

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 4 March 2026
SPONSORING EXEC:	Isobel Clements, Chief People Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Graham Hughes, Chair of the People Committee
DATE:	12 May 2026

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
<input checked="" type="checkbox"/> For Assurance	<input type="checkbox"/> For Approval / Decision	<input type="checkbox"/> For Information

Executive Summary and Reason for presentation to Committee/Board	<p>The People Committee met on 4 March 2026 and reviewed key workforce priorities.</p> <p>Assurance was received on continued improvement in recruitment efficiency, reductions in agency usage and strong retention. The Committee noted good progress against People Strategy Year 4 priorities, including the development of improved people data and dashboards to support targeted leadership action. Service-level assurance was provided through the Surgical Service Group People Plan and a colleague story from Ophthalmology Theatre Services, demonstrating effective leadership, resilience and application of People Strategy principles. The Committee also reviewed staff survey results and cultural assurance, noting performance broadly in line with peers.</p> <p>Concerns remain regarding sickness absence, appraisal completion and quality, declining staff engagement and increasing employee relations case complexity, alongside emerging workforce risks in specific services. These areas will continue to be monitored closely.</p> <p>This report provides assurance and highlights key risks for Board oversight.</p>
Recommendation	<p>The Board is asked to note the assurance provided and the key risks identified, including sickness absence, appraisal quality, engagement, employee relations pressures and workforce sustainability, and to support continued focus on recruitment, leadership, culture and People Strategy delivery.</p>



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)

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|------------------------------------|---|------------------------------------|----------------------------------|------------------------------|--|
| <input type="checkbox"/> Financial | <input checked="" type="checkbox"/> Legislation | <input type="checkbox"/> Workforce | <input type="checkbox"/> Estates | <input type="checkbox"/> ICT | <input checked="" type="checkbox"/> Patient Safety/Quality |
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Details: N/A

Equality

The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

- This report has been assessed against the Trust's People Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
- This report has been assessed against the Trust's People Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities

Public/Staff Involvement History

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

Staff involvement takes place through the regular service group and topic updates.

Previous Consideration

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

The report is presented to the Board after every meeting.

Reference to CQC domains (Please select any which are relevant to this paper)

- | | | | | |
|--|---|--|--|--|
| <input checked="" type="checkbox"/> Safe | <input checked="" type="checkbox"/> Effective | <input checked="" type="checkbox"/> Caring | <input checked="" type="checkbox"/> Responsive | <input checked="" type="checkbox"/> Well Led |
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Is this paper clear for release under the Freedom of Information Act 2000?

- Yes No

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE MEETING HELD ON 4 MARCH 2026

1. PURPOSE

The People Committee met on 4 March 2026 to review key workforce, people strategy and cultural priorities. This report provides assurance to the Board on matters discussed, highlights areas of concern, and identifies risks requiring escalation or continued oversight.

2. ASSURANCE RECEIVED

- 2.1. The Committee reviewed delivery of the People Strategy and was assured that Year 4 priorities remain on track, with a clear focus on leadership, culture, data and wellbeing. Good progress was noted in the development of improved people dashboards and workforce intelligence, supporting more targeted leadership oversight and intervention.
- 2.2. The Chief People Officer's Report provided assurance on improvements in recruitment and time to hire, which continues to reduce and remains on a positive trajectory, although further improvement is required to meet national ambition. Assurance was also received regarding visa and sponsorship arrangements, with robust grip and control in place despite a complex and evolving national policy environment.
- 2.3. The People Performance Report provided assurance on continued reduction in agency usage, stable and strong retention, and improving mandatory training compliance at a Trust-wide level.
- 2.4. Assurance was received from the Surgical Service Group People Plan, which demonstrated tangible improvement in leadership visibility, engagement and retention following targeted interventions. The colleague story from Ophthalmology Theatre Services further provided strong assurance regarding leadership capability, resilience and the effective application of People Strategy principles at service level.
- 2.5. The Committee also received assurance from the Culture Maturity Review, which confirmed that appropriate frameworks and governance are in place to support cultural development, with recommendations being addressed through a monitored action plan.

3. AREAS OF CONCERN OR FOLLOW UP

- 3.1. The Committee identified several ongoing concerns requiring continued focus. Sickness absence remains high, with limited sustained improvement despite targeted interventions. Appraisal completion and quality continue to improve only incrementally and remain a cultural challenge.

- 3.2. Members noted increasing pressure arising from the volume and complexity of employee relations casework, which is impacting management capacity and organisational resilience.
- 3.3. The Committee also highlighted continuing workforce sustainability risks, including recruitment and retention challenges in specific services such as Estates and Facilities and community settings, alongside emerging concerns regarding paediatric recruitment.

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

- 4.1. The Committee agreed that Strategic Objective 5 remains above risk appetite, driven by sustained sickness absence, appraisal quality, workforce sustainability and growing employee relations pressures.
- 4.2. Risks relating to declining staff engagement and staff survey results, workforce planning visibility and succession planning were noted, alongside emerging service-level recruitment risks requiring escalation.
- 4.3. The Committee emphasised the importance of continued triangulation of workforce data, staff survey intelligence and lived experience to strengthen assurance and mitigate these risks.

Graham Hughes
CHAIR OF THE PEOPLE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Integrated Performance Exception Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	<p>Lee Cornell, Associate Director – Planning and Performance</p> <p>Ian Clift, Senior Performance Manager</p> <p>Isobel Clements, Chief of People and Organisational Development</p> <p>Xanthe Whittaker, Director of Elective Care</p> <p>Stacy Barron-Fitzsimons, Director for Medical Services Group</p> <p>Sally Bryant, Director of Midwifery</p> <p>Leanne Ashmead, Director of Children, Young People and Families</p> <p>Mark Arruda-Bunker, Service Director, Mental Health and Learning Disabilities</p> <p>Abbie Furnival, Service Group Director – Neighbourhoods and Communities</p> <p>Kerry White, Managing Director – Symphony Healthcare Services</p> <p>Emma Davey, Director of Patient Experience and Engagement</p>
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	12 May 2026

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
<input checked="" type="checkbox"/> For Assurance	<input type="checkbox"/> For Approval / Decision	<input checked="" type="checkbox"/> For Information

Executive Summary and Reason for presentation to Committee/Board	<p>Our Integrated Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends.</p> <p>Areas in which performance has been sustained or has notably improved include:</p> <ul style="list-style-type: none"> performance against the 28-day faster cancer diagnosis measure was above the compliance standard.
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	<ul style="list-style-type: none"> • the percentage of patients waiting under six weeks to be seen by our community mental health services remained high. • the percentage of patients waiting under 18 weeks from referral to be seen by our community services remains better than the target level. • the number of patients waiting 18 weeks or more to be seen by our community dental service remains below (i.e. better than) the target level for the sixth month in a row. • patient satisfaction levels across our Symphony Healthcare practices remain high. <p>National priority areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include:</p> <ul style="list-style-type: none"> • improving the percentage of patients waiting no longer than 18 weeks for treatment and for a first appointment • the numbers of patients waiting 52 weeks or more for treatment. • compliance in respect of the 62-day cancer standard. • compliance against the A&E delivery standard in respect of patients being admitted, discharged or transferred within four hours and within 12 hours of attendance. • the average length of stay in our adult mental health wards.
Recommendation	The Board is asked to discuss and note the report.

Links to Joint Strategic Aims (Please select any which are impacted on / relevant to this paper)
<input checked="" type="checkbox"/> Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities <input checked="" type="checkbox"/> Aim 2 Provide the best care and support to people <input checked="" type="checkbox"/> Aim 3 Strengthen care and support in local communities <input checked="" type="checkbox"/> Aim 4 Respond well to complex needs <input checked="" type="checkbox"/> Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture <input checked="" type="checkbox"/> Aim 6 Live within our means and use our resources wisely <input checked="" type="checkbox"/> 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)					
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Details: N/A					

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

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

Reference to CQC domains (Please select any which are relevant to this paper)				
<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Effective	<input checked="" type="checkbox"/> Caring	<input checked="" type="checkbox"/> Responsive	<input checked="" type="checkbox"/> Well Led

SOMERSET NHS FOUNDATION TRUST
INTEGRATED PERFORMANCE EXCEPTION REPORT: MARCH 2026

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



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

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

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

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

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

- CQIM NHS England Clinical Quality Improvement Metric
- FYFV NHS Five Year Forward View for Mental Health Services
- HDS NHS Hospital Discharge Service: Policy and Operating Model
- ICB Locally agreed measure from the NHS Contract with Somerset Integrated Commissioning Board
- LTP The NHS Long Term Plan, 2019
- NHSC National measure from the NHS Contract
- NHSM NHS Mandate
- NOF NHS Oversight Framework for 2025/26

- NSG Measures derived from a range of guidance documents for Stroke services
- OPG NHS England Priorities and Operational Planning Guidance
- PAF NHS England Performance Assessment Framework for 2025/26
- SFT Somerset NHS Foundation Trust internal target / monitoring
- SHS Symphony Healthcare Services internal target / monitoring
- VWOFF NHS England Virtual Wards Operational Framework

CHIEF FINANCE OFFICER

NARRATIVE REPORT

NHS ENGLAND NATIONAL PRIORITIES AND SUCCESS MEASURES FOR 2025/26

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

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

- improving performance against the headline 28-Day cancer Faster Diagnosis standard to 80% by March 2026.
- reducing agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems.

For these measures, our performance in March 2026 was better than our target trajectory. Areas in respect of which we were underperforming against planned levels included:

- improving the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement against the November 2024 baseline.
- improving the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026 - with every trust expected to deliver a minimum 5%-point improvement against the November 2024 baseline.
- reducing the proportion of people waiting over 52 weeks for treatment to less than 1.5% of the total waiting list by March 2026.
- improving performance against the headline 62-day cancer standard to 75% by March 2026.
- improving A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within four hours in March 2026.
- improving A&E waiting times, with a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25.
- reducing the average length of stay in our adult acute and older persons mental health beds.

As at 31 March 2026, the percentage of patients waiting under 18 weeks RTT was 65.4%, up from 63.1% in February 2026. The percentage of patients waiting under 18 weeks for a first outpatient appointment increased to 73.9% in March 2026 but remained below plan. The number of patients waiting over 52 weeks reduced to 1,028 which represents 2.0% of the waiting list, against a plan level of 1.5% or lower. A range of actions are in place to manage this position, including waiting list validation, and specialty-level planning and

reporting arrangements. It was acknowledged that the requirement to reduce 52-week waiters to less than 1.5% of the total waiting list by March 2026 would be a significant challenge, and one which was likely not to be achieved.

During February 2026 – the latest validated position available - compliance in respect of the 62-day cancer standard was 73.1% which was above the current national standard of 70%, but below our trajectory of 75.5%. The main breaches of the 62-day standard were in urology (29% of breaches), colorectal (21%) and breast (14%). Urology and Colorectal have taken part in the 100 Days Matter national pathway improvement challenge; colorectal is repeating the 100-day challenge to gain more traction on identified parts of the pathway that cause delays.

Compliance in respect of the A&E and UTC four-hour reporting standard increased from 70.1% in February 2026 to 72.8% in March 2026, the highest level since August 2025, but below the 78% national standard to be achieved in March 2026. A range of actions and developments are in progress to improve the position at both sites, which include a review of administration job descriptions for progress chasers to bring alignment, allowing sharing and learning, and discussion around the implementation of point of care testing for patients needing contrast, allowing quicker time to scan and increased patient safety.

The average length of stay in our adult acute and older persons mental health beds during the three months ending 31 March 2026 was 73.1 days, above the agreed trajectory to achieve an average of 66.4 days for the three months ending 31 March 2026. The increase was due mainly to the discharge during February 2026 of nine patients from our Older Persons wards with lengths of stay totalling 1,257 days, compared to 753 days in respect of patients discharged from the same setting during January 2026. The average length of stay just for March 2026 was 59.4 days. Work continues with the Somerset Integrated Care Board and Social Care to improve the allocation of Social Workers and ensure key activities are completed to support discharge in a timely manner. Learning from South West London and St George's Mental Health NHS Trust in reducing length of stay is also being taken forward.

Responsive

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

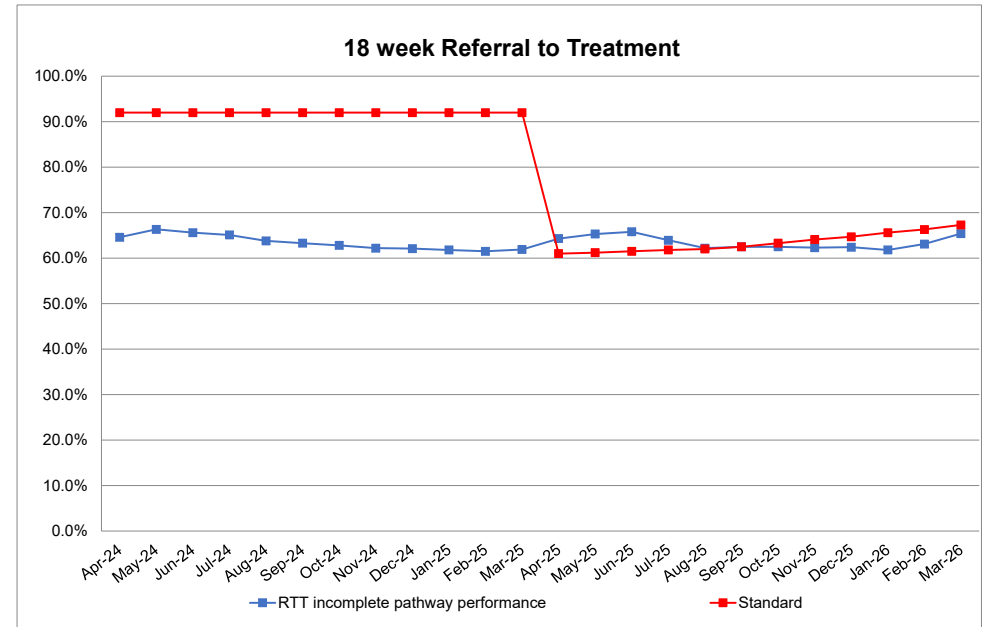
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT improved to 65.4% in March 2026. This is 1.9% below (i.e. worse than) plan at year-end. The percentage of patients waiting under 18 weeks for a first appointment increased to 73.9%.
- Total waiting list size decreased by 683 pathways and is 1,124 better than trajectory (52,302 actual vs. 53,426 plan). This is mainly due to additional Advice & Refer specialties going live, additional RTT validation efforts and the endocrinology service closure.
- The number of patients waiting over 52 weeks decreased to 1,028 against an original plan of 825. This represents 2.0% of the waiting list against the plan of 1.5%. In part the position is worse than trajectory because of the waiting list size being below plan.
- The number of patients waiting over 65 weeks decreased to 17 at the end of March against a national expectation of zero; no patients waited over 78 weeks RTT.

Focus of improvement work

- A specialty-level RTT planning model was developed for 2025/26, which took account of productivity and quantified the level of activity needed to deliver a 5% improvement in performance against the 18-week RTT and first appointment within 18 weeks standards. Delivery plans for the twelve lower-performing, high-volume specialties were refreshed in August 2025 and continue to be reviewed monthly.
- The Trust continues to take part in the national RTT Validation Sprint; we are also developing ways to increase the effectiveness and levels of validation coverage of the waiting list.
- Monitoring reports for all of the RTT standards are in place, along with reports to monitor the delivery against the core productivity measures, such as Advice & Guidance, Patient Initiated Follow-ups (PIFU), Did Not Attend (DNA) rates and capped theatre utilisation.

Line Chart



How do we compare

The national average performance against the 18-week RTT standard was 62.5% in February 2026, the latest data available; our performance was 63.1%. National performance remained improved by 1.1% between January and February 2026; our performance improved by 1.3%. The number of patients waiting over 52 weeks across the country decreased by 12,989 to 122,668 (1.7% of the national waiting list compared with 2.1% for the Trust). The number of patients waiting over 78 weeks nationally increased by 239 to 1,375.

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

Area	Oct	Nov	Dec	Jan	Feb	Mar
18-week trajectory	63.3%	64.1%	64.7%	65.6%	66.3%	67.3%
18-week actual	62.5%	62.3%	62.4%	61.8%	63.1%	65.4%
First OPA 18 weeks trajct.	74.7%	75.8%	76.3%	77.7%	78.8%	80.3%
First OPA 18 weeks actual	70.3%	70.7%	70.3%	70.2%	72.4%	73.9%
52-week trajectory	2.2%	2.2%	2.0%	1.8%	1.7%	1.5%
52-week actual	2.7%	2.3%	2.4%	2.2%	2.1%	2.0%

Responsive

62-day Cancer is a measure of the length of wait from referral from a GP, screening programme or consultant, through to the start of first definitive treatment. The target is that by March 2026 at least 75% of patients are treated within 62 days of referral. The 28-day Faster Diagnosis is the first part of the 62-day pathway.

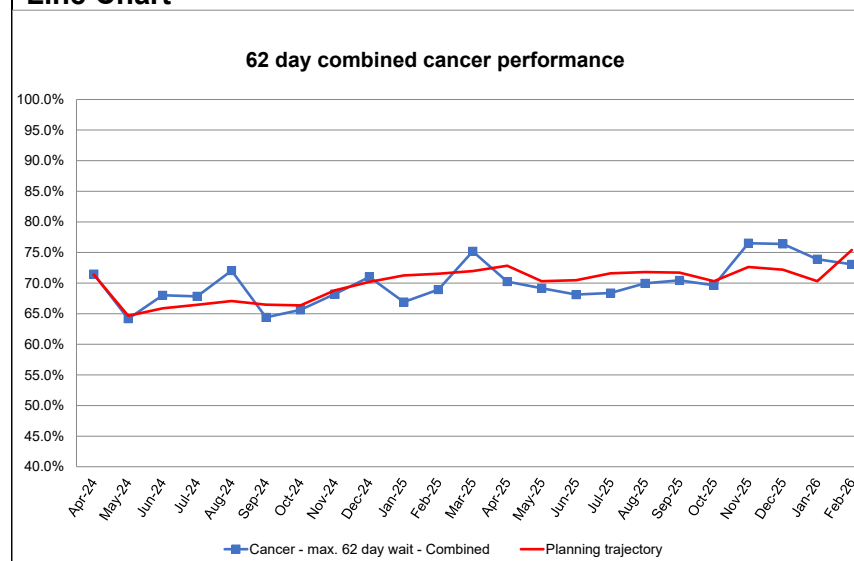
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 73.1% in February 2026, which is above the current national standard of 70%, but below our trajectory of 75.5%.
- The main breaches of the 62-day standard were in urology (29% of breaches), colorectal (21%) and breast (14%).
- The main cause of the breaches for urology continues to be high demand which cannot be accommodated within available capacity. This is mainly for the diagnostic phase of cancer pathways, when tests are still being undertaken to confirm whether a patient has a cancer or a benign condition.
- The breaches of the standard in colorectal relate to CT colon and endoscopy waits, as well as insufficient theatre capacity to meet bulges in demand for surgery consistently.
- There were also more patient choice related breaches in February 2026 because of patients choosing to defer tests and appointments during Christmas and the New Year.
- Seventeen GP-referred patients were treated in February 2026, on or after day 104 (the national 'backstop'); please see Appendix 1.

Focus of improvement work

- Urology job planning is complete, however there have been recent departures from the team and the capacity plan is being revisited.
- Urology and Colorectal have taken part in the 100 Days Matter national pathway improvement challenge (please see the Cancer report); colorectal is repeating the 100-day challenge to gain more traction on identified parts of the pathway that cause delays.
- Self-referral services are being rolled out for patients with symptoms of cancer, to encourage patients to come forward sooner to get checked out; this will also help to smooth demand.
- Please also see the Elective Care report for details of endoscopy capacity improvements.

Line Chart



How do we compare

National average performance for providers was 68.6% in February 2026, the latest data available. Our performance was 73.1%. We ranked 64 out of 146 providers.

Although the national standard remains 85%, the operating plan guidance for 2024/25 sets the improvement target as 70% for March 2025, rising to 75% by March 2026.

Recent performance

Performance in recent months was as follows:

62-day GP cancer performance

Area	Sep	Oct	Nov	Dec	Jan	Feb
Trajectory	71.7%	71.7%	72.6%	72.3%	70.3%	75.5%
Compliance	70.4%	69.6%	76.5%	76.4%	73.7%	73.1%

Responsive

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

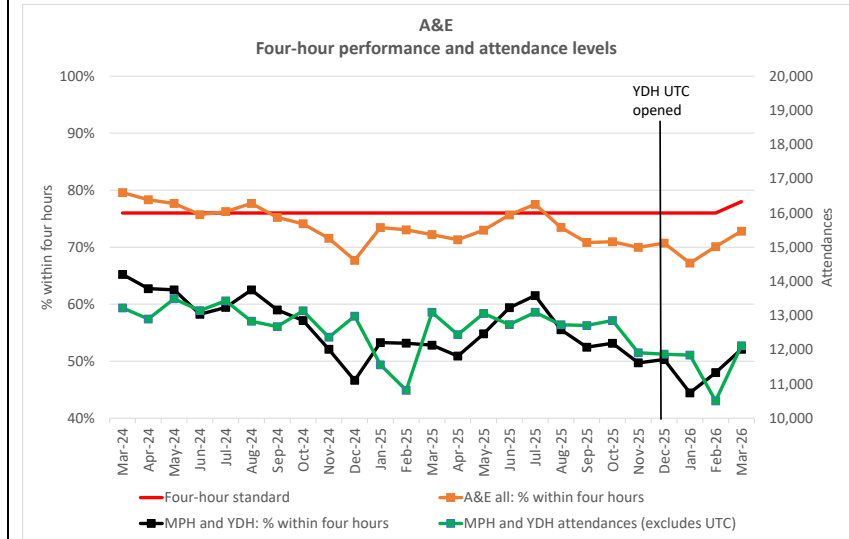
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 52.1% during March 2026, up from 48.0% in February 2026. With Urgent Treatment Centres (UTCs) compliance included at 96.9%, overall compliance was 72.8%, the highest level since August 2025, but below the 78% national standard to be achieved in March 2026.
- Compliance in respect of our two A&E departments was:
 - Musgrove Park Hospital (MPH): 49.9%.
 - Yeovil District Hospital (YDH): 55.5%.
- At YDH the UTC became operational from 11 November 2025. In March 2026, 1,632 out of 1,703 patients (95.8%) were discharged, admitted or transferred with four hours.
- Between 1 April 2025 and 31 March 2026, 96.7% of patients spent less than 12 hours in the departments, below the 97.3% for the 12 months ending 31 March 2025.

Focus of improvement work

- Both**
 - Review of administration job description for progress chasers to bring alignment, allowing sharing and learning.
 - Discussion with pathology to implement point of care testing for patients needing contrast, allowing quicker time to scan and increased patient safety.
- MPH:**
 - The Redirection and Deflection pilot seems to be making a successful start.
 - The focus has been on ambulatory majors, ensuring quick decisions are made and any delays are being escalated at the earliest opportunity.
 - Progress Chasers are following up on all decisions as well as bed allocations comments being updated regularly on MAXIMS.
 - Weekly UTC development conversations are ongoing.
- YDH:**
 - The Frailty at the Front Door initiative is now active, providing benefits that help reduce hospital admissions for our frail patient population.
 - Trust fellow recruitment is progressing, with expected start dates in June 2026.
 - There is an ongoing focus on improving diagnostic waiting times within the department.
 - Streaming/redirection at the front door is seeing more patients going through the UTC.

Line Chart



How do we compare

In March 2026, the national average performance for Trusts with a major Emergency Department was 64.1%. Our performance was 52.1%. We were ranked 106 out of 121 trusts. With Urgent Treatment Centre attendances included, we were ranked 75 with performance of 72.8%. National average performance was 75.0%.

Recent performance

Area	Oct	Nov	Dec	Jan	Feb	Mar
A&E only	53.1%	49.7%	50.3%	44.5%	48.0%	52.1%
Including UTC	71.0%	70.0%	70.7%	67.2%	70.1%	72.8%

Length of Responsive

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

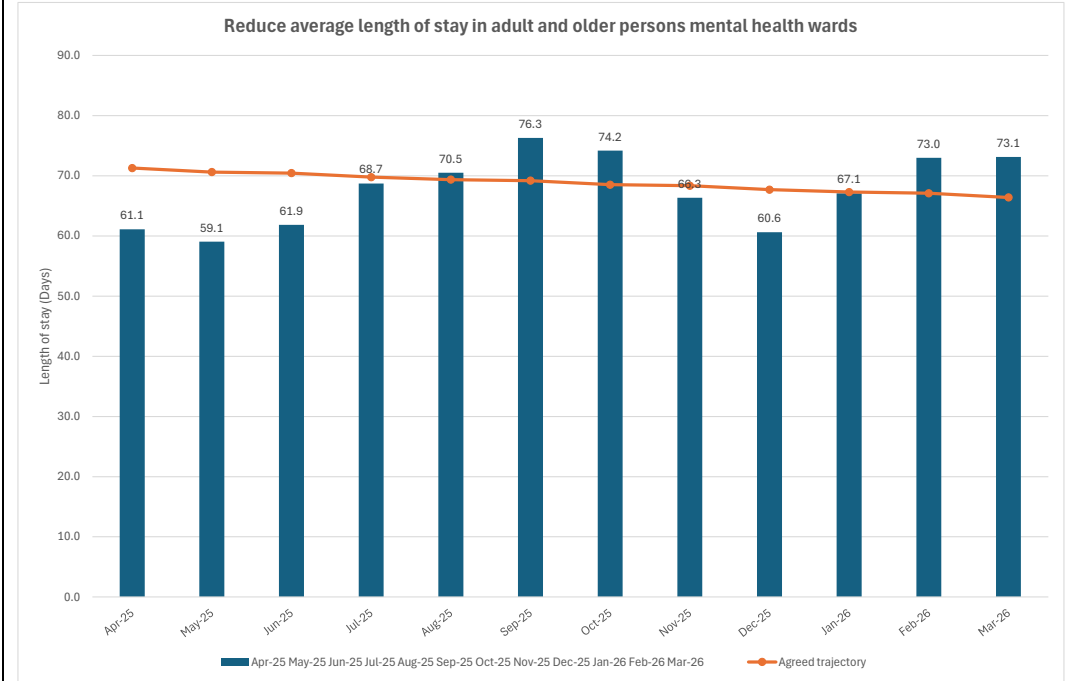
Current performance (including factors affecting this)

- As at 31 March 2026 the rolling three-month average length of stay within our adult mental health wards was 73.1 days, above the trajectory agreed with the Somerset Integrated Care Board to reduce our average length of stay from a baseline level of 71.7 days for the three months ending 30 November 2024, to an average of 66.4 days for the three months ending 31 March 2026.
- The increase was due mainly to the discharge during February 2026 of nine patients from our Older Persons wards with lengths of stay totalling 1,257 days, compared to 753 days in respect of patients discharged from the same setting during January 2026.
- During March 2026 a total of 33 patients were discharged from both adult and older persons wards with lengths of stays totalling 1,959 which is an average of 59.4 days per patient, significantly below the 66.4 day March 2026 three-month target.

Focus of improvement work

- Work continues with the ICB and Social Care to improve the allocation of Social Workers and ensure key activities are completed to support discharge in a timely manner. A meeting between senior leaders of both SFT and Social Care has now taken place.
- Mental Health Local Improvement Network investment has supported the development of an inpatient dashboard to provide greater overview of patient admissions and timescales. This is now active and is starting to be used within the service.
- Learning from South West London and St George's Mental Health NHS Trust in reducing length of stay is being taken forward to include more senior clinical oversight, when admissions reach trigger points.
- Clinically Ready for Discharge (CRFD) meetings are being refocused to consider all patients requiring social care input, rather than just those identified as CRFD.

Line Chart



How do we compare

The average length of stay in the three months to 31 March 2026 increased, when compared to the three months to 28 February 2026.

Performance over the last six months

Area	Oct	Nov	Dec	Jan	Feb	Mar
Average length of stay	74.2	66.3	60.6	67.1	73.0	73.1
Operational plan	68.5	68.4	67.7	67.3	67.1	66.4

SOMERSET NHS FOUNDATION TRUST

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

No.	Priority	Success Measure	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance
NP1	Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline	1,2	64.3%	65.3%	65.8%	63.9%	62.2%	62.5%	62.5%	62.3%	62.4%	61.8%	63.1%	65.4%	Per the planning trajectory, culminating in 67.3% in March 2026.		
NP2		Improve the percentage of patients waiting longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline	1,2	74.7%	75.4%	74.1%	72.3%	68.2%	70.6%	70.3%	70.7%	70.3%	70.2%	72.4%	73.9%	Per the planning trajectory, culminating in 80.3% in March 2026.		
NP3		Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	1,2	2.5%	2.8%	2.8%	3.0%	3.2%	3.0%	2.7%	2.3%	2.4%	2.2%	2.1%	2.0%	Per the planning trajectory, culminating in 1.5% in March 2026.		
NP4	Improve performance against the headline 62-day cancer standard to 75% by March 2026	Improve performance against the headline 62-day cancer standard to 75% by March 2026	1,2	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	From April 2025 at or above trajectory =Green >=70% =Green <70% =Red		
NP5		Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	1,2	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	From April 2025 at or above trajectory =Green >=77% =Amber <77% =Red		
NP6	Improve A&E waiting times	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026: Trust-wide performance	2	71.3%	73.0%	75.7%	77.5%	73.5%	70.8%	71.0%	70.0%	70.7%	67.2%	70.1%	72.8%	From April 2025 >=76% = Green >=66% - <76% =Amber <66% =Red (the standard rose to 78% in March 2026, and will increase to 82% in March 2027)		
NP7		Improve A&E waiting times, with a higher proportion of patients admitted, discharged or transferred from ED and UTCs within 12 hours across 2025/26 compared to 2024/25 - Trust-wide performance	2	95.9%	96.5%	97.1%	97.4%	97.5%	97.4%	97.2%	97.2%	97.1%	96.8%	96.7%	96.7%	From April 2025 >=97.3% = Green <97.3% = Red		
NP8	Improve mental health and learning disability care	Reduce average length of stay in adult acute and older persons mental health beds	2,6	61.1	59.1	61.9	68.7	70.5	76.3	74.2	66.3	60.6	67.1	73.0	73.1	From April 2025 at or below trajectory = Green above trajectory = Red		
NP9		Live within the budget allocated, reducing waste and improving productivity	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	6	-40.8% £1,827K	-40.7% £3,489K	-37.0% £5,098K	-35.5% £6,747K	-36.8% £8,247K	-35.8% £9,731K	-38.2% £11,040K	-39.2% £12,341K	-38.6% £13,798K	-38.5% £15,185K	-35.4% £17,293K	-36.8% £18,270K	>=30% reduction= Green >=25% - <30% reduction =Amber <25% reduction =Red	
NP10	Maintain focus on quality and safety of services	Close the activity / WTE gap against pre-Covid levels (adjusted for case mix)	6	Included in the Productivity report.											To be confirmed.			
NP11		Improve safety in maternity and neonatal services, delivering the key actions of the 'Three year delivery plan'	1,2	Progress reported via regular updates to our Quality and Governance Assurance Committee.											To be confirmed.			

Sector-Based Performance Summaries

NARRATIVE REPORT

NEIGHBOURHOODS AND COMMUNITY SERVICES

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

Achievements

- The phased temporary closure of beds at Burnham on Sea and Crewkerne community hospitals for the test and learn commenced on 1 April 2026, with both units down to eight-bedded units by 24 April 2026.
- The service group received the most Our Somerset Colleague Award (OSCA) nominations per headcount across the clinical service groups.
- The service group is compliant with 100% of consultant and SAS job plans, signed off on the system in March 2026.
- The service group hit the financial plan at the year end.

Challenges

- Hospital at Home: In March 2026 the team accepted a total of 251 referrals, around half of our plan for the month of 488. The respiratory team are able to continue with full caseloads, but the frailty H@H team are down to 33% of expected capacity with an average caseload of 77 across both sub-specialties.
- Concerns have been flagged about the how consistent clinical triage is within the community UTCs. Between registered nurses and ENPs a rapid review of patient experience is underway.
- There has been a deterioration of the Podiatry waiting times as staffing pressures return.

Actions to Address Underperformance:

- External recruitment for Hospital at Home continues with an advert current out for eight consultant sessions. A trajectory for increases to the frailty caseload is currently in the design phase as colleagues join the team.
- The Deputy Chief Nurse and service group Associate Director of Patient Care (ADPC) are currently assessing each UTC, staffing resilience and options to boost the triage of patients within the agreed standard.

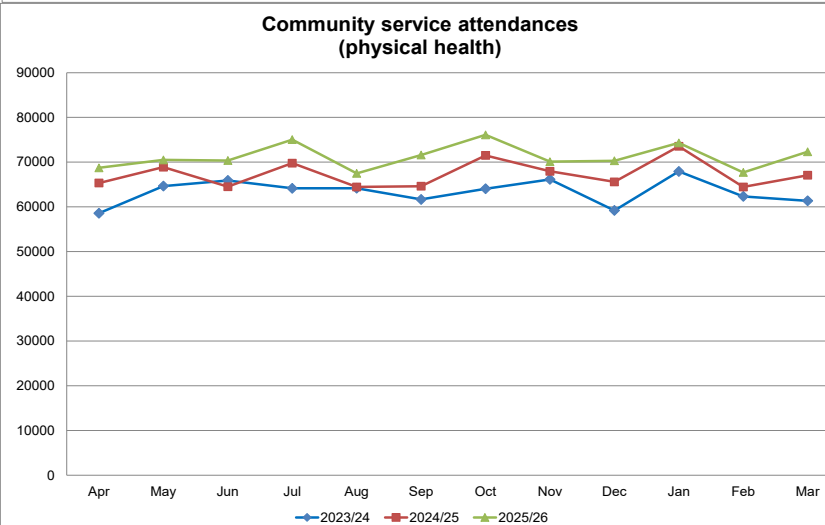
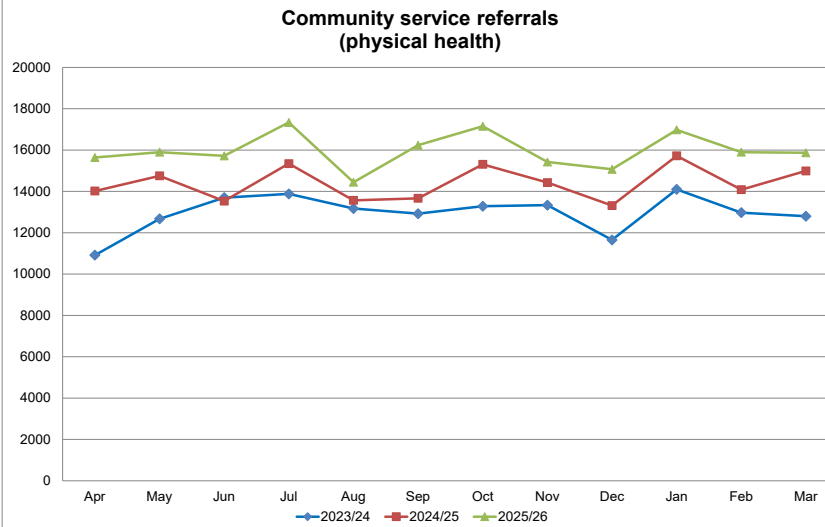
- The podiatry team are looking to appoint more Band 5 staff and expand their successful apprentice scheme. They are also looking to appoint a substantive consultant podiatric surgeon following a successful trial of the clinical model over the last 18 months.

