegation and make recommendation to the Board for approval.

Treasury Management

- Review the cash position of the Trust.

- To approve and review the Trust's treasury management and working capital policy.

Financial Sustainability

- Oversee the development of a medium to longer term financial sustainability plan.

- Receive updates of the Long-Term Financial Model.

Investment Appraisal

- Review and approve revenue business cases in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

- Review those revenue business cases above the Committee's authority limits as set out within the Trust's Standing Financial Instructions and Scheme of Delegation and make recommendation to the Board for approval.

- Review the benefits realisation of business cases and post implementation reviews to ensure that the standard of business case preparation is consistently high.

Commercial Development

- To review major procurements and tenders that require Board approval.

- Review tender opportunities for new business for the Trust and receive an update on horizon scanning of opportunities.

- Monitor performance of commercial activities as necessary. In doing so the committee will seek assurance that such activities deliver improved patient care and/or experience and that the Trust's principal purpose is not jeopardised by over-development of commercial activity.

- Keep under review key strategic, commercial contracts and seek assurance that appropriate due diligence is undertaken on any new contracts and/or renewals.

Risk

- Reviewing and scrutinising the objective(s) of the Board Assurance Framework delegated to the Committee, and Finance and Digital Risk Registers, to ensure that risks are appropriately assessed, monitored, prioritised, and that effective controls and plans are in place to mitigate the risks identified, referring to the executive management team or escalating to the Board any identified unresolved risks arising that require executive action or that pose significant threats to the operation, resources or reputation of the Trust.

- Recommend changes to the objective(s) of the Board Assurance Framework delegated to the Committee relating to emerging risks and existing entries within its remit for the executive to consider.

- To receive assurance in respect of significant programme risks associated with major transformation programmes within the Committee's remit, including the Healthset programme, with a focus on financial exposure, commercial and contractual risks, affordability, benefits realisation and the financial implications of delivery decisions or delays, and to escalate material concerns to the Board as appropriate.

9. Accountability and Reporting Responsibilities

9.1 The Committee will function as a sub-committee of the Board and be accountable to the Board.

9.2 The minutes of each Committee meeting will be formally recorded and the Chair of the Committee will provide a written report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or that require executive action.

9.3 The Committee will be administratively supported by the PA to the Chief Finance Officer or a nominated deputy who will be solely responsible to the Chair of the Committee when undertaking work for the Committee.

9.4 The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible. In agreement with the Chair or Deputy Chair of the Committee, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

9.5 The Chair of the Committee will report six monthly to the Audit Committee to provide assurance on finance systems and internal control arrangements.

10 Subgroups

10.1 The Committee receives information and assurance about the Trust's business and activities from any sub-groups it considers will support its work.

10.2 In addition, the Committee shall receive regular reports from:

- Business Planning Management Group

- Digital Strategy Group
- Strategic Estates Group

11 Relationships with other committees

11.1 This Committee and other Board Committees have a shared responsibility to provide assurances to the Board. As such, all committees need to work collaboratively, to ensure that all aspects of governance and risk management are covered, and that the Board receives comprehensive assurances on the Trust's business and activities.

12 Monitoring of Effectiveness

12.1 The Committee will develop and agree an annual workplan and will review its work and effectiveness annually.

12.2 The effectiveness of the Committee will be monitored by the Board through its regular reporting.

12.3 The Board will also evaluate the effectiveness of the Committee through its internal audit programme and Annual Governance Statement.

13 Review

13.1 The Committee will review these Terms of Reference at least annually or more frequently in the event of significant political, organisational, staff or policy changes.

13.2 The Committee will present the Terms of Reference to the Board for approval.

Approval Date: TBC
Review Date: TBC

SOMERSET NHS FOUNDATION TRUST (THE 'TRUST')

QUALITY AND GOVERNANCE ASSURANCE COMMITTEE
TERMS OF REFERENCE

1. Strategic Statement

1.1 The Board hereby resolves to establish a sub-committee to be known as the Quality and Governance Assurance Committee[1] (the 'Committee'). The Committee is accountable to the Trust Board (the 'Board') and has delegated authority as set out in these Terms of Reference.

1.2 The role of the Committee is to provide assurance to the Board, along with the Audit Committee, that the Trust is governed appropriately and well managed across the full range of its clinical activities in support of the Trust's strategic aims, using its authority delegated by the Trust Board.

1.3 The Committee will provide objective review and assurance to the Board that governance and risk management processes are effective and support the delivery of the Trust's Clinical Plan and the functioning of the Trust's assurance framework and risk management systems, as overseen by the Audit Committee. The Committee may also identify any gaps in control and assurance that fall within its remit and review progress in closing them.

2. Authority

2.1 The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

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

2.5 The Committee is authorised to make requests that the Audit Committee commissions internal audit reviews relevant to its remit.

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[1] This approach reflects the definition of quality set out in the Darzi Review, which identifies patient experience, clinical effectiveness, and safety as the three core dimensions of high-quality care (High Quality Care for All, 2008).

3. Membership

3.1 The Committee will be established by the Board, in accordance with the Constitution, the core membership of the Committee will comprise:

- A minimum of three Non-Executive Directors (which will exclude the Chair of the Audit Committee, although they can be in attendance), appointed by the Trust Chair
- Chief Medical Officer
- Chief Nurse and Midwife
- Director of Governance
- Chief Operating Officer
- Associate Director of Planning and Performance
- Associate Medical Director for Governance and Patient Safety
- Director of Allied Health Professions
- Deputy Chief Nurse/DIPC
- Director of Patient Experience and Engagement
- Consultant Anaesthetist, Associate CCIO
- Chief Nursing Officer, NHS Somerset Integrated Care Board or representative

In attendance: The following participants are invited to attend meetings of the Committee:

- Other executive directors or other colleagues invited as required.
- Nominated Governor(s)
- Director of Midwifery
- Deputy Medical Director(s)
- Medical Director of Mental Health & Learning Disability Head of Health and Safety and Risk
- Head of Legal Services
- Head of Compliance and Effectiveness
- Head of Patient Safety
- Chief Pharmacist

3.2 The Chairman of the Trust will appoint the Chair of the Committee.

3.3 The Chair of the Committee will nominate a Deputy Chair to act in their absence.

3.4 Executive directors may appoint an appropriate deputy to attend meetings in their absence.

3.5 The minute taker will be appointed by the Chief Medical Officer and Chief Nurse & Midwife.

4. Attendance

4.1 There is a standing invitation for the Chief Executive, Chair and Trust Governors to attend the Committee meetings as observers. All other Non-Executive Directors also have a standing invitation to attend the Committee meetings. They will be able to contribute to the discussions but will not be able to vote.

4.2 All members should attend all meetings either in person or via electronic means and Executive Directors may send a nominated deputy. In addition, other directors, senior managers and advisers will be invited to attend as and when required.

4.3 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. This may include personnel from system partners.