SOMERSET NHS FOUNDATION TRUST
NEIGHBOURHOODS AND COMMUNITY SERVICES

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance	
NC1	Mental health referrals offered first appointments within 6 weeks	Older Persons mental health services	ICB	1,2,3	97.5%	98.0%	100.0%	96.8%	97.2%	99.0%	97.9%	95.8%	97.1%	95.7%	94.5%	90.7%	>=90%= Green >=80% - <90% =Amber <80% =Red		
NC2	Community service waiting times: number of people waiting over 18 weeks from referral to first appointment (excluding dental)	Numbers waiting	SFT	1,2,3	538	536	472	405	473	465	663	760	749	810	1,255	1,593	From April 2026 =<22% of the total waiting list = Green >22% of the total waiting list = Red		
NC3		% waiting under 18 weeks	NOF	1,2,3	94.7%	95.1%	95.6%	96.4%	95.8%	95.7%	94.3%	93.9%	93.9%	95.8%	90.8%	89.1%	From April 2026 >78% = Green <78% = Red		
NC4	Community service waiting times: number of people waiting over 52 weeks from referral to first appointment (excluding dental)	PAF	1,2,3	2	1	1	0	0	0	0	0	0	0	0	0	0	From April 2025 0 = Green >0 = Red		
NC5	Community service waiting times: percentage of people waiting over 52 weeks from referral to first appointment (excluding dental)	PAF	1,2,3	0.02%	0.01%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%			
NC6	Intermediate Care - Patients all ages discharged home from acute hospital beds on pathway 0 or 1	HDS	1,2,3	95.5%	94.9%	94.9%	94.5%	95.3%	95.3%	93.8%	95.2%	95.0%	94.1%	94.3%	94.3%		>=95%= Green >=85% - <95% =Amber <85% =Red		
NC7	Urgent Community Response: percentage of patients seen within two hours	NHSC	1,2,3	91.9%	93.0%	92.6%	93.5%	92.0%	92.7%	91.2%	93.9%	91.9%	91.6%	93.4%	Data not yet due		>=70%= Green >=60% - <70% =Amber <60% =Red		
NC8	Hospital at Home - Caseload Size	VWOF	1,2,3	92	77	77	74	85	100	107	98	99	100	89	77		>167 = Green >134 - <167 =Amber <134 =Red		
NC9	Hospital at Home - Admissions	VWOF	1,2,3	266	258	242	289	288	308	364	304	313	342	254	251		>419 = Green >377 - <419 =Amber <377 =Red		
NC10	Total number of patient falls - community hospitals	NHSC	2	27	37	29	39	38	27	27	36	28	29	30	34		Monitored using Statistical Process Control rules. Report by exception.		
NC11	Rate of falls per 1,000 occupied bed days - community hospitals	NHSC	2	4.94	6.65	5.52	7.32	7.62	5.99	5.78	8.06	6.29	6.16	7.16	7.28		Monitored using Statistical Process Control rules. Report by exception.		
NC12	Community hospitals - number of pressure ulcers	NHSC	2	11	4	1	4	7	5	5	5	11	12	3	Data not yet due		Monitored using Statistical Process Control rules. Report by exception.		
NC13	Rate of pressure ulcer damage per 1,000 occupied bed days	NHSC	2	2.01	0.54	0.19	0.75	1.40	1.11	1.07	1.12	2.47	2.55	0.72	Data not yet due		Monitored using Statistical Process Control rules. Report by exception.		
NC14	District nursing - number of pressure ulcers	NHSC	2	75	69	56	59	72	66	77	74	64	99	91	Data not yet due		Monitored using Statistical Process Control rules. Report by exception.		
NC15	Rate of pressure ulcer damage per 1,000 district nursing contacts	NHSC	2	2.36	2.11	1.72	1.78	2.32	2.08	2.37	2.32	2.00	3.05	2.98	Data not yet due		Monitored using Statistical Process Control rules. Report by exception.		
NC16	Total number of medication incidents in a community setting	NHSC	2	31	21	36	26	27	44	34	34	29	26	21	29		Monitored using Statistical Process Control rules. Report by exception.		

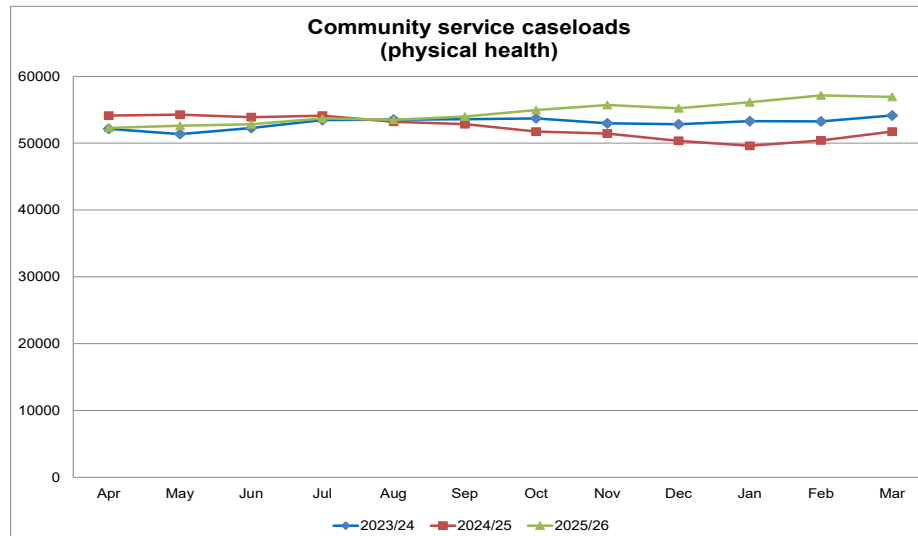
Operational context

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



Summary:

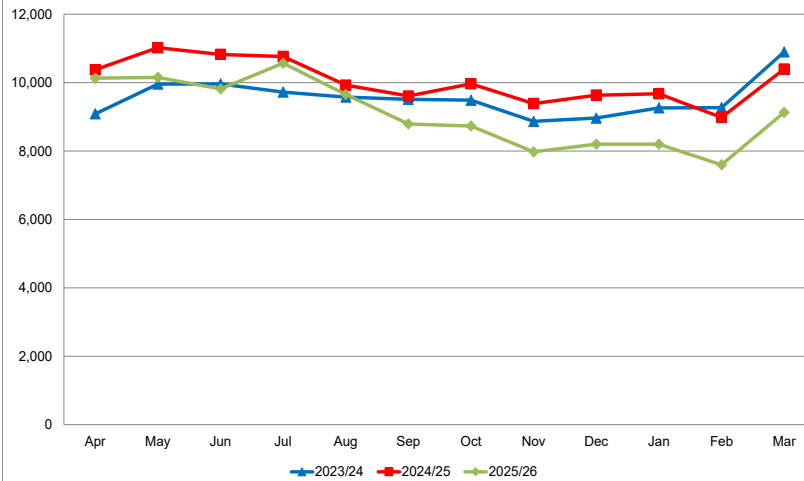
- Direct referrals to our community physical health services between 1 April 2025 and 31 March 2026 were 11.0% higher than the same months of 2024/25 and 23.3% higher than the same months of 2023/24. Services with the highest increases include Rapid Response, Diabetes Integrated Care and District Nursing.
- Attendances for the same reporting period were 5.8% higher the same months of 2024 and 12.4% higher than the same months of 2023.
- Community service caseload levels as at 31 March 2026 were 10.1% higher than as at 31 March 2025, and 5.1% higher than as at 31 March 2024.



Operational context

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

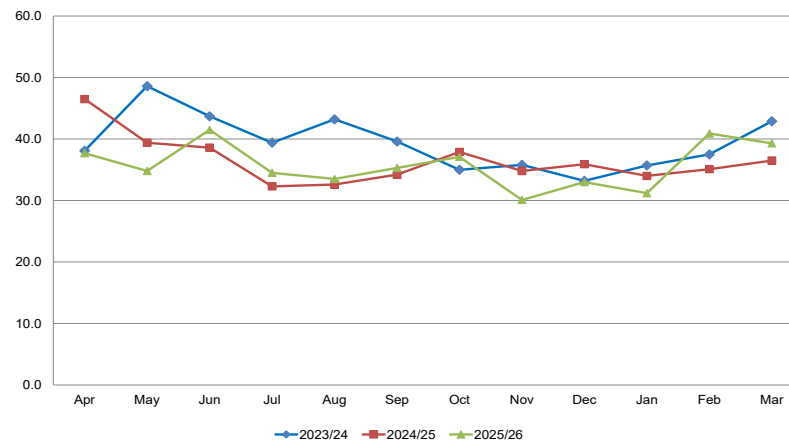
Urgent Treatment Centre attendances



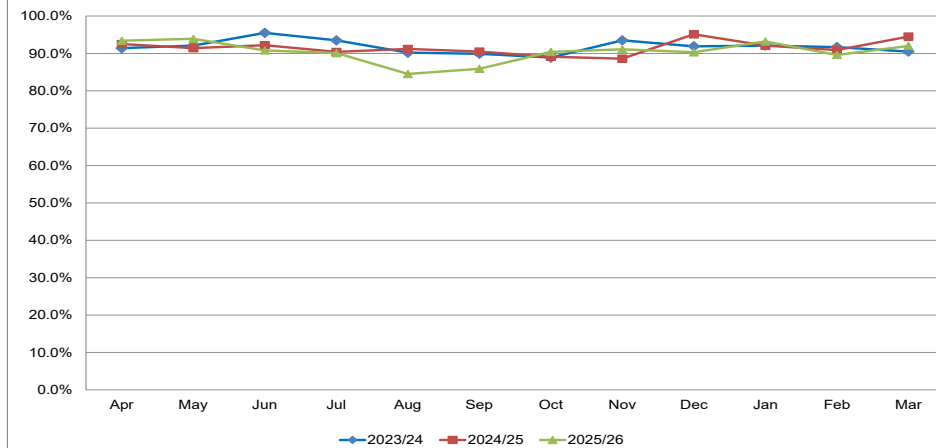
Summary:

- Between 1 April 2025 and 31 March 2026, the number of Urgent Treatment Centre (UTC) attendances (excluding the YDH UTC) was 9.6% lower than the same months of 2024/25 and 4.9% lower than the same months of 2023/24. During March 2026, 97.1% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 76%.
- The average length of stay for non-stroke patients in our community hospitals in March 2026 was 39.3 days; a decrease compared to February 2026. During March 2026 three discharged patients had a length of stay of 100 days or more. The rolling 12-month average length of stay in respect of non-stroke patients as at 31 March 2026 was 35.7 days, compared to 36.5 days for the 12-month period ending 31 March 2025.
- The community hospital bed occupancy rate for non-stroke patients in March 2026 increased to 92.0%, from 89.6% in February 2026.

Community Hospital - average length of stay (days, excluding stroke beds)



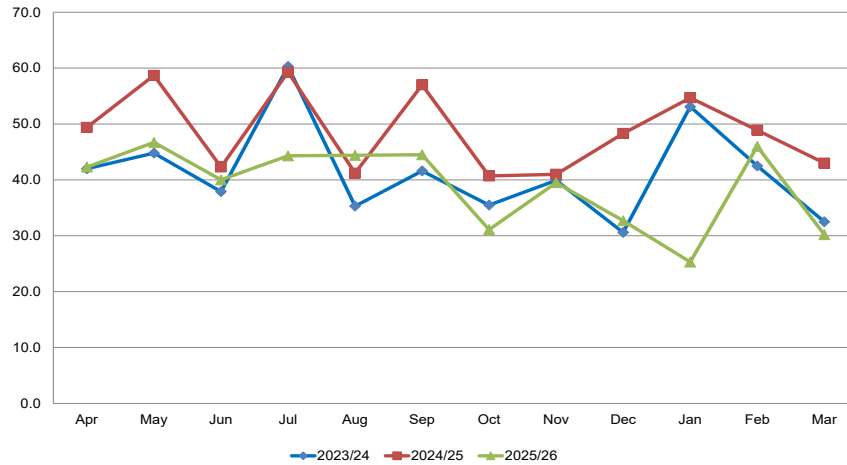
Community Hospital - average bed occupancy (excluding stroke beds)



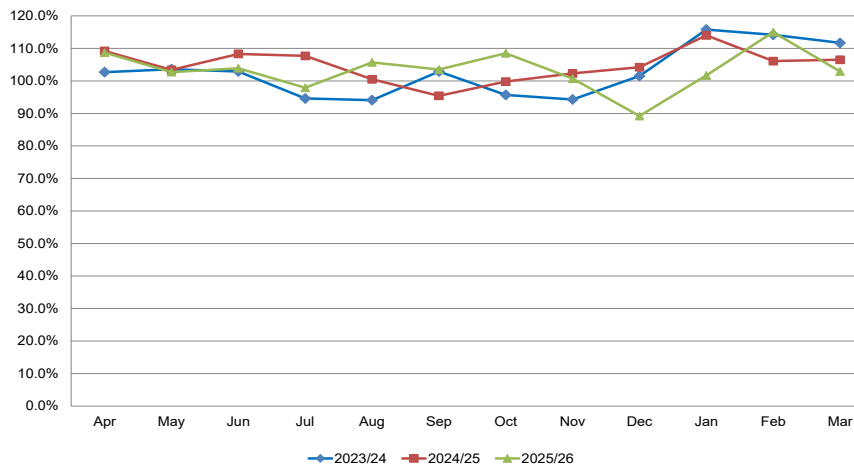
Operational context

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

Community Hospital Stroke Beds - average length of stay (days)



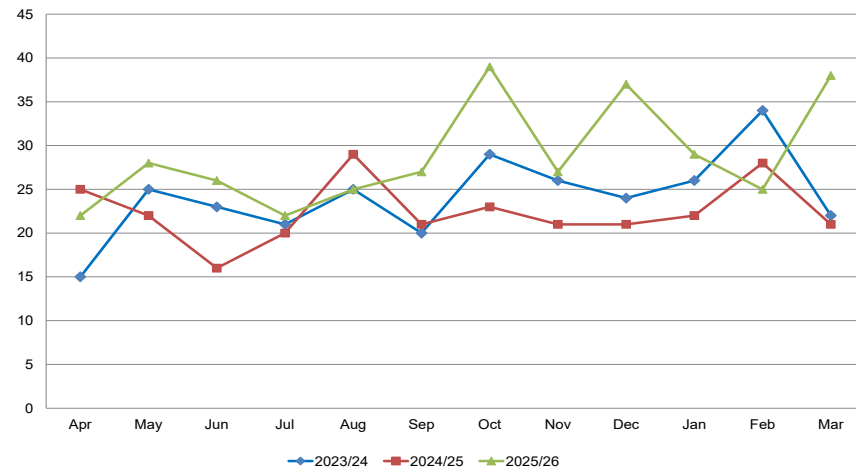
Community Hospital Stroke Beds - average bed occupancy



Summary:

- The average length of stay for stroke patients in our community hospitals in March 2026 significantly decreased to 30.2 days, from 46.0 days in February 2026. One patient discharged had a length of stay of 100 days or more. The rolling 12-month average length of stay in respect of stroke patients for the period ending 31 March 2026 was 38.0 days, compared to 48.6 days for the 12-month period ending 31 March 2025.
- Stroke bed occupancy in March 2026 decreased compared to February 2026.
- During March 2026 there were 38 discharges of stroke patients, compared to 25 during February 2026.

Community Hospital Stroke Beds - number of discharges during month



NARRATIVE REPORT
SYMPHONY HEALTHCARE SERVICES

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

What is Going Well

- **Finance 2025/26**

The financial budget for 2025/26 and the Cost Improvement Programme were achieved.

- **Quality and Outcomes Framework (QOF) (S5)**

While the outcome was 1% below our internal target, the 2025/26 QOF requirements were especially challenging, particularly for childhood immunisations, amid increasing parental hesitancy. Achieving 93.9% is therefore a result we are proud to celebrate as an organisation.

- **Average time for calls (S7)**

Average call-waiting times reduced by around 20% in March 2026, demonstrating the positive impact of the work under way in the contact hubs to improve responsiveness.

What Requires Improvement and Planned Actions

- **Dementia Diagnosis Rates (S1)**

Symphony are collaborating with the Complex Care team on a bid as part of a national incentive to improve diagnosis rates.

- **Hypertension treatment (S2):**

The score improved and was just under the national requirement. This is a national issue with this QOF indicator. For 2026/27 patients have been worked up better, to be in an improved place to achieve the target this year. As stated previously, this target requires demonstrable improvements in patient outcomes and active patient engagement.

- **GP Vacancy (S4)**

The rate has reduced although we remain mindful of the impact of organisational change on turnover rates particularly, in practices where mergers are occurring.

- **Document Backlog:**

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

Other updates

- **Symphony South**

We remain on track to bring together Symphony South, commencing in June 2026 and finalising by 7 July 2026. We remain confident that the property issue will be resolved.

- **Neighbourhoods**

The Diabetes pathway was reviewed in an away day with multiple stakeholders, with an agreement on a cohort of patients to focus on to measure impact.

SOMERSET NHS FOUNDATION TRUST

SYMPHONY HEALTHCARE SERVICES

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance
S1	Dementia diagnosis rates for patients aged 65 years plus	OPG	1,3,4	52.5%	53.1%	54.0%	53.8%	54.1%	54.1%	54.6%	54.2%	54.1%	53.8%	53.6%	Data awaited	>=66.7%= Green >=61.7% - <66.7% =Amber <61.7% =Red		
S2	Increase the % of patients with hypertension treated according to NICE guidance	OPG	1,2,3	70.0%	72.0%	73.5%	73.3%	72.4%	73.1%	72.3%	72.7%	74.4%	75.2%	77.8%	82.8%	Profiled target: 85% by year end		
S3	Increase the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance	OPG	1,2,3	65.0%	65.0%	55.0%	65.0%	61.0%	61.0%	62.3%	63.1%	63.9%	65.0%	67.0%	68.1%	>=50%= Green >=40% - <50% =Amber <40% =Red. Target to be achieved by year end		
S4	GP Vacancy rate	SHS	6	3.5%	6.8%	4.0%	2.4%	3.5%	5.6%	5.0%	6.0%	7.5%	9.4%	9.5%	6.0%	=<5%= Green >5% - <10% =Amber >10% =Red		
S5	Percentage of total Quality and Outcomes Framework (QOF) points	SHS	1,2,3	75.0%	75.0%	75.0%	75.3%	76.4%	77.4%	78.9%	81.5%	83.7%	86.8%	90.6%	93.9%	Profiled target: 95% by year end		
S6	Patient satisfaction rate	SHS	2,3	92.1%	91.8%	89.7%	92.1%	90.4%	91.1%	93.8%	90.8%	92.7%	92.4%	91.3%	90.9%	>=85%= Green >=75% - <85% =Amber <75% =Red		
S7	Average time for calls in the queue	SHS	2,3	05:20	05:52	05:23	04:45	05:12	06:58	07:36	07:30	07:15	07:27	06:57	05:23	=<4 minutes = Green >4 minutes - =<6 minutes = Amber >6 minutes = Red		
S8	Ask My GP/Klinik/AccuRX/Anima – percentage of requests raised online	SHS	2,3	52.5%	52.9%	52.9%	52.0%	51.7%	52.2%	53.6%	53.2%	52.6%	52.8%	52.1%	51.2%	>=50%= Green >=40% - <50% =Amber <40% =Red		
S9	Seen within two weeks of request (acute team only)	SHS		83.6%	86.8%	87.3%	88.1%	88.1%	89.1%	82.8%	87.0%	90.3%	88.6%	88.6%	87.3%	>=90%= Green >=80% - <90% =Amber <80% =Red		

NARRATIVE REPORT

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

The key points of note in respect of Mental Health and Learning Disabilities services, in March 2026, are as follows:

What is going well

The mental health and learning disabilities dashboard remains positive, maintaining good performance across most measures, including national priority areas.

All community mental health and community learning disabilities services continue to exceed their targets for access to services. The percentage of people beginning treatment with our Early Intervention in Psychosis service with a NICE-recommended care package within two weeks of referral was 100% in March 2026, significantly above the 60% national standard. The number of women accessing our specialist community Perinatal mental health service continues to exceed the planned level.

Inpatient follow-up within 72 hours of discharge and within two days of discharge remains well above the compliance standards.

Talking Therapies compliance against the six-week waiting times standard fell back below the 75% national standard in February 2026 and so remained during March 2026. This dip in performance is mainly due to the reduction in activity over the Christmas and New Year period. It is expected that compliance will be restored once the April 2026 figures are available. During March 2026, the service again exceeded the national standards for 18-week waiting times, and people moving to recovery, reliable recovery, and reliable improvement.

Staffing metrics continue to demonstrate good performance, and an improving trajectory. Appraisal rates have increased again to 87.9%. For Safeguarding training, the service group is maintaining the Safeguarding Adults Level 3 training target at 90.9%, and Safeguarding Children Level 3 training is at 86.8% with all staff who are currently out of date having a future booking to renew.

What is going less well

Bed demand and flow have continued to be challenging, with high numbers of patients awaiting social care input, which has been escalated within the Local Authority. Local Authority feedback is that all Social Work posts are now recruited to, so it is expected that this

will improve the bed flow position as outstanding work, such as Care Act assessments is completed. The bed flow position is further exacerbated by the temporary reduction of three acute beds whilst the Rydon environmental improvement works are being undertaken, with completion expected in mid-May 2026. There has continued to be a need to use inappropriate Out of Area or Out of Trust admissions, with four people placed out of area at the month end.

The percentage of patients identified as clinically ready for discharge (CRFD) has decreased in month due to some patients with long lengths of stay being discharged. However this impacted on the average length of stay indicator, which increased in March 2026 and was higher than our target trajectory, mainly due to the discharge of patients with lengths of stay >100 days in February and March. Flow out of our older adult wards in particular remains challenging and affects the wider Trust, with patients requiring ongoing admittance to the acute hospitals whilst awaiting a mental health bed.

Focus of improvement work

Inpatient services

- Work continues with the ICB and Social Care to improve the allocation of Social Workers and ensure key activities are completed to support discharge in a timely manner.
- Mental Health Local Improvement Network investment is supporting the development of an inpatient dashboard to support the better overview of patient admissions and timescales, to support improved decision making and escalation.
- Learning from South West London and St George's Mental Health NHS Trust in reducing length of stay is being taken forward to include more senior clinical oversight, when admissions reach trigger points.
- Clinically Ready for Discharge (CRFD) meetings are being refocused to consider all patients requiring social care input, rather than just those identified as CRFD.































Community Services

Pre-engagement work has been taking place for the start of the community mental health services transformation project, particularly with Lived Experience Partners, medical colleagues and two locality teams, which has been received well. Formal workshops are set up for Lived Experience Partners in April and May 2026, with staff engagement events in June 2026. The aims are to improve multi-disciplinary functioning within the service, streamline processes to improve productivity including clarification of clinical recording processes, and consider the overall model with Open Mental Health and Neighbourhood working.







SOMERSET NHS FOUNDATION TRUST
MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance
MH1	Mental health referrals offered first appointments within 6 weeks	Adult mental health services	ICB 1,2,3	94.0%	92.6%	92.1%	97.1%	98.2%	91.9%	92.2%	93.8%	92.0%	90.7%	97.4%	94.6%	>=90%= Green >=80% - <90% =Amber <80% =Red		
MH2		Learning disabilities service		ICB	100.0%	100.0%	100.0%	100.0%	100.0%	-	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0% 80.0% 60.0%
MH3	Percentage of women accessing specialist community Perinatal Mental Health service - 12 month rolling reporting	LTP	1,2	689	690	657	655	642	658	658	653	668	702	726	Data not yet due	>=640 = Green <640 = Red		
MH4	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)	NHSC	1,2,3	80.0%	75.0%	83.3%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>=60%= Green <60% =Red		
MH5	Talking Therapies RTT : percentage of people waiting under 6 weeks	NHSC	1,2,3	66.0%	58.8%	60.3%	63.6%	64.3%	73.1%	73.7%	73.1%	74.1%	77.7%	71.2%	70.5%	>=75%= Green <75% =Red		
MH6	Talking Therapies RTT: percentage of people waiting under 18 weeks	NHSC	1,2,3	98.7%	98.6%	100.0%	99.3%	99.2%	99.2%	99.3%	99.1%	99.2%	100.0%	99.3%	99.2%	>=95%= Green <95% =Red		
MH7	Talking Therapies (formerly Improving Access to Psychological Therapies [IAPT]) Recovery Rates	NHSC	1,2,3	55.5%	57.8%	56.9%	50.4%	53.1%	51.3%	49.2%	54.6%	50.9%	53.2%	49.9%	51.5%	>=50%= Green <50% =Red		
MH8	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Improvement	NHSC	1,2,3	72.7%	76.1%	74.2%	70.0%	74.3%	70.8%	70.9%	74.1%	69.6%	76.4%	71.9%	69.7%	>=67%= Green <67% =Red 61% from April 2026		
MH9	Talking Therapies: Completing a course of treatment for anxiety and depression achieving Reliable Recovery	NOF, NHSC	1,2,3	50.9%	56.7%	52.1%	47.4%	49.1%	48.3%	45.7%	50.7%	46.6%	50.4%	47.8%	48.5%	>=48%= Green <48% =Red 51% from April 2026		
MH10	Adult mental health inpatients receiving a follow up within 72 hours of discharge	NHSC	1,2	96.7%	96.2%	94.9%	100.0%	94.3%	100.0%	97.1%	100.0%	97.7%	96.6%	97.5%	93.3%	>=80%= Green <80% =Red		
MH11	Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end	LTP	1,2	2	2	4	3	3	2	1	0	0	3	4	4	1= Green >1 = Red		
MH12	Percentage of adult inpatients discharged with a length of stay exceeding 60 days	NOF, PAF	2,3	27.1%	25.5%	30.2%	32.6%	34.8%	36.2%	33.3%	25.8%	25.0%	30.6%	33.7%	27.3%	To be confirmed		
MH13	Percentage of inpatients referred to stop smoking services	PAF	1,2	The topic lead is working with our Data Analytics team to investigate some identified data anomalies, and resolution is awaited.												To be confirmed		
MH14	Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours	NOF, PAF	1,2,3	92.3%	90.8%	91.3%	90.2%	90.1%	91.2%	91.2%	91.0%	90.6%	91.1%	90.8%	91.2%	>=90%= Green >=80% - <90% =Amber <80% =Red		
MH15	Number of people accessing community mental health services with serious mental illness - rolling 12 month number.	NOF, PAF	1,2,3,4	9,805	9,744	9,977	10,113	10,141	10,143	10,255	10,202	10,227	10,276	10,349	10,439	No stated target		

SOMERSET NHS FOUNDATION TRUST
MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

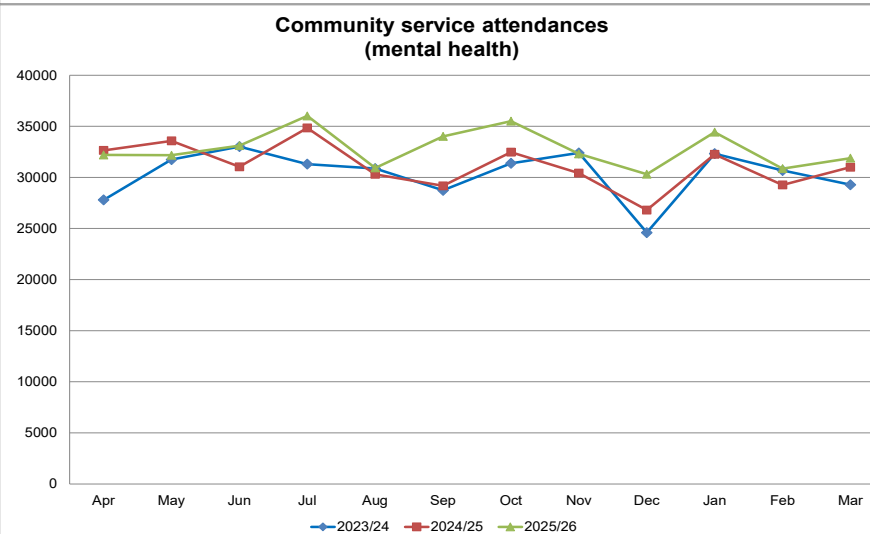
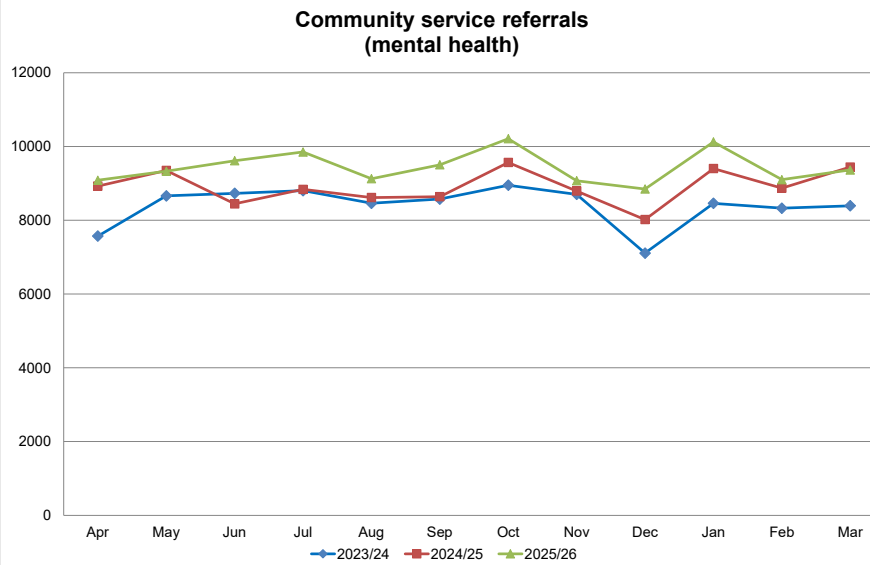
No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance
MH16	Number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission	PAF	2,3	1	0	1	1	2	1	2	0	1	0	0	2	No stated target		
MH17	Percentage of people with suspected autism awaiting contact for over 13 weeks (aged 18 or over)	NOF, PAF	2,3,4	97.0%	98.7%	98.0%	99.0%	98.2%	97.6%	97.6%	97.1%	97.0%	97.7%	97.4%	97.7%	To be confirmed		
MH18	Percentage of adults over the age of 65 with a length of stay beyond 90 days at discharge (Older Person wards only)	NOF, PAF	2,3	50.0%	52.0%	50.0%	44.0%	34.6%	37.0%	41.4%	39.3%	28.0%	21.4%	54.5%	66.7%	To be confirmed		
MH19	Total number of patient falls - mental health inpatient wards	NHSC	2	13	3	7	11	11	6	17	24	12	17	9	15	Monitored using Statistical Process Control rules. Report by exception.		
MH20	Rate of falls per 1,000 occupied bed days	NHSC	2	3.9	0.9	2.1	3.2	3.1	1.9	5.1	7.3	3.7	5.2	3.0	4.5	Monitored using Statistical Process Control rules. Report by exception.		
MH21	Restrictive Interventions - total number of incidents	NOF, NHSC	2	114	72	155	108	43	70	48	58	25	32	44	34	Monitored using Statistical Process Control rules. Report by exception.		
MH22	Restrictive Interventions per 1,000 occupied bed days	NHSC	2	34.3	20.9	45.7	31.2	12.3	21.8	14.4	17.6	7.8	9.0	14.8	10.3	Monitored using Statistical Process Control rules. Report by exception.		
MH23	Number of prone restraints	NHSC	2	15	9	3	5	3	2	11	15	3	10	6	8	Monitored using Statistical Process Control rules. Report by exception.		
MH24	Prone restraints per 1,000 occupied bed days	NHSC	2	4.5	2.6	0.9	1.4	0.9	0.6	3.3	4.5	0.9	2.8	2.0	2.4	Monitored using Statistical Process Control rules. Report by exception.		
MH25	Total number of medication incidents in a mental health setting	NHSC	2	11	13	18	16	21	15	3	8	10	11	13	9	Monitored using Statistical Process Control rules. Report by exception.		
MH26	Ligatures: Total number of incidents	NHSC	2	130	192	126	89	133	54	15	10	15	7	15	5	Monitored using Statistical Process Control rules. Report by exception.		
MH27	Number of ligature point incidents	NHSC	2	0	0	1	1	0	0	0	0	0	0	2	0	Monitored using Statistical Process Control rules. Report by exception.		
MH28	Violence and Aggression: Number of incidents patient on patient (inpatients only)	NHSC	2	2	2	2	5	8	3	4	2	13	9	1	7	Monitored using Statistical Process Control rules. Report by exception.		
MH29	Violence and Aggression: Number of incidents patient on staff	NHSC	2	23	19	29	31	66	57	32	48	36	31	42	20	Monitored using Statistical Process Control rules. Report by exception.		
MH30	Number of Type 1 -Traditional Seclusion	NHSC	2	20	11	7	9	11	9	22	24	20	21	19	14	Monitored using Statistical Process Control rules. Report by exception.		

SOMERSET NHS FOUNDATION TRUST
MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance
MH31	Number of Type 2 -Short term Segregation	NHSC	2	1	0	1	0	0	1	0	1	2	7	0	1	Monitored using Statistical Process Control rules. Report by exception.		
MH32	Employment Support service - Time to First face to face employer contact (number of days)	NHSC	2	13	13	12	12	11	11	9	11	10	15	11	18	<30 days = Green >30 days =Red		
MH33	Employment Support service - Percentage of clients supported into work (rolling 12 months)	NHSC	2	35.7%	28.7%	28.4%	34.1%	25.8%	29.0%	23.4%	27.8%	25.0%	24.8%	24.7%	25.0%	>=40% = Green >=30% and <40% =Amber <30% =Red		

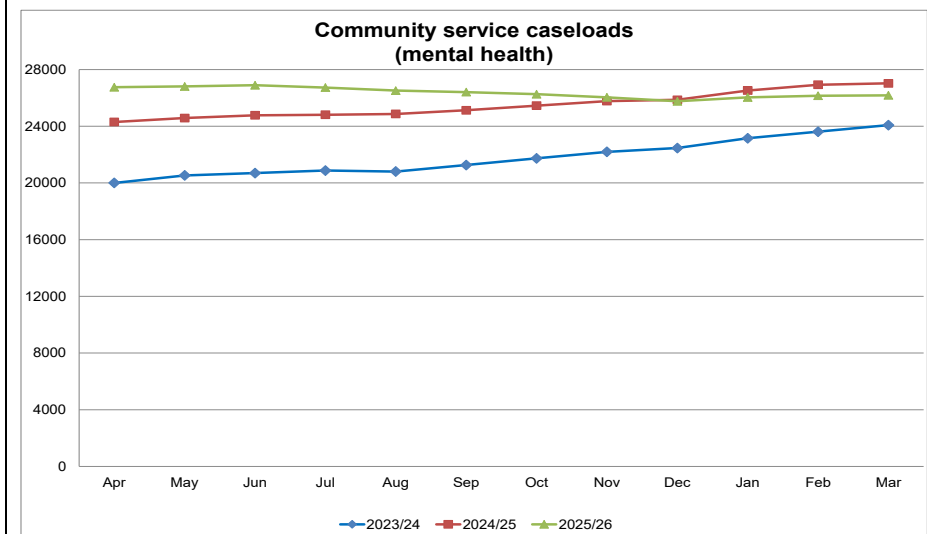
Operational context

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



Summary:

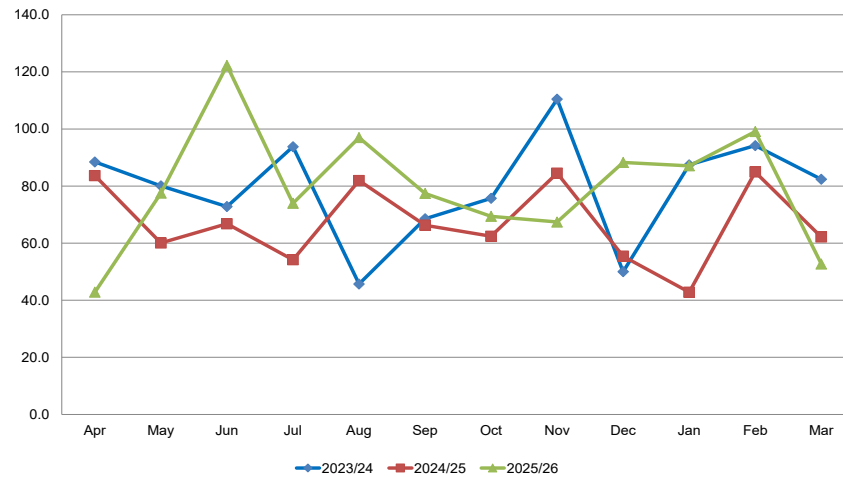
- Direct referrals to our community mental health services between 1 April 2025 and 31 March 2026 were 5.9% higher than the same months of 2024/25 and 12.4% higher than the same months of 2023/24.
- Attendances for the same reporting period were 5.3% higher than the same months of 2024/25 and 8.1% higher than the same months of 2023/24. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services.
- Community mental health service caseloads as at 31 March 2026 3.1% lower than as at 31 March 2025 but were 8.7% higher than as at 31 March 2024. It should be noted that investment has facilitated the expansion of some community mental health services.



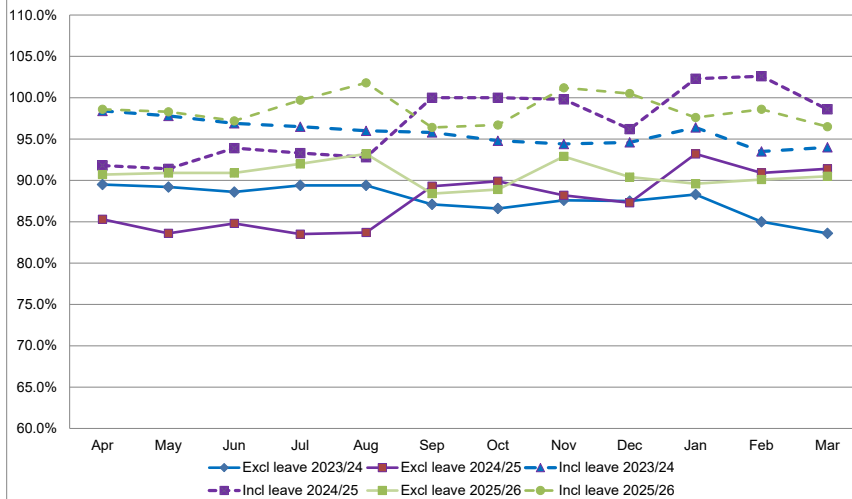
Assurance and Leading Indicators

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

Mental Health wards - average length of stay (days)



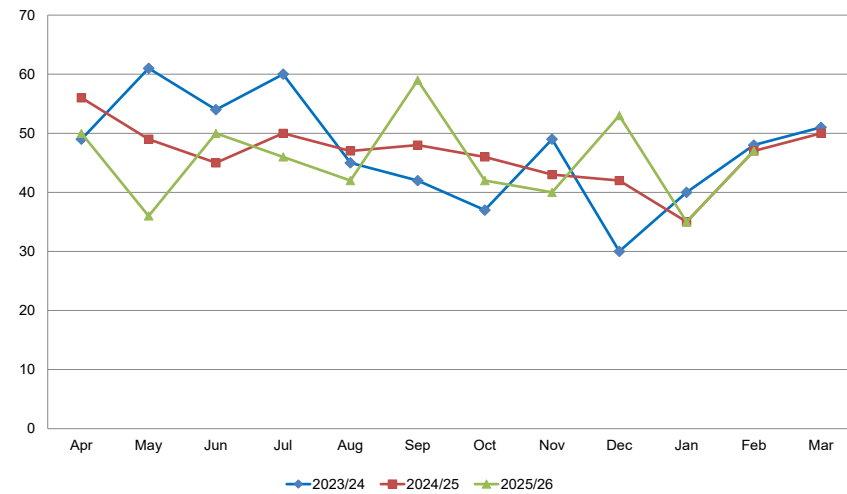
Mental Health wards - average bed occupancy



Summary:

- The average length of stay across all of our mental health wards in March 2026 was 52.7 days, down from 99.1 days in February 2026. During March 2026, four patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Rydon Ward One, one of our adult wards, who had a length of stay of 466 days. The rolling 12-month average length of stay for the period ending 31 March 2026 was 80.2 days, compared to 67.8 days for the 12-month period ending 31 March 2025.
- The mental health bed occupancy rates excluding leave slightly increased but including leave decreased compared to February 2026.
- A total of 33 patients were discharged in March 2026, down from 47 discharged in February 2026.

Mental Health wards - number of discharges during month



NARRATIVE REPORT

URGENT AND EMERGENCY CARE SERVICES

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

Ambulance handovers - In March 2026, ambulance handovers within 30 minutes improved at each site for the second month in a row, rising from 85.3% in February to 88.0% in March at MPH and from 66.3% to 71.4% at YDH. The Trust-wide average ambulance handover time was just over 21.7 minutes (19.1 minutes at MPH and 26.2 minutes at YDH), down from 23.0 minutes in February and 26.1 minutes in January.

Front Door – In March 2026, both Emergency Departments (EDs) continued to see exceptional increases in attendances, compared to 2025. Trust-wide growth in ED attendances in March 2026 was 6%, with MPH up by 0.5% and YDH up by 12% compared to March 2025. However, Community UTC attendances have reduced by 13% in March 2026 compared to March 2025. This follows Trust-wide ED growth of 10% across January to March 2026, compared with the same period in 2025. The YDH Urgent Treatment Centre (UTC) activity levels continue to increase month on month, with numbers now consistently between 55 and 70 per day.

Focus of improvement work:

- The Trust continues to work with colleagues from SWAST to support a reduction to levels of conveyances to hospital, in addition to supporting the ICB to improve 'call before conveyance' rates.
- The YDH Urgent Treatment Centre (UTC) opened officially in November 2025. There is work under way to support ENP colleagues and GPs to review the scope and upskill colleagues.
- As a result of increased demand, additional escalation beds were in use across both acute sites during the month.

No criteria to reside (NCTR) - During March 2026, the percentage of occupied bed days lost due to patients not meeting the criteria to reside increased to 25.4% at MPH and decreased to 22.8% at YDH. This remains significantly above the system plan ambition for NCTR.

The average Length of Stay at MPH decreased, from 7.2 days in February 2026 to 6.5 days in March 2026 but increased at YDH to 9.5 days, from 9.0 days in February. Both indicators are having a significant impact on bed occupancy.

Despite the challenges, SFT continues to perform well in discharging over 85% of our patients on a Pathway 0; for March 2026, this was 86.6% at MPH and 85.5% at YDH. Access to pathway 3 is a significant area of concern, with around 2.2% of patients in acute hospital beds awaiting pathway 3, compared to a target of no more than 1%.

Focus of improvement work

- A continued drive to improve hospital-related delays as well as continued focused work on board rounds and criteria-led discharge through the GIRFT work programme.
- A focus on our capacity-related delays across pathways 1, 2 and 3, working with system partners to understand the reduction in flow.

Stroke

The percentage of patients admitted to a stroke ward within four hours improved at MPH during March 2026, with performance of 62.5% but deteriorated at YDH, with performance of 22.2%. The level of therapy minutes provided to stroke inpatients was 60 minutes at MPH, and 48 minutes at YDH, above the target of 42 minutes or more.

Focus of improvement work

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

SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance	
UEC1	Ambulance handovers waiting less than 30 minutes	MPH	NHSC	2	64.6%	65.7%	79.6%	91.4%	88.2%	84.6%	83.2%	87.1%	79.4%	75.8%	85.3%	>=95%= Green >=85% - <95% =Amber <85% =Red			
UEC2		YDH			51.0%	62.2%	65.4%	66.9%	68.7%	67.6%	67.9%	72.3%	66.9%	64.0%	66.3%		71.4%		
UEC3	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	SFT	2.6	6.9	7.0	6.7	6.3	6.6	6.6	6.8	6.1	6.5	7.2	6.5	Monitored using Statistical Process Control rules. Report by exception.			
UEC4		YDH			9.0	8.7	8.9	9.1	8.3	8.8	9.6	8.5	9.3	9.2	9.0		9.5		
UEC5	Patients not meeting the criteria to reside: percentage of occupied bed days lost	MPH	SFT	2.6	23.7%	26.7%	22.5%	22.3%	22.1%	22.8%	23.0%	22.3%	18.7%	21.9%	24.0%	<=9.8%= Green >15% =Red			
UEC6		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%		
UEC7	Percentage of Stroke Patients directly admitted to a stroke ward within four hours	MPH	NSG	1,2,4	75.0%	62.3%	72.2%	70.8%	45.3%	53.3%	69.6%	60.7%	58.3%	46.2%	57.4%	>=90%= Green >=75% - <90% =Amber <75% =Red			
UEC8		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%		
UEC9	Percentage of patients spending >90% of time in stroke unit - acute services	MPH	NSG	1,2,4	70.0%	81.7%	73.6%	79.1%	72.3%	63.3%	62.5%	70.7%	60.3%	63.3%	64.9%	>=80%= Green >=70% - <80% =Amber <70% =Red			
UEC10		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%		
UEC11	Percentage of patients scanned within 20 minutes of clock start	MPH	NSG	1,2,4	70.0%	37.1%	52.7%	46.3%	46.2%	46.0%	44.7%	5.4%	60.9%	62.7%	52.7%	>=32%= Green >=27% - <32% =Amber <27% =Red			
UEC12		YDH			21.1%	14.5%	33.3%	51.1%	19.4%	24.4%	21.6%	24.0%	17.8%	5.3%	14.7%		27.3%		
UEC13	Percentage of patients assessed by a Stroke Specialist Consultant within 14 hours of clock start	MPH	NSG	1,2,4	50.0%	48.4%	49.1%	50.7%	35.4%	46.0%	53.2%	62.1%	56.5%	52.5%	56.4%	>=70%= Green >=60% - <70% =Amber <60% =Red			
UEC14		YDH			57.9%	61.8%	72.7%	74.5%	69.4%	70.7%	51.4%	60.0%	57.4%	68.4%	69.7%		63.6%		
UEC15	Stroke: Median number of minutes of total therapy received per inpatient day	MPH	NSG	1,2,4	No Data	46	41	57	45	30	28	54	59	55	61	60	>=42= Green >=32 - <42 =Amber <32 =Red		

SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance	
UEC16	Stroke: Median number of minutes of total therapy received per inpatient day	YDH	NSG	1,2,4	42	53	35	35	45	42	32	29	31	36	40	48	>=42= Green >=32 - <42 =Amber <32 =Red		
UEC17	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the	MPH, YDH, Community Hospitals and Mental Health wards	NHSC	1,2,4	New reporting	83.3%	64.7%	64.3%	58.3%	83.3%	80.0%	78.6%	72.7%	65.2%	73.3%	80.0%			
UEC18	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	NHSC	1,2,4	96.9%	84.8%	90.0%	90.6%	92.0%	88.9%	100.0%	97.1%	79.4%	90.0%	90.3%	88.2%	>=90%= Green >=80% - <90% =Amber <80% =Red		
UEC19	Percentage of emergency patients screened for sepsis - Emergency Departments				88.2%	90.0%	100.0%	100.0%	100.0%	66.7%	52.5%	69.7%	66.7%	70.7%	58.6%	62.5%			
UEC20	Percentage of patients admitted as an emergency within 30 days of discharge	NOF, PAF		2,3	9.0%	9.0%	9.0%	8.7%	9.5%	8.7%	7.3%	8.4%	9.1%	9.0%	9.0%	8.8%	To be confirmed.		
UEC21	Average number of days between planned and actual discharge date	NOF, PAF		2,3	3.1	2.7	2.6	2.6	2.5	2.3	2.4	2.2	2.2	1.7	1.5	1.7	To be confirmed.		
UEC22	Monthly number of inpatients to suffer a new hip fracture	PAF		2	0	1	1	1	0	1	0	3	1	1	0	1	To be confirmed.		
UEC23	Percentage of mental health patients spending under 12 hours in A&E	PAF		2,3	87.4%	90.7%	91.0%	91.3%	92.1%	91.8%	91.7%	92.3%	92.6%	92.1%	92.0%	91.7%	From April 2025 >=91.4% = Green <91.4% = Red		
UEC24	Percentage of over 65s attending emergency departments to be admitted	PAF		2,3	45.6%	45.7%	46.2%	44.7%	44.5%	44.5%	44.6%	47.4%	49.4%	47.8%	47.4%	48.5%	To be confirmed.		
UEC25	Percentage of under 18s attending emergency departments to be admitted	PAF		2,3	12.9%	11.3%	12.2%	12.2%	14.1%	14.0%	15.4%	18.7%	18.0%	17.8%	15.0%	17.5%	To be confirmed.		
UEC26	Percentage of inpatients referred to stop smoking services	PAF		1,2	Report awaited from topic lead who is liaising with our Data Analytics team to resolve some identified data quality issues.											To be confirmed.			
UEC27	Average daily number of medical and surgical outliers in acute wards during the month	MPH	NHSC	2	1	2	3	1	2	4	9	1	3	5	4	4	Monitored using Statistical Process Control rules. Report by exception.		
UEC28		YDH	NHSC	2	14	13	15	18	11	9	9	9	9	10	7	9	Monitored using Statistical Process Control rules. Report by exception.		
UEC29	Number of patients transferred between acute wards after 10pm	MPH	NHSC	2	85	96	75	83	82	103	61	67	78	143	102	80	Monitored using Statistical Process Control rules. Report by exception.		
UEC30		YDH	NHSC	2	126	85	98	109	133	92	137	104	175	138	120	130	Monitored using Statistical Process Control rules. Report by exception.		

SOMERSET NHS FOUNDATION TRUST

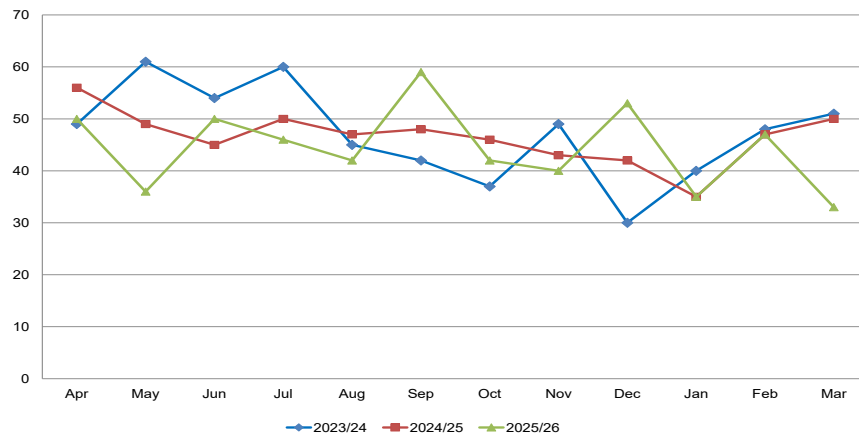
URGENT AND EMERGENCY CARE

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance	
UEC31	Summary Hospital-level Mortality Indicator (SHMI)	NOF, NHSC	2	107.2	108.8	109.4	107.4	105.8	106.7	105.1	102.1	Data not yet due - December 2025 to be reported after March 2026				Monitored using Statistical Process Control rules. Report by exception.			
UEC32	Total number of patient falls - acute services	NHSC	2	169	156	133	152	168	163	165	121	160	186	178	162	Monitored using Statistical Process Control rules. Report by exception.			
UEC33	Rate of falls per 1,000 occupied bed days - acute services	NHSC	2	5.62	5.20	4.70	5.32	5.86	5.72	5.56	4.29	5.66	6.08	6.60	5.57	Monitored using Statistical Process Control rules. Report by exception.			
UEC34	Number of pressure ulcers	MPH	NOF, NHSC	2	18	20	27	18	31	32	27	34	40	27	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.			
UEC35	Rate of pressure ulcer damage per 1,000 occupied bed days	MPH	NOF, NHSC	2	0.93	1.02	1.46	0.96	1.63	1.70	1.40	1.27	1.89	2.01	1.56	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC36	Number of pressure ulcers	YDH	NOF, NHSC	2	22	18	12	10	18	9	12	13	18	14	14	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC37	Rate of pressure ulcer damage per 1,000 occupied bed days	YDH	NOF, NHSC	2	2.04	1.74	1.22	1.01	1.86	0.93	1.15	1.28	1.76	1.31	1.45	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC38	No. ward-based cardiac arrests - acute wards	MPH	NHSC	2	4	2	1	1	3	3	6	2	4	5	1	7	Monitored using Statistical Process Control rules. Report by exception.		
UEC39	No. ward-based cardiac arrests - acute wards	YDH	NHSC	2	0	2	1	2	3	2	5	0	2	1	0	1	Monitored using Statistical Process Control rules. Report by exception.		
UEC40	Total number of medication incidents	MPH	NHSC	2	97	75	80	92	88	67	113	105	103	98	72	79	Monitored using Statistical Process Control rules. Report by exception.		
UEC41	Total number of medication incidents	YDH	NHSC	2	33	50	42	46	54	50	47	45	33	47	41	39	Monitored using Statistical Process Control rules. Report by exception.		

Operational context

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

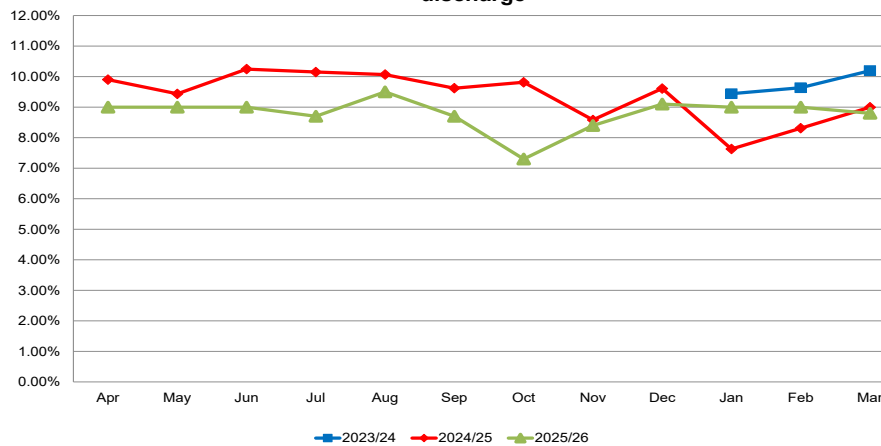
Mental Health wards - number of discharges during month



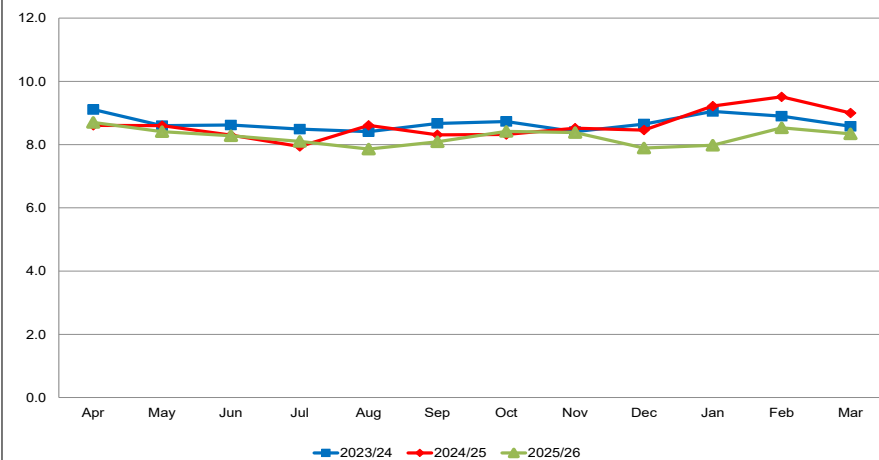
Summary:

- Between 1 April 2025 and 31 March 2026, non-elective admissions decreased by 4.9% compared to the same months of 2024/25 and decreased by 0.8% compared to the same months of 2023/24. Activity for 1 April 2025 to 31 March 2026 was 3.7% below the planned level.
- Between 1 April 2025 and 31 March 2026, emergency readmissions totalled 13,727, 7.5% lower than the same period in 2024/25, when there were 14,848 readmissions.
- The trust-wide monthly non-elective average length of stay decreased in March 2026 to 8.3 days, from 8.5 days in February 2026.

Percentage of patients admitted as an emergency within 30 days of discharge



Combined non elective average length of stay



NARRATIVE REPORT

ELECTIVE CARE SERVICES

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

- 1) The percentage of patients receiving the diagnostic test they need within six weeks of the request being made was 80.7% at the end of March 2026, compared with 79.1% at the end of February 2026. The number of patients waiting over six weeks for a diagnostic test remained similar in the period (2,479 in February versus 2,519 in March). The total waiting list size was higher than plan (13,061 versus a plan of 12,298). The number of over six-week waiters was also worse than plan at 2,519 against a plan of 1,380. Performance improved between the end of February and March 2026 positions, mainly due to the increase in total waiting list size.

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

	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Trajectory (%)	76.0	75.7	77.4	78.2	79.2	81.0	83.0	85.1	83.0	85.3	87.0	88.8
Actual (%)	75.7	74.5	78.7	79.6	78.4	79.7	81.3	77.7	72.5	73.0	79.1	80.7
Total w/l	13914	13396	13426	12005	11057	11127	11385	11610	11554	12020	11871	13061

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

- Opening of the Yeovil Community Diagnostic Centre – CT, including CT colon, MRI, ultrasound, endoscopy, audiology and echo.
- Six GP mid-county border practices have been asked to refer suspected cancer patients needing an endoscopy to Yeovil, to make use of new Yeovil Community Diagnostic Centre capacity.
- A locum commenced in post, supporting the DEXA service, but has now left.
- Recruitment to endoscopy nursing vacancy gaps.

- Piloting drugless cardiac CT protocol adoption (supported by University Hospitals Plymouth).
- Review of the echo insourcing contract due to under delivery, with the provider now implementing a recovery plan to meet contract activity levels.

Additional actions being taken in the coming months include:

- Completion of the Bridgwater Diagnostic Centre (June 2026), providing an increase in complex CT and MRI scanning capacity.
- Bridgwater endoscopy scope washer decontamination capacity plans being developed for 2026/27, as part of a wider plan for expansion of diagnostic capacity.
- Changing the balance of inpatient to outpatient echo capacity, following a review of demand needing to be met.
- Band 5 echo physiologists now trained to work independently.
- Plan to close direct access to an echo, because Cinapsis Advice & Refer has a straight to test pathway.
- Additional DEXA locum being sought.
- Apprentice and trainee radiographer for the DEXA service in progress.
- Digital patient enabled booking solution is being progressed, to improve utilisation of radiology sessions and improve patient experience.

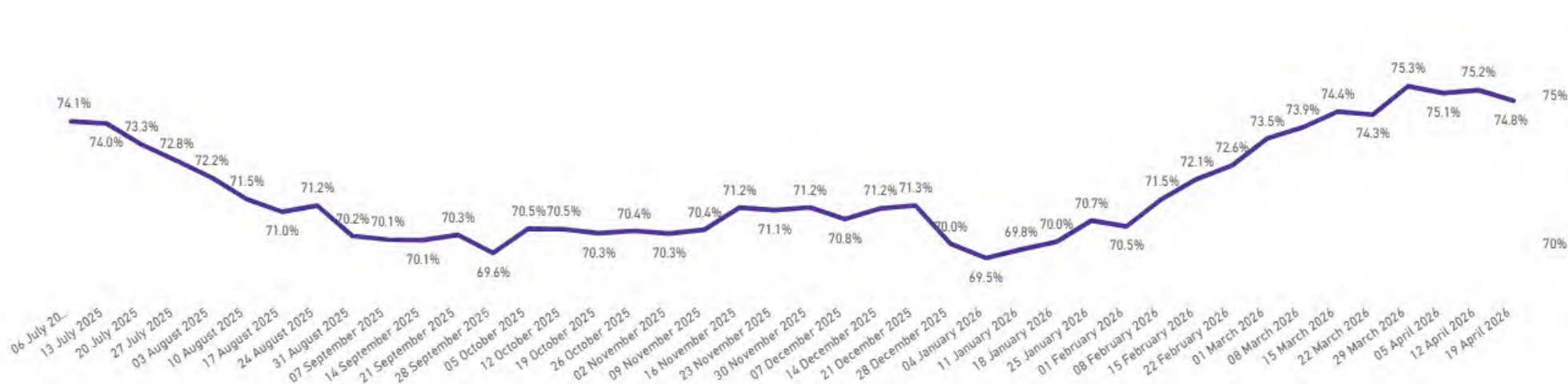
Table 2. The number of patients waiting over six weeks by diagnostic modality

	Apr 25	Ma y 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
MRI	335	260	148	130	96	136	88	105	143	262	206	221
CT	439	367	343	335	293	278	252	212	239	167	79	40
Ultrasound	849	1177	988	473	191	141	61	91	70	91	71	121
Barium Enema	71	61	30	23	21	21	12	19	10	4	4	18
DEXA	105	116	126	193	243	309	337	355	387	360	234	150
Audiology	176	90	92	163	111	120	79	117	239	161	148	92
Echo	526	327	254	256	328	142	130	296	564	757	639	766
Neurophysiology	25	41	46	25	28	62	26	35	50	33	16	37
Sleep studies	124	175	130	86	53	14	8	20	6	22	15	19
Urodynamics	38	48	35	36	24	26	30	25	58	65	68	68
Colonoscopy	304	302	258	326	447	442	465	520	618	628	501	460
Flexi sigmoid.	104	103	109	139	215	222	224	225	247	263	181	163
Cystoscopy	44	21	16	30	16	19	19	27	27	22	26	16
Gastroscopy	248	327	280	231	324	332	398	538	523	409	291	348

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

- 18-weeks RTT (plan 67.3%; actual 65.4%).
- First OPA within 18 weeks (plan 80.3%; actual 73.9%) – see Graph 1 below.
- 52-week waits (plan 1.5%; actual 2.0%) – the forecast was 0.9% by end of March 2026, with further investment from regional monies, although for reasons set out below this has not been achieved.
- 65-week waits (17 against a national requirement of zero)

Graph 1 – Percentage of patients waiting under 18 weeks for a first outpatient appointment



18-week RTT performance (i.e. the percentage of patients waiting under 18 weeks on a Referral to Treatment pathway), deteriorated across quarters 2 and 3 but has recovered by year-end to 1.9% below (i.e. worse than) plan. The reason for the deterioration in quarters 2 and 3 was multifactorial and includes a reduction in referrals (shorter-waiting patients), largely because of Advice & Refer implementation. In addition, there is the impact of competing demands, because we are being asked to improve waiting times at both the front (i.e. outpatient appointments within 18 weeks) and the back end (i.e. over 52- and 65-week waiters) of RTT waiting lists. In February 2026 we opened more first outpatient capacity through insourcing in gynaecology, T&O and ENT. This additional capacity also explains why we have seen improvements in first outpatient waiting times within 18 weeks (Graph 1).

The number of patients waiting over 52 weeks decreased across quarter 4, but at a slower rate than forecast. The main specialties making up the current 52-week waiters are: Trauma & Orthopaedics, Urology, Upper GI, ENT and Gynaecology, together making up 75% of all current over 52-week waiters. Overall, the Trust's 52-week wait position has improved in the last six months, mainly due to additional capacity coming on line including more insourcing (T&O), the return of two urologists from maternity leave and the appointment of a further two (although two urologists have since left), outsourcing of T&O patients to the Independent Sector, and increased scrutiny as part of waiting list management, on patients due to breach 52 weeks in the coming month. At the start of quarter 4 we bid for funding for a 52-week wait 'Sprint'. This money has been used to fund the establishment of additional capacity. However, a number of issues have resulted in activity being lower than planned, including the impact of the national shortage of bone cement, urgent ENT patients needing to be prioritised to a greater extent than the previous few months, limiting the amount of longer waiters that can be operated on, and fewer than expected Nuffield Hospital, Taunton theatre sessions able to be purchased, due to us not being able to align with surgeon availability.

The 65-week waiters have reduced significantly over the past six months. We saw a small further reduction in long waiters at the end of March. The 65-week waiters are largely in the same specialties as for the 52-week waiters. We have been monitoring individual patient pathways in the quarter 4 monthly cohorts, and provisionally establishing dates for appointment and surgery, to determine where we have gaps. This same approach will continue until all 65-week waiters are treated and the zero position has been maintained. Actions to get to zero 65-week waiters, above those being taken to improve our 52-week wait position, largely relate to establishing additional capacity for the specific consultants / services where we have capacity gaps and continued very close tracking of progress of individual patient pathways. A shortfall in upper GI capacity presents the greatest risk to achieving this aim in the next few months. Upper GI plans are being revised following a low uptake of patients wanting to transfer to Yeovil for treatment, and a smaller than expected cohort of patients being appropriate for treatment in the Independent Sector, which include additional lists being undertaken internally and making use of the theatre capacity at Nuffield Hospital that is being procured.

Refreshed plans to support the improvement in performance against all three RTT targets were developed for the twelve high-volume specialties contributing most to the over 18-week waiters. This list is as follows and includes specialties which, whilst performing generally well currently, have greater future performance risks: ENT, Urology, T&O, Upper GI, Spinal surgery, Maxillo Facial, Ophthalmology, Neurology, Cardiology, Endocrinology, Gynaecology and Pain Management. The plans developed include a significant focus on productivity as a primary means of delivering improvements, along with other ways of increasing capacity and throughput. These plans and associated trajectories were reviewed by a sub-set of the executive team at a meeting with Service Group Directors and the Director of Elective Care at the end of August 2025, and again in September 2025. Monthly review meetings remained in place for all specialties in quarter 4, and the plans continue to be updated with new actions identified. The themes for the main actions to improve RTT performance are as follows:

- Continued implementation of the Advice & Refer (Cinapsis) advice & guidance platform, which will enable enhanced referrals for all routine GP requests for secondary care opinion. In addition to ENT, Cardiology, Neurology and Urology having gone live, joining a

number of other specialties already live including Dermatology, Gynaecology, Rheumatology, Vascular, Gastroenterology and Endocrinology, work will commence shortly on pathway design and onboarding process for Haematology, Respiratory and General Surgery. This will reduce the number of patients needing to have an outpatient appointment and being added to the waiting list. However, in the short term 18-week and First OPA within 18 weeks, performance is being affected as a result of fewer shorter waiting patients being on the waiting list.

- Enhanced cross-site management of capacity to smooth demand and reduce maximum waiting times across Musgrove and Yeovil; this should reduce 52-week waiters (Cardiology, Gynaecology and Neurology); we continue to explore ways of supporting cross-site use of capacity in the context of still having two Patient Administration Systems (PASs).
- Increasing capacity through insourcing (T&O, ENT and gynaecology); additional theatre capacity being allocated to T&O at Yeovil, with a shift in job plans from outpatients to theatres.
- Ambient Voice Technology (AVT) utilisation in clinic, to replace dictation of letters and increase patient throughput of clinics. We have now deployed this in with champions in a range of specialties, including neurology, ENT, T&O, pain management, cardiology respiratory, haematology, oncology and gynaecology. We have re-visited the deployment process, to speed up the establishment of AVT in as wide a group of specialties as possible, with a seven-day implementation process now in place for fully engaged services.
- Review and development with commissioners a new service delivery model for endocrinology weight management services, which is nearing completion.

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

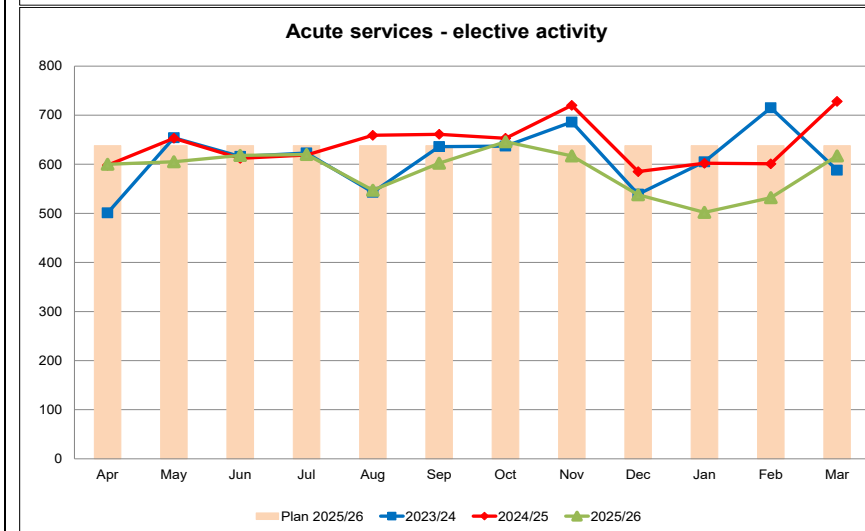
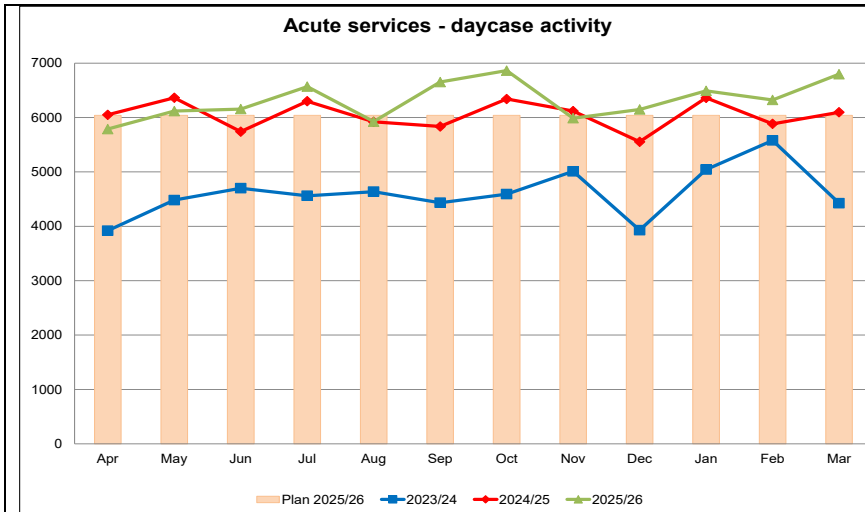
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ELECTIVE CARE

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance	
EC1	Diagnostic 6-week wait - acute services	MPH	NOF	1,2	79.7%	81.4%	83.6%	83.8%	80.3%	80.6%	82.0%	76.8%	71.7%	73.4%	80.0%	81.9%	From March 2024 At or above regional ambition 85% = Green Above trajectory = Amber Below trajectory = Red		
EC2		YDH			65.5%	64.3%	67.5%	68.1%	73.2%	76.6%	78.9%	80.9%	75.2%	71.9%	76.1%	76.8%	In 2026/27, the national requirement is performance of 80%, or an improvement of at least 3% compared to March 2026, whichever is higher.		
EC3		Combined			75.7%	74.5%	78.7%	79.6%	78.4%	79.7%	81.3%	77.7%	72.5%	73.0%	79.1%	80.7%			
EC4	52 week RTT breaches - Patients of all ages	OPG	1,2	1,438	1,572	1,588	1,749	1,826	1,740	1,575	1,313	1,290	1,195	1,111	1,028	From April 2023 At or below trajectory = Green Above trajectory = Red			
EC5	52 week RTT breaches - Patients aged under 18	OPG		122	134	150	133	138	124	106	81	81	84	96	120				
EC6	65 week RTT breaches - Patients of all ages	NHSC		86	112	108	136	149	157	141	79	18	11	26	17				
EC7	Referral to Treatment (RTT) incomplete pathway waiting list size - all ages	NHSC		58,470	57,069	57,440	57,905	57,715	57,935	58,068	56,659	53,781	53,143	52,985	52,302				
EC8	Referral to Treatment (RTT) incomplete pathway waiting list size - under 18	NHSC		4,115	4,128	4,312	4,160	4,027	3,967	4,005	3,918	3,820	3,762	3,803	3,868		From April 2025 at or below trajectory = Green above = Red		
EC9	Rate of annual growth in under 18s elective activity - Rolling 12 months comparison of previous 12 months	NOF, PAF		-4.7%	-3.1%	-2.1%	-1.6%	-4.0%	-4.5%	-6.1%	-5.1%	-6.3%	-14.1%	-9.3%	-7.6%		To be confirmed		
EC10	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	SFT	2,6	3.0	3.5	3.1	2.9	2.4	2.7	2.4	2.3	2.7	2.2	2.6	2.3	Monitored using Statistical Process Control rules. Report by exception.		
EC11		YDH			2.6	2.3	2.6	3.2	2.1	2.3	2.1	2.2	2.4	2.1	2.4	2.4			

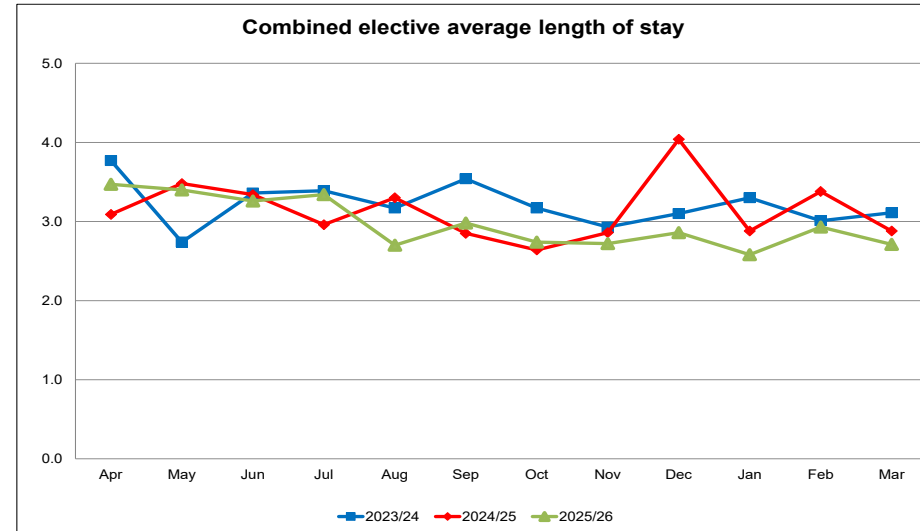
Operational context

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



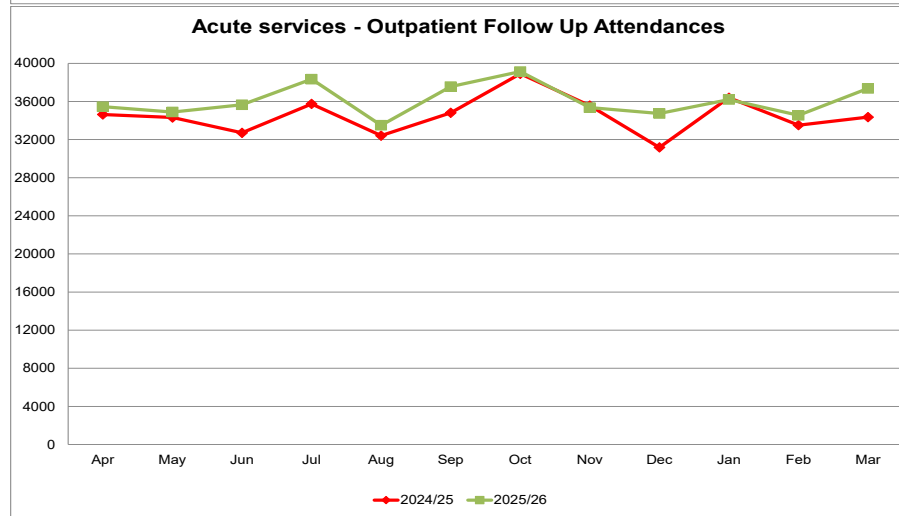
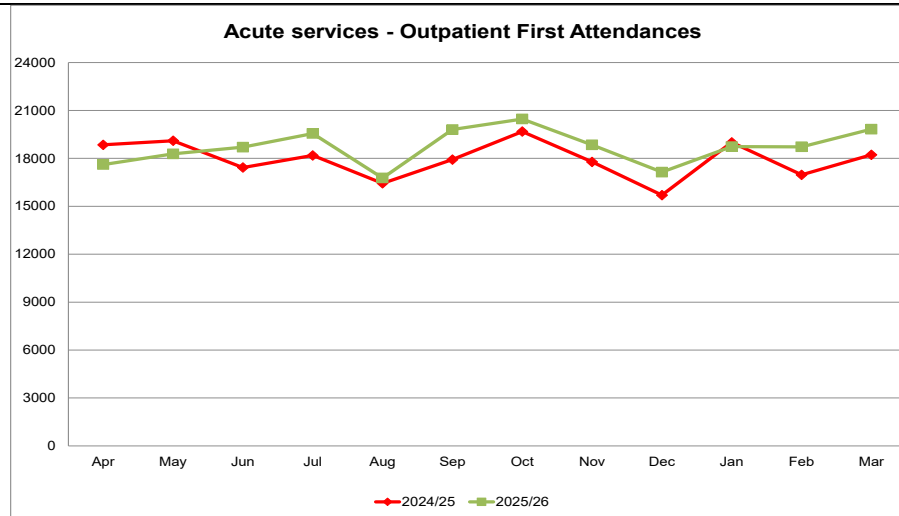
Summary:

- The number of day cases undertaken by our acute services between 1 April 2025 and 31 March 2026 increased by 4.5% compared to the same months of 2024/25 and increased by 37.1% compared to the same months of 2023/24. Activity for the year to date was 4.6% above the current year plan.
- Over the same period, elective admissions were 8.4% lower than the corresponding months of 2024/25 and 4.1% lower compared to the same months of 2023/24. Activity for the year to date was 8.0% below the current year plan.
- The trust-wide monthly elective average length of stay was 2.7 days in March 2026, a decrease from 2.9 days in February 2026.