4.4 Attendance will be recorded within the minutes of each meeting and monitored annually.

5. Quorum

5.1 A quorum will be at least five members who will include:

- the Chair or Deputy Chair of the Committee
- one other Non-Executive Director
- two other Executive Directors, at least one member should have a clinical background

5.2 All non-executive directors (including the Trust Chair), regardless of whether or not they are a member of the Committee, will be deemed eligible for the purposes of establishing a quorum.

6. Frequency of Meetings

6.1 The Committee will meet monthly, with full business meetings and focus meetings taking place on alternate months. Additional meetings may be convened at the request of the Chair of the Committee. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1 The Committee's objective is to provide assurance to the Board that the Trust is delivering its Clinical Plan, in particular its aims to:

- Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
- Provide the best care and support to people
- Strengthen care and support in local communities
- Respond well to complex needs

8. Duties

8.1 Delegated Responsibility

The duties of the Committee as defined in the Trust Board Scheme of Delegation are to:

- Enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

  - Promote safe, high quality healthcare, with positive patient experience and clinical outcomes
  - Identify, prioritise and manage risks within the Trust
  - Ensure the effective and efficient use of resources through evidence-based clinical practice
  - Protect the health and safety and wellbeing of Trust employees

- Enable the Board to obtain assurance that the Trust has systems in place to ensure it is compliant with and delivers:

  - Legal and statutory requirements
  - Agreed clinical standards and quality objectives
  - Quality standards required by NHS Improvement and the Care Quality Commission

- Review the annual reports on the implementation of strategies for:

  - Safeguarding Adults and Children
  - Health and Safety
  - Emergency Preparedness, Resilience and Response
  - Information Governance
  - Organ Donation
  - Infection Control
  - Experience of Care

- Ensure effective arrangements are in place to assure high standards of clinical governance, including clinical effectiveness, management of clinical risk, practice standards, experience of care and patient safety.

- Ensure effective arrangements are in place to deliver Care Quality Commission registration, requirements and outcomes in response to any CQC inspections and reports.

- Enable the Board to obtain assurance that the Trust has systems and procedures in place to identify learning from deaths, Serious Incidents and other incidents, complaints and claims, ensuring they are shared across the Trust and implemented to improve patient safety, patient experience and colleague health and wellbeing.

- Ensure the Trust has in place procedures to monitor and review the operational effectiveness of policies and procedures.

8.2 **Discharge of Duties**

The Committee's duties will be discharged, though not exclusively, by the following:

- Ensuring that the Trust has appropriate performance objectives for improving patient safety, clinical effectiveness and patient experience, and robust strategies for delivering them, monitoring in-year performance and corrective action to ensure quarterly and annual targets are achieved.

- Receiving, by exception, details of Quality Impact Assessments for any business cases not supported by the Trust for progression in order to understand the impact on patient safety and experience.

- Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and considering the implications to the governance of the Trust. These will include reviews undertaken by the Care Quality Commission, professional bodies, and NHS Resolution as well as patient experience, clinical audit and the Quality Report & Account.

- Ensuring that effective arrangements are in place to assure high standards of clinical governance, clinical effectiveness, management of clinical risk, practice standards and patient safety.

- Requesting and reviewing reports and positive assurances from the Integrated Quality Assurance Board/Quality Assurance Committee and other sub-committees on the overall arrangements for governance.

- Overseeing the development and implementation of effective systems to ensure that the views of patients and carers are central to the provision and development of services, so that services are responsive to the needs of these individuals.

- Reviewing and scrutinising the objective(s) of the Board Assurance Framework delegated to the Committee and the Corporate Risk Register, to ensure that clinical risks are appropriately assessed, monitored, prioritised, and that effective controls and plans are in place to mitigate the risks identified, referring to the executive management team or other Board Committee; or escalating to the Trust Board any identified unresolved risks arising that require executive action or that pose significant threats to the operation, resources or reputation of the Trust. This will include receiving assurance in respect of significant programme risks within the Committee's remit, including the Healthset programme, with specific focus on clinical safety, people impact and inclusion, information governance, oversight of clinical pathways, quantitative quality and outcome benefits, and associated quality-related risks and mitigations.

- Seeking assurance on the robustness of the governance arrangements for the Trust's joint ventures, strategic partnerships and subsidiary organisations.

- Seeking assurance on the governance arrangements and effective implementation of the Trust's estates and facilities and sustainability strategies.

- Receiving an annual report on the governance assurance arrangements for all trust joint ventures and significant commercial contracts

- Reviewing the annual quality report/account and agreeing yearly quality indicators before submission to the Board, in conjunction with the Audit Committee.

- Monitoring and keeping under review claims and litigation activity.

- Examining any matter referred to the Committee by the Trust Board.

9. Accountability and Reporting Responsibilities

9.1 The Committee will function as a sub-committee of the Board and be accountable to the Board.

9.2 The minutes of each Committee meeting will be formally recorded and the Chair of the Committee will provide a written report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or that require executive action.

9.3 The Committee will be administratively supported by the EA to the Chief Nurse & Midwife or a nominated deputy, who will be solely responsible to the Chair of the Committee when undertaking work for the Committee.

9.4 The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible. In agreement with the Chair or Deputy Chair of the Committee, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

9.5 The Chair of the Committee will report six monthly to the Audit Committee to provide assurance on the systems for risk management and internal control in place within the Trust.

10 Subgroups

10.1 The Committee receives information and assurance about the Trust's business and activities from any sub-groups it considers will support its work.

10.2 In addition, the Committee shall receive regular reports from:

- the Quality Assurance Group, Data Review Group, Patient Safety Board and other sub-committees or governance groups relating to clinical and non-clinical governance, patient safety and improvement.

11 Relationships with other committees

11.1 This Committee and other Board Committees have a shared responsibility to provide assurances to the Board. As such, all committees need to work collaboratively, to ensure that all aspects of governance and risk management are covered, and that the Board receives comprehensive assurances on the Trust's business and activities.

12 Monitoring of Effectiveness

12.1 The Committee will develop and agree an annual workplan and will review its work and effectiveness annually.

12.2 The effectiveness of the Committee will be monitored by the Board through its regular reporting.

12.3 The Board will also evaluate the effectiveness of the Committee through its internal audit programme and Annual Governance Statement.

13 Review

13.1 The Committee will review these Terms of Reference at least annually or more frequently in the event of significant political, organisational, staff or policy changes.

13.2 The Committee will present the Terms of Reference to the Board for approval.

Approval Date: TBC
Review Date: TBC

SOMERSET NHS FOUNDATION TRUST (THE 'TRUST')

PEOPLE COMMITTEE
TERMS OF REFERENCE

1. Strategic Statement

1.1 The Board hereby resolves to establish a sub-committee to be known as the People Committee (the 'Committee'). The Committee is accountable to the Trust Board (the 'Board') and has delegated authority as set out in these Terms of Reference.