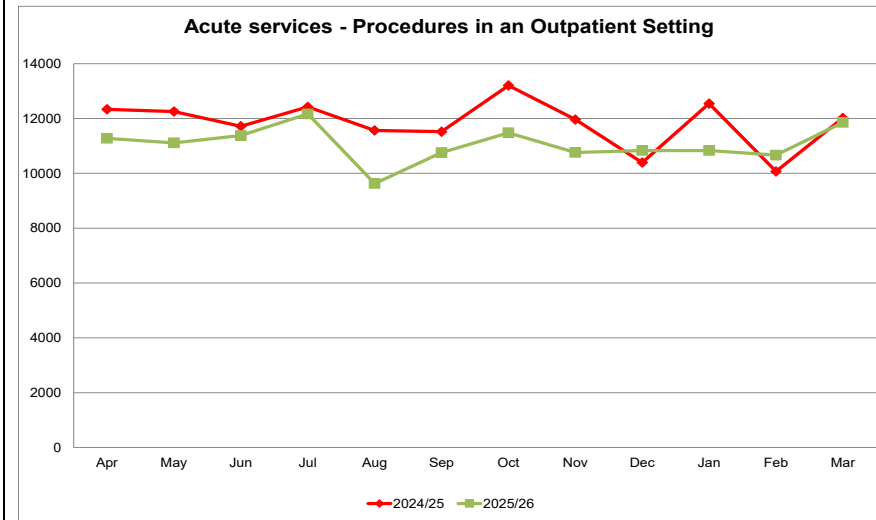
Operational context

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



Summary:

- The number of first outpatient attendances undertaken by our acute services between 1 April 2025 and 31 March 2026 increased by 4.3% compared to the same months of 2024/25.
- Over the same period, follow up outpatient attendances were 4.4% higher than the corresponding months of 2024/25.
- Between 1 April 2025 and 31 March 2026, the reported number of procedures undertaken within an outpatient setting decreased by 6.5% compared to the same months of 2024/25. Due a backlog of coding, the reported numbers for April 2025 to March 2026 are understated.



NARRATIVE REPORT

CANCER SERVICES

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

- 1) 28-day Faster Diagnosis Standard (FDS) performance was 80.8% in February 2026, above the national standard (77.0%), and above our planning trajectory of 80.0% (Table 1). Three tumour sites, lower GI, gynaecology and head & neck, were the main contributors to the breaches of the standard in February 2026 as shown in Table 2 below, together making up 65% of breaches. Please note March's performance is draft, pre final validation.

Table 1. Faster Diagnosis Standard performance July 24 to March 26.

	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26 (draft)
Trajectory (%)	79.4	78.8	77.1	77.0	78.3	78.3	77.1	80.3	81.2	78.7	81.5	78.1	77.6	78.7	81.7	81.8	80.3	77.3	75.1	80.0	80.6
Actual (%)	70.0	70.9	75.4	75.4	79.0	76.5	75.8	72.0	75.4	72.6	65.1	73.0	75.5	71.3	71.9	77.8	78.5	79.0	76.2	80.8	77.8

Table 2. Top five tumour sites contributing to current FDS performance in breach number terms, and in the previous month.

Tumour sites	Breaches (Jan 26)	Performance (Jan 26)	% of breaches (Jan 26)	Breaches (Feb 26)	Performance (Feb 26)	% of breaches (Feb 26)
Colorectal	215	53%	34%	162	62%	35%
Gynaecology	67	69%	10%	70	69%	15%
Head & Neck	100	68%	16%	68	76%	15%
Urology	78	71%	12%	51	75%	11%
Skin	60	90%	9%	42	90%	9%

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

Colorectal:

- Yeovil Community Diagnostic Centre opening (complete) to increase CT colon capacity (already reduced waits to below 14 days in Yeovil) – there is now a national shortage of gastrografin which may have an impact on waiting times.
- Increase endoscopy capacity, through filling nurse vacancies – vacancies appointed to, with all except two nurses now in post; sessions utilisation was above 90% in January and February, with target activity levels being achieved. But there is a newly established limit on the number of scopes that can be decontaminated each day in Bridgwater Community Hospital, which is proving to be a rate limiter for maintaining this level of throughput; work is underway to look at alternative options.
- Diversion of general surgery to Yeovil to free-up more colorectal theatre capacity on the Musgrove site for cancer surgery.
- Double clinic slots put in place for patients needing best interest meetings.
- Suspected cancer patients now picking up their bowel prep to enable endoscopy appointments to be booked sooner.
- Review of iron deficiency anaemia pathway in the context of nationally defined pathways and reducing un-necessary tests.
- The high volume of patients needing general anaesthetic scopes is being reviewed, to determine whether appropriate.
- Restart internal 100-days challenge (ongoing).
- Job planning review for Musgrove and Yeovil (ongoing).
- Registrar clinics being converted to two-week wait clinics to increase outpatient capacity.

Head & Neck:

- Reviewing two-week wait capacity and process/responsiveness to escalation of capacity shortfalls.
- ENT locum consultant appointed for one year starting September, to cover maternity leave.
- A locum ENT specialty doctor is being sought.
- Pathway redesign work being undertaken to establish a straight to Max Fac / Plastics for appropriate patients that would otherwise be referred to Dermatology with a suspected skin cancer.
- We remain out to advert for a Max Fac consultant; locum appointment for Max Fac being sourced, if possible, in the interim.
- Insourcing of ENT supporting the release of capacity for two-week wait (ongoing).
- Out to advert for an ENT consultant (ongoing).

Gynaecology:

- A pilot of WID-easy high vaginal swabs has commenced, which will provide a rule-out for endometrial cancers within 72 hours; initial feedback is positive; Saturday clinics are being run to reduce delays for those patients waiting for a diagnosis who are appropriate for the WID-easy swab.
- Hysteroscopy and theatre capacity and demand will be reviewed following the above pilot because demand will reduce; a plan for community hysteroscopy being developed.
- A locum consultant has been appointed.
- Mapping of tracking and management of investigations and histology under way, to optimise results management.
- Transfer of patients across acute sites being streamlined to make best use of available capacity (under way).

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

- One-stop endoscopy and staging CT pathway implemented where a cancer is identified at colonoscopy.
- Faecal Immunochemistry Test (FIT) guidelines and resulting pathways have been reviewed.
- Colorectal Clinical Nurse Specialists have been given access to radiology imaging sharing system.
- One stop bladder cancer clinics have been established in Bridgwater.
- Urology clinic template and job plan reviews have been completed – which has liberated more capacity.
- Uro-Oncology Clinical Nurse Specialist has been appointed; Uro-Oncology band 6 posts x 1.6 WTE is being recruited.

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

Tumour site	Q4 24/25	Target Oct 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Colorectal	52%	57%	57%	40%	49%	62%	52%	53%	65%	60%	55%	53%	62%
Urology	52%	57%	53%	38%	50%	61%	67%	75%	68%	76%	71%	71%	75%

3) 62-day referral to cancer treatment performance was 73.1% in February 2026, above the current national standard of 70% but below the March 2026 target of 75%. Draft March 2026 performance represents an improvement in performance on the February 2026 position. Colorectal and urology are the main tumour sites contributing to breaches, although the urology performance has improved with far fewer breaches of the standard than in most of 2025/26.

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

- Urology capacity – two additional operating sessions per week from the beginning of September 2026, with the team picking-up extras where possible in the interim; a specialty doctor is being considered, to fill team gaps from the resignation and retirement of two consultants in the team.
- Four additional theatre sessions per week going into ENT from September 2026.
- Lung – ring-fenced PET scan slots; one-stop echo slots for two-week wait patients; AI for chest x-rays (February 2027); streamlining MDT discussion effectiveness by ensuring only those patients with new results are discussed.
- Skin – additional insourcing being sourced where possible; a new straight to Max Facs pathway and consultant supervised GP with Extended Roles plastics lists for the less complex cases, is being considered; a review of the Service Level Agreement with Royal Devon University Healthcare NHS Foundation Trust for plastics service provision is underway; a summer resilience plan has been developed.
- Colorectal - demand and capacity review for theatre sessions; additional theatre lists to be identified.
- Weekend operating sessions until Musgrove Surgical Centre opens (September 2026) – mainly for benign pathways but again alleviates pressure.

Table 4. 62-Day Cancer performance July 2024 to March 2026.

	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26 (draft)
Trajectory (%)	66.4	67.1	66.5	66.4	68.8	70.2	71.3	71.5	72.0	72.8	70.3	70.5	71.6	71.8	71.7	71.7	72.6	72.3	70.3	75.5	75.1
Actual (%)	67.8	72.0	64.4	65.6	68.2	71.0	66.9	68.9	75.2	70.2	69.2	68.1	68.4	70.0	70.4	69.6	76.5	76.4	73.7	73.1	76.7

SOMERSET NHS FOUNDATION TRUST

CANCER SERVICES

No.	Description	Source	Links to strategic aims	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Thresholds	Trend	Variation / Assurance
C1	31 day wait - from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment	NHSC	1,2	96.7%	95.4%	95.0%	95.2%	93.6%	94.1%	90.9%	91.6%	90.0%	92.1%	89.2%	94.4%	>=96% = Green >=Above trajectory = Amber <below trajectory = Red		
C2	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104	OPG	1,2	25	32	20	36	19	31	25	40	24	14	20	18	0= Green >0 = Red		
C3	Cancer: 62-day wait from referral to treatment for urgent referrals – Breast	OPG	1,2	87.5%	78.7%	62.2%	75.9%	74.6%	70.9%	67.3%	78.1%	73.1%	68.4%	81.5%	69.0%	At or above trajectory =Amber and below trajectory =Red		
C4	Cancer: 62-day wait from referral to treatment for urgent referrals – Colorectal	OPG	1,2	58.1%	55.2%	50.0%	53.8%	60.0%	67.8%	65.6%	37.9%	48.5%	72.5%	55.3%	51.9%	At or above trajectory =Amber and below trajectory =Red		
C5	Cancer: 62-day wait from referral to treatment for urgent referrals – Gynaecology	OPG	1,2	77.8%	78.9%	100.0%	80.0%	62.5%	75.0%	72.7%	86.4%	57.1%	94.4%	81.8%	50.0%	At or above trajectory =Amber and below trajectory =Red		
C6	Cancer: 62-day wait from referral to treatment for urgent referrals – Haematology	OPG	1,2	78.9%	78.6%	100.0%	84.6%	75.0%	78.9%	63.4%	74.4%	100.0%	82.6%	100.0%	95.8%	At or above trajectory =Amber and below trajectory =Red		
C7	Cancer: 62-day wait from referral to treatment for urgent referrals – Head and Neck	OPG	1,2	77.8%	68.8%	72.7%	91.7%	52.6%	51.4%	68.8%	67.5%	77.8%	61.3%	77.8%	66.7%	At or above trajectory =Amber and below trajectory =Red		
C8	Cancer: 62-day wait from referral to treatment for urgent referrals – Lung	OPG	1,2	73.1%	69.8%	75.5%	60.0%	57.6%	66.7%	68.1%	69.6%	100.0%	86.9%	40.0%	45.2%	At or above trajectory =Amber and below trajectory =Red		
C9	Cancer: 62-day wait from referral to treatment for urgent referrals – Other	OPG	1,2	88.9%	92.9%	100.0%	69.2%	92.3%	86.7%	77.8%	61.5%	58.8%	100.0%	87.5%	76.5%	At or above trajectory =Amber and below trajectory =Red		
C10	Cancer: 62-day wait from referral to treatment for urgent referrals – Skin	OPG	1,2	92.8%	98.7%	91.6%	92.0%	81.4%	83.1%	82.3%	76.3%	89.7%	81.1%	85.1%	89.3%	At or above trajectory =Amber and below trajectory =Red		
C11	Cancer: 62-day wait from referral to treatment for urgent referrals – Upper GI	OPG	1,2	91.1%	63.2%	82.1%	69.2%	66.7%	95.8%	63.8%	77.8%	86.2%	56.7%	76.6%	88.9%	At or above trajectory =Amber and below trajectory =Red		
C12	Cancer: 62-day wait from referral to treatment for urgent referrals – Urology	OPG	1,2	52.8%	37.5%	39.9%	40.7%	58.3%	52.7%	64.8%	55.0%	68.3%	55.2%	68.8%	67.5%	At or above trajectory =Amber and below trajectory =Red		
C13	Cancer: Percentage of all cancers diagnosed that are diagnosed at stage 1 or 2 (75% to be achieved by 2028)	PAF	1,2	72.4%	73.3%	71.8%	72.5%	70.8%	76.1%	72.8%	68.6%	72.5%	72.1%	82.2%	86.0%	>=60.1%= Green >=55.1% to <60.1% = Amber <55.1% =Red		

NARRATIVE REPORT

MATERNITY SERVICES

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

The service successfully re-launched the YDH inpatient maternity and neonatal services at midday on Tuesday 21 April 2026.

Following a significant amount of work from colleagues across all services within SFT including IT, Estates, Paediatrics, Site and many others, the Maternity and Neonatal team were able to make final adjustments in preparation for welcoming in the first service users. Our first baby was born just before 4pm on 21 April 2026, by caesarean section.

The residual impact of the temporary closure continues to be monitored via daily tactical calls with system and SFT partners and activity and staffing levels across both YDH and MPH sites are closely monitored. Acuity and activity remain high on the MPH site, with resulting challenges in delays in induction of labour and elective caesarean section at all stages of the pathway. The service is actively monitoring and working to mitigate where possible with the YDH site now open supporting workload on the MPH site.

The themes of reported incidents for March 2026 were:

- Delay in induction of labour.
- Delay in transfer to labour ward from the antenatal ward.
- Short staffing for SNICU, community, postnatal ward and maternity triage.
- Delay in Elective Caesarean pathways.
- Delay in transfer to theatre for non-elective work
- Challenges with obtaining a second theatre team.
- No beds available on the antenatal ward for incoming inductions.

The service continues to implement actions to mitigate delays in elective care including the use of bank and agency staffing, active recruitment to obstetric vacancy, improvements to flow and escalation processes as well as exploring potential options to move elective work away from the main maternity unit site. Actions have had a significant impact on reducing waiting times in triage. Themes from safety events identify issues related to delays in care due to acuity, and escalation of clinical concerns.

We remain in the improvement phase of the Maternity and Neonatal Improvement Support Team (MNIST) programme and are preparing to publicly launch the plan in collaboration with our Maternity & Neonatal Services user Voices Partnership (MNVP) on 9 May 2026 at a special event in Yeovil.

SOMERSET NHS FOUNDATION TRUST

MATERNITY SERVICES

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance
M1	Babies readmitted to hospital who were under 30 days	CQIM	2	4	2	0	0	0	0	0	0	0	0	0	0	Monitored using Statistical Process Control rules. Report by exception.		
M2	Babies who were born preterm - less than 37 weeks gestation	CQIM	2	13	15	26	13	15	16	24	26	9	20	18	22	Monitored using Statistical Process Control rules. Report by exception.		
M3	Percentage of babies where breast feeding was initiated	CQIM	1,2	91.9%	89.6%	87.6%	88.7%	88.8%	91.3%	86.9%	89.2%	92.0%	91.9%	91.1%	86.4%	>=80%= Green >=75% - <80% =Amber <75% =Red		
M4	Percentage of babies with an APGAR score between 0 and 6	CQIM	1,2	0.3%	2.4%	1.6%	0.7%	1.6%	1.8%	2.9%	1.2%	3.1%	1.0%	2.1%	2.1%	=<1%= Green >1% - <=2%=Amber >2% =Red		
M5	Women who had a 3rd or 4th degree tear at delivery	CQIM	2	8	5	3	8	4	10	9	4	4	8	6	10	To be confirmed, following benchmarking against regional performance.		
M6	Women who had a postpartum haemorrhage (PPH) of 1,500ml or more	CQIM	2	13	2	10	6	15	9	10	8	9	6	8	8	To be confirmed, following benchmarking against regional performance.		
M7	Women who were current smokers at booking appointment	CQIM	1,2	6.3%	8.6%	7.0%	5.9%	6.4%	6.7%	5.2%	4.5%	1.5%	7.1%	4.8%	4.9%	No target level.		
M8	Women who were current smokers at delivery	CQIM	1,2	5.8%	4.2%	5.4%	6.8%	6.6%	4.2%	6.8%	3.7%	5.0%	8.2%	3.5%	5.9%	=<10%= Green >10% - <=12%=Amber >12% =Red		
M9	No. of still births	CQIM	2	0	0	1	0	0	0	0	1	0	0	0	2	Monitored using Statistical Process Control rules. Report by exception.		
M10	No. of babies with Hypoxic Ischaemic Encephalopathy Diagnosis (rate per 1,000 births)	CQIM	2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.6	0.0	0.0	0.0	Monitored using Statistical Process Control rules. Report by exception.		
M11	Babies under observation should have Newborn Early Warning Score assessment recorded as per trust clinical guidelines.	SFT	1,2,4	94.6%			98.1%			96.7%			100.0%			=>90%= Green >=80% - <90% =Amber <80% =Red		
M12	Babies under observation who have NEWS score alerts should be escalated to the paediatrics team for review	SFT	1,2,4	100.0%			93.3%			100.0%			100.0%					

NARRATIVE REPORT

CHILDREN AND YOUNG PEOPLE'S SERVICES

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

Children and Young People's Eating disorders service

The Children and Young People's Eating Disorder Service (CEDDS) workforce continues to stabilise, supported by improved staff retention and the eradication of agency nursing. This strengthened position is reflected in the progress made against routine referral performance.

The three-month rolling figure for routine referrals was 91.0% in February 2026 compared with the national standard of 95%:

CEDDS: 82.4% - Red (28 out of 34 patients inside 28 days); **SWEDA:** 100% - Green (33 out of 33 patients inside 28 days).

Urgent Referrals

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

Further improvement is expected through Spring 2026 as a result of service model changes following the launch of the Intensive Treatment Houses.

Children and Young People's Community Mental Health service

Somerset CAMHS continues to demonstrate strong performance nationally in relation to waiting times and timely access to community mental health support. In March 2026, 90.9% of children and young people waiting had waited under six weeks for their first appointment. The service has achieved or exceeded the 90% reporting standard across the whole of the 12-month reporting period from April 2025 to March 2026, reflecting the service's robust triage, referral management processes, and effective system flow.

In addition to waiting time performance, the service continues to make progress towards the national ambition for increasing the number of children and young people (aged 0–25) accessing mental health services. This month's data demonstrates a steady and sustained increase in access throughout the reporting period, with activity rising from 5,216 in the 12 months to March 2025 to 5,896 in the 12 months to February 2026. This upward trend indicates improving reach, strong system engagement, and continued expansion of early intervention and community-based mental health support pathways.

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

Primary care dental service

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

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

Waiting List Improvements: 18-Week Standard

The Somerset service has delivered consistent reductions in the number of patients waiting 18 weeks or more for General, Domiciliary or Minor Oral Surgery procedures. In March 2026 the number of patients waiting over 18 weeks was 1,815, a slight increase in the number waiting due to:

- The service is seeing more frequent cancelled GA lists across both counties due to local service staffing pressures, wider trust seasonal pressures and industrial action. Work is happening at pace to strengthen the resilience of the service workforce working within GA with the support of the consultant in special care and her network links in paediatrics.
- Productive care work in Somerset has been affected by increased levels of sickness absence. The same piece of work has now been launched in Dorset.

Overall, compliance continues to reflect improvement (the waiting list in March 2025 was 2,544). This places the service below the monitoring target and demonstrates effective delivery of recovery plans.

Improvement Against Long-Wait Backlogs – 52 Weeks

There has also been a significant reduction in very long waits. The number of people waiting over 52 weeks has decreased from 571 in February 2025 to 316 in March 2026, although March 2026 showed an increase from February 2026, due to the factors outlined above. Overall, the sustained improvement remains evident and aligns with the service's targeted work to prioritise the longest waiters and strengthen scheduling efficiency.

Acute Paediatric service

National Paediatric Early Warning System (PEWS)

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

MPH

MPH has demonstrated a marked and sustained improvement in medium-risk PEWS compliance. Performance rose significantly through the autumn, increasing from 58.3% in November 2025 to 80% in March 2026. However, this is a reduction from February 2026 standard and is being followed up. This improvement follows targeted teaching sessions and enhanced oversight by the nurse in charge. Continued focused education remains a priority to consolidate these gains.

YDH

Compliance at YDH with PEWS performance reduced from 100% to 50%. This decline is disappointing and will be followed up. The team will be asked to place increased focus on this element within their teaching updates going forward.

CYP Neurodevelopmental Partnership (CYPNP) service

Referrals and Service Demand

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

Waiting List Pressures

Numbers waiting 52 weeks or more increased by 103 compared with the position on 28 February 2026.

Between 1 April 2023 and 31 March 2024 monthly referrals into the service totalled 184 per month. Referrals between 1 April 2024 and 31 March 2025 averaged 198 per month. During the period 1 April 2025 to 31 March 2026 referrals received totalled 2,071, an average of 173 per month, still significantly above the capacity of the service.

Waiting list pressures remain a critical concern:

- As at 31 March 2026, numbers waiting 104 weeks increased by 108 compared with 28 February 2026.
- Of the 4,381 patients listed as waiting, 1,370 had waited 104 weeks or more. The longest wait was 205 weeks in respect of a child who moved into Somerset in January 2026 and where the original referral to North Somerset service was transferred to CYPNP.

ADHD Pathway Update

Access and Performance

- Delays remain in parts of the pathway for first appointments and reviews.
- Time from nursing assessment to medical review for medication is now over six months.
- Six-month medication reviews are occurring at around 12 months in some localities (Frome, Bridgwater, Yeovil), while other areas remain on track.

- Additional clinics and online reviews are being used to mitigate delays.

Capacity and Demand

- DNA rates for post-diagnostic reviews remain high at 15–20%; tighter application of the DNA policy is under way.
- The ADHD nursing team remains one WTE down due to sickness absence, affecting capacity but with strong team commitment to managing workload.

Transitions

- Work is under way to strengthen transition planning for young people moving into adult ADHD services.
- Separate pathways are being developed for:
 - Young people not yet started on medication.
 - Young people stable on medication.

Right to Choose (RTC)

- Continued high demand for RTC assessments is creating challenges around shared care and follow-up.
- Agreed plan with the ICB to introduce CYPNP-led triage via a Single Point of Access (SPA) and revise the RTC process.
- Referral documentation (Next Steps form) will be simplified to support referrers.

Clinical Complexity

- High levels of co-occurring Autism and ADHD diagnoses continue, in line with the national picture, increasing post-diagnostic demand.

Key Positives and Enablers

Operational Improvement

- Half-day assessment model fully embedded, protecting quality and clinic capacity.
- Most clinicians have cleared historic assessment backlogs.

Active Caseload

- Only 88 young people remain on the active “in-progress” assessment caseload.

Partnership Working

- Positive feedback from WISE Up and PINS workshops delivered by CYPNP clinicians.
- Ongoing work with ICB on RTC guidance and consistency for families.
- Local Authority has confirmed suitable accommodation to support service expansion, subject to future ICB investment.

Improving Emergency Department Waiting Times

Reducing waiting times for children and young people in the Emergency Departments (ED) at Yeovil District Hospital (YDH) and Musgrove Park Hospital (MPH) and our UTCs remains a critical operational priority. The Trust is working towards the national requirement that at least 78% of patients are admitted, discharged, or transferred within four hours by March 2026, rising to 95% by September 2026. In March 2026, Trust-wide performance for under-16s attending the Emergency Department showed that 88.4% of patients who were admitted, discharged or transferred did so within four hours.

Current Performance

Trust-wide CYP performance improved slightly in March 2026 reflected the early impact of improvement actions already under way. However, further work is required to achieve sustained progress. Regular improvement meetings take place. These sessions have

strengthened cross-service group working and supported quicker adoption of process improvements. In addition, Ward 10 at YDH has continued to provide paediatric staff to support the Emergency Department during periods of pressure, helping to improve flow and patient experience where capacity allows.

This remains a key area of focus, and the Paediatric Senior Leadership Team is reviewing care pathways to ensure transfers are more efficient and consistently delivered. An improvement action plan is in development.

Paediatric Assessment Unit (PAU) Requirements

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

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

However, two major challenges remain:

1. Workforce Model

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

2. Estate and evacuation Constraints

A suitable footprint for a PAU on the YDH site is yet to be identified. It was hoped that Paediatric Outpatients on Level 10 could be converted to a PAU, however, this has been confirmed not possible due to lack of piped oxygen in the space and the inability to store

large cannisters of oxygen on level 10 due to the evacuation risk. Furthermore, extensive estates works to install piped oxygen in this space are not possible.

The evacuation risk for ward 10 has a risk score of 15, with simulation training highlighting:

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

An Equality and Quality Impact Assessment (EQIA) is in development regarding the provision of paediatric care in this space, and further mitigations are being implemented. Nonetheless, the environment remains a substantial safety concern.

Evidence indicates that Paediatric Assessment Units (PAUs) are most effective when either embedded within the Emergency Department (ED) or co-located with the acute paediatric ward. At Musgrove Park Hospital, the service operates a paediatric-ward co-located PAU model. Replicating this model across the county would support workforce flexibility and enable greater standardisation of clinical policies and procedures.

At Yeovil District Hospital, options to locate a PAU within the ED footprint have been explored; however, no suitable space has been identified.

The absence of a PAU on the YDH site therefore presents an ongoing risk to achieving the 95% ED performance target for children and young people.

Potential Relocation

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

- Significant capital investment.

- Re-provision of Paediatric Outpatients (off-site).

Maternity and SCBU reopening YDH

Neonatal and inpatient maternity services at Yeovil District Hospital fully reopened at 12:00 on 21 April 2026. This represents a significant milestone and restores local access to care for families in the east of the county.

The reopening reflects the sustained commitment and hard work of clinical and corporate teams. Particular recognition is given to staff who maintained their skills while working at alternative sites and have now returned to their substantive roles. We also acknowledge the continued support of the Board and Executive Team, and the critical contributions of Estates, Digital, HR, Safeguarding and wider support services.

We are grateful to system partners for their collaboration throughout this period, during which partnership working has strengthened.

While this is a major achievement, further work is required to stabilise and embed services, and this will remain an ongoing focus.

SOMERSET NHS FOUNDATION TRUST
CHILDREN AND YOUNG PEOPLE'S SERVICES

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance	
CYP1	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week (rolling 3 months)	NHSC	1,2,3,4	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	85.7%	85.7%	Data not yet due	>=95%= Green >=85% - <95% =Amber <85% =Red			
CYP2	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)		1,2,3,4	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	>=95%= Green >=85% - <95% =Amber <85% =Red			
CYP3	Increase the number of CYP accessing mental health services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019	NOF, OPG	1,2	5,246	5,315	5,408	5,524	5,451	5,610	5,676	5,691	5,751	5,822	5,896	5,945	From April 2025 >=5,400 = Green <5,400 = Red			
CYP4	Mental health referrals offered first appointments within 6 weeks	Children and young people's mental health services	ICB	1,2,3	95.6%	100.0%	96.8%	100.0%	96.7%	97.1%	96.6%	94.9%	100.0%	90.0%	97.0%	90.9%	>=90%= Green >=80% - <90% =Amber <80% =Red		
CYP5	Community Waiters Percentage waiting under 18 weeks from referral to first appointment (excludes dental)	NOF	1,2,3	85.1%	87.0%	87.4%	83.7%	82.9%	83.7%	81.9%	85.1%	86.4%	84.6%	85.0%	82.0%	From April 2025 >=80% = Green <80% = Red			
CYP6	Improve A&E waiting times, with a minimum of 76% of patients admitted, discharged and transferred from ED within 4 hours in March 2026: Trust-wide performance - Under 16 years old	PAF	2	86.3%	87.3%	88.4%	90.4%	88.6%	88.0%	87.8%	82.8%	83.7%	86.3%	87.8%	88.4%	From April 2025 >=76%= Green >=66% - <76% =Amber <66% =Red <small>(the standard rose to 78% in March 2026, and will rise to 95% in September 2026)</small>			
CYP7	Community dental services - General, Domiciliary or Minor Oral surgery waiting 18 weeks or more	SFT	1,2,3	2,516	2,532	2,523	2,495	2,420	2,252	1,956	1,747	1,747	1,645	1,766	1,815	From April 2024 <1,979 = Green >=1,979 = Red			
CYP8	Community dental services - General, Domiciliary or Minor Oral surgery waiting 52 weeks or more			502	535	501	456	393	234	84	39	55	81	189	316	From April 2024 <574 = Green >=574 = Red			
CYP9	Community dental services - Child GA waiters waiting 18 weeks or more	SFT	1,2,3	563	552	551	537	522	491	454	395	405	397	380	316	From April 2023 <463 = Green >=463 = Red			
CYP10	National paediatric early warning system (PEWS) - Medium risk: percentage reviewed by the nurse in charge	MPH	SFT	1,2,4	70.0%	43.8%	62.5%	100.0%	57.1%	66.7%	73.3%	58.3%	81.0%	76.9%	91.7%	80.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
CYP11		YDH	SFT	1,2,4	100.0%	100.0%	100.0%	100.0%	71.4%	88.9%	66.7%	100.0%	93.3%	100.0%	50.0%				

NARRATIVE REPORT

PEOPLE

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

Areas of Success / Celebration

- Flu Vaccination – the programme ended on 20 March 2026 with a final position of 56.4%. The slight drop in the percentage from February is likely due to incoming colleagues and may be an area for us to address next year. The government ambition for next year for the Trust will be 61.4%; our ambition will be to exceed this.
- Retention - Turnover remains in a positive position, with improvements reflected nationally within the NHS. National reports suggest retention rates as low as they are currently in the NHS, have not been seen in over a decade. Although retention rates are in a positive position for SFT, the working environment for many is challenging and in the first three months of 2026, other than 'unknown', 'work life balance' was the highest reason for leaving. Focus is being redirected on the flexible working agenda and how we can support colleagues to manage their home and their working lives effectively.
- The introduction of the ESR self-service application form will significantly improve the reporting of flexible working practices and approval rates. For the first time, the Trust will be able formally to report on the volume of applications submitted, alongside approval and decline rates. This enhanced visibility will enable targeted support for areas experiencing challenges and help signpost relevant support where needed. The rollout of manager self-service also aligns with the wider pilot, through which managers will process leavers via this route. This provides an opportunity to improve the quality and consistency of reasons-for-leaving data, supporting more informed workforce insights

Areas of Concern

- Job Planning – At the year end, job planning compliance reached 91%, narrowly missing the national target of 95%. Whilst recent months have seen limited further movement, this position represents significant progress over the year, rising from 6.6% in April 2025, following sustained organisational focus and engagement. Compliance remains highest in smaller and better-resourced service areas, with CSCS and Families and Neighbourhoods consistently exceeding 97%, while larger service groups continue to

face capacity challenges due to the volume of plans requiring sign-off. The foundations are now in place to support further improvement in 2026/27, including earlier engagement, enhanced support mechanisms and closer team-based alignment between job planning and Patchwork rostering.

- Sickness absence - remains high, but has stabilised with little change in the underlying reasons for absence. More colleagues are progressing through formal sickness absence procedures, but this has not yet translated into a clear reduction in overall absence levels.

Work continues, to review the practical steps to support reducing absence management across areas outside of the acute setting. The HR Advisory team have been undertaking coaching sessions across service areas to increase the knowledge base on managing sickness absence, which has been well received and will continue to be offered as required. A national programme of work has been taking place to research and pilot alternative methods of managing sickness absence, with final adjustments to process and policy taking place. Upon completion of this work the Trust will look to introduce the revised method of supporting attendance and will monitor progress against this.

Focus Areas

- Vacancy levels increased in March 2026, driven by a continued reduction in starters and a higher-than-average number of leavers. Starter numbers fell marginally to 61.48 in March from 62.28 in February, while leavers rose to 111 compared with 90.43 in February. This increase reflects, in part, colleagues leaving under the Mutually Agreed Resignation Scheme (MARS), with many electing to exit at the financial year-end. Recruitment capacity has also been temporarily affected by insufficient cover for maternity leave, and by and sickness absence within the recruitment team, contributing to a slight increase in Trust time-to-hire. Both vacancy levels and time-to-hire will be closely monitored, with mitigating actions in place to support improvement over the coming months.
- Mandatory training – compliance has increased to 92.6% for March 2026 with all but one of the service groups showing an increase in mandatory training and the number of colleagues in date with their training. The February 2026 dip in training was mainly down to the mandating of the Oliver McGowan eLearning topic. This topic has seen an increase of 8.4% this month, to 75%.
- Appraisal - compliance improved slightly, by 0.1% to 80.2%. Due to a shortage of Medical Appraisers, some colleagues had their appraisals rescheduled to April and May 2026. As such we envisage improvement over the next couple of months within this

staffing group. Service Groups with their People Business Partners continue to highlight the importance of appraisal compliance within relevant meetings, as well as directly with colleagues and managers. Notably, the Mental Health & Learning Disabilities (MH&LD) service group has demonstrated consistent month-on-month improvement over the last nine months. This progress reflects proactive communication from the Service Group Director and the implementation of a clear trajectory. To support sustainable improvement, the Appraisal Deliverable Workstream has selected two Service Groups, MH&LD and Neighbourhoods, to participate in a test and learn approach aimed at identifying the most effective ways of working. This project will continue for the remainder of 2026.

- Formal HR cases - It is nearing 12 months since the improvement programme commenced, and a review is currently under way to establish activity against the original plan and begin to understand any initial differences this may have made. Significant work has been undertaken to update and develop guidance and toolkits for managers, which include guides, templates, FAQs and a range of bitesize videos to guide managers on areas such as carrying out return to work interviews, developing terms of reference and managing performance concerns. Activity to align the requirements with the Leadership offerings continues.

Despite the range of activity taking place to support employee relations, case numbers remain very high, which is adding pressure to the already stretched Advisory service. The Trust is not alone in this position, with reports indicating that there has been a national increase in HR related cases, concerns and conflict within the NHS. Contributing factors are linked to stress and burnout, high workload and cases being 'stranded' due to the level of complexity.

Alongside local work taking place to improve our position in relation to investigating officers, the Trust has also applied to take part in a national programme of work which has been developed to cover key areas such as the fundamentals of effective investigations, specialist modules relating to sexual misconduct and race discrimination and cultivating restorative cultures.

SOMERSET NHS FOUNDATION TRUST

PEOPLE

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance	
P1	Mandatory training: percentage completed	Combined	SFT	5	93.0%	93.0%	93.2%	93.2%	93.5%	93.9%	94.0%	94.0%	94.1%	94.2%	91.9%	92.6%	All courses >=90%= Green Overall rate <80%=Red Any other position = Amber		
P2	Monthly percentage of days lost due to sickness absence	NOF	5	4.6%	4.8%	5.1%	5.2%	5.1%	5.2%	5.6%	5.4%	5.7%	5.6%	5.4%	5.1%	SPC (Upper Control Limit 5.4%)			
P3	Sickness absence levels - rolling 12 month average (Trust-wide)	NOF	5	5.2%	5.2%	5.2%	5.1%	5.2%	5.2%	5.2%	5.1%	5.2%	5.2%	5.2%	5.2%	SPC (Upper Control Limit 5.2%)			
P4	Career conversations (12 months)	SFT	5	77.0%	77.0%	76.4%	77.4%	78.7%	77.7%	79.8%	81.1%	82.4%	81.4%	80.1%	80.2%	>=90%= Green >=80% - <90% =Amber <80% =Red			
P5	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)	SFT	5	8.4%	8.3%	8.4%	8.3%	6.7%	7.8%	7.8%	7.4%	7.9%	8.2%	8.3%	8.6%	<=8.5%= Green >8.5% to <=9.0% =Amber >9.0% =Red			
P6	Retention rate – rolling 12 months percentage of colleagues in post	SFT	5	89.1%	89.4%	89.5%	89.6%	89.4%	89.7%	89.8%	89.8%	89.9%	90.0%	89.9%	90.0%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red			
66	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	SFT	1,5	23.2%		24.4%		24.7%		25.3%						>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red		
		Who are female	SFT	1,5	57.9%		58.7%		59.0%		59.1%								
		With a recorded disability	SFT	1,5	4.2%		4.8%		4.8%		5.0%								
P10	Job planning: Percentage of Consultant and SAS doctor job plans signed off	SFT	5	6.6%	10.2%	12.8%	20.2%	31.6%	60.4%	76.4%	80.6%	83.7%	84.1%	84.1%	91.0%	>=95%= Green >=85% to <95% =Amber <85% =Red			
P11	Percentage of patient-facing staff receiving a 'flu vaccination	PAF	1,5	Reporting to run from October 2025 to January 2026.						35.4%	45.3%	50.7%	50.2%	56.5%	56.4%	By February 2025 >=33.1% = Green <33.1% = Red			
P12	Number of formal HR case works (disciplinary, grievance and capability).	SFT	5	58	69	55	68	86	88	128	105	95	124	111	123	SPC (Upper Control Limit 78)			

NARRATIVE REPORT

PATIENT EXPERIENCE AND INVOLVEMENT

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

What is going well

All of the Care Opinion stories the Trust received were responded to in March 2026. Key themes include kindness, compassion and staff behaviour being positive, with high confidence being mentioned for some consultants.