1.2 The role of the Committee is to provide assurance to the Board that the Trust is governed appropriately and well managed across the full range of its people and organisational development activities in support of the Trust's strategic aims, using its authority delegated by the Trust Board.

1.3 The Committee will provide objective review and assurance to the Board that the people and organisational development governance and risk management processes are effective, supporting the delivery of the People Plan and the functioning of the Trust's assurance framework and risk management systems, as overseen by the Audit Committee. The Committee may also identify any gaps in control and assurance that fall within its remit and review progress in closing them.

2. Authority

2.1 The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

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

2.5 The Committee is authorised to make requests that the Audit Committee commissions internal audit reviews relevant to its remit.

3 Membership

3.1 The Committee will be established by the Board, in accordance with the Constitution, the core membership of the Committee will comprise:

- A minimum of three Non-Executive Directors (which will include the Chair and Deputy Chair), appointed by the Trust Chair
- Chief of People and Organisational Development
- Deputy Chief People Officer
- Two Executive Directors

In attendance: the following participants are invited to attend meetings of the Committee:

- Director of Communications
- Local staff side representative x 1 (by nomination)
- Staff governor representation x 1 (by nomination)
- Other colleagues may be invited as required
- Non-Executive Directors may attend meetings even if they are not a member
- Subsidiary company representatives (Symphony Healthcare Services & Simply Serve Limited)
- Executive PA to Chief of People and OD (who shall act as secretary to the Committee)

3.2 The Chairman of the Trust will appoint the Chair of the Committee.

3.3 The Chair of the Committee will nominate a Deputy Chair to act in their absence.

3.4 Executive Directors may appoint an appropriate deputy to attend meetings in their absence.

3.5 The minute taker will be appointed by the Chief of People and Organisational Development.

4 Attendance

4.1 There is a standing invitation for the Chief Executive, Chair and Trust Governors to attend the Committee meetings as observers. All other Non-Executive Directors also have a standing invitation to attend the Committee meetings. They will be able to contribute to the discussions but will not be able to vote.

4.2 All members should attend all meetings either in person or via electronic means and Executive Directors may send a nominated deputy. In addition, other directors, senior managers and advisers will be invited to attend as and when required.

4.3 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

4.4 Attendance will be recorded within the minutes of each meeting and monitored annually.

5. Quorum

5.1 A quorum will be at least five members who will include:

- the Chair or Deputy Chair of the Committee
- one other Non-Executive Director
- The Chief of People and Organisational Development, or their nominated deputy.
- A further two Executive Directors

5.2 All non-executive directors (including the Trust Chair), regardless of whether or not they are a member of the Committee, will be deemed eligible for the purposes of establishing a quorum.

5.3 In the absence of a quorum, the meeting may proceed for discussion, but no decisions may be taken.

6. Frequency of Meetings

6.1 The Committee will meet quarterly, with focused deeper dive meetings taking place twice a year. Additional meetings may be convened at the request of the Chair of the Committee. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1 The Committee's objective is to provide assurance to the Board that the Trust is delivering its People Plan and related people and organisational development strategies and providing strategic direction to the Board in respect of the elements contained within it.

8. Duties

8.1 Delegated Responsibility

The duties of the Committee as defined in the Trust Board Scheme of Delegation are to:

- Oversee the development and delivery of the People Plan, Promise and Staff Standards and provide strategic direction to the Board in respect of the elements contained within it.

- Identify and monitor key performance indicators relating to the delivery of the People Plan, undertaking detailed review against these indicators and aspects of the People Plan, as required, or as directed by the Board or another Committee of the Board.

- Review arrangements by which colleagues may raise in confidence, concerns about possible improprieties of financial reporting and control, clinical quality, patient safety or other matters.

- Ensure the implementation of strategies for:

  - Shared direction and culture
  - Organisational Development
  - Workforce equality, diversity and inclusion

- Ensure that effective arrangements are in place to secure the availability of a competent and appropriately qualified workforce to deliver healthcare for the Trust.

8.2 **Discharge of Duties**

The Committee's duties will be discharged, though not exclusively, by the following:

- Ensuring that robust arrangements, including engagement processes, are in place to develop and deliver the People Plan, Promise, Staff Standards and related strategies.

- Identifying appropriate workforce performance objectives to ensure the delivery of the People Plan and related plans and ensuring that robust plans for delivering and monitoring the performance objectives are in place.

- Undertaking detailed review of these indicators and aspects of the People Plan, as required, or as directed by the Board or another Committee of the Board.

- Ensuring that the Trust has effective freedom to speak up processes, including reporting, monitoring and support arrangements, in place.

- Overseeing the development and implementation of an inclusive culture, including assurances relating to capable, compassionate and inclusive leadership arrangements.

- Ensuring that robust processes are in place to monitor and improve Guardian of Safe working hours and reduce violence and aggression to colleagues.

- Ensuring that robust processes are in place to monitor and improve colleague wellbeing and that the Guardian of Health and Wellbeing function is well resourced.

- Seeking assurance on the robustness of processes through the internal audit function.

- Reviewing and scrutinising the objective(s) of the Board Assurance Framework delegated to the Committee, and people related risks on the Corporate Risk Register, to ensure that colleague risks are appropriately assessed, monitored,

prioritised, and that effective controls and plans are in place to mitigate the risks identified, referring to the executive management team or escalating to the Board any identified unresolved risks arising that require executive action or that pose significant threats to the operation, resources or reputation of the Trust.

- Recommend changes to the objective(s) of the Board Assurance Framework delegated to the Committee relating to emerging risks and existing entries within its remit for the executive to consider.

- Ensuring that adequate and appropriate workforce processes and controls are in place.

- Reviewing the findings of the values and cultural work, including Staff Survey and Pulse results.

- Ensure the National and Regional programme to transform People services is on track and aligned to the Trust strategic objectives.

- Seeking assurance on the workforce implications of Healthset (organisational readiness, people resourcing, workforce implications and training risks)

- Examine any matter referred to the Committee by the Trust Board.

9. Accountability and Reporting Responsibilities

9.1 The Committee will function as a sub-committee of the Board and be accountable to the Board.

9.2 The minutes of each Committee meeting will be formally recorded and the Committee Chair will provide a written report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or that require executive action.

9.3 The Committee will be administratively supported by the PA to the Chief of People and Organisational Development Director or a nominated deputy, who will be solely responsible to the Chair of the Committee when undertaking work for the Committee.

9.4 The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible. In agreement with the Chair or Deputy Chair of the Committee, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

9.5 The Committee may establish task and finish groups to undertake specific pieces of work connected to the development and delivery of the People Plan.

9.6 The Chair of the Committee will report six monthly to the Audit Committee to provide assurance on workforce systems and internal control arrangements.

10 Subgroups

10.1 The Committee receives information and assurance about the Trust's business and activities from any sub-groups it considers will support its work.

11 Relationships with other committees

11.1 This Committee and other Board Committees have a shared responsibility to provide assurances to the Board. As such, all committees need to work collaboratively, to ensure that all aspects of governance and risk management are covered, and that the Board receives comprehensive assurances on the Trust's business and activities.

12 Monitoring of Effectiveness

12.1 The Committee will develop and agree an annual workplan and will review its work and effectiveness annually.

12.2 The effectiveness of the Committee will be monitored by the Board through its regular reporting.

12.3 The Board will also evaluate the effectiveness of the Committee through its internal audit programme and Annual Governance Statement.

13 Review

13.1 The Committee will review these Terms of Reference at least annually or more frequently in the event of significant political, organisational, staff or policy changes.

13.2 The Committee will present the Terms of Reference to the Board for approval.

Approval Date: TBC
Review Date: TBC

Topic	26 Sept 2025	9 Dec 2025	March 2026	June 2026	September 2026	December 2026
Annual Review of TOR and Annual Workplan			✔			
Annual Assessment of Committee Effectiveness			✔			
Colleague Story and/or Learning Item	✔	✔	✔	✔	✔	✔
Chief People Officer Report to include: • Equality, Diversity and Inclusion (Ops) • Employee Relations Improvement Programme • Learning, Education and Training (LET) • People Transformation Programme • Medical Workforce (Job planning) • Simply Serve Limited • Internal Audit (workforce related)	✔	✔	✔	✔	✔	✔
Corporate Risk Register (Including yearly risk appetite)	✔	✔	✔	✔	✔	✔
People Performance Report	✔	✔	✔	✔	✔	✔
Board Assurance Framework	✔	✔	✔	✔	✔	✔
People Plan Progress Report	✔		✔		✔	
Culture/Employee Experience Progress Report (Worker Experience)		✔		✔		✔
National Staff Survey Results/Quarterly Pulse Results		✔	✔			
Strategic Workforce Planning					✔	
Service – People Plan Updates						
Surgical			✔			

Mental Health and Learning				✔		
Clinical Support and Cancer Services				✔		
Medical Services					✔	
CYP and Families					✔	
Neighbourhoods and Community Services						✔

SOMERSET NHS FOUNDATION TRUST (THE 'TRUST')

MENTAL HEALTH LEGISLATION COMMITTEE
TERMS OF REFERENCE

1. Strategic Statement

1.1 The Board hereby resolves to establish a sub-committee to be known as the Mental Health Legislation Committee (the 'Committee'). The Committee is accountable to the Trust Board (the 'Board') and has delegated authority as set out in these Terms of Reference.

1.2 The role of the Committee is to provide assurance to the Board that the Trust is governed appropriately and well managed in relation to the implementation and operation of mental health legislation, including the Mental Health Act 1983, the Mental Capacity Act 2005 and associated statutory frameworks in support of the Trust's strategic aims, using its authority delegated by the Trust Board.

1.3 The Committee will perform its functions in the context of the guiding principles of the Mental Health Act Code of Practice:

- To maximise independence and encourage an environment of using the least restrictive options for patients.
- To promote respect and dignity of patients and their family while delivering effective treatment, maximising safety and well-being.
- To ensure patients are cared for in the most effective, efficient and equitable way.
- To involve patients in planning and reviewing their treatment.
- To improve partnership working across the system involving other agencies as required.

2. Authority

2.1 The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

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

2.5 The Committee is authorised to make requests that the Audit Committee commissions internal audit reviews relevant to its remit.

3. Membership

3.1 The Committee will be established by the Board, in accordance with the Constitution, the core membership of the Committee will comprise:

- Three Non-Executive Directors of the Board, appointed by the Trust Chair
- Chief Operating Officer
- Chief Nurse and Midwife or Deputy
- Medical Director – Mental Health and Learning Disabilities
- Director of Governance
- Service Group Director, Mental Health and Learning Disabilities
- Deputy Service Group Director, Mental Health and Learning Disabilities
- Associate Director of Patient Care, Mental Health and Learning Disabilities
- Director of Patient Experience and Engagement
- Mental Health Act Lead
- Mental Capacity Act and DoLS Lead
- Head of Forensic Services

In attendance: The following participants are invited to attend meetings of the Committee:

- Other executive directors or other colleagues invited as required
- Nominated Governor(s)
- Representative(s) from the Somerset Council's AMHP service
- Representative(s) from the Somerset Integrated Care Board

3.2 The Chair of the Trust will appoint the Chair of the Committee.

3.3 The Chair of the Committee will nominate a Deputy Chair to act in their absence.

3.4 Executive directors may appoint an appropriate deputy to attend meetings in their absence.

3.5 The minute taker will be appointed by the Director of Governance.

4. Attendance

4.1 There is a standing invitation for the Chief Executive, Chair and Trust Governors to attend the Committee meetings as observers. All other Non-Executive Directors also have a standing invitation to attend the Committee meetings. They will be able to contribute to the discussions but will not be able to vote.

4.2 All members should attend all meetings either in person or via electronic means and Executive Directors may send a nominated deputy. In addition, other directors, senior managers and advisers will be invited to attend as and when required.

4.3 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.

4.4 Attendance will be recorded within the minutes of each meeting and monitored annually.

5. Quorum

5.1 A quorum will be at least four members who will include:

- the Chair or Deputy Chair of the Committee;
- one other Non-Executive Director;
- the Medical Director, Mental Health and Learning Disabilities or the Director of Governance; and
- Service Group Director, Mental Health and Learning Disabilities (or Deputy)
- at least one member with a clinical background

5.2 All non-executive directors (including the Trust Chair), regardless of whether or not they are a member of the Committee, will be deemed eligible for the purposes of establishing a quorum.

5.3 In the absence of a quorum, the meeting may proceed for discussion, but no decisions may be taken.

6. Frequency of Meetings

6.1 The Committee will meet at least four times a year. Additional meetings may be convened at the request of the Chair of the Committee. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1 The Committee's objectives are to provide assurance to the Board:

- that adequate and appropriate governance, systems and controls are in place to ensure compliance with mental health legislation and any proposed changes to such legislation;

- that members of hospital managers' panels and all relevant staff groups across mental health, community and acute services receive relevant guidance, education and training on their responsibilities under the Mental Health Act, in line with Trust policies; and

- that risks relating to mental health legislation are identified, managed and escalated appropriately.