What is going less well

A notable reduction was observed in the number of Care Opinion stories received during March 2026. This period coincided with system changes implemented to improve the service tree, which may have contributed to the decrease. By mid-April 2026 the volume of stories had returned to expected levels, with numbers back on track to reach an average of around 30 per month.

Of the stories submitted, a small number raised concerns via Care Opinion, including reports of inconsistent clinical decision making and patients feeling that their symptoms were minimised or dismissed during the early stages of care.

The number of complaints received by the Trust has shown a sustained increase since June 2025. The Trust currently has 133 open formal complaints, compared with an average of 121 open formal complaints during Q4, and an average of 75 open formal complaints in Q4 2024/25. Analysis of complaints continues to identify recurrent themes, including an increase in dismissive communication and concerns that patients and the people who matter to them do not feel listened to, heard or understood.

There are also persistent themes relating to a lack of personalised care and concerns regarding fundamental aspects of nursing care, including nutrition and hydration, end-of-life care, and pressure area care. In addition, complaints are demonstrating increasing levels of complexity, with more legalistic language being used. This is thought to be influenced, in part, by the increasing use of artificial intelligence tools by complainants to support the formulation of their correspondence.

In March 2026, the response rate for formal complaints responded to within agreed time frame reduced to 49.0%. Delays were attributable to the following factors:

- Intensified focus on the quality of responses, with a focus on the accuracy of information and comprehensive responses to all questions within the initial response.
- Ongoing operational and workforce challenges across all areas to be able to review, prioritise and respond to complaints.
- Continued challenges with ownership and accountability of formal complaints within some service areas and individual clinicians. This is being addressed through proactive support and engagement of the patient experience leadership team alongside service group governance leads and Associate Directors of Patient Care.
- Continued complexity, with a large proportion of complaints overlapping teams and service groups, and challenges with service groups identifying a lead for the review and ongoing management of a complaint.
- The timely availability of paper medical notes when multiple teams are involved across service groups.













During March 2026, the Trust received eight requests for second letters, an increase compared with previous months. Seven related to the Medical Services Group and one to the Surgical Services Group. In all cases, the requests reflected dissatisfaction with, or disagreement about, the content of the initial response provided.

Focus of improvement work

- To promote Care Opinion during the Patient Experience week at the end of April.
- To continue facilitation of co-production work, ensuring the Patient Voice is part of every stage of a project.
- Continue with job planning within the team to ensure that 100% of stories can be responded to / engaged with.
- The Care Opinion service tree is now complete for Musgrove and work continues to complete this for the rest of the Trust.
- Staff engagement was planned for April, but due to capacity within the team, this work will be progressing into May 2026.
- Complaints training has been successfully piloted, with delivery dates now scheduled across multiple sites, including West Mendip Community Hospital. Uptake has been high, and all current sessions are fully booked. Additional training dates are being arranged to meet ongoing demand.
- A weekly sit rep outlining each service group's position on formal complaints is submitted to the Director of Patient Experience and Engagement. Its purpose is to provide senior leaders with clear oversight - particularly of complaints that are approaching risk status (30 to 40 days) - to support timely and effective escalation.
- Tailored escalation pathways have been established for each service group (Families, Neighbourhoods, and Surgical), including escalation to Associate Medical Directors and Associate Directors of Patient Care before complaints reach the breach point.
- Regular tracker meetings are held between complaints co-ordinators and service groups to identify emerging delays and raise any concerns promptly.

- Development of a set of principles to assist in the categorisation of complaints (i.e. fully upheld, partially upheld, not upheld).
- A review of performance targets has been undertaken to ensure they remain aligned with national standards.
- The NHS Complaint Standards action plan has been developed and is subject to ongoing review.
- Work is in progress to develop an interactive dashboard designed to improve visibility of complaint timelines and overall performance.

SOMERSET NHS FOUNDATION TRUST
PATIENT EXPERIENCE AND INVOLVEMENT

No.	Description	Source	Links to strategic aims	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Thresholds	Trend	Variation / Assurance
PE1	Care Opinion: Number of stories per month	SFT	2	48	38	34	33	35	34	25	37	30	36	34	16	Increase from 2024/25 baseline		
PE2	Care Opinion: Percentage of stories with responses	SFT	2	97.9%	100.0%	100.0%	100.0%	100.0%	91.2%	92.0%	81.0%	100.0%	97.2%	100.0%	100.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE3	Percentage of complaints responded to within the timescale agreed with the complainant	SFT	2	39.3%	54.5%	73.3%	73.3%	56.8%	62.0%	52.8%	73.0%	50.0%	55.8%	51.5%	49.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE4	Number of complaints resulting in second letters	SFT	2	3	2	5	7	8	10	3	8	2	6	4	8	Monitored using Statistical Process Control rules. Report by exception.		
PE5	Percentage of formal complaints fully upheld	SFT	2	17.6%			14.8%			10.7%			10.4%			Compare to national average		
PE6	Percentage of formal complaints partially upheld	SFT	2	63.7%			62.3%			72.8%			73.6%			Compare to national average		

Appendix 1 – Specialty and tumour-site level performance

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

RTT specialty	Over 18-week waiters	Over 52-week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	779	24	2657	70.7%
Urology	1375	64	3020	54.5%
Trauma & Orthopaedics	3140	278	8419	62.7%
Ear, Nose & Throat (ENT)	2141	196	4948	56.7%
Ophthalmology	685	14	2990	77.1%
Oral Surgery	1581	80	3335	52.6%
Plastic Surgery	11	1	113	90.3%
Cardiothoracic Surgery	1		24	95.8%
General Medicine	13		48	72.9%
Gastroenterology	459	5	1935	76.3%
Cardiology	1005	6	3353	70.0%
Dermatology	677	8	2975	77.2%
Thoracic Medicine	164	1	1448	88.7%
Neurology	587	4	1399	58.0%
Rheumatology	305	4	739	58.7%
Geriatric Medicine	100		611	83.6%
Gynaecology	1577	92	3629	56.5%
Other – Medical Services	964	12	3677	73.8%
Other - Paediatric Services	260	14	1018	74.5%
Other - Surgical Services	2264	225	5744	60.6%
Other – Other Services	5		220	97.7%
Total	18093	1028	52302	65.4%

Table 2 – Performance against the 62-day GP cancer standard in February 2026.

Tumour site	No of breaches	Trust performance
Breast	13.0	69.0%
Colorectal	19.5	51.9%
Gynaecology	4.0	50.0%
Haematology	1.0	95.8%
Head & Neck	3.0	66.7%
Lung	11.5	45.2%
Other	2.0	76.5%
Skin	9.5	89.3%
Upper GI	2.0	88.9%
Urology	26.5	67.5%
Total	92.0	73.1%

Seventeen patients were treated in February 2026 on or after day 104 (the national 'backstop' for GP pathways). A breakdown of the breaches is as follows:

- Eight patient pathways had internal delays mainly related to a lack of capacity. Most of these pathways also had elements of unavoidable delays, due to additional investigations, medical complexity, waiting times at other organisations and periods of patient choice.
- Four patients had a complex pathway, including patients requiring additional or repeat diagnostics, transferring from a different cancer pathway and being treated at the same time for another cancer.
- Three patients chose to delay their diagnostic tests and treatments.
- One pathway had administrative / pathway management delays.
- One pathway was delayed due to a range of factors, including elements outside of our control.

Appendix 2 – Infection Control and Prevention – March 2026

MRSA bloodstream infections	Commentary on MRSA /MSSA BSIs
Musgrove Park Hospital = 0 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0 End of year total = 7	There are no national thresholds assigned to MRSA or MSSA bloodstream infections (BSI). However, there is a zero tolerance of MRSA BSIs and as a Trust we assign an internal threshold for MSSA. MRSA – case numbers have increased this year, almost double the previous year.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 0 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 0 Internal Threshold = 64 End of year total = 53	MSSA – Trust apportioned case numbers have reduced this year. We end the year under our internal threshold and have had 24 cases fewer than the previous year. Overall case numbers of MSSA BSI remain stable but our proportion of Trust attributable cases has decreased: <ul style="list-style-type: none"> • 2023/24 – 152 cases, 43% trust attributed • 2024/25 – 162 cases, 48% trust attributed • 2025/26 – 163 cases, 32% trust attributed <p>It is not clear why MRSA BSIs are rising and yet MSSA BSIs are reducing. Sources of MRSA BSIs are varied with no clear themes. However, one of the most common sources of MSSA BSI remains peripheral vascular cannulae. Although Trust case numbers of MSSA have reduced, the portion due to peripheral cannulae has increased. A concentration of cases has occurred in Cardiology on the MPH site and improvement work has begun there. In the new financial year, this will be extended to Cardiology in YDH as this appears to account for some of the increased case numbers.</p>
E. coli bloodstream infections	Commentary on Gram-negative bloodstream infections
Musgrove Park Hospital = 3 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 0 Threshold = 100 Total year to date = 125	The number of Trust apportioned cases of Gram-negative BSIs have increased this year (205) in comparison to last year (184). We end the financial year having breached the thresholds for all Gram-negative bloodstream infections. In comparison to the previous year case numbers of E. coli and Klebsiella remain stable, but case numbers of pseudomonas have increased from 14 to 30 (114%). The reason for this remains unclear at this point. The most common sources are still urine (27%) and biliary (24%). Improvement work has been in place since 2023 to reduce the number of Gram-negative BSIs due to a Catheter Associated Urinary Tract Infection (CAUTI) with an aim to reduce BSIs from 32% to 20%. The end of year data is not finalised but as of January 2026, this aim has been sustained with 12.7% Gram-negative BSIs due to CAUTI.

<p>Klebsiella bloodstream infections</p> <p>Musgrove Park Hospital = 3 Yeovil District Hospital = 2 Community Hospitals / Mental Health = 0</p> <p>Threshold = 36 Total year to date = 50</p>	<p>There needs to be more analysis of the data to try to determine the unusual increase in Pseudomonas aeruginosa cases.</p>
<p>Pseudomonas bloodstream infections</p> <p>Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0</p> <p>Threshold = 12 Total year to date = 30</p>	
<p>C. difficile</p> <p>Musgrove Park Hospital = 0 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0</p> <p>Threshold = 91 Total year to date = 83</p>	<p>Commentary on C. difficile</p> <p>The Trust ends the financial year below threshold, and we continue to have the lowest rates of infection in the region.</p>
<p>Respiratory Viral Infections - inpatients</p> <p>COVID (Trust Cases) = 16 Musgrove Park Hospital = 11 Yeovil District Hospital = 5 Community / Mental Health = 0</p> <p>Influenza = 25 (Inpatients) Musgrove Park Hospital = 18 Yeovil District Hospital = 7 Community Hospitals / Mental Health = 0</p> <p>Respiratory Syncytial Virus (RSV) = 15 (Inpatients) Musgrove Park Hospital = 8 Yeovil District Hospital = 6 Community / Mental Health = 1</p>	<p>Commentary on Respiratory Viral Infections</p> <p>Respiratory Viruses All respiratory virus case numbers have reduced in line with the end of the winter period.</p>

Outbreaks	Commentary on outbreaks
<p>COVID = 5 Musgrove Park Hospital = 3 Yeovil District Hospital = 2</p> <p>Influenza = 1 Musgrove Park Hospital = 1</p> <p>Norovirus = 0</p> <p>Carbapenemase Producing Organism (CPO) - YDH</p> <ul style="list-style-type: none"> • YDH - Since January 2022 there have been 113 cases of CPO identified on the YDH site possibly linked to the overall outbreak. 	<p>Carbapenemase Producing Organism (CPO) - YDH This has been managed as a Trust-wide outbreak which has spanned two key time periods, January 2022 to August 2023 and December 2023 to the current time. There are two different resistance mechanisms involved. The genes that encode for these resistance mechanisms can move between different species of bacteria which makes the linking of cases in the outbreak more challenging.</p> <p>During February and March, five cases linked to a single ward on the YDH site have been identified. A separate outbreak management group has been established to investigate and manage this cluster. There are two possible routes of transmission, direct patient to patient and environmental. Interventions are focusing on both transmission routes. Some targeted patient testing is in place to identify unknown cases and monitor further cases. This will be monitored by the Quarterly Infection Control Committee.</p>
Surgical Site Infections	Commentary on Surgical Site Infections
<p>Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions.</p> <p>Musgrove Park Hospital Site Continuous surveillance for Total Hip Replacement (THR), Total Knee Replacement (TKR) and Spinal Surgery has been in place on the MPH site since 2009.</p> <p>Caesarean Section Continuous surveillance for Caesarean Section on the MPH site started in December 2025. There is no national benchmark for C-sections against which we can compare. However, in 2022/2023, an initiative run by Health</p>	<p><u>Musgrove Park Hospital Site</u></p> <ul style="list-style-type: none"> • Hip Replacement Within the last year (March 2025 to February 2026) a total of 344 operations were undertaken with no infections identified. • Knee Replacement Within the last year (March 2025 to February 2026) a total of 203 operations were undertaken and no infections identified • Spinal Surgery Within the last year (March 2025 to February 2026) a total of 339 operations were undertaken and 4 infections identified giving an infection rate of 1.18%. The infection rate is in line the national benchmark of 1.1%.

<p>Innovation, West of England launched PreCiSSlon: Preventing Caesarean Birth Surgical Site Infection. This project reduced infection rate from 18.5% to 13.3%. Therefore, the lower rate of 13.3% will be used as a benchmark to monitor our rates against.</p> <p>Yeovil District Hospital Site Continuous surveillance on total hip replacement surgery has been in place on the YDH site since April 2022 and continuous surveillance was commenced on total knee replacement surgery from January 2024.</p>	<ul style="list-style-type: none"> • Caesarean Section Between December 2025 to January 2026 a total of 257 C-sections were undertaken and 16 infections identified (2 readmissions and 14 patient-reported) giving an infection rate of 6.2% which is below the adopted benchmark of 13.3%. <p><u>Yeovil District Hospital Site</u></p> <ul style="list-style-type: none"> • Hip Replacement Within the last year (March 2025 to January 2026) a total of 334 operations were undertaken with no infections identified. • Knee Replacement Within the last year (March 2025 to January 2026) a total of 447 operations were undertaken with no infections identified. <p>The national rate is calculated over the period April 2019 to March 2024 and therefore not directly comparable to trust infection rates. However, as a trust the national benchmark is always used as a guide.</p>
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SOMERSET NHS FOUNDATION TRUST

PRODUCTIVITY OPPORTUNITIES IN OUR COMMUNITY, MENTAL HEALTH AND ACUTE SERVICES

1. PURPOSE

- 1.1 This paper sets out a range of potential productivity opportunities for Somerset NHS Foundation Trust (SFT), based upon data and charts drawn from the 'Productivity and Efficiency Benchmarking' section of NHS England's Model Health System (formerly Model Hospital), a digital, data-driven tool designed for NHS providers and commissioners to benchmark quality and productivity. The paper also draws upon information contained in NHS England's productivity improvement packs for mental health services and community physical health services, and also the findings of national benchmarking projects undertaken and published by the NHS Benchmarking Network.

2. PRODUCTIVITY OPPORTUNITIES – COMMUNITY PHYSICAL HEALTH SERVICES

- 2.1 NHS England's productivity improvement pack for community physical health services indicates that a potential productivity gain of £11.3 million exists for SFT, through reducing the average length of stay in its community hospital inpatient wards. SFT is classified as falling in the 'Highest opportunity' quartile of providers.
- 2.2 This opportunity is calculated using the average length of stay implied by bed day data submitted to the Secondary Uses Services (SUS) for episodes discharged between April and September 2025, where the bed type is classified as 'community'. The opportunity is the value of reducing the length of stay in line with the top 25% of performers for all community providers submitting data to SUS, so that it is assumed that additional community episodes might then be delivered. These additional episodes are quantified using the average episode cost (£5,936) reported in the 2023/24 National Cost Collection.

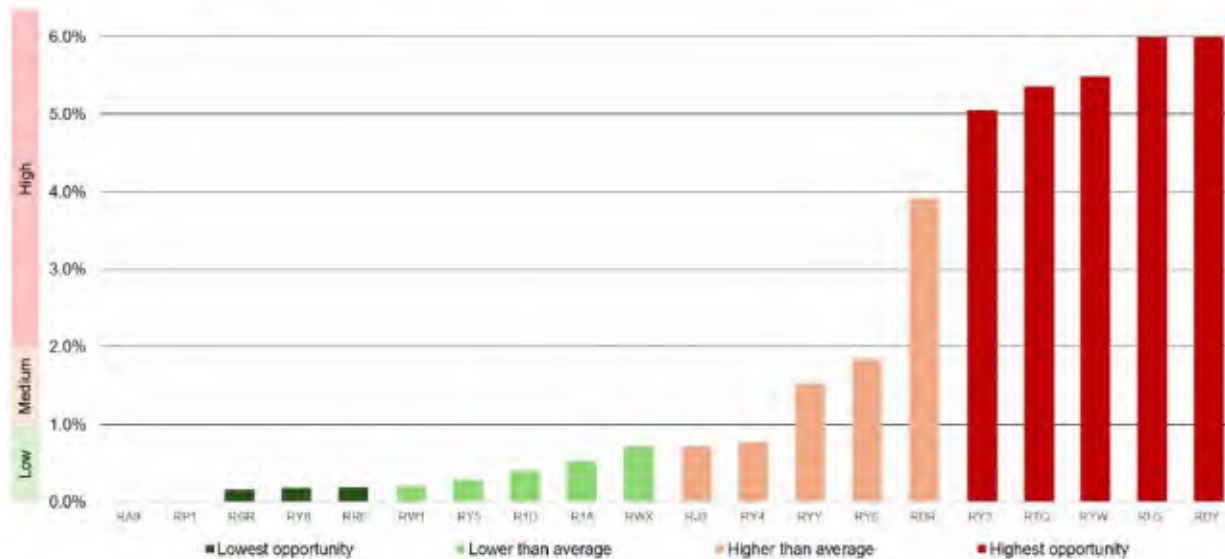
Community length of stay

Somerset NHS Foundation Trust
 Potential opportunity: £11.3m

Summary
 Trusts can improve productivity performance by reducing how long patients stay in community inpatient services, in line with best performing trusts..
 Higher means bigger opportunity.

Chart 4 - Community length of stay opportunity (% of operating expenditure) ⁽¹⁾

Value: 6.0% **Median:** 0.7%
Group: Highest opportunity



- 2.3 The productivity improvement pack also indicates a potential gain of £1.3 million, through the reduction of patient-did-not-attend (DNA) rates for SFT’s community physical health services. SFT is classified as ‘lower than average’, in terms of the potential level of opportunity.
- 2.4 This opportunity is based on the data recorded in the Community Services Data Set (CSDS) as DNA or arrived too late to be seen, which is compared to total attendances to give a DNA rate. Trusts are benchmarked to the top 25% of performers for

community providers, with additional activity converted to patient contacts. This additional activity is quantified using the average national cost for community contacts (£86) to give the estimated financial opportunity.

Patient DNAs

Somerset NHS Foundation Trust

Potential opportunity: £1.3m

Summary

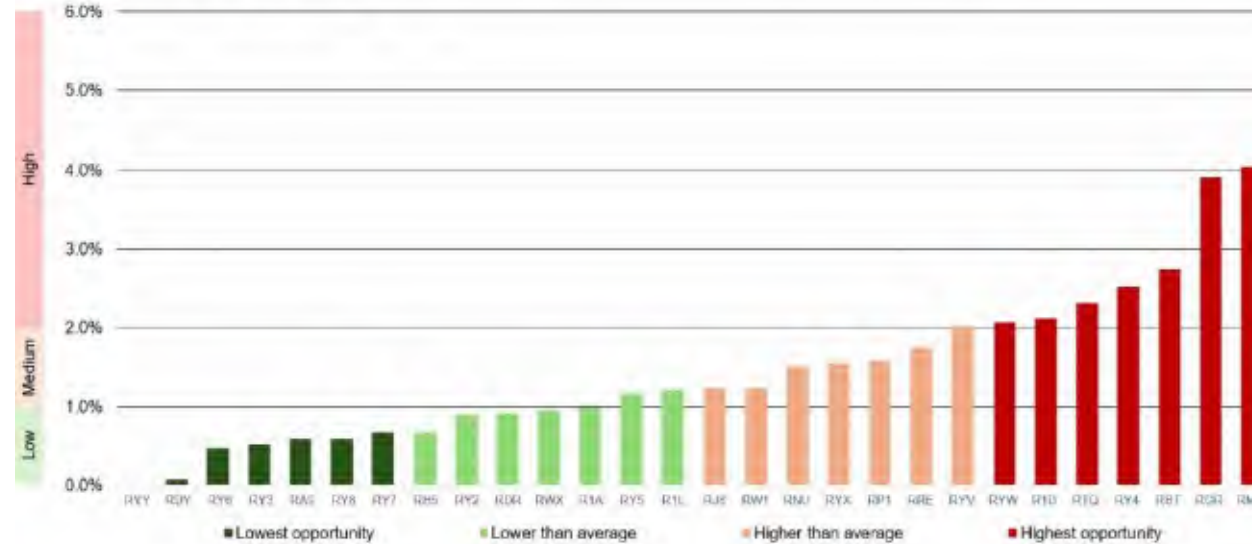
Trusts can improve productivity performance by reducing how many patients did not attend appointments.

Higher means bigger opportunity.

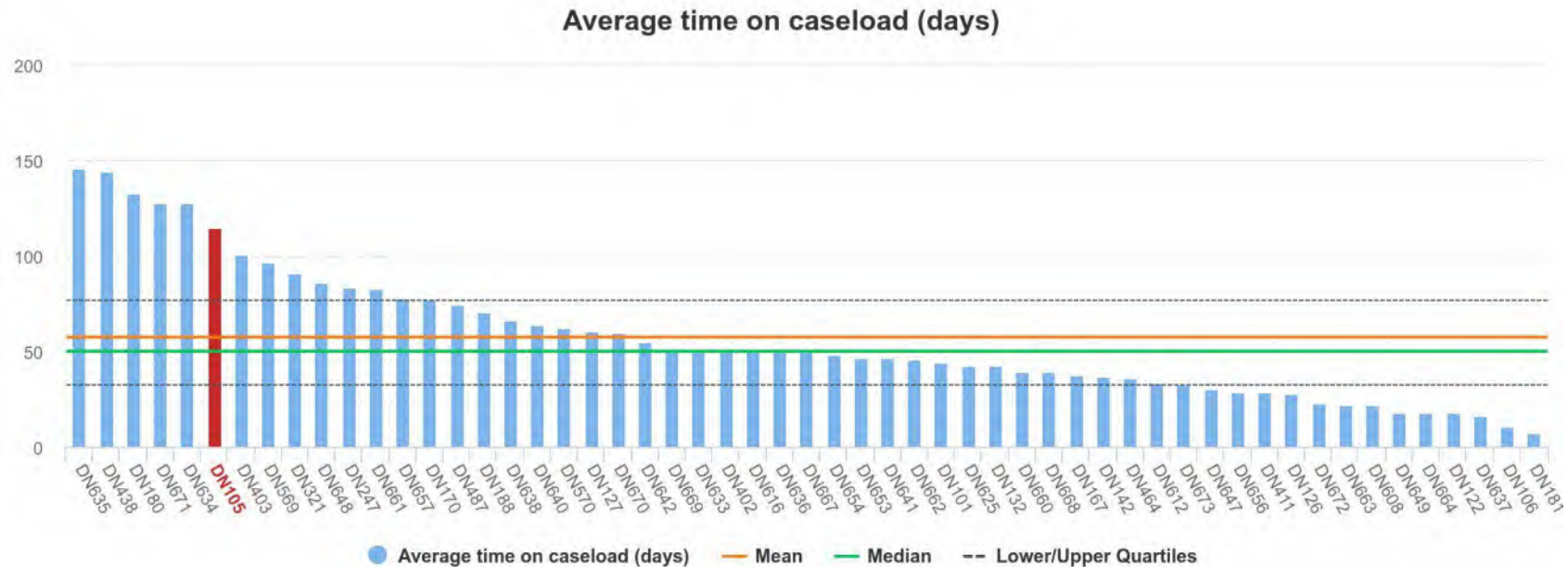
Chart 5 - Patient did not attend (DNAs) opportunity (% of operating expenditure) [1]

Value: 0.7% Median: 1.4%

Group: Lower than average



2.5 The productivity improvement pack also identifies an additional, financially unquantified opportunity in relation to community nursing. The opportunity shows the number of care contacts a clinician carries out per day, dividing care contacts in community nursing divided by total clinical full-time equivalents (FTEs) reported by the Trust against community nursing. Data is reported into CSDS and NHS workforce statistics.



<https://members.nhsbenchmarking.nhs.uk/outputs/60?tier=87917&group=0>

3. PRODUCTIVITY OPPORTUNITIES – MENTAL HEALTH SERVICES

- 3.1 NHS England’s productivity improvement pack for mental health services indicates that a potential productivity gain of £5.2 million exists for SFT, through reducing the average length of stay in its mental health inpatient wards.
- 3.2 This figure is calculated from data in the 2024/25 Mental Health Services Dataset (MHSDS), showing how long patients are treated, in non-secure bed days. This data is used to calculate a national 75th percentile for each ward type (with secure wards excluded), which is where only 25% of patients are waiting longer than that patient. Trusts are benchmarked to this point and the excess bed days represent the opportunity, for example if these bed days were replaced with additional patients being treated. The opportunity is quantified by multiplying the excess bed days by half the national average bed day cost (£356), as derived from the 2023/24 National Cost Collection.

Mental Health LoS

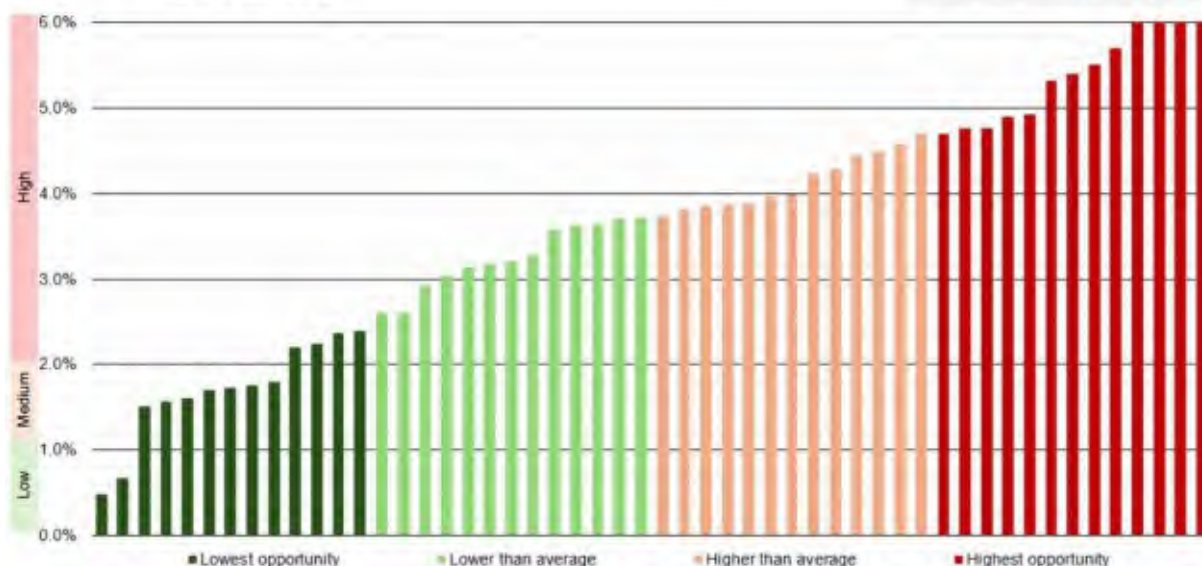
Somerset NHS Foundation Trust
 Potential opportunity: £5.2m

Summary

Trusts can improve productivity performance by reducing how long patients stay in non-secure mental health wards, in line with best performing trusts. This may include shifting care into community settings, where it is clinically appropriate to do so.
 Higher means more opportunity

Chart 4 - Mental health length of stay opportunity (% of operating expenditure) [7]

Value: 2.9% Median: 3.7%
 Group: Lower than average



3.3 The productivity improvement pack also indicates a potential gain of £4.3 million in relation to SFT’s Talking Therapies service, through a combination of reducing DNA rates and increasing clinical contact hours. SFT is classified as being in the highest quartile, in terms of the potential level of opportunity.

NHS Talking Therapies

NHS Somerset

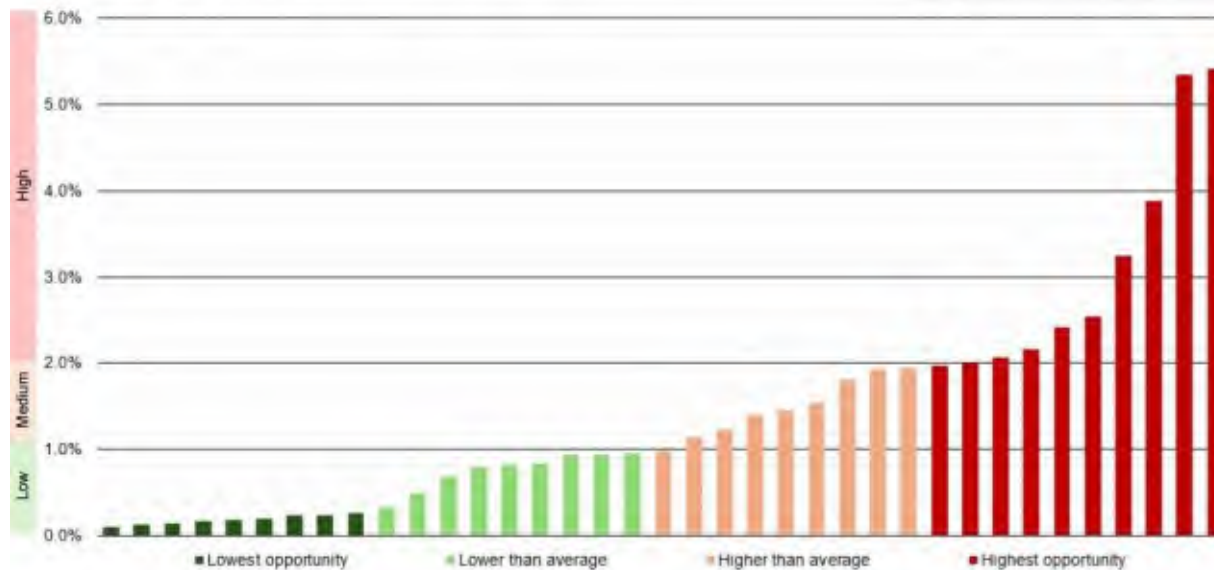
Potential opportunity: £4.3m

Summary

Trusts can improve productivity performance through the delivery of NHS Talking Therapies. This includes increasing contact hours per therapist or reducing patient did not attend (DNAs). Opportunities are calculated at a system level based on available data. Higher means more opportunity.

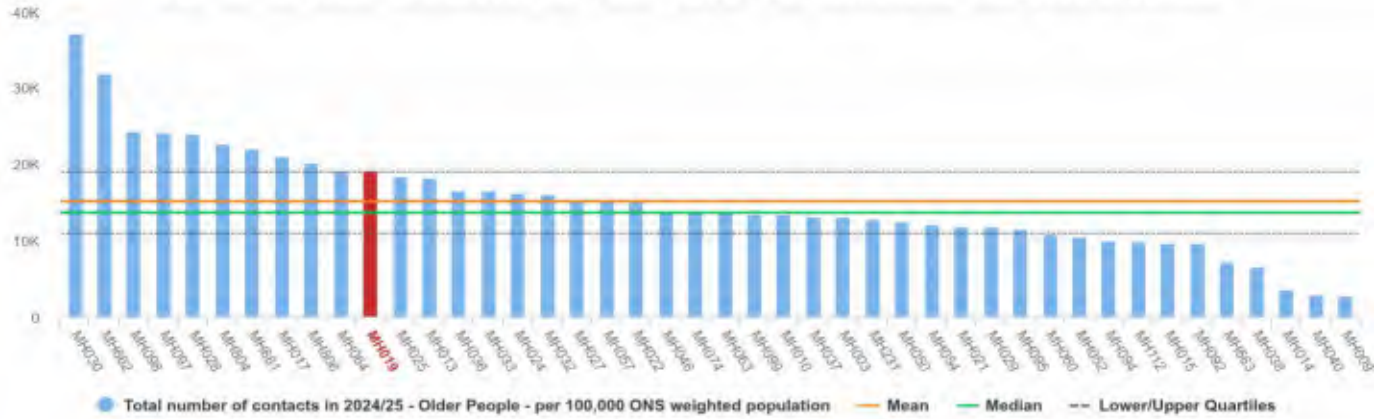
Chart 5 - NHS Talking Therapies opportunity (% of operating expenditure) [10]

Value: 2.4% Median: 1.0%
 Group: Highest opportunity



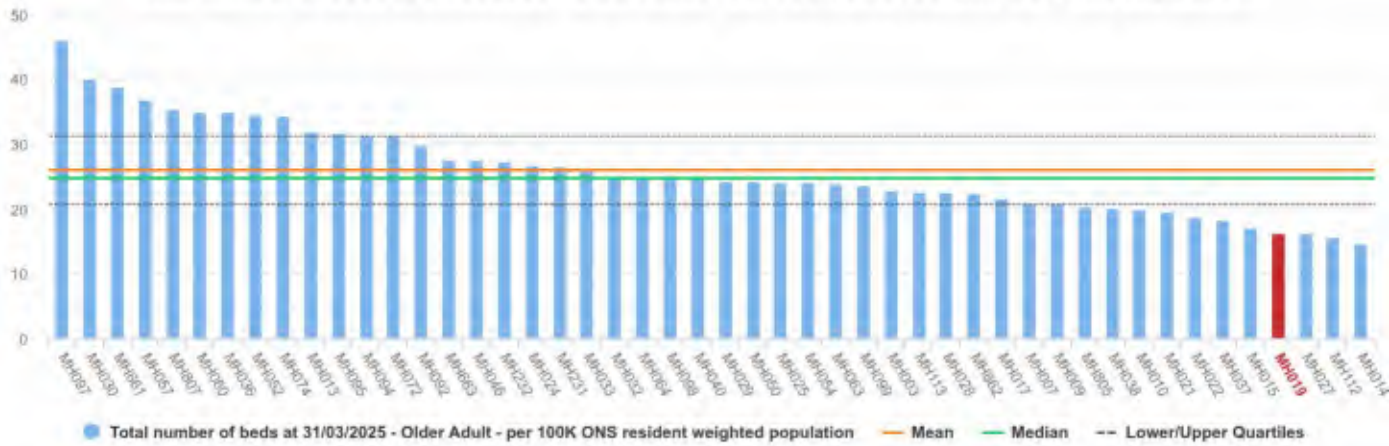
3.4 Data is reported on the proportion of patients not attending booked appointments and systems are assumed to move to the top quartile, with each additional appointment valued at the national average cost of an appointment (£159), based on the 2023/24 National Cost Collection. Data is also reported on contact hours per week for a clinical full-time equivalent (FTE). This includes face-to-face, telephone and video contact, and assumes a 46-week year. Systems are assumed to move to the top quartile of contact rates, and an average NHS Talking Therapies appointment (£159) is expected to take 45 mins of clinical contact time, so an hour is valued at £212. All systems are assumed to make a further 2% reduction in both the number of DNA appointments and contact hours per FTE.