8. Duties

8.1 Delegated Responsibility

The duties of the Committee as defined in the Trust Board Scheme of Delegation are:

- to monitor the Trust's implementation of, and compliance with, current mental health legislation and proposed changes to such legislation, in particular the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, within the Trust taking into account best practice;

- to consider the implication of any changes to legislation and regulations within the policies, practices, procedures and resource requirements of the Trust and our partner organisations;

- to monitor the processes relating to and outcomes of First Tier Tribunals (Mental Health) and of hearings held by the hospital managers' panels;

- to ensure there is an appropriate number of Hospital Managers panel members in place with the appropriate skills and experience to fulfil their role;

- to monitor trends in compliance with and the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary;

- to receive reports on the application of the Mental Capacity Act 2005 within the Trust and make recommendations where necessary;

- to receive reports following Care Quality Commission Mental Health Act compliance visits for information and comment and ensure appropriate action is agreed and implemented within the organisation;

- to monitor delivery against the Trust's action plans developed as a result of any recommendations from reports of the Care Quality Commission relating to aspects of the Mental Health Act, Mental Capacity Act and the Deprivation of Liberty Safeguards;

- to approve policies in relation to the Mental Health Act and Mental Capacity Act across the Trust and scrutinise the application of these policies throughout the Trust in relation to both Acts;

- to identify and address training issues in terms of delegation of responsibilities under the Mental Health Act 1983;

- to identify and address quality issues in terms of delegation of responsibilities under the Mental Health Act 1983; and
- to manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation.

8.2 **Discharge of Duties**

The Committee's duties will be discharged, though not exclusively, by the following:

- Reviewing and scrutinising information reports and data in relation to the following:

  - Administration of the Mental Health Act, Mental Capacity Act and the Deprivation of Liberty Safeguards
  - Assessment and admission of patient under the Mental Health Act
  - Advocacy services
  - Placement of adults and children and young people out of county and into the county from other areas
  - Training attendance at mandatory and other MHA and MCA related courses

- Monitoring and reviewing reports of the Care Quality Commission and action plans to address issues identified for our services.

- Reviewing key publications, including the Care Quality Commission's Annual Report, and legislative changes to assess the impact on our services and recommending actions to address any issues identified.

- Agreeing and reviewing audits of compliance with the Mental Health Act, Mental Capacity Act and the Deprivation of Liberty Safeguards.

- Reviewing complaints and incidents raised in relation to application of the Mental Health Act Mental Capacity Act and the Deprivation of Liberty Safeguards.

9. Accountability and Reporting Responsibilities

9.1 The Committee will function as a sub-committee of the Board and be accountable to the Board.

9.2 The minutes of each meeting Committee will be formally recorded and the Chair of the Committee will provide a written report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or that require executive action.

9.3 The Committee will be administratively supported by an individual appointed by the Director of Governance, who will be solely responsible to the Chair of the Committee when undertaking work for the Committee.

9.4 The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible. In agreement with the Chair or Deputy Chair of the Committee, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

10 Subgroups

10.1 The Committee receives information and assurance about the Trust's business and activities from any sub-groups it considers will support its work.

10.2 In addition, the Committee shall receive regular reports from:

- Mental Health Act Lead
- Mental Capacity Act and DoLS Lead
- Hospital Managers Panels

10.3 The Committee shall receive quarterly statistical reports covering:

- Assessment and admission under the Mental Health Act
- Place of Safety detentions under s135/s136
- AWOLs

10.4 The Committee shall invite quarterly updates from Somerset Council AMHP service and 6 monthly updates from advocacy services.

11 Relationships with other committees

11.1 This Committee and other Board Committees have a shared responsibility to provide assurances to the Board. As such, all committees need to work collaboratively, to ensure that all aspects of governance and risk management are covered, and that the Board receives comprehensive assurances on the Trust's business and activities.

12 Monitoring of Effectiveness

12.1 The Committee will develop and agree an annual workplan and will review its work and effectiveness annually.

12.2 The effectiveness of the Committee will be monitored by the Board through its regular reporting.

12.3 The Board will also evaluate the effectiveness of the Committee through its internal audit programme and Annual Governance Statement.

13 Review

13.1 The Committee will review these Terms of Reference at least annually or more frequently in the event of significant political, organisational, staff or policy changes.

13.2 The Committee will present the Terms of Reference to the Board for approval.

Approval Date: TBC
Review Date: TBC

SOMERSET NHS FOUNDATION TRUST (THE ‘TRUST’)

CHARITY COMMITTEE
TERMS OF REFERENCE

1. Strategic Statement

1.1 The Board hereby resolves to establish a sub-committee to be known as the Charity Committee (the ‘Committee’). The Committee is accountable to the Trust Board (the ‘Board’) and has delegated authority as set out in these Terms of Reference and the charitable funds section of the Standing Financial Instructions. The Trust Board has the responsibility for exercising the functions of the Trustee.

1.2 The role of the Committee is to provide assurance to the Board, The Charity Committee has been established to exercise the Trust’s functions as sole corporate trustee of Somerset NHS Foundation Trust’s Charity (registered charity number 1059922) (including the Yeovil District Hospital Charity).

2. Authority

2.1 The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

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

3. Membership

3.1 The Committee will be established by the Board, in accordance with the Constitution, the core membership of the Committee will comprise:

- Three Non-Executive Directors, one of whom will act as Chair.
- Three Executive Directors, including the Chief Finance Officer and Director of Strategy and Digital Development

In attendance: The following participants are invited to attend meetings of the Committee:

- Other executive directors or other colleagues invited as required.
- Head of Charity
- Charitable Funds Accountant
- Director of Communications
- Representation by a public governor

3.2 The Chair of the Trust will appoint the Chair of the Committee.

3.3 The Chair of the Committee will nominate a Deputy Chair to act in their absence.

3.4 Executive directors may appoint an appropriate deputy to attend meetings in their absence.

3.5 The minute taker will be appointed by the Director of Strategy and Digital Development.

4. Attendance

4.1 There is a standing invitation for the Chief Executive, Chair and Trust Governors to attend the Committee meetings as observers. All other Non-Executive Directors also have a standing invitation to attend the Committee meetings. They will be able to contribute to the discussions but will not be able to vote.

4.2 All members should attend all meetings either in person or via electronic means and Executive Directors may send a nominated deputy. In addition, other directors, senior managers and advisers will be invited to attend as and when required.

4.3 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.

4.4 Attendance will be recorded within the minutes of each meeting and monitored annually.

5. Quorum

5.1 A quorum will be at least three members who will include:

- the Chair or Deputy Chair of the Committee and one other Non-Executive
- one Executive Director

5.2 All non-executive directors (including the Trust Chair), regardless of whether or not they are a member of the Committee, will be deemed eligible for the purposes of establishing a quorum.

5.3 In the absence of a quorum, the meeting may proceed for discussion, but no decisions may be taken.

6. Frequency of Meetings

6.1 The Committee will meet at least four times a year. Additional meetings may be convened at the request of the Chair of the Committee. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1 The Committee's objective is to provide assurance to the Board in relation to the delivery of the following objectives:

- To develop the strategy and objectives for the Charity for consideration by the Board.
- To oversee the implementation of an infrastructure appropriate to the efficient and effective running of the Charity.
- To oversee the fundraising conducted by the Trust.
- To oversee the expenditure of the Charity.
- To oversee the Charity's investment plans
.
- To monitor the performance of all aspects of the Charity's activities and ensure that it adheres to the principles of good governance and complies with all relevant legal requirements.
- To ensure effective liaison with the League of Friends forum

8. Duties

8.1 Delegated Responsibility

The duties of the Committee as defined in the Trust Board Scheme of Delegation are to:

- Ensure Funds Held on Trust (charitable funds) are managed in accordance with the Trust's SOs and SFIs, as approved by the Board.
- Ensure that all expenditure and contractual commitments made using charitable funds are allocated to a specific named charitable fund, in accordance with the SFIs.
- Receive regular reports from the Chief Finance Officer covering:
  - Number and value of funds
  - Purpose of funds
  - Income and expenditure analysis
- Decide upon expenditure criteria.

- Ensure that the requirements of the Charities Acts and the Charities Commission are met.

- Ensure that any contracts involving charitable funds comply with the requirements of the Charities Acts, as set out in the SFIs.

- Provide reports to the Board of Directors (acting as the Corporate Trustee) as appropriate.

- Review the Annual Accounts prior to submission to the Corporate Trustee for formal approval.

- Ensure that procurement, contracting and expenditure undertaken using charitable funds are subject to the same SFIs and procurement controls that apply to exchequer funds, unless otherwise required by the Charities Acts.

- Ensure that all charitable funds are used strictly in accordance with the purpose for which they were established, maintaining clear audit trails and governance as required by the SFIs.

8.2 **Discharge of Duties**

The Committee's duties will be discharged, though not exclusively, by the following:

- Act as the committee which discharges the Trust Board's responsibilities (as Sole Corporate Trustee) as they relate to Charitable Funds under the Trust's custodianship.

- Ensure that the charitable funds held by the Trust are managed in a manner consistent with the requirements of the relevant regulatory and statutory frameworks and in accordance with the guidance on NHS Charities set out by the Charity Commission.

- Oversee the Charity's strategy, governance, major plans and key risks on behalf of the corporate Trustee.

- Review the spending plans and balances held within individual funds.

- Receive and approve expenditure requests from Charitable Funds Managers in accordance with the SFIs, ensuring that all proposed expenditure is consistent with the purpose of the relevant charitable fund and delivers clear charitable benefit.

- Monitor the performance of the fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met.

- Devise and implement an investment strategy for the Charity, including the appointment and monitoring of any investment managers.

- Ensure the approval and submission of Annual accounts and Trustees' report in accordance with the Charity Commission's Statement of Recommended Practice.

9. Accountability and Reporting Responsibilities

9.1 The Committee will function as a sub-committee of the Board and be accountable to the Board.

9.2 The minutes of each Committee meeting will be formally recorded and the Chair of the Committee will provide a written report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or that require executive action.

9.3 The Committee will be administratively supported by the PA to the Director of Strategy and Digital Development or a nominated deputy, who will be solely responsible to the Chair of the Committee when undertaking work for the Committee.

9.4 The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible. In agreement with the Chair or Deputy Chair of the Committee, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

10 Subgroups

10.1 The Committee receives information and assurance about the Trust's business and activities from any sub-groups it considers will support its work. The Committee may establish an investment subgroup, to meet annually to review the investment strategy of the Trust.

11 Relationships with other committees

11.1 This Committee and other Board Committees have a shared responsibility to provide assurances to the Board. As such, all committees need to work collaboratively, to ensure that all aspects of governance and risk management are covered, and that the Board receives comprehensive assurances on the Trust's business and activities.

12 Monitoring of Effectiveness

12.1 The Committee will develop and agree an annual workplan and will review its work and effectiveness annually.

12.2 The effectiveness of the Committee will be monitored by the Board through its regular reporting.

13 Review

12.1 The Committee will review these Terms of Reference at least annually or more frequently in the event of significant political, organisational, staff or policy changes.

12.2 The Committee will present the Terms of Reference to the Board for approval.

Approval Date: TBC
Review Date: TBC

SOMERSET NHS FOUNDATION TRUST (THE 'TRUST')

EXECUTIVE COMMITTEE
TERMS OF REFERENCE

1. Strategic Statement

1.1 The Board hereby resolves to establish a sub-committee to be known as the Executive Committee (the 'Committee'). The Committee is accountable to the Trust Board (the 'Board') and has delegated authority as set out in these Terms of Reference.

1.2 The Committee will provide objective review and assurance to the Board that robust governance, performance management, risk management, improvement and transformation processes are effective and support the delivery of the Trust's strategic aims, objectives, plan and statutory responsibilities.

2. Authority

2.1. The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

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

2.5. The Committee is authorised to make requests that the Audit Committee commissions internal audit reviews relevant to its remit.

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

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

3. Membership

3.1. The Committee will be established by the Board, in accordance with the Constitution, the core membership of the Committee will comprise:

- Chief Executive (Chair)
- Chief Operating Officer (Deputy Chair)
- Chief Finance Officer
- Chief Medical Officer
- Chief Nurse
- Director of Strategic Development and Digital Development
- Chief of People
- Director of Corporate Services
- Service Group Directors (x6)
- Service Group Director for Acute Patient Flow
- Managing Director of Simply Serve Limited (SSL)
- Managing Director of Symphony Healthcare Services (SHS/Symphony)
- Director of Estates & Facilities
- Director of Communications
- Director of Governance
- Director of Elective Care

3.2. The Chair of the Committee will nominate a Deputy Chair to act in their absence.

3.3. Executive directors may appoint an appropriate deputy to attend meetings in their absence.

3.4. The minute taker will be appointed by the Chief Executive.

4. Attendance

4.1. All members should attend all meetings either in person or via electronic means and Executive Directors may send a nominated deputy. In addition, other directors, senior managers and advisers will be invited to attend as and when required.

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.

4.3. Attendance will be recorded within the minutes of each meeting and monitored annually.

5. Quorum

5.1. A quorum will be at least 10 members who will include:

- the Chair or Deputy Chair of the Committee;
- three other Executive Directors;
- representation from each of the operational service group triumvirates.

5.2. In the absence of a quorum, the meeting may proceed for discussion, but no decisions may be taken.

6. Frequency of Meetings

6.1 The Committee will meet monthly. Additional meetings may be convened at the request of the Chair of the Committee. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1 The Committee's objective is to provide assurance to the Board.

8. Duties

8.1. Delegated Responsibility

The duties of the Committee as defined in the Trust Board Scheme of Delegation are to:

- make management decisions on issues within the remit of the executive directors and to support individual executive directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information and resolution of issues.

- ensure timely operational decision making and risk mitigation processes in delivering the Trust's strategic objectives and priorities.

8.2. Discharge of Duties

The Committee's duties will be discharged, though not exclusively, by monitoring and reviewing the following key areas:

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

- significant planning and change management initiatives.
- acting as the primary forum for operational oversight of the Healthset programme: responsible for monitoring delivery progress; readiness across service groups; performance and data impacts and programme-level risks; ensuring effective triumvirate ownership at service group level and providing the principal route of delivery assurance to the Trust Board.