Total number of contacts in 2024/25 - Older People - per 100,000 ONS weighted population



<https://www.ons.gov.uk/people-population/population-demographics/population/population-in-the-uk>

Total number of beds at 31/03/2025 - Older Adult - per 100K ONS resident weighted population

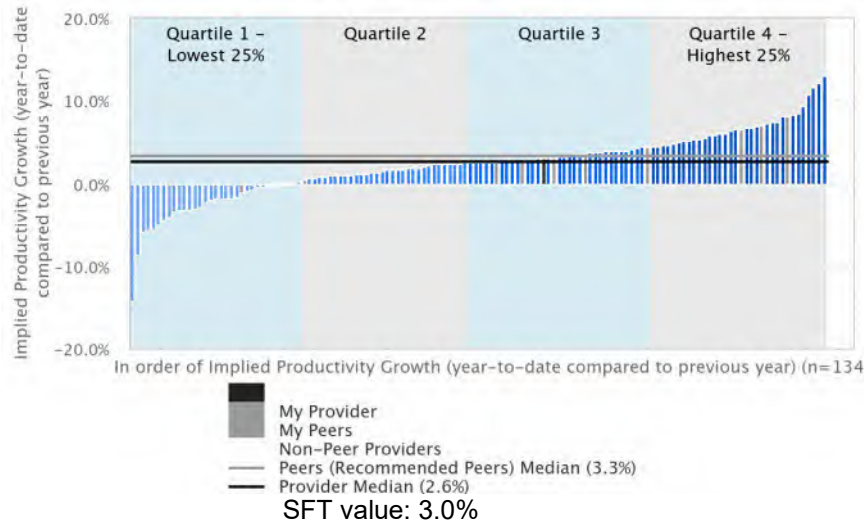


<https://www.ons.gov.uk/people-population/population-demographics/population/population-in-the-uk>

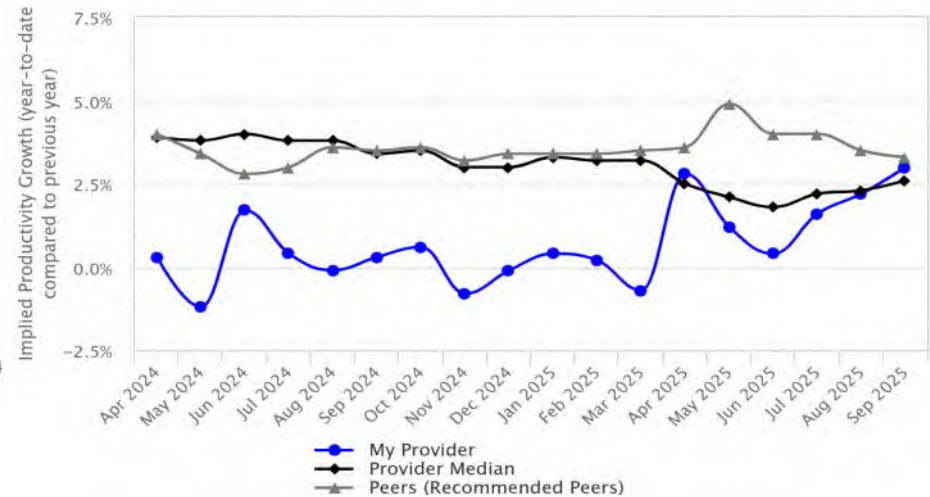
4. PRODUCTIVITY OPPORTUNITIES - ACUTE SERVICES

- 4.1 The Model Health System illustrates the Trust's position in relation to a broad range of indicators, and provides a comparison with the median and top decile performance levels, as well as the performance of ten recommended peer organisations.
- 4.2 The recommended peers are Trusts that are deemed similar to SFT, according to a range of factors that affect productivity, which the trust cannot change in the short to medium term, and that have an impact on cost per weighted activity unit (WAU). The ten comparator peers identified by Model Health for SFT are:
- East Kent Hospitals University NHS Foundation Trust
 - Gloucestershire Hospitals NHS Foundation Trust
 - Norfolk and Norwich University Hospitals NHS Foundation Trust
 - North West Anglia NHS Foundation Trust
 - Northumbria Healthcare NHS Foundation Trust
 - Portsmouth Hospitals University NHS Trust
 - Shrewsbury and Telford Hospital NHS Trust
 - South Tyneside and Sunderland NHS Foundation Trust
 - University Hospitals Dorset NHS Foundation Trust
 - Worcestershire Acute Hospitals NHS Trust
- 4.3 The NHS Oversight Framework includes a measure for productivity, to “Close the activity / WTE gap against pre-Covid levels” and the chart below sets out the implied productivity growth for the year to date, showing SFT to be similar to the median level.
- 4.4 The trend data for this measure shows that SFT has been tracking below the peer and provider average levels, but closed the gap in August and September 2025.

Implied Productivity Growth (year-to-date compared to previous year), National Distribution



Implied Productivity Growth (year-to-date compared to previous year)



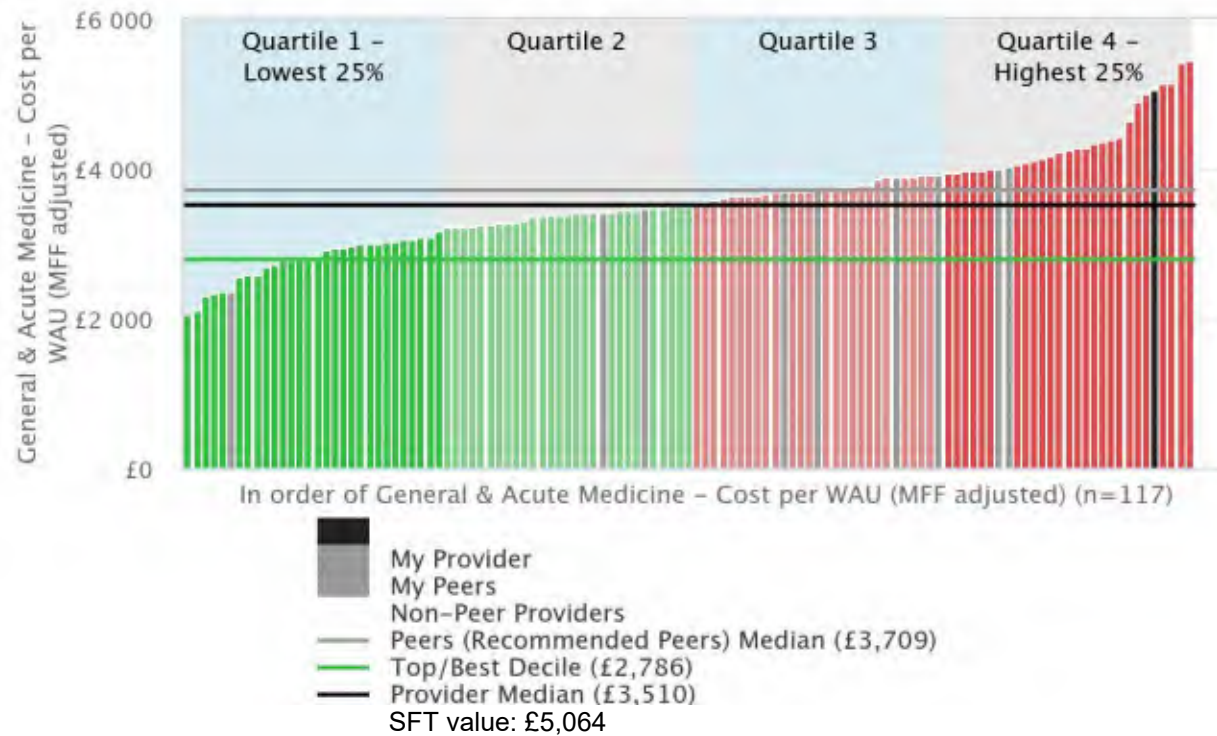
SPECIALTY-LEVEL OPPORTUNITIES FOR IMPROVEMENT

- 4.5 In terms of their levels of potential financial opportunity, the top five areas identified by the Model Health System as 'Opportunities for Improvement' for Somerset NHS Foundation Trust are set out below.
- 4.6 For these opportunities, the cost per Weighted Activity Unit (WAU) for each specific specialty is used. This figure is then compared with both the recommended peer group's median and the lowest quartile for the same metric. If the cost per WAU value exceeds the recommended peer group's median, two distinct opportunity values are identified. The first opportunity is to reach the peer median, and the second is to attain the lowest quartile cost. However, if the cost per WAU value falls below the median but remains above the lowest quartile, only a single opportunity is presented, focusing on reaching the lowest quartile cost.

- 4.7 The opportunity value to achieve the median is calculated as the difference between the Cost per WAU value and the recommended peer median Cost per WAU, multiplied by the Cost per WAU activity value for that specific specialty. Similarly, the opportunity value to reach the lowest quartile is determined by subtracting the recommended peer lowest quartile Cost per WAU from the Cost per WAU value, and then multiplying this by the Cost per WAU activity value for the given specialty.
- 4.8 Separately to the WAU, but also used to inform the NHSE Benchmarking outputs, is the nationally mandated National Cost Collection (NCC) information. This analysis provides slightly differing values for the financial opportunities to those which follow, as the WAU is not the calculating factor. However, those outputs can be utilised to support both the trust productivity and transformation agendas.
- 4.9 We are looking to utilise the NCC information to support this work to recognise where opportunities are identified, determine whether cost can be removed based on allocation drivers, and classify what the drivers of the cost variation are (for example, whether they are nurse or clinician driven).
- 4.10 The National Cost Index (NCI) is the calculation to the national average of the work undertaken by the Trust. The NHSE benchmarking work has been derived based on all activity by Point of Delivery (POD) reaching the top cost quartile. This does mean where a service is better than the national average (NCI 100) there is still potentially a financial opportunity for the service to achieve the national top quartile.
- 4.11 The identified opportunities at specialty level, and also in respect of Nursing and support staff are due in large part to SFT having a comparatively long length of stay, linked to its unfavourable position for the percentage of beds occupied by patients who do not meet the criteria to reside.

General and Acute Medicine

General & Acute Medicine – Cost per WAU (MFF adjusted), National Distribution



Financial opportunity: £38.7 million to £51.1 million.

Stroke

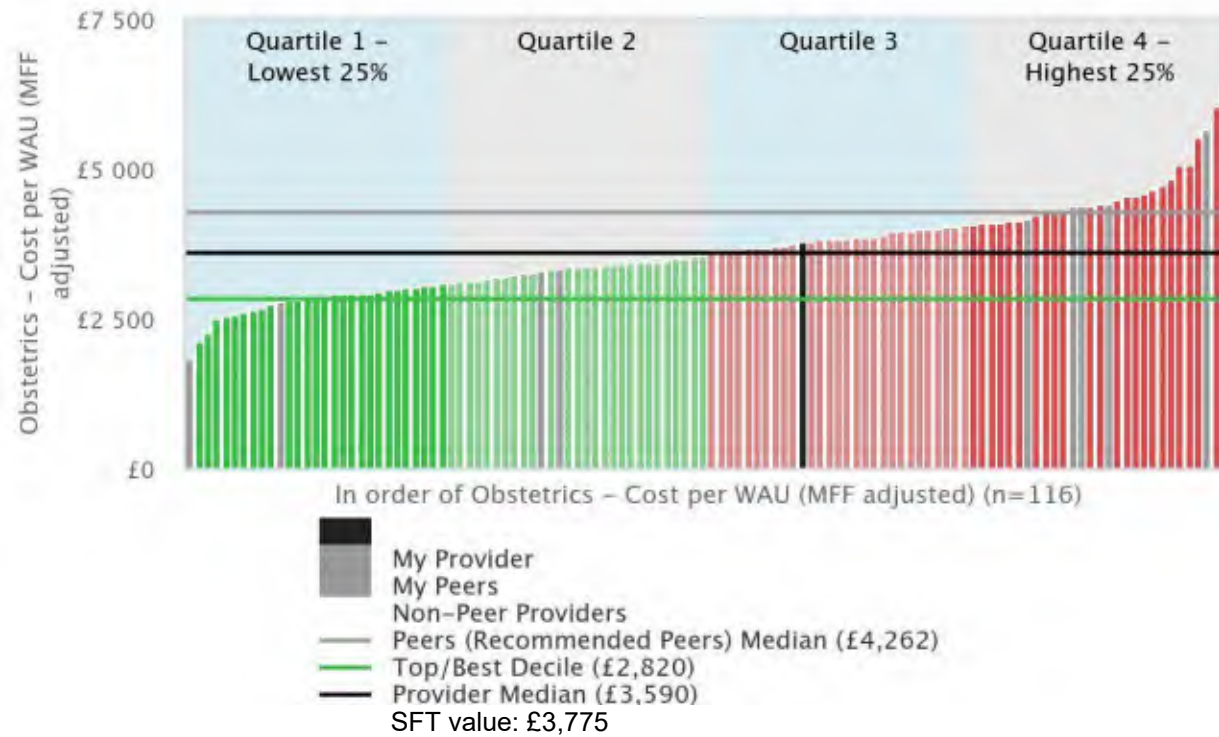
Stroke- Cost per WAU (MFF adjusted), National Distribution



Financial opportunity: £10.9 million to £13.2 million.

Obstetrics

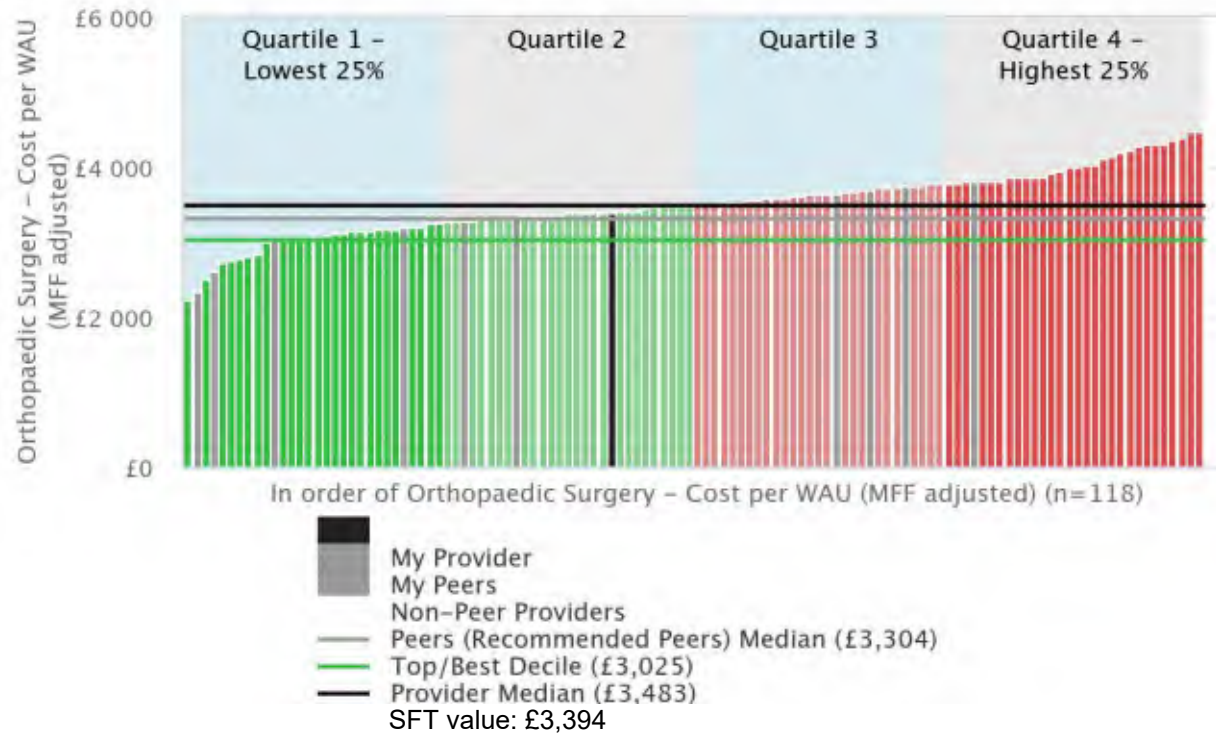
Obstetrics – Cost per WAU (MFF adjusted), National Distribution



Financial opportunity: £3.1 million to £8.2 million.

Orthopaedics

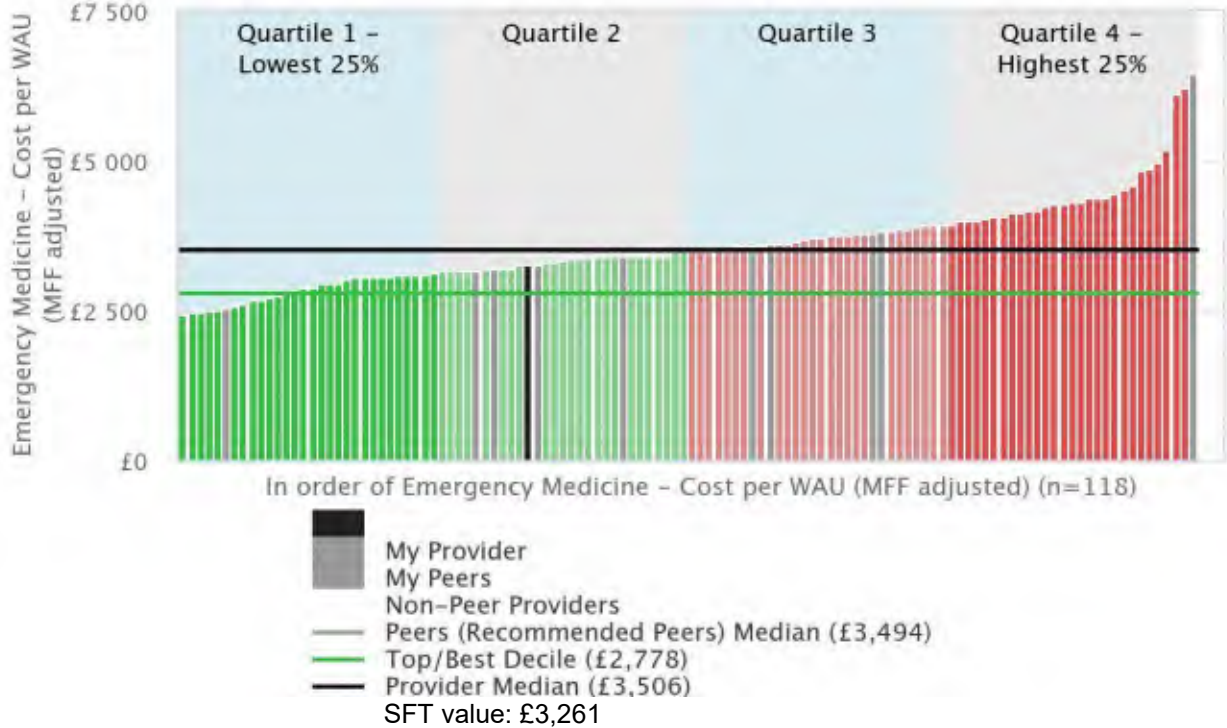
Orthopaedic Surgery – Cost per WAU (MFF adjusted), National Distribution



Financial opportunity: 0 to £7.3 million.

Emergency Medicine

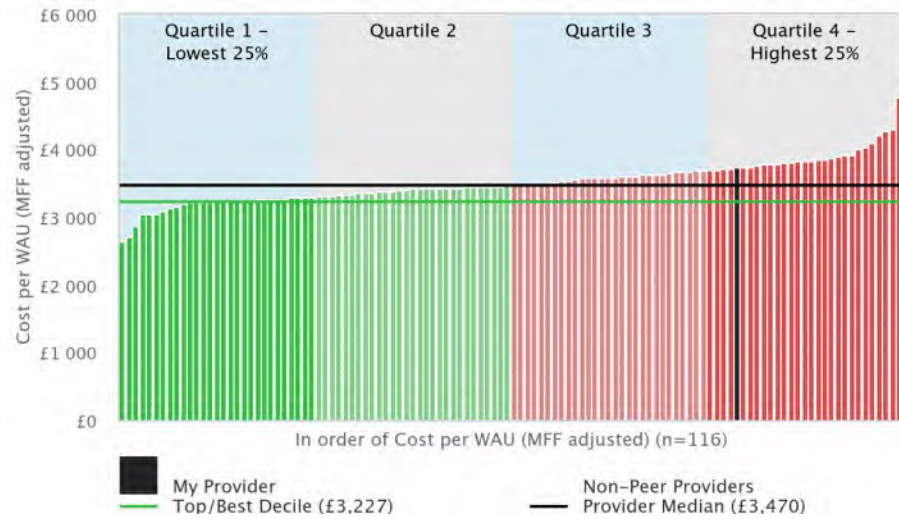
Emergency Medicine – Cost per WAU (MFF adjusted), National Distribution



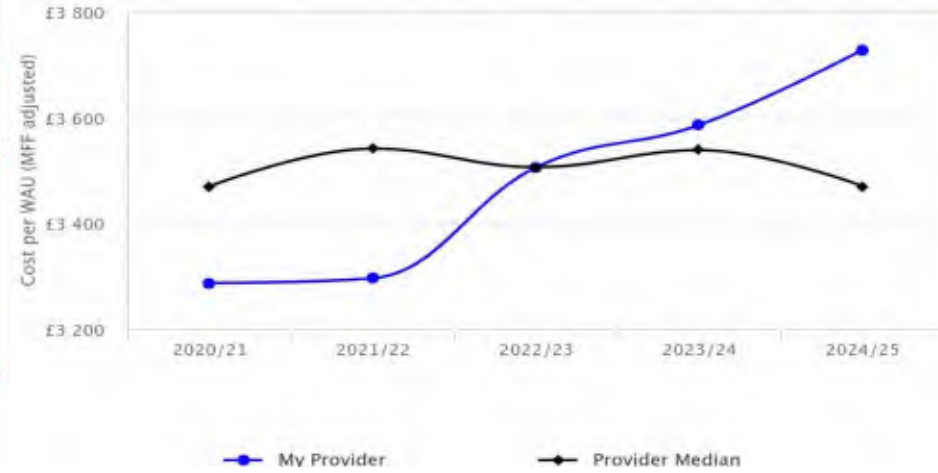
Financial opportunity: 0 to £6.8 million.

4.12 At an organisational level, SFT's cost per WAU is in the highest quartile nationally, with a figure of £3,728, compared to a national average of £3,470. SFT's cost per WAU had been tracking below the national average until 2022/23, since when it has been higher.

Cost per WAU (MFF adjusted), National Distribution

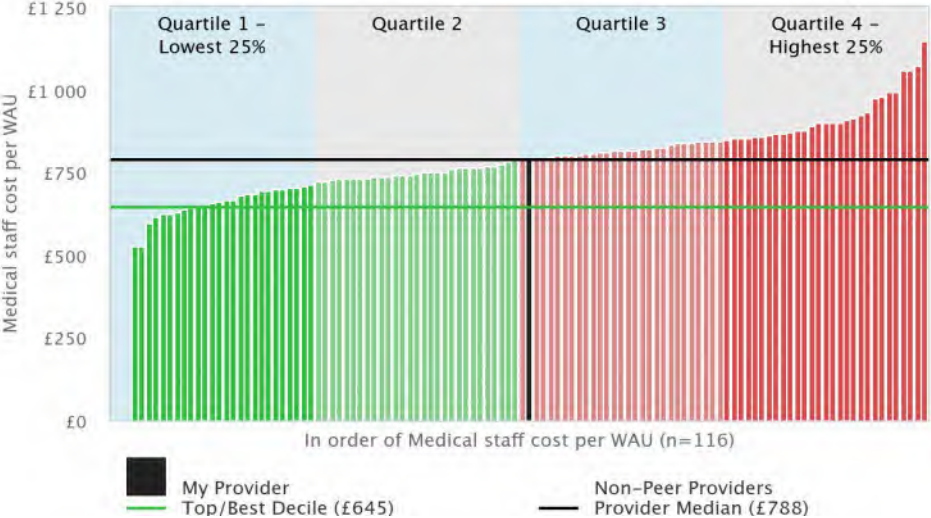


Cost per WAU (MFF adjusted)

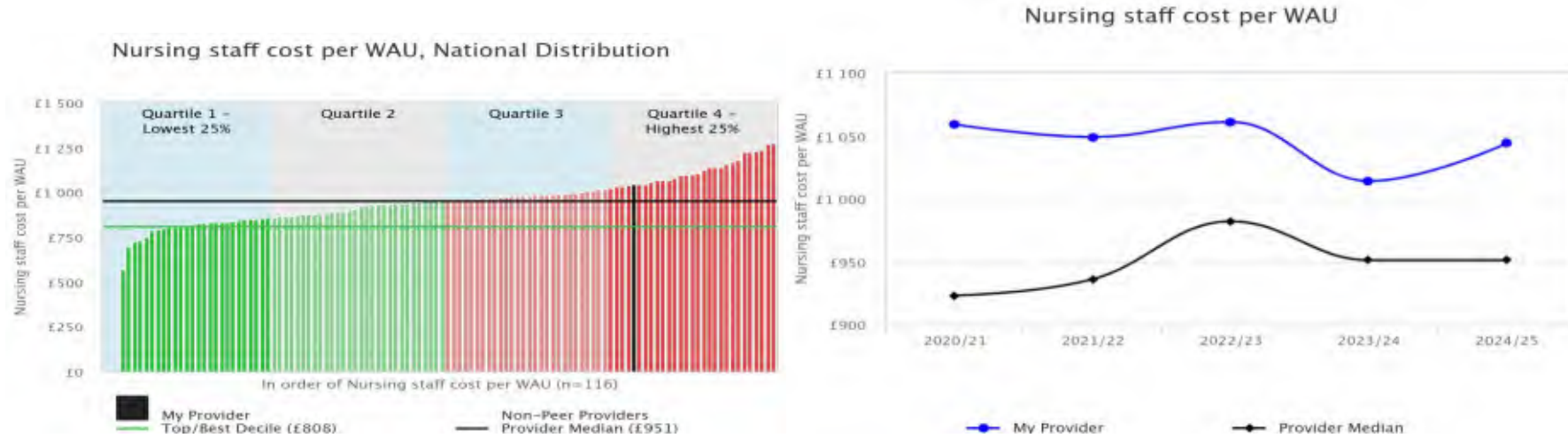


4.13 Within the organisational level cost per WAU, SFT's medical cost per WAU (£791) is similar to the national average of £788, and had been tracking below the national average until 2024/25.

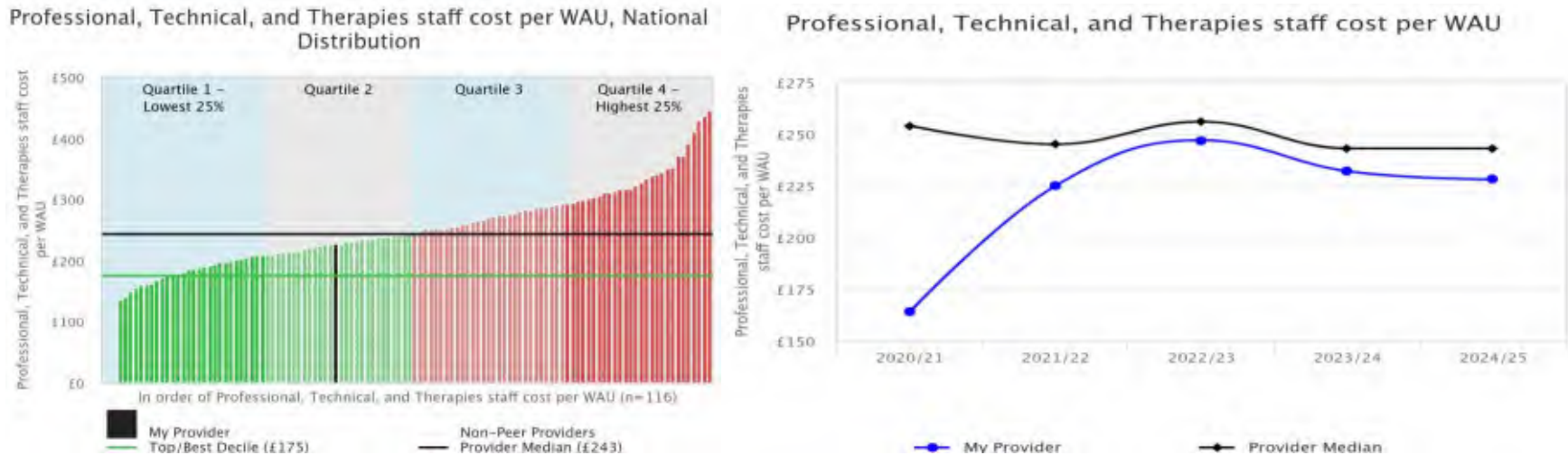
Medical staff cost per WAU, National Distribution



4.14 SFT's nursing cost per WAU (£1,044) is in the highest quartile nationally, and has been consistently above the national average level.

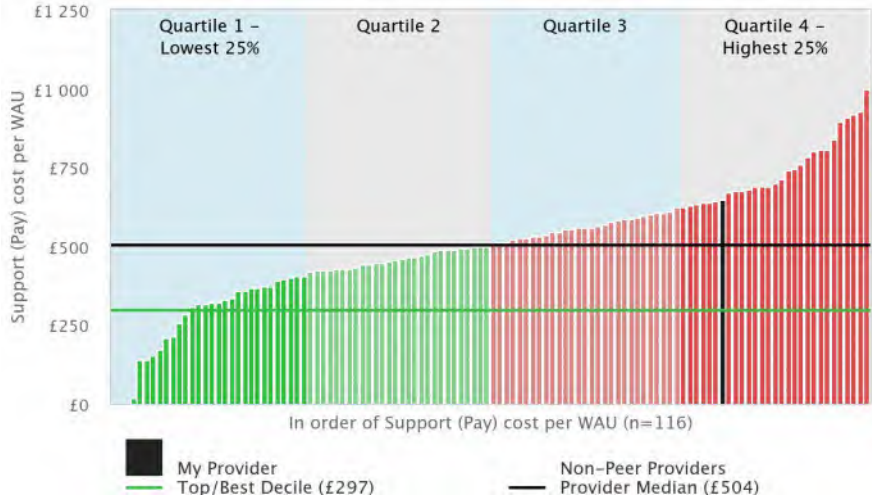


4.15 SFT's cost per WAU for Professional, Technical, and Therapies staff (£228) is below the national average of £243, and has been consistently below the national average.

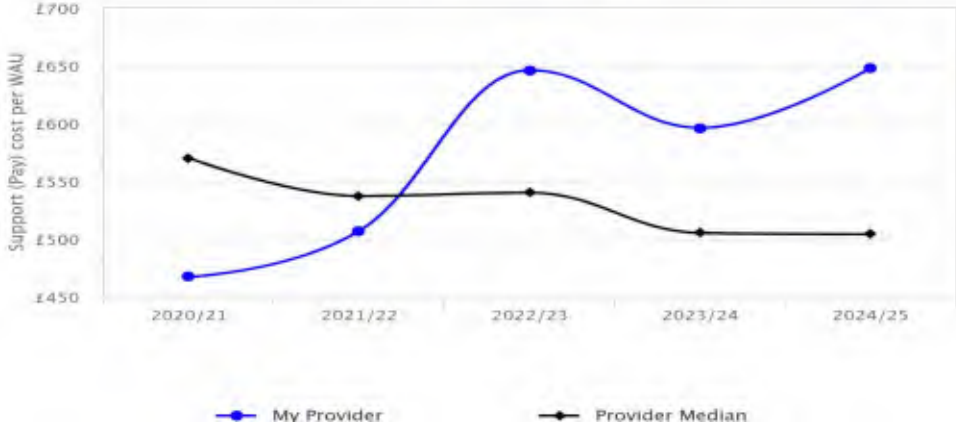


4.16 SFT's cost per WAU for support (non-clinical) staff per WAU (£648) is in the highest quartile nationally and has been above the national average since 2022/23.

Support (Pay) cost per WAU, National Distribution



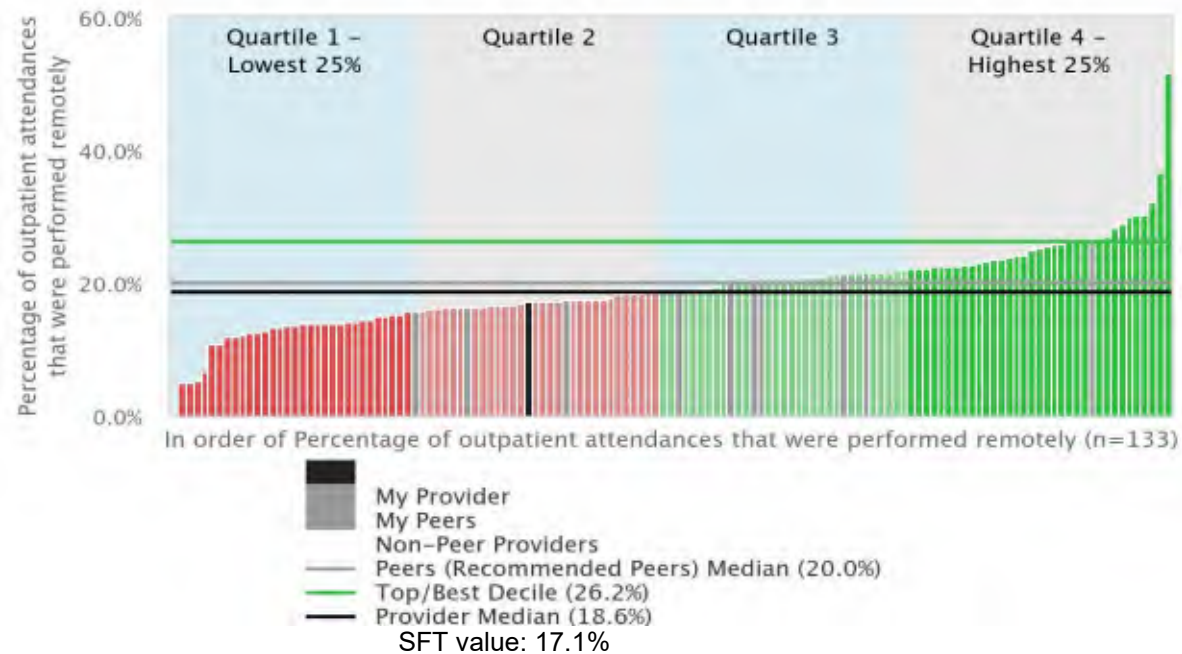
Support (Pay) cost per WAU



ELECTIVE CARE

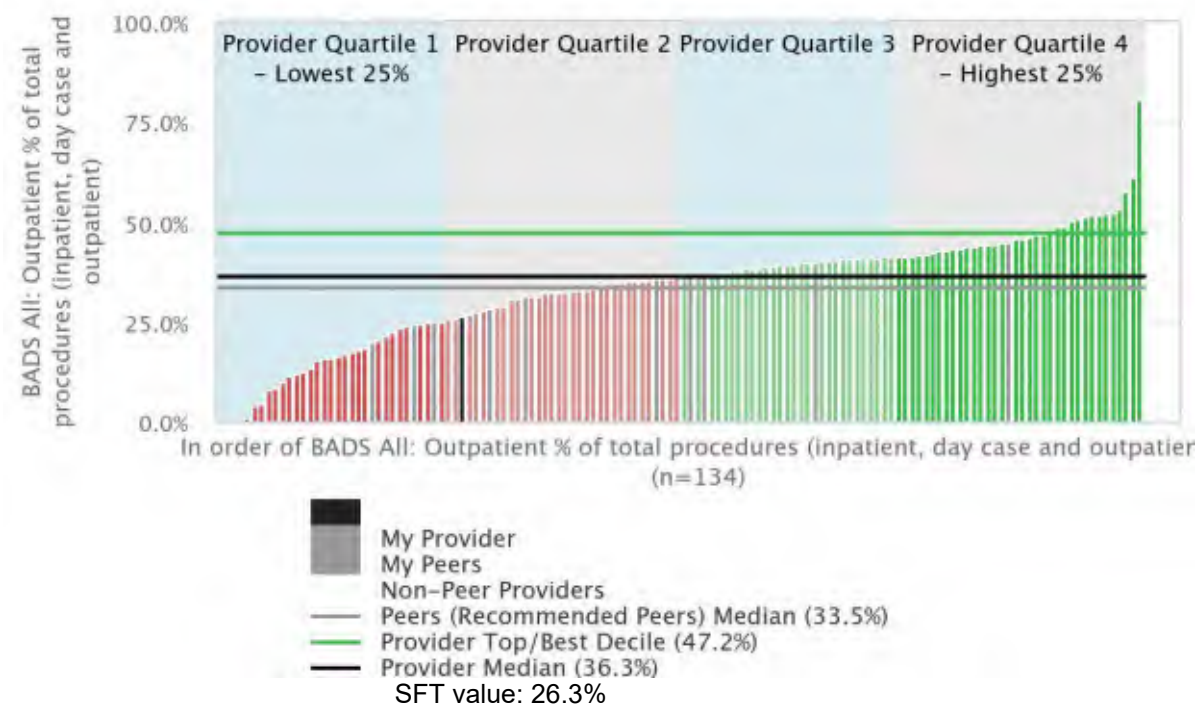
4.17 Key areas identified by the Model Health System as having potential for productivity and efficiency gains in elective care provided by SFT are set out below.

Percentage of outpatient attendances that were performed remotely, National Distribution



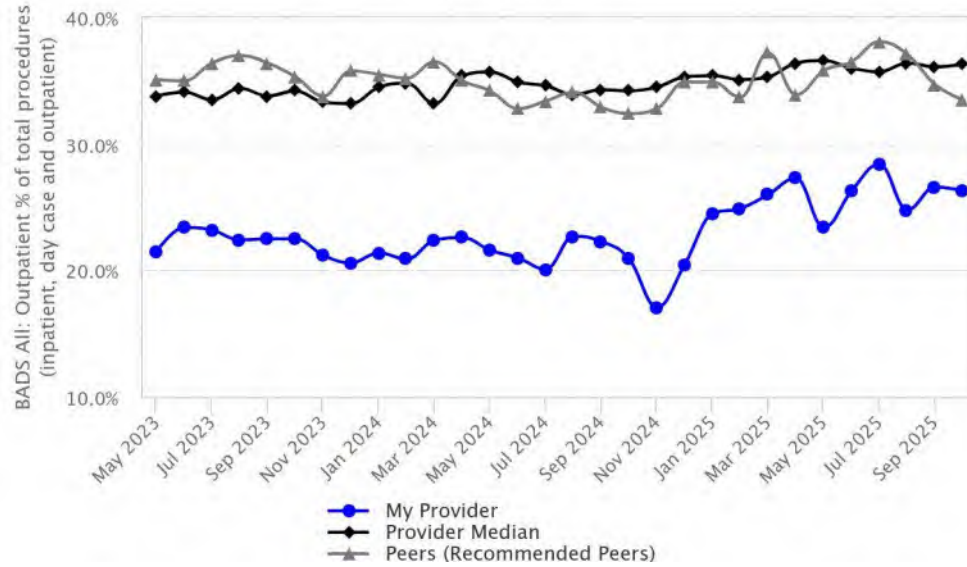
- 4.18 Outpatient transformation is a key commitment set out in the NHS Long Term Plan and the NHS' Delivery Plan for tackling the COVID-19 backlog of elective care. The latest Operational Planning Guidance also sets out requirements for providers and systems to deliver outpatient transformation and recovery. SFT percentage of outpatient appointments which are performed remotely is below the peer and all-provider averages.