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

9. Accountability and Reporting Responsibilities

9.1 The Committee will function as a sub-committee of the Board and be accountable to the Board.

9.2 The minutes of each Committee meeting will be formally recorded and the Chair of the Committee will draw to the attention of the Board any issues that require disclosure through the Chief Executive's report to the Board.

9.3 The Committee will be administratively supported by the Executive Assistant to the Chief Executive or a nominated deputy, who will be solely responsible to the Chair of the Committee when undertaking work for the Committee.

9.,4 The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible. In agreement with the Chair or Deputy Chair of the Committee, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

10 Subgroups

10.1 The Committee receives information and assurance about the Trust's business and activities from any sub-groups it considers will support its work.

10.2 In addition, the Committee shall receive regular reports as follows:

Monthly

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

Bi-monthly

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

Quarterly

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

Six Monthly

- Reports from the Freedom to Speak Up Guardians

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

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

- Annual Staff Survey feedback results and action plans

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

- Internal and external audit reports identifying limited assurance and/or high risk findings and recommendations, to oversee implementation of agreed management actions

- Regular updates on business developments and new business cases for significant service developments and service changes, including plans for engagement and consultation with staff, patients and the public

- Updates on significant national and local policy changes affecting the services provided, or potentially provided, by the Trust.

11 Relationships with other committees

11.1 This Committee and other Board Committees have a shared responsibility to provide assurances to the Board. As such, all committees need to work collaboratively, to ensure that all aspects of governance and risk management are covered, and that the Board receives comprehensive assurances on the Trust's business and activities.

12 Monitoring of Effectiveness

12.1 The Committee will develop and agree an annual workplan and will review its work and effectiveness annually.

12.2 The effectiveness of the Committee will be monitored by the Board through its regular reporting.

12.3 The Board will also evaluate the effectiveness of the Committee through its internal audit programme and Annual Governance Statement.

13 Review

13.1 The Committee will review these Terms of Reference at least annually or more frequently in the event of significant political, organisational, staff or policy changes.

13.2 The Committee will present the Terms of Reference to the Board for approval.

Approval Date: TBC
Review Date: TBC

SOMERSET NHS FOUNDATION TRUST (THE 'TRUST')

RESEARCH AND INNOVATION COMMITTEE
TERMS OF REFERENCE

1. Strategic Statement

1.1 The Board hereby resolves to establish a sub-committee to be known as the Research and Innovation Committee (the 'Committee'). The Committee is accountable to the Trust Board (the 'Board') and has delegated authority as set out in these Terms of Reference.

1.2 The role of the Committee is to provide assurance to the Board that the Trust is governed appropriately and well managed and driving, promoting and supporting research and innovation culture across the Trust and through partnerships and collaborations, in support of the Trust's strategic aims, using its authority delegated by the Trust Board.

1.3 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.

2. Authority

2.1. The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

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

2.5. The Committee is authorised to make requests that the Audit Committee commissions internal audit reviews relevant to its remit.

3. Membership

3.1. The Committee will be established by the Board, in accordance with the Constitution, the core membership of the Committee will comprise:

- Non-Executive Director (Chair)
- 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 five lead researchers representing clinical and operational practice including a representative from Symphony Healthcare Services
- Up to five representatives from partner organisations including universities and local authorities

3.2. The Chair of the Trust will appoint the Chair of the Committee.

3.3. The Chair of the Committee will nominate a Deputy Chair to act in their absence.

3.4. Executive directors may appoint an appropriate deputy to attend meetings in their absence.

4. Attendance

4.1. There is a standing invitation for the Chief Executive, Chair and Trust Governors to attend the Committee meetings as observers. All other Non-Executive Directors also have a standing invitation to attend the Committee meetings. They will be able to contribute to the discussions but will not be able to vote.

4.2. All members should attend all meetings either in person or via electronic means and Executive Directors may send a nominated deputy. In addition, other directors, senior managers and advisers will be invited to attend as and when required.

4.3. 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.

4.4. Attendance will be recorded within the minutes of each meeting and monitored annually.

5. Quorum

5.1. A quorum will be at least one third of members who will include:

- One Non-Executive Director;
- One Executive Director.

5.2. All non-executive directors (including the Trust Chair), regardless of whether or not they are a member of the Committee, will be deemed eligible for the purposes of establishing a quorum.

5.3. In the absence of a quorum, the meeting may proceed for discussion, but no decisions may be taken.

6. Frequency of Meetings

6.1. The Committee will meet at least four times a year. Additional meetings may be convened at the request of the Chair of the Committee. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1. The Committee's objective is to provide assurance to the Board that the Trust is delivering its agreed research and innovation plans and related strategies.

8. Duties

8.1. Delegated Responsibility

The duties of the Committee as defined in the Trust Board Scheme of Delegation are to:

- Make recommendations to the Trust Board of Directors on research related matters.
- 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.
- Ensure active consideration of equality, diversity and inclusion in the conduct of the Committee business and the provision of research activities.
- Ensure that risks arising from research and innovation activities are being managed and escalated appropriately, in line with the Trust's policies and procedures.

8.2. Discharge of Duties

The Committee's duties will be discharged, though not exclusively, by the following:

- Developing and implementing the Trust's Research and Development objectives and plans and ensuring alignment with the Trust Corporate Strategy, reflecting the Trusts unique position as an integrated provider of healthcare.
- Overseeing the development of the infrastructure to support the strategic aims of the Trust and associated annual objectives.
- Ensuring any task and finish groups or special interest groups are created as required to address specific research and innovation-related matters.
- 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 and any other strategic initiatives.

- Developing closer collaboration with research and academic environments including PenArc, Health Innovation South West and Exeter Biomedica Research Centre.

9. Accountability and Reporting Responsibilities

9.1. The Committee will function as a sub-committee of the Board and be accountable to the Board.

9.2. The minutes of each Committee meeting will be formally recorded and the Chair of the Committee will provide a written report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or that require executive action.

9.3. The Committee will be administratively supported by an individual appointed by the Director of Strategy and Digital Development, who will be solely responsible to the Chair of the Committee when undertaking work for the Committee.

9.4. The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible. In agreement with the Chair or Deputy Chair of the Committee, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

10. Subgroups

10.1. The Committee receives information and assurance about the Trust's business and activities from any sub-groups it considers will support its work. It is anticipated that existing operational and executive groups will have delivery responsibility.

11. Relationships with other committees

11.1 This Committee and other Board Committees have a shared responsibility to provide assurances to the Board. As such, all committees need to work collaboratively, to ensure that all aspects of governance and risk management are covered, and that the Board receives comprehensive assurances on the Trust's business and activities.

12. Monitoring of Effectiveness

12.1. The Committee will develop and agree an annual workplan and will review its work and effectiveness annually.

12.2. The effectiveness of the Committee will be monitored by the Board through its regular reporting.

12.3. The Board will also evaluate the effectiveness of the Committee through its internal audit programme and Annual Governance Statement.