BADS All: Outpatient % of total procedures (inpatient, day case and outpatient), National Distribution



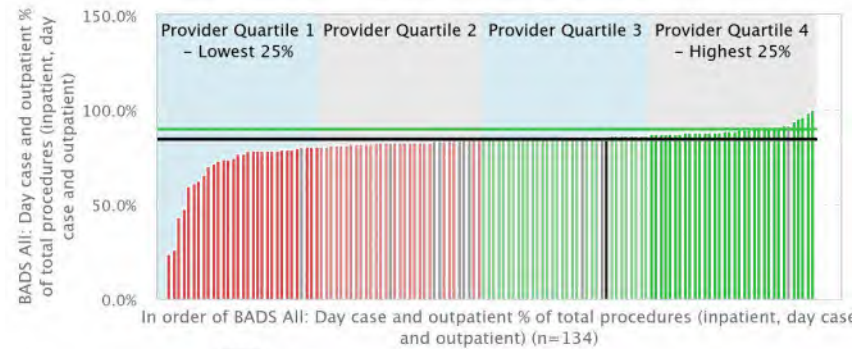
4.19 The figure above shows that SFT’s figure for outpatients as a percentage of all procedures falls in the lowest quartile nationally. The figure below shows that SFT’s rate has consistently tracked significantly below the national average, but showed some improvement in 2025.

BADS All: Outpatient % of total procedures (inpatient, day case and outpatient)



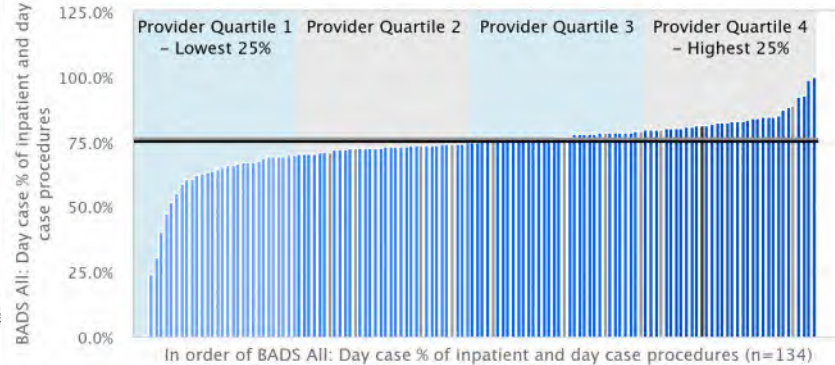
4.20 However, it should be noted that SFT performs at above the average rate for day cases and outpatients as a percentage of total procedures, and also for day cases as a percentage of day case + inpatient procedures (charts below).

BADS All: Day case and outpatient % of total procedures (inpatient, day case and outpatient), National Distribution



■ My Provider
 ■ My Peers
 ■ Non-Peer Providers
 — Peers (Recommended Peers) Median (84.0%)
 — Provider Top/Best Decile (89.6%)
 — Provider Median (84.4%)
 — SFT value: 82.1%

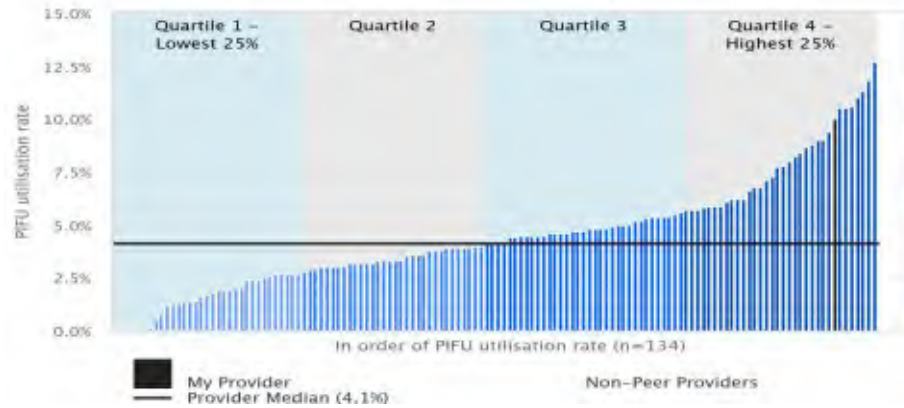
BADS All: Day case % of inpatient and day case procedures, National Distribution



■ My Provider
 ■ My Peers
 ■ Non-Peer Providers
 — Peers (Recommended Peers) Median (76.0%)
 — Provider Median (75.0%)
 — SFT value: 86.1%

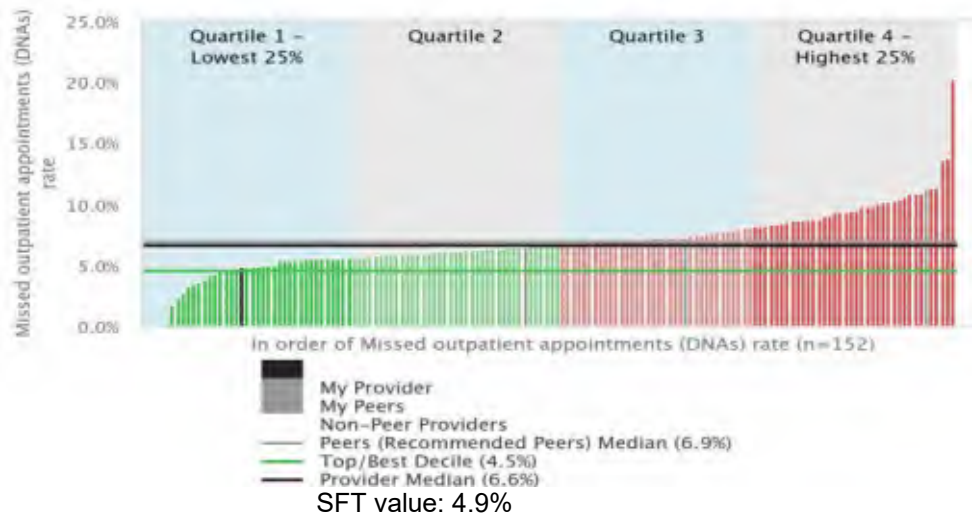
- 4.21 This metric allows organisations to understand variation in their combined day case and outpatient procedure rate in the BADS (British Association of Day Surgery) basket of procedures. A low rate can indicate an opportunity to release inpatient bed days and cost savings. This rate includes day cases (planned as a day case, with no overnight stay) and outpatient procedures.
- 4.22 The Model Health system shows SFT to be in the highest (best) quartile nationally for the use of Patient Initiated Follow Up (PIFU), with a rate of 10.0% against a national average of 4.1%.

PIFU utilisation rate, National Distribution



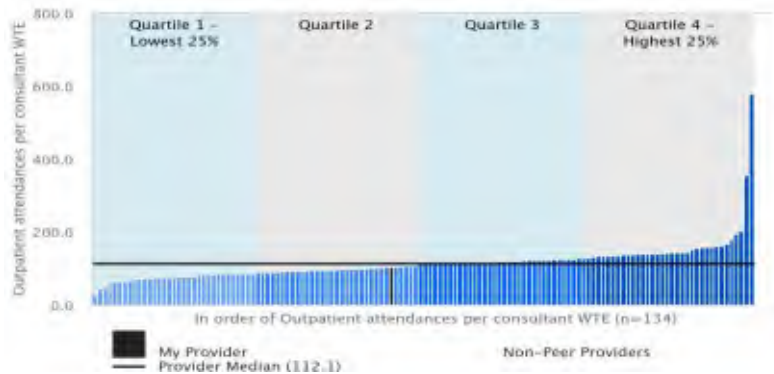
4.23 Similarly, SFT is in the lowest (best) quartile, and close to the best decile level nationally for its missed outpatient appointments (DNAs) rate, with a rate of 4.9% against a national average of 6.6% and a peer average of 6.9%.

Missed outpatient appointments (DNAs) rate, National Distribution



4.24 However, SFT's number of outpatient attendances per consultant WTE is below the national average of 112.1, at 103.1. This is calculated by dividing the number of outpatient attendances (new, follow-up and procedure) in-month by the WTE number of consultants. This includes substantive, bank and agency staff.

Outpatient attendances per consultant WTE, National Distribution



4.25 SFT's capped elective theatre utilisation rate is almost exactly equal to the peer and national average figure of 80.4%, at 80.6%.

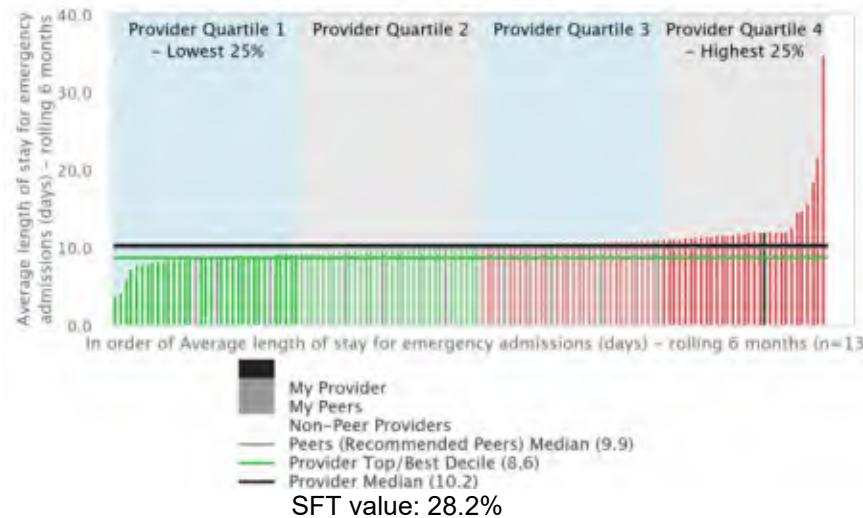
Capped elective theatre utilisation % (monthly), National Distribution



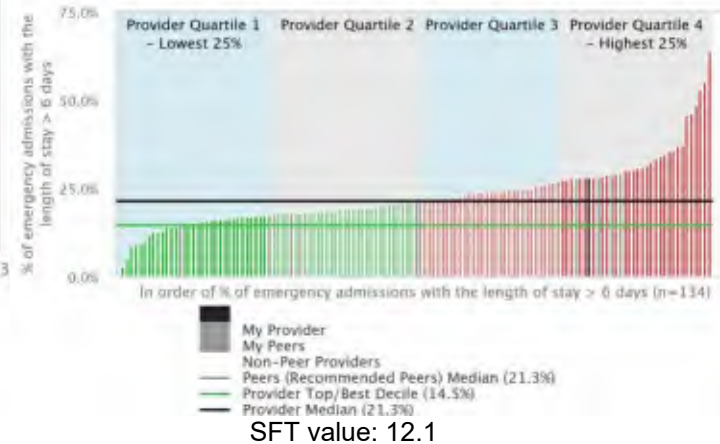
NON-ELECTIVE CARE

4.26 Key areas identified by the Model Health System as having potential for productivity and efficiency gains in non-elective care provided by SFT are set out below. The chart below shows SFT's average length of stay for emergency admissions to be in the highest (i.e. worst) quartile nationally, and around two days longer than the median. This, and the measures which follow, are reflective of the known local issue relating to high levels of patients in acute beds who do not meet the criteria to reside.

Average length of stay for emergency admissions (days) – rolling 6 months, National Distribution

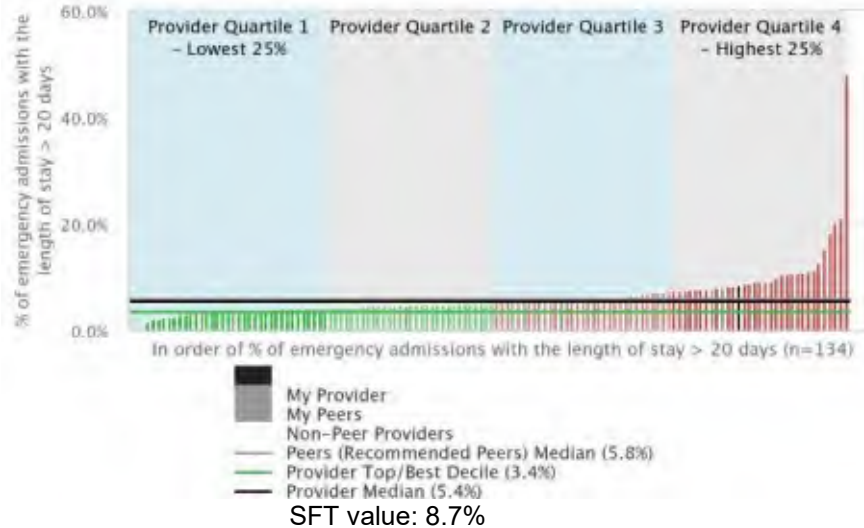


% of emergency admissions with the length of stay > 6 days, National Distribution

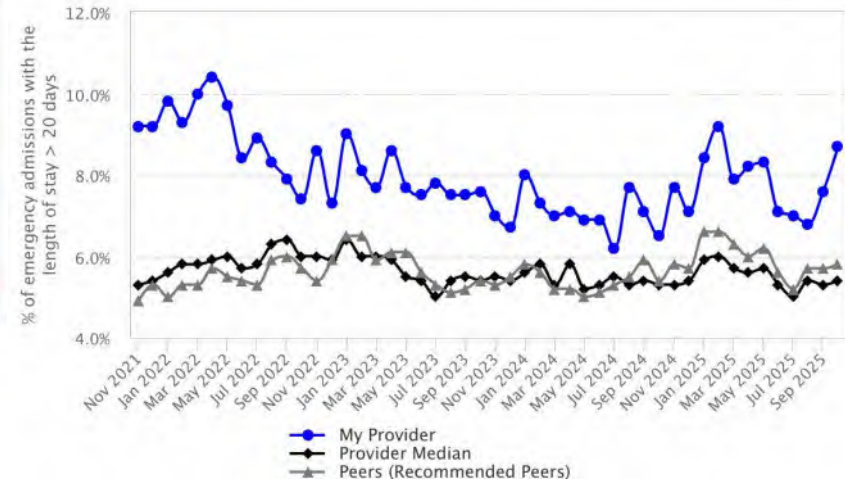


4.27 The proportion of emergency admissions with a length of stay of seven days or longer is used as an improvement metric by the Emergency Care Improvement Programme.

% of emergency admissions with the length of stay > 20 days, National Distribution

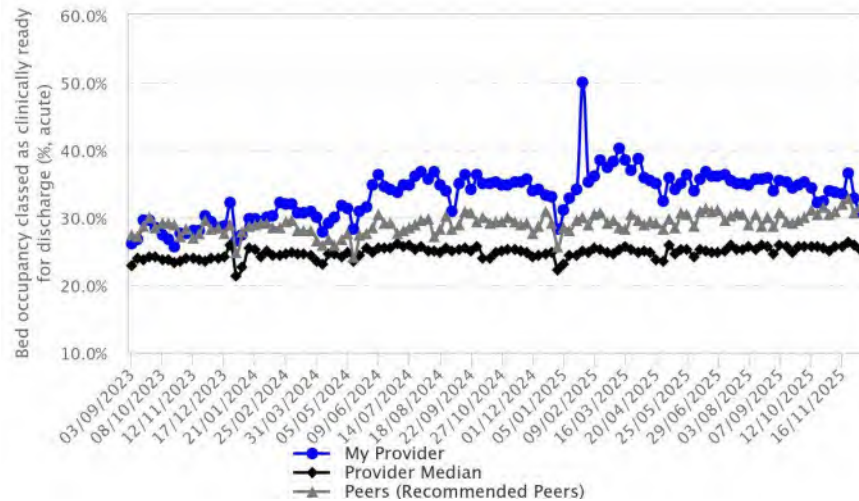


% of emergency admissions with the length of stay > 20 days



- 4.28 SFT's percentage of emergency admissions with a length of stay of over 20 days falls into the highest (i.e. worst) quartile nationally. The chart above shows that SFT's performance against this measure has consistently been worse than the national average level. This measure is also used as an improvement metric by the Emergency Care Improvement Programme.
- 4.29 The chart below shows the trend for the percentage of acute bed days occupied by patients who are clinically ready for discharge (i.e. who do not meet the criteria to reside), which reflects this known local area of adverse performance, although it can be seen that there has been a gradual improvement to the position from May 2025 onwards, and a convergence with the peer average.

Bed occupancy classed as clinically ready for discharge (% , acute)



NHS ENGLAND DATA

- 4.30 Data published by NHS England in February 2026 set out the levels of productivity growth – and reductions – in the first six months of the financial year, at Trust level.
- 4.31 Across acute Trusts, productivity growth over the period from April to September 2025 was just under 3%, compared to 3.5% across all Trust types. The largest year-on-year growth – more than 8% – was seen in mental health providers, according to NHSE’s calculations. Among acute trusts, growth figures ranged from 14% to minus 14%.
- 4.32 SFT was classified as one of seven Multi-Service acute Trusts, with a productivity growth level of 3%:

Organisation Name	Region	Acute trust type	Productivity growth (%)
Isle of Wight Trust	South East	Multi-Service	12
Whittington Health Trust	London	Multi-Service	8
Somerset FT	South West	Multi-Service	3
Wye Valley Trust	Midlands	Multi-Service	2
County Durham and Darlington FT	North East	Multi-Service	2
Torbay and South Devon FT	South West	Multi-Service	1
Buckinghamshire Healthcare Trust	South East	Multi-Service	Minus 3

5. RECOMMENDATION

5.1 The Trust Board is asked to discuss and note the report.

ASSOCIATE DIRECTOR OF PLANNING AND PERFORMANCE

SOMERSET NHS FOUNDATION TRUST
PATIENT AND CARER RACE EQUALITY FRAMEWORK

1. INTRODUCTION

1.1 The Patient and Carer Race Equality Framework (PCREF) was originally published by NHS England in October 2023 and was updated in May 2024. The framework is designed to support providers of mental health services to improve access, experiences and outcomes for racialised and ethnically and culturally diverse communities.

(The term ‘racialised communities’ refers to ethnic, racial and cultural communities who are minoritised populations in England, have been racialised, and who experience marginalisation. This includes white minorities such as Gypsy, Roma and Irish Traveller groups.

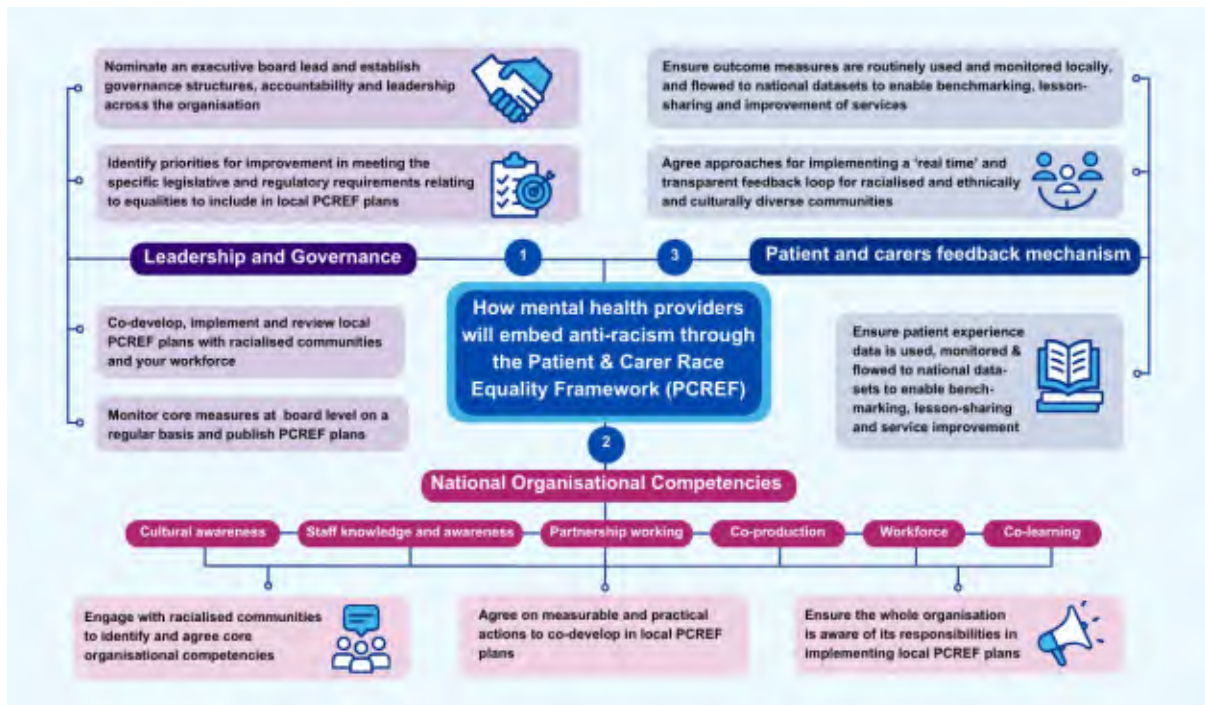
The term ‘ethnically and culturally diverse’ refers to people with distinct cultural or ethnic identities, which can include diverse language groups and communities upholding specific cultural customs and spiritual beliefs).

1.2 The PCREF is a mandatory framework for all mental health providers, with an aim that they become actively anti-racist organisations by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. Assessment of progress against this will become part of future CQC inspections.

1.3 The PCREF will support improvement in three main domains:

- **Leadership and governance:** trusts’ boards will be leading on establishing and monitoring concrete plans of action to reduce health inequalities, including the assurance that trusts are meeting their statutory and regulatory obligations. To evidence this, new data sets on improvements in reducing health inequalities will need to be published, as well as details on ethnicity in all existing core data sets for all mental health service.
- **Organisational competencies:** the framework includes a set of 6 organisational competencies against which trusts are required to assess themselves, working with service users, carers and communities and develop and action plan to improve them.
- **Feedback mechanisms:** visible and effective ways for patients and carers to feedback will be established, as well as clear processes to act and report on that feedback.

1.4 In summary, the expectations of PCREF are captured in the graphic below:



1.5 It is important to note that, although mental health trusts are responsible for delivery of the PCREF, it is very much envisaged as a collaborative and participatory approach between health service providers, local authorities, criminal justice services, social care provider, the voluntary sector, and service users and carers from racialised and ethnically and culturally diverse communities.

2. DATA COLLECTION AND MONITORING

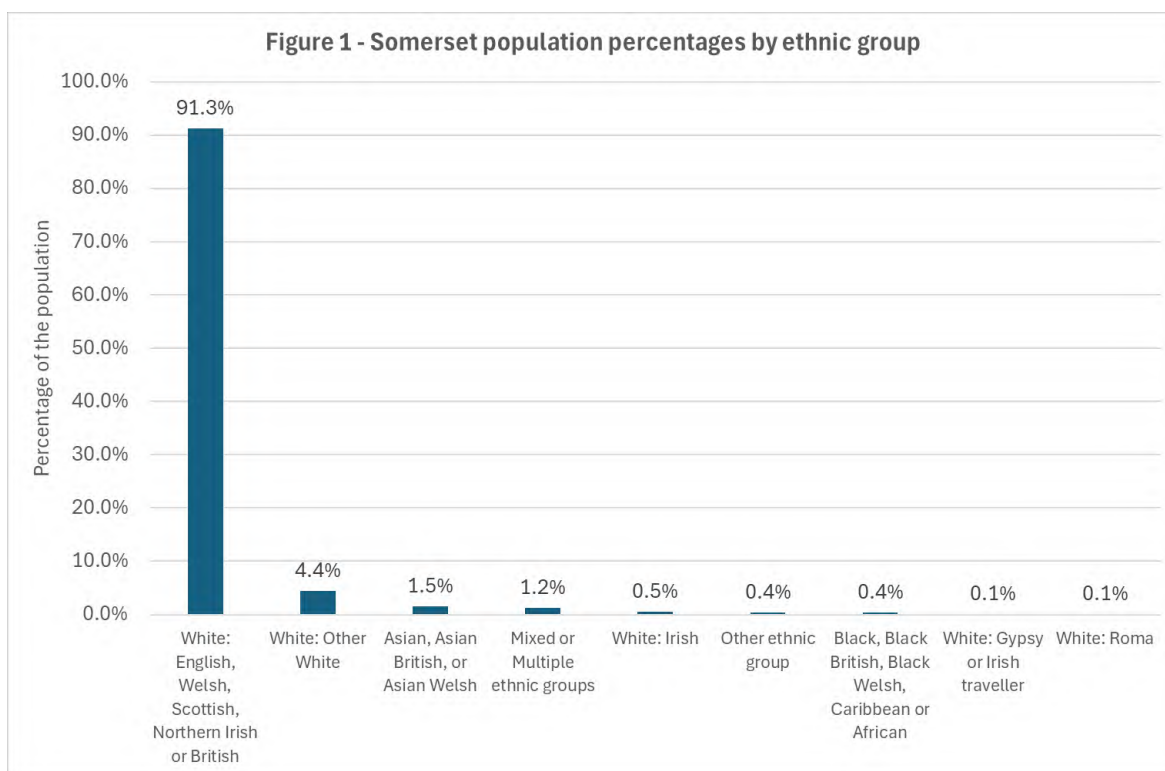
2.1 To evidence how we are fulfilling our core legislative obligations, from a racialised and ethnically and culturally diverse lens, we need to collect and monitor data in relation to our mental health services, broken down by ethnicity and publish at the end of the financial year, including as a minimum:

- The number of cases of detention under the MHA, and the cause and duration of these detentions
- Restraint including the type of restraint (physical, mechanical, chemical or use of isolation) and by ethnicity, age and gender as aligned with the MHA Code of Practice guiding principles
- As required by Core20Plus5:
 - physical health checks for those adults (18+) with Severe Mental Illness (SMI).
 - improve access rates to Children and Young People's mental health services for 0-17 year olds.
- A sample of locally agreed access, experience and outcomes metrics where inequalities are the most evident. This may include Mental Health Act detentions (i.e. the duration of community treatment orders, out of area placements, aftercare placements and suicide rates by ethnicity).
- Reports on any deaths in mental health inpatient units, notified to CQC, by protected characteristics.

2.2 The information set out below represents a view of the data for each of the respective indicators. Our aim is to build upon this, and broaden the range of information through the inclusion of further indicators. We produce regular updates to the data, and have begun to introduce trend analyses.

Ethnicity profile of Somerset

2.3 The ethnicity profile of Somerset is set out in Figure 1 below. This information is drawn from the 2021 Census data, as published on the ‘Somerset Intelligence’ website.



2.4 The chart shows that 96.4% of Somerset residents class themselves as being from a White ethnic group.

2.5 At present, there is no published analysis that provides Somerset-specific ethnicity percentages broken down by the age bands that correspond to the services provided for children & young people, adults, and older adults outlined below.

Detentions under the Mental Health Act

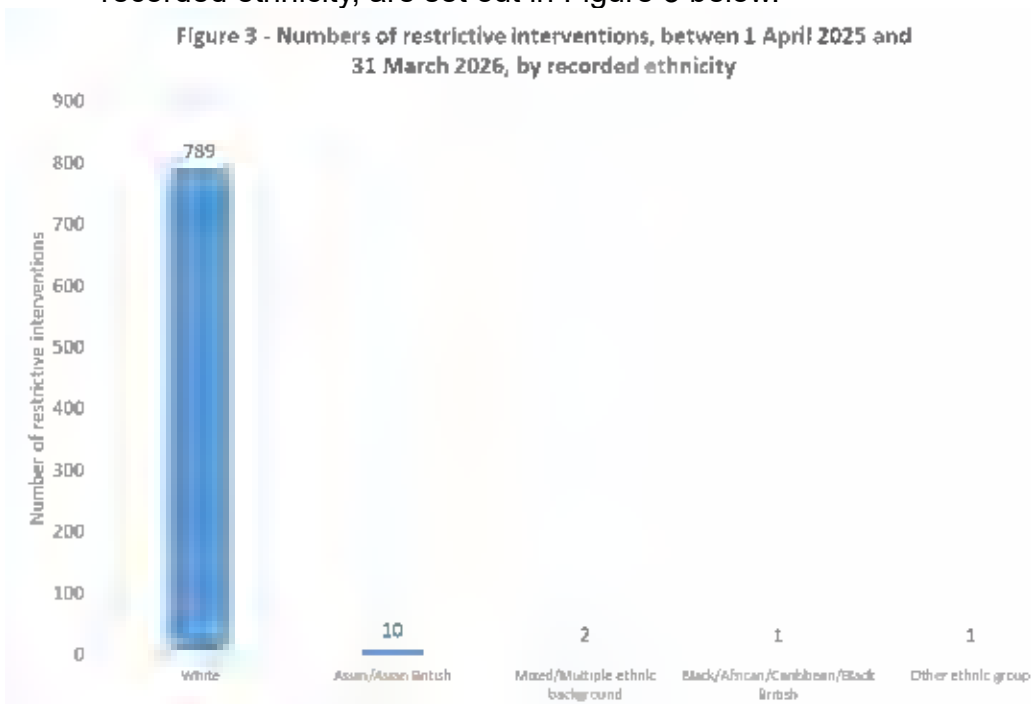
2.6 The numbers of detentions under the Mental Health Act during the period from 1 April 2025 to 31 March 2026, by recorded ethnicity, are set out in Figure 2 below.



2.7 The data shows that there were 657 detentions during the period, relating to 412 patients. Of the 657 detentions, 591 (90.0%) were of patients from a White ethnic group, and 38 (5.8%) were of patients whose ethnicity was either not stated (5.2%) or not recorded (0.6%).

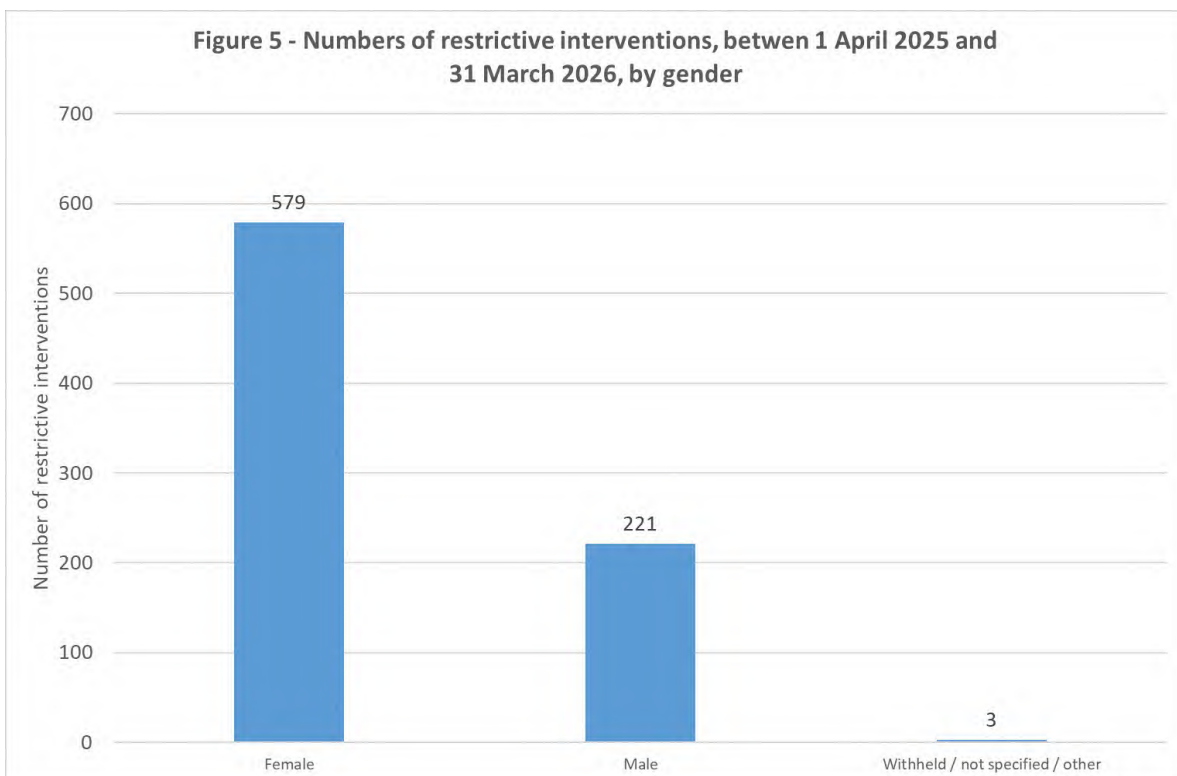
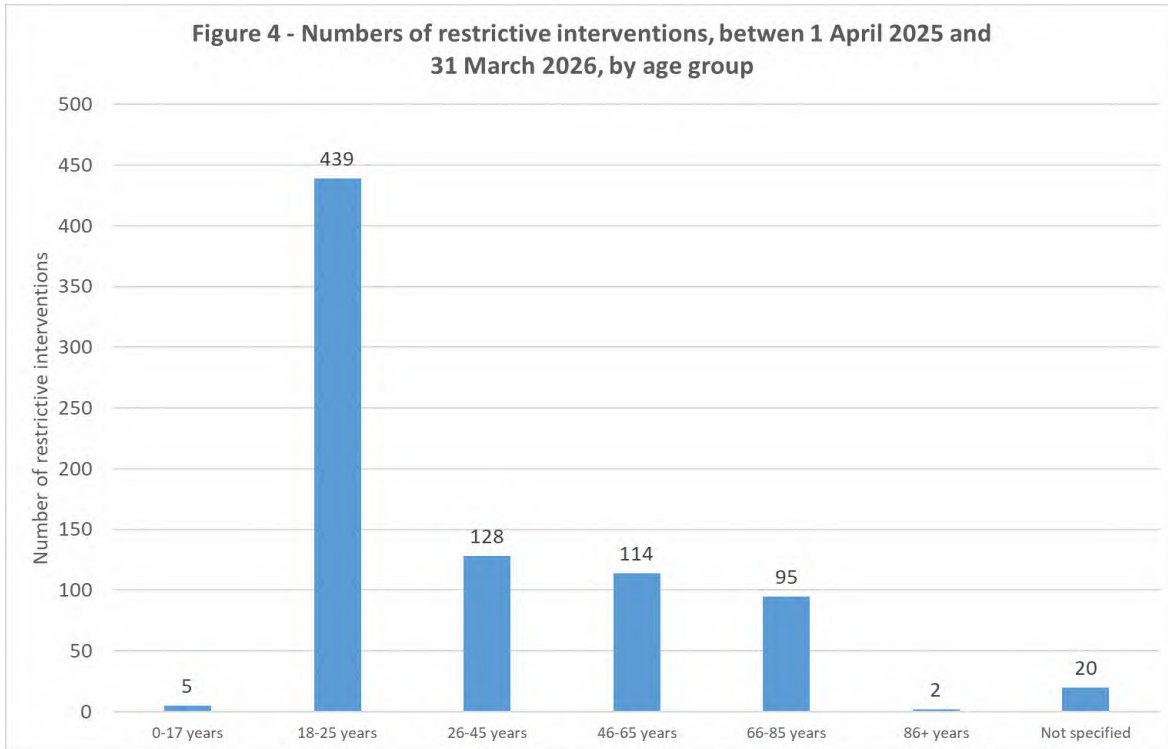
Restrictive Interventions

2.8 The numbers of restrictive interventions (i.e. restraints, seclusions, and segregations) during the period from 1 April 2025 to 31 March 2026, by recorded ethnicity, are set out in Figure 3 below.



2.9 The data shows that there were 803 restrictive interventions during the period, relating to 201 patients. Of the 803 interventions, 789 (98.3%) were of patients from a White ethnic group. There were no patients whose ethnicity was recorded as either Not Stated or Not Asked.

2.10 The numbers of restrictive interventions by age group, and by gender are set out in Figures 4 and 5 below:



Physical health checks for adults with Severe Mental Illness (SMI)

2.11 Table 1 below shows the numbers of patients admitted as a mental health inpatient with severe mental illness (SMI) during the period from 1 April 2025 to 31 March 2026, by recorded ethnicity, for whom a physical health check was completed.