13. Review

13.1. The Committee will review these Terms of Reference at least annually or more frequently in the event of significant political, organisational, staff or policy changes.

13.2. The Committee will present the Terms of Reference to the Board for approval.

Approval Date: TBC
Review Date: TBC

SOMERSET NHS FOUNDATION TRUST (THE 'TRUST')

NOMINATON AND REMUNERATION COMMITTEE
TERMS OF REFERENCE

1. Strategic Statement

1.1 The Board hereby resolves to establish a sub-committee to be known as the Nomination and Remuneration Committee (the 'Committee'). The Committee is accountable to the Trust Board (the 'Board') and has delegated authority as set out in these Terms of Reference

1.2 The role of the Committee is to provide assurance to the Board that the Trust is governed appropriately and well managed across the full range of its activities in support of the Trust's strategic aims, using its authority delegated by the Trust Board.

1.3 The Committee will provide objective review and assurance to the Board that the processes for setting the remuneration and terms of service for all executive directors, selected senior management and all employees on spot salaries; for establishing the process for the identification and nomination of executive directors; and for ensuring organisational resilience by reviewing the process for succession planning, are effective.

2. Authority

2.1 The Committee is a committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

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

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

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

2.5 The Committee is authorised to make requests that the Audit Committee commissions internal audit reviews relevant to its remit.

3. Membership

3.1 The Committee will be established by the Board, in accordance with the Constitution, the core membership of the Committee will comprise:

- The Chairman
- All Non-Executive Directors.

In attendance: The following participants are invited to attend meetings of the Committee, as required:

- The Chief Executive;
- Any other Executive Directors.

3.2 The Chair of the Trust will appoint the Chair of the Committee.

3.3 The Chair of the Committee will nominate a Deputy Chair to act in their absence.

3.4 Executive directors may appoint an appropriate deputy to attend meetings in their absence.

3.5 The minute taker will be appointed by the Chairman.

3.6 The Chief Executive will be in attendance to advise of Executive Directors' remuneration and terms of service but not be present for discussions about his/her remuneration and terms of service. The Committee may require the attendance of any Trust employee to help in its deliberations. The Director of Human Resources and Workforce Development will support the Committee with advice and administration.

3.7 The Chair of the Board shall be the Chair of the Committee, other than in respect of matters relating to remuneration and terms of employment of Executive Directors, for which the Trust Board's Senior Independent Director will take the Chair.

3.8 The composition of the Committee shall be presented in the Annual Report.

4. Attendance

4.1 All members should attend all meetings either in person or via electronic means and Executive Directors may send a nominated deputy.

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.

4.3 Attendance will be recorded within the minutes of each meeting and monitored annually.

5. Quorum

5.1 A quorum shall be at least five members who will include:

- Four Non-Executive Directors;
- The Chairman.

5.2 In the absence of a quorum, the meeting may proceed for discussion, but no decisions may be taken.

6. Frequency of Meetings

6.1 The Committee will meet at least annually. Additional meetings may be convened at the request of the Chair of the Committee. Meetings may be held by electronic means and their decisions accepted as valid and binding.

7. Objectives

7.1 The Committee's objective is to provide assurance to the Board that the Trust:

- Ensures that there is a formal, rigorous and transparent procedure in place to facilitate the appointment of new executive directors of appropriate calibre to the Trust.

- Gives full consideration to succession planning, taking into account the challenges and opportunities facing NHS Foundation Trusts and the skills and expertise required on the Board.

- Ensures that there is a formal, rigorous and transparent procedure for setting the remuneration and terms of service of new executives and existing executive directors of the Trust.

- Ensures that levels of remuneration are sufficient to attract, retain and motivate executive directors of the quality required to run the Trust successfully, whilst avoiding paying more than is necessary.

- Monitors the level and structure of remuneration for the Trust's senior management for all employees on spot salaries and to advise the Board accordingly. The definition of senior management is to be determined by the Board.

8. Duties

8.1 Delegated Responsibility

The duties of the Committee as defined in the Trust Board Scheme of Delegation are to:

- Review regularly the remuneration and terms of service of the Chief Executive and other Executive Directors (and other Very Senior Officers) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to

the provisions of any national arrangements where appropriate. This will include all aspects of salary (including any performance related elements/bonuses); provisions for other benefits, including pensions and cars; arrangements for termination of employment and other contractual terms.

- Decide the appropriate remuneration of the Chief Executive and other Executive Directors. Any decisions made by the Remuneration Committee shall be recorded in the minutes of the Remuneration Committee meetings.

- Monitor and evaluate the performance of individual Directors;

- Advise on and oversee appropriate contractual arrangements for such staff including calculating and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.2 **Discharge of Duties**

The Committee's duties will be discharged, though not exclusively, by ensuring the following:

- Remuneration packages should be such as to enable people of appropriately high ability to be recruited, retained and motivated within levels of affordability.

- Decisions must be publicly defensible.

- The Committee has the duty to consider whether or not to seek advice about pay structures and the state of the market for the kind of managers to be recruited.

- A clear statement of the responsibilities of the individual posts and their accountabilities for meeting objectives of the organisation should be included for every remuneration package.

- They have comparative salary information, where possible, from NHS and other public sector organisations and other industrial and service organisations.

- They have means of assessing the comparative job "weight" e.g. by job evaluation.

9. Accountability and Reporting Responsibilities

9.1 The Committee will function as a sub-committee of the Board and be accountable to the Board.

9.2 The minutes of each Committee meeting will be formally recorded and retained by the Chair. They shall not be shared with executive directors. The Committee will report to the Board after each meeting as appropriate.

9.3 The Committee will be administratively supported by the Board Secretary and Corporate Services Manager , who will be solely responsible to the Chair of the Committee when undertaking work for the Committee.

9.4 The agenda and any supporting papers shall be distributed no less than three working days prior to a meeting, wherever possible. In agreement with the Chair or Deputy Chair of the Committee, if an item needs to be raised on the day, this shall be covered under Any Other Business, subject to there being available time.

9.5 The Remuneration Committee shall ensure that Board of Directors' emoluments are accurately reported in the required format in the Trust's annual report.

10 Relationships with other committees

10.1 This Committee and other Board Committees have a shared responsibility to provide assurances to the Board. As such, all committees need to work collaboratively, to ensure that all aspects of governance and risk management are covered, and that the Board receives comprehensive assurances on the Trust's business and activities.

11 Monitoring of Effectiveness

11.1 The effectiveness of the Committee will be monitored by the Board through its regular reporting.

12 Review

12.1 The Committee will review these Terms of Reference at least annually or more frequently in the event of significant political, organisational, staff or policy changes.

12.2 The Committee will present the Terms of Reference to the Board for approval.

Approval Date: TBC
Review Date: TBC