Table 1 - Physical health checks for adults with Severe Mental Illness (SMI), by recorded ethnicity

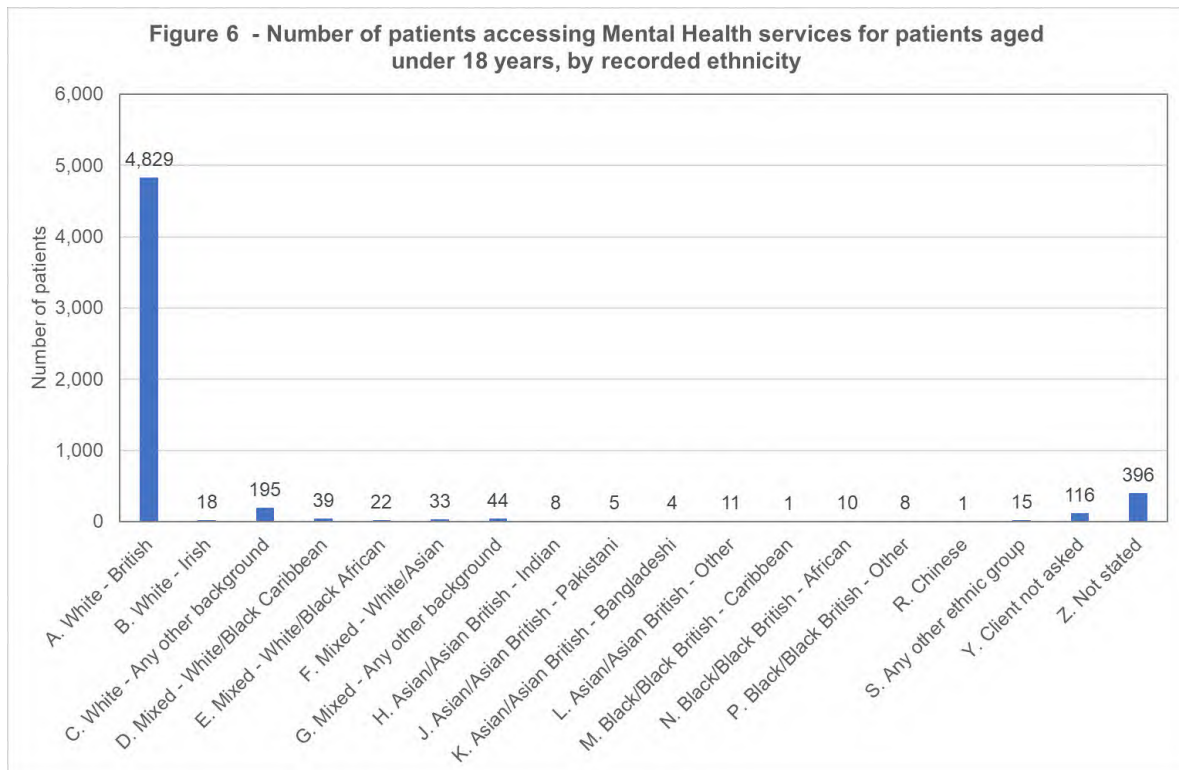
Recorded ethnicity	Admitted	Physical health check not completed	Percentage with physical health check completed
A. White – British	115	8	93.0%
C. White - Any other background	5		100.0%
D. Mixed - White/Black Caribbean	3		100.0%
F. Mixed - White/Asian	2		100.0%
G. Mixed - Any other background	2		100.0%
M. Black/Black British - Caribbean	2		100.0%
R. Chinese	2		100.0%
S. Any other ethnic group	2	1	50.0%
Y. Client not asked	1		100.0%
Z. Not stated	1		100.0%
Total	135	9	93.3%

2.12 The data shows that overall compliance for the completion of a physical health check was 93.3%. Of the 135 patients admitted with SMI, 120 (88.9%) were patients from a White ethnic group, with one patient (0.7%) recorded as Not Asked, and one recorded as Not Stated.

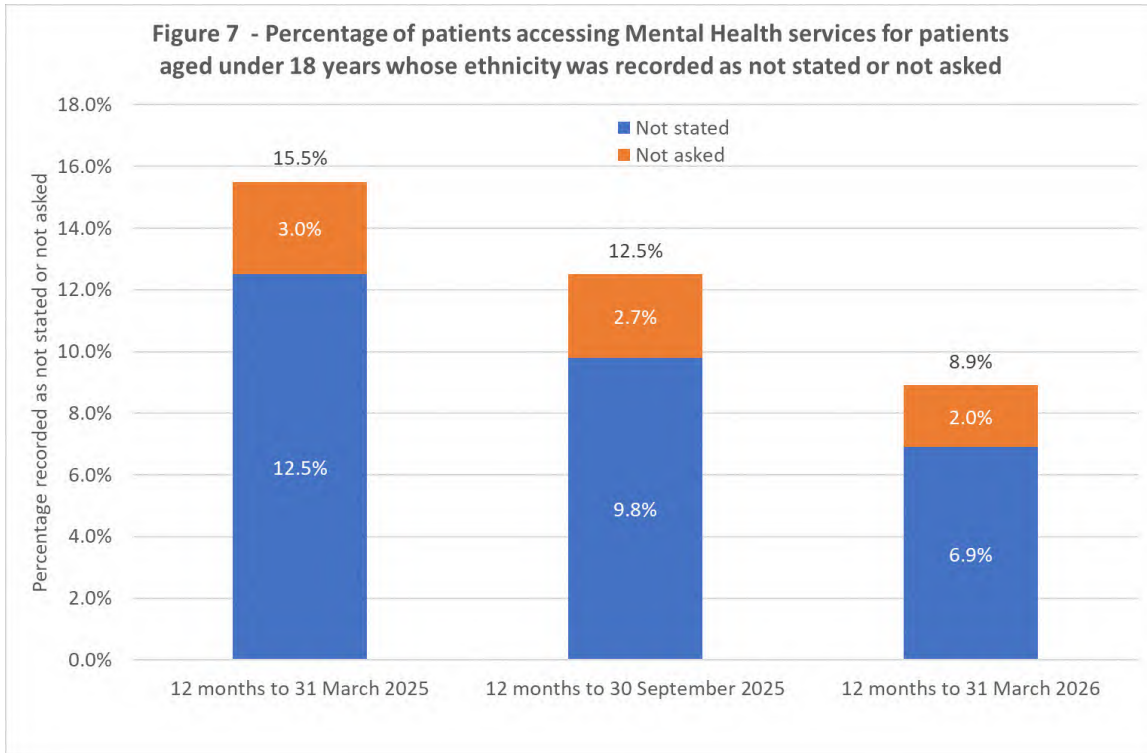
2.13 It should be noted that, due to a coding issue which is being addressed, the numbers of patients identified with SMI is likely to be understated.

Access to Children and Young People’s mental health services for 0–17 year-olds

2.14 The numbers of patients accessing mental health services during the period from 1 April 2025 to 31 March 2026, for patients aged under 18 years, by recorded ethnicity, are set out in Figure 6 below.

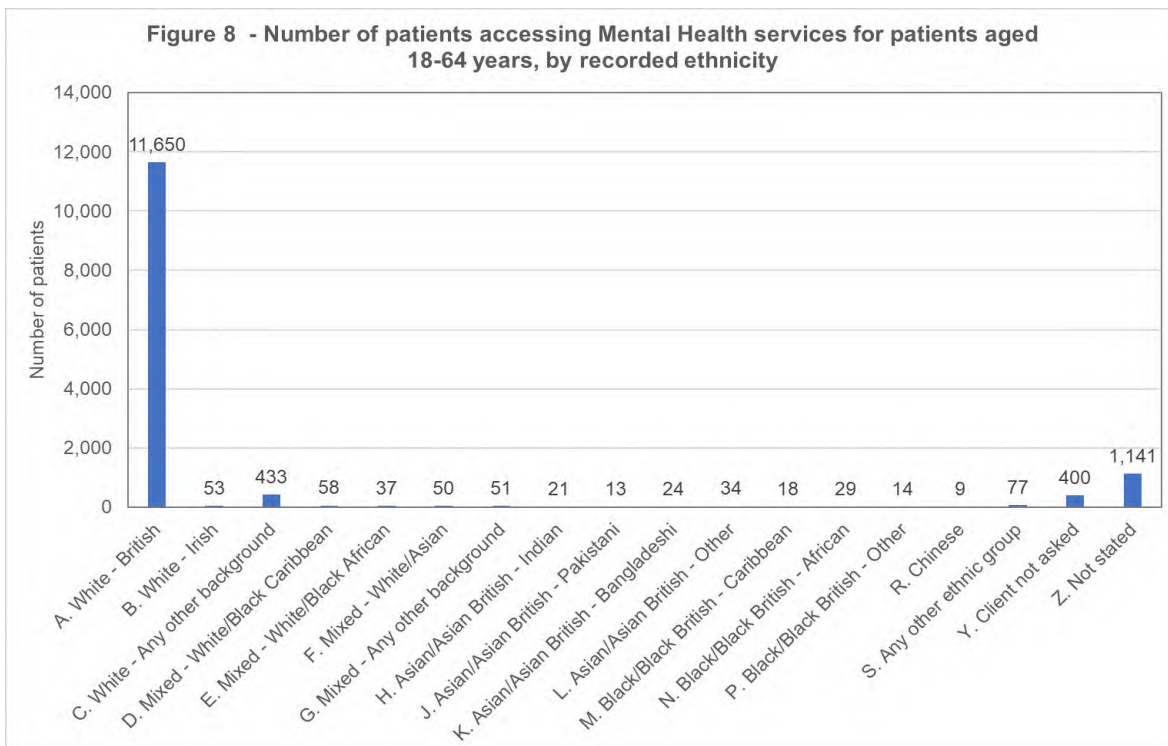


- 2.15 The data shows that, of the total of 5,755 patients accessing mental health services during the period, 5,042 (87.6%) were patients from a White ethnic group, and 512 (8.9%) were patients whose ethnicity was either not stated (6.9%) or was not asked (2.0%).
- 2.16 Patients of mixed ethnicity comprised 2.4% of the total, compared to 1.2% for the wider population of Somerset (all ages), and patients recorded as Black / Black British made up 0.3% of patients, compared to 0.4% for the wider population of Somerset (all ages).
- 2.17 It is notable that patients whose ethnicity was Asian or Asian British comprised only 0.5% of the total – up from 0.4% on the last report - compared to 1.5% for the wider population of Somerset (all ages).
- 2.18 Figure 7 below shows how the percentages of patients whose ethnicity was recorded either as not stated or not asked have changed over time.



Access to mental health services for adults

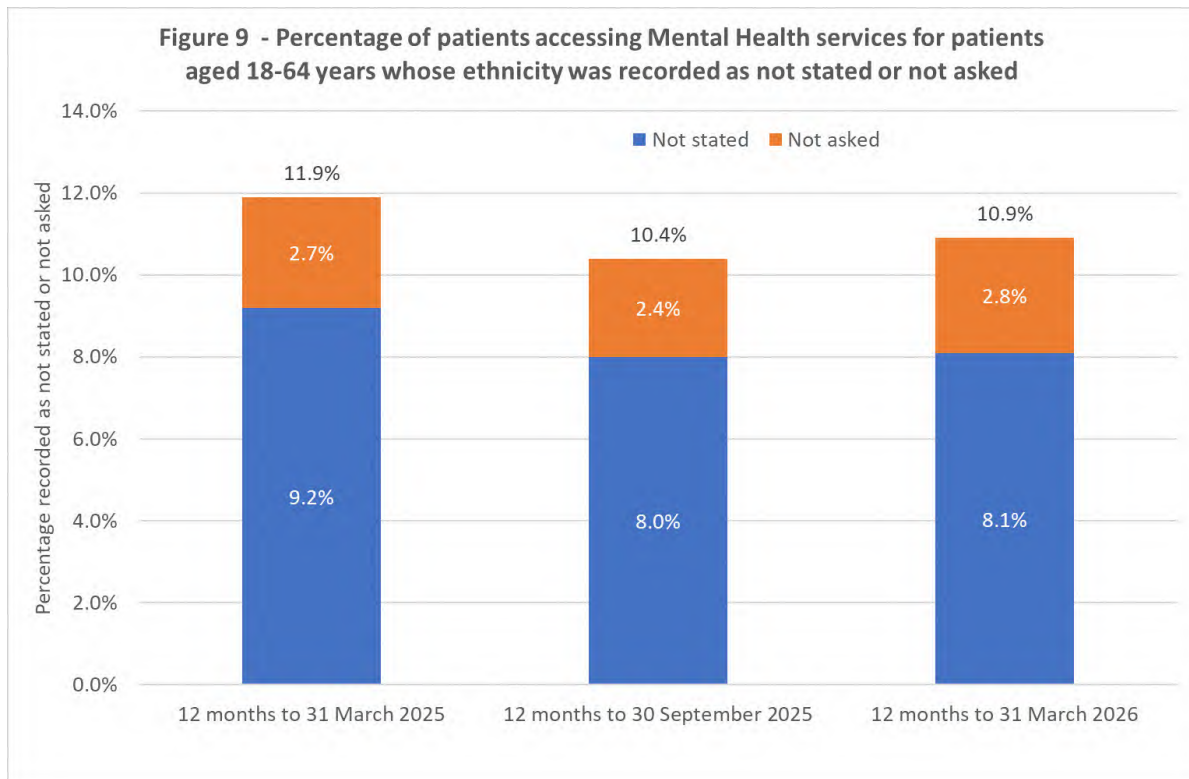
2.19 The numbers of adult patients (aged 18 to under 65 years) accessing mental health services during the period from 1 April 2025 to 31 March 2026, by recorded ethnicity, are set out in Figure 8 below.



2.20 The data shows that, of the total of 14,112 patients accessing adult mental health services during the period, 12,136 (86.0%) were patients from a White

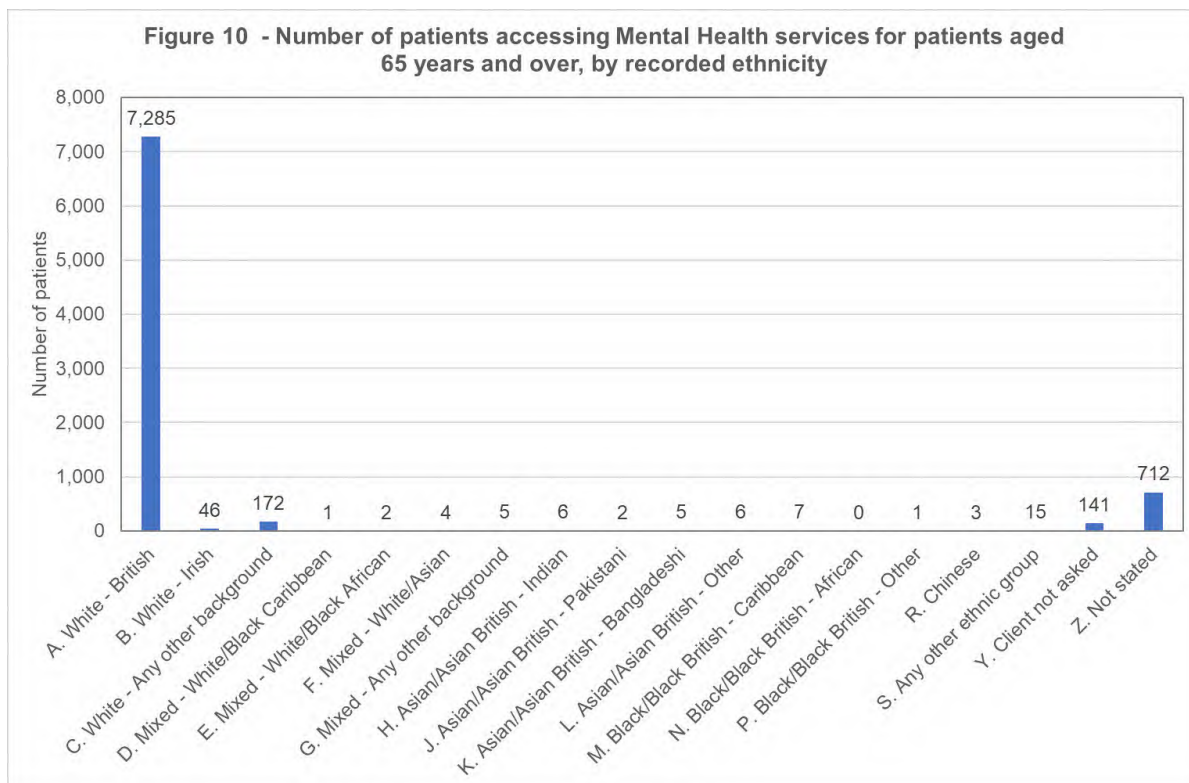
ethnic group, and 1,541 (10.9%) were patients whose ethnicity was either not stated (8.1%) or was not asked (2.8%).

- 2.21 Patients of mixed ethnicity comprised 1.4% of the total, compared to 1.2% for the wider population of Somerset (all ages), and patients recorded as Black / Black British made up 0.4% of the total, exactly equal to the percentage for the wider population of Somerset (all ages).
- 2.22 As is the case with access to mental health services for children and young people, it is notable that patients aged 18 years or over whose ethnicity was Asian or Asian British made up a smaller proportion of activity than their percentage of the population, comprising only 0.7% of the total (up from 0.6% on the previous report), compared to 1.5% for the wider population of Somerset (all ages).
- 2.23 Figure 9 below shows how the percentages of patients whose ethnicity was recorded either as not stated or not asked have changed over time.

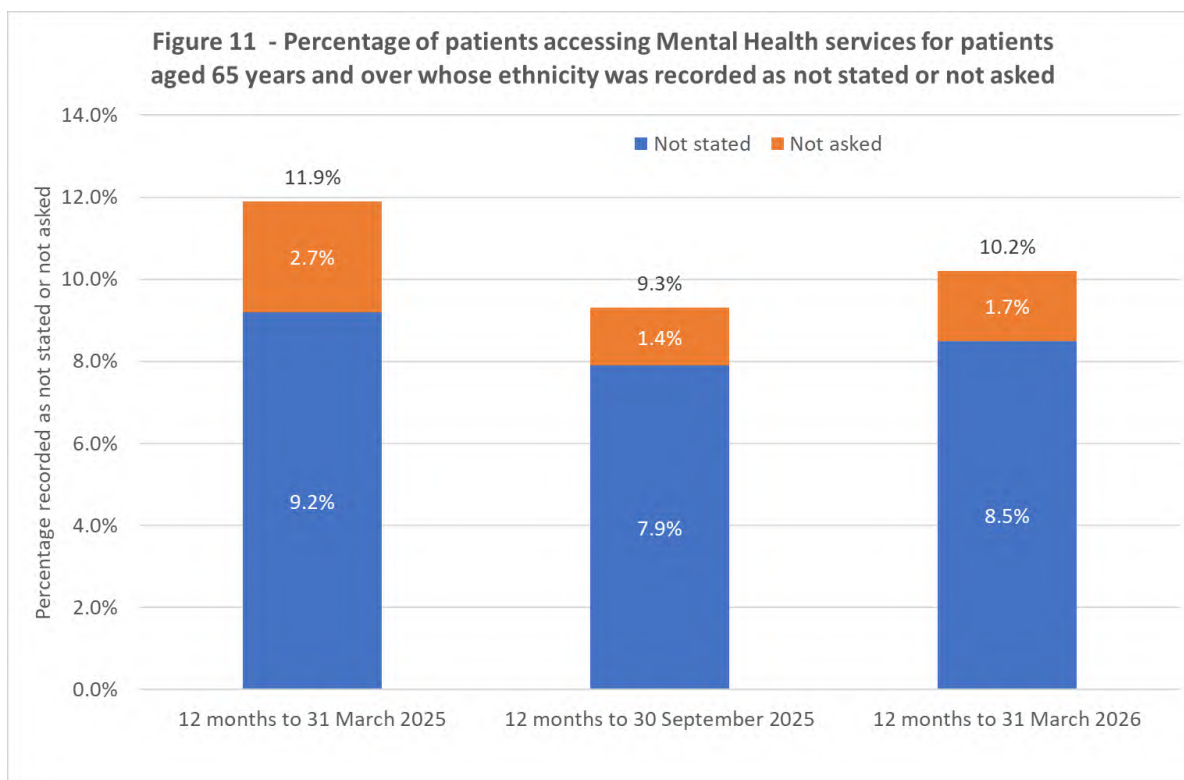


Access to mental health services for older adults

- 2.24 The numbers of patients accessing mental health services for older adults (aged 65 years or more) during the period from 1 April 2025 to 31 March 2026, by recorded ethnicity, are set out in Figure 10 below.



- 2.25 The data shows that, of the total of 8,413 patients accessing adult mental health services during the period, 7,502 (89.2%) were patients from a White ethnic group, and 853 (10.2%) were patients whose ethnicity was either not stated (8.5%) or was not asked (1.7%).
- 2.26 As was the case on the previous report, patients of mixed ethnicity comprised 0.1% of the total, compared to 1.2% for the wider population of Somerset (all ages), and patients recorded as Black / Black British also made up 0.1% of the total, compared to 0.4% for the wider population of Somerset (all ages).
- 2.27 As is also the case with access to mental health services for children and young people, it is notable that patients aged 18 years or over whose ethnicity was Asian or Asian British also made up a smaller proportion of activity than their percentage of the population, comprising only 0.2% of the total, compared to 1.5% for the wider population of Somerset (all ages).
- 2.28 Figure 11 below shows how the percentages of patients whose ethnicity was recorded either as not stated or not asked have changed over time.



Community treatment orders

2.29 Table 2 below shows the numbers of community treatment orders (CTOs) which were in place as at 31 March 2026, by recorded ethnicity, and by year of commencement of the CTO.

Table 2 - CTOs in place as at 31 March 2026, by recorded ethnicity, and by year of commencement

Year	White – British	Mixed - White/Black Caribbean	Any other ethnic group	Total
2013	1			1
2016	1			1
2017			2	2
2018	4			4
2019	1			1
2020	1			1
2021	1			1
2022	4			4
2024	4	1		5
2025	13			13
2026	4			4
Total	34	1	2	37

2.30 The data shows that, of the total of 37 CTOs which were open as at 31 March 2026, 34 (91.9%) related to patients from a White ethnic group, unchanged from the last report. There were no patients whose ethnicity was not known or not stated, also unchanged from the last report.

3. **CONCLUSION**

- 3.1 The data shows that the ethnicity profile for the majority of the measures is broadly in line with the wider ethnicity profile of the county of Somerset.
- 3.2 For the measures 'Access to Children and Young People's mental health services for 0–17 year olds', 'Access to mental health services for adults' and 'Access to mental health services for older adults', the percentages of patients whose ethnicity was Asian or Asian British were all lower than the percentage for the wider ethnicity profile of the county of Somerset. For older adults, this was also true of patients of mixed ethnicity and patients recorded as Black / Black British.
- 3.3 The percentages of patients aged 0-17 years whose ethnicity was either not stated or not asked has reduced in successive reports. For adults and older adults, the percentages increased slightly compared to previous report. We need to undertake further work to improve the recording of ethnicity across our services.
- 3.4 Our aim remains to build upon the data set out above, producing regular updates to the data, and broadening the range of information through the inclusion of further indicators.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 25 February 2026
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Rosie Benneyworth, Acting Chair of the Quality and Governance Assurance Committee
DATE:	12 May 2026

Purpose of Paper/Action Required (Please select any which are relevant to this paper)

<input checked="" type="checkbox"/> For Assurance	<input type="checkbox"/> For Approval / Decision	<input type="checkbox"/> For Information
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Executive Summary and Reason for presentation to Committee/Board	<p>The Committee met on 25 February 2026 and reviewed the Board Assurance Framework, the Corporate Risk Register, patient safety and quality oversight, emerging executive concerns, and arrangements for patient experience and learning from deaths.</p> <p>Assurance was noted on the robustness of governance and quality oversight during a period of sustained operational pressure, including progress with the Every Minute Matters programme and continued assurance through the Patient Safety Board. Key risks remain around deteriorating patient care, urgent and emergency care pressures, maternity and neonatal workforce capacity, variation in service-level governance and the impact of increasing complaint volume and complexity.</p> <p>A further Committee meeting scheduled for 25 March 2026 was stood down.</p>
Recommendation	<p>That the Board notes the assurance provided and the key risks highlighted, particularly those relating to deteriorating patient care, urgent and emergency care pressures, maternity and neonatal workforce capacity, service-level governance and the impact of rising and complex complaints.</p>

Links to Strategic Aims

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

<input type="checkbox"/> 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)

- | | | | | | |
|------------------------------------|--------------------------------------|------------------------------------|----------------------------------|------------------------------|--|
| <input type="checkbox"/> Financial | <input type="checkbox"/> Legislation | <input type="checkbox"/> Workforce | <input type="checkbox"/> Estates | <input type="checkbox"/> ICT | <input checked="" type="checkbox"/> Patient Safety/Quality |
|------------------------------------|--------------------------------------|------------------------------------|----------------------------------|------------------------------|--|

Details: N/A

Equality
The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

- This report has been assessed against the Trust’s People Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
- This report has been assessed against the Trust’s People Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities

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

Staff involvement takes place through the regular service group and topic updates.

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

The report is presented to the Board after every meeting.

Reference to CQC domains (Please select any which are relevant to this paper)

- | | | | | |
|--|---|--|--|--|
| <input checked="" type="checkbox"/> Safe | <input checked="" type="checkbox"/> Effective | <input checked="" type="checkbox"/> Caring | <input checked="" type="checkbox"/> Responsive | <input checked="" type="checkbox"/> Well Led |
|--|---|--|--|--|

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MEETING OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE HELD ON 25 FEBRUARY 2026

1. PURPOSE

1. This report provides a summary of the key items discussed at the Quality and Governance Assurance Committee (Q&GAC) meeting held on 25 February 2026, including assurance received, areas of concern, and risks or issues to be escalated to the Board. A further Q&GAC meeting scheduled for 25 March 2026 was stood down.

2. ASSURANCE RECEIVED

- 2.1. The Committee received updates on the Board Assurance Framework (BAF) and the Corporate Risk Register, noting that several risks within the Committee's remit remain above appetite, with limited movement since the previous quarter. These continue to reflect sustained pressures relating to urgent and emergency care, patient flow, workforce capacity, system pressures and digital transformation. Assurance was noted regarding progress in hospital at home activity, community access expansion and strengthened governance arrangements within integrated care programmes.
- 2.2. The Committee received assurance that future iterations of the BAF will strengthen the balance between performance and quality metrics, including clearer patient safety and experience indicators. Members supported the proposal for a future focus session on deteriorating patient care to provide deeper assurance.
- 2.3. The Corporate Risk Summary reflected a reduction in overall risk numbers alongside an increase in high-rated risks. Improvements were noted in pressure ulcer risk, with new risks identified relating to patient identification processes and workforce pressures. The Committee welcomed progress towards finalisation of the revised Risk Management Strategy, with approval scheduled via the Audit Committee.
- 2.4. The Committee received updates on emerging executive concerns, including maternity, neonatal and paediatric services. Assurance was noted that governance arrangements remain robust during a period of increased scrutiny, including an unannounced CQC inspection of maternity and neonatal services, with issues identified being addressed promptly.
- 2.5. Assurance was also received on progress with the Every Minute Matters programme, supported by strong engagement and emerging early learning, alongside continued oversight through the Patient Safety Board, Governance Support Summary, Patient Experience and Engagement and Learning from Deaths reports.

3. AREAS OF CONCERN OR FOLLOW UP

- 3.1. The Committee noted ongoing concerns regarding deteriorating patient care, including sepsis recognition and escalation, and the need for strengthened assurance on consistency of policy application. Members highlighted the importance of sufficient governance and patient safety capacity to sustain

improvement.

- 3.2. Concerns were also raised regarding the clarity and consistency of quality metrics, particularly within community and neighbourhood services, and the need for improved outcome-based reporting.
- 3.3. The Committee noted rising complaints volumes, increasing complexity of complaint handling (including AI-generated and duplicate correspondence), and the impact on organisational capacity.
- 3.4. Workforce pressures remain an area of concern, including neonatal nursing vacancies, cleaning workforce capacity, decontamination leadership arrangements and variability in service-level quality and safety infrastructure.

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

- 4.1. The Committee agreed that risks relating to deteriorating patient care remain an area of concern and continue to sit above the Trust's risk appetite. These risks are driven by variability in sepsis recognition and escalation, consistency of policy application and the capacity of governance and patient safety structures to support sustained improvement.
- 4.2. The Committee noted that urgent and emergency care pressures continue to pose significant risk to patient flow and length of stay. The interaction between system pressures, increased occupancy and the risk of patient deterioration was highlighted as a compound risk requiring continued Board oversight.
- 4.3. The Committee agreed that maternity and neonatal workforce pressures remain a key risk, reflecting ongoing neonatal nursing shortages and increased external scrutiny. While assurance was received regarding governance arrangements, the Committee emphasised the need for clear oversight of actions arising from inspections and improvement programmes.
- 4.4. The Committee highlighted risks arising from variation in service-level governance and patient safety infrastructure, alongside the increasing impact of complaint volume and complexity on organisational capacity. The importance of clarifying assurance and reporting routes, including for the EPIC programme, was emphasised to avoid duplication and strengthen Board-level oversight.

Rosie Benneyworth
ACTING CHAIR OF THE QUALITY AND GOVERNANCE ASSURANCE
COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Mental Health Legislation Committee meeting held on 27 March 2026
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Alex Priest, Chair of the Mental Health Legislation Committee
DATE:	12 May 2026

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
<input checked="" type="checkbox"/> For Assurance	<input type="checkbox"/> For Approval / Decision	<input type="checkbox"/> For Information

Executive Summary and Reason for presentation to Committee/Board	<p>The Committee met on 27 March 2026 and reviewed Mental Health Act coordination, Section 117 aftercare, advocacy services, MCA/DoLS compliance, AMHP services, commissioning updates, out-of-area placements and complaints.</p> <p>Assurance was received on approval of the revised Section 117 Aftercare Policy, progress with advocacy capacity and improvements in MCA/DoLS training within mental health services. Key risks remain around delays in AMHP assessments, pressures from bed availability and out-of-area placements, Trust-wide MCA/DoLS training compliance and readiness for forthcoming Mental Health Act reforms.</p>
Recommendation	<p>That the Board notes the assurance provided and the key risks highlighted, particularly those relating to AMHP assessment delays, bed capacity and out-of-area placements, Section 117 review capacity, MCA/DoLS training compliance and the implementation of future Mental Health Act reforms.</p>

Links to Strategic Aims (Please select any which are impacted on / relevant to this paper)	
<input type="checkbox"/> Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities	
<input checked="" type="checkbox"/> Aim 2 Provide the best care and support to people	
<input type="checkbox"/> 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)

<input type="checkbox"/> Financial	<input type="checkbox"/> Legislation	<input type="checkbox"/> Workforce	<input type="checkbox"/> Estates	<input type="checkbox"/> ICT	<input checked="" type="checkbox"/> Patient Safety/ Quality
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Details: N/A

Equality

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- This report has been assessed against the Trust’s People Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities

Public/Staff Involvement History

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

Staff involvement takes place through the regular service group and topic updates.

Previous Consideration

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

The report is presented to the Board after every meeting.

Reference to CQC domains (Please select any which are relevant to this paper)

<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Effective	<input checked="" type="checkbox"/> Caring	<input checked="" type="checkbox"/> Responsive	<input checked="" type="checkbox"/> Well Led
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Is this paper clear for release under the Freedom of Information Act 2000?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 27 MARCH 2026

1. PURPOSE

This report provides a summary of the key items discussed at the Mental Health Legislation Committee meeting held on 27 March 2026, including assurance received, areas of concern, and risks or issues requiring escalation to the Board. It is presented to provide assurance on compliance with mental health legislation and the oversight of associated governance, quality and patient safety matters.

2. ASSURANCE RECEIVED

- 2.1. The Committee received assurance on a number of areas relating to Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards compliance.
- 2.2. The Committee approved the revised Section 117 Aftercare Policy, noting strong partnership working and assurance that the policy reflects current legislation, with arrangements in place for post-implementation review. Assurance was also received from Swan Advocacy, with recruitment progress supporting a return to full IMHA capacity and evidence of strong advocacy engagement across wards.
- 2.3. The Mental Health Act Co-ordination Report provided assurance that arrangements remain effective, with recruitment underway to the vacant Lead post and improvements to AMHP reporting expected to strengthen future analysis. Updates on MCA and DoLS provided assurance that mental health services continue to perform strongly in relation to training compliance, supported by targeted training and use of the DoLS prioritisation tool.
- 2.4. The Committee also received assurance regarding AMHP services, noting improved staffing stability, continued trainee progression and constructive system working despite ongoing pressures.

3. AREAS OF CONCERN OR FOLLOW UP

- 3.1. The Committee noted ongoing pressures relating to AMHP processes, including delays linked to referral arrangements and bed availability, which continue to impact timely assessments and patient flow. Capacity constraints for reviewing historic Section 117 cases were highlighted as requiring prioritisation.
- 3.2. Concerns also remain regarding inconsistent ward round communication, continued use of out-of-area placements and Trust-wide MCA/DoLS training compliance, particularly outside mental health services.

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

- 4.1. The Committee agreed that key risks requiring escalation or continued oversight include delays in AMHP assessments, pressures from out-of-area placements and bed capacity, and the resource implications of forthcoming Mental Health Act reforms. The Committee emphasised the need to maintain strong governance and assurance arrangements as legislative changes are implemented.

Alex Priest

CHAIR OF THE MENTAL HEALTH LEGISLATION COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Wellbeing Guardian Report
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Dr Rosemary Novak
PRESENTED BY:	Graham Hughes, Non-Executive Director (Wellbeing Guardian)
DATE:	12 May 2026

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
<input checked="" type="checkbox"/> For Assurance	<input type="checkbox"/> For Approval / Decision	<input type="checkbox"/> For Information

Executive Summary and Reason for presentation to Committee/Board	Focussed update on Compassionate Leadership, Enabling Improved Wellbeing.
Recommendation	Consider how Board can raise issue of tension between service pressures and attendance to learning and development opportunities across their relative areas of responsibility.

Links to Joint Strategic Aims (Please select any which are impacted on / relevant to this paper)
<input checked="" type="checkbox"/> Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities <input type="checkbox"/> Aim 2 Provide the best care and support to people <input type="checkbox"/> Aim 3 Strengthen care and support in local communities <input type="checkbox"/> Aim 4 Respond well to complex needs <input checked="" type="checkbox"/> Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture <input checked="" type="checkbox"/> Aim 6 Live within our means and use our resources wisely <input type="checkbox"/> 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)					
<input type="checkbox"/> Financial	<input type="checkbox"/> Legislation	<input checked="" type="checkbox"/> Workforce	<input type="checkbox"/> Estates	<input type="checkbox"/> ICT	<input type="checkbox"/> Patient Safety/ Quality
Details: N/A					

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- 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 data reported here is drawn from staff surveys, People Services data and research which included SFT colleagues as participants and stakeholders.

Previous Consideration

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

Reference to CQC domains (Please select any which are relevant to this paper)

<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Effective	<input checked="" type="checkbox"/> Caring	<input checked="" type="checkbox"/> Responsive	<input checked="" type="checkbox"/> Well Led
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Is this paper clear for release under the Freedom of Information Act 2000?

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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SOMERSET NHS FOUNDATION TRUST

Wellbeing Guardian Report April 2026

1. BACKGROUND AND PURPOSE

Please note that this report reflects an update on current areas of focus for the Wellbeing teams. Further information on the multilayered approaches for colleague wellbeing is available on request.

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

2. Local Data and Research and activity – where are we now?

2.1 2025 Staff Survey Results: national results indicate improved scores on measures for the People Promise element “We are Compassionate and Inclusive” in comparison to previous years, which highlights the value of a whole organisation response and developmental learning opportunities, for example:

- Allyship Programme and release of guidance for managers on how to support colleagues experiencing incidents of discrimination, racism bullying and harassment.
- Violence and Aggression policy and resources – posters, awareness raising and beat surgeries with police partners
- Sexual Safety Response Framework for colleagues
- Staff networks refresh – creating an ‘inclusion community’ to break down barriers and stigma around protected characteristics
- Leadership expectations framework and supporting activities including: Compassionate Leadership Training, Senior Doctor Leadership Structure development etc

Internal indicators for Wellbeing (which include questions in relation specifically to health and safety, burnout and negative experiences) remain higher than average according to national benchmarking but have fallen in relation to previous years, with sickness rates for AHP professional groups particularly highlighted as an area for improvement via Model Hospital data.

2.2 S10 Anxiety and Stress remain the top reasons for absence across the organisation, however SFT sickness rates are lower than other trusts in the region for this measure.

- 2.3 We are now in the second year of our contract with PAM as provider of OH Services. Data shows the service is well embedded in the organisation with increasing referrals over the last 3 months in comparison with the same period last year. There remains work to do in reducing DNA rates for OH appointments. Also of note is the significant administrative workload generated by the interface of trust ESR and PAM systems.
- 2.4 The Manager referral pathway for Physio4U has been in place for over a year. 60 slots per month are shared across service groups and these are routinely exceeded – resulting in a 5 day response KPI rather than the original 2 day agreement. This is no longer quicker than the primary care route in some localities.
- 2.5 In recognition of current global and national pressures, and the impact on colleagues' financial wellbeing, the Cost of Living Task & Finish group has been reconvened with the purpose to review supports for colleagues particularly affected by rising fuel costs. At present the focus is for colleagues in community services, but may also be required in preparation of the widely anticipated impact of rising fossil fuel costs affecting UK logistics more generally, that will likely be passed on to the consumer. This will be more impactful for colleagues on lower income and from poorer socioeconomic backgrounds.
- 2.6 Data for Senior Dr Wellbeing shows Dr Burnout Rates at 46% (Stanford Professional Fulfilment Index). Perceptions regarding positive action being taken by the trust to support wellbeing vary considerably across sites – MPH 72%, Community 76% and YDH 42%. Work is ongoing to understand YDH colleague experiences with a view to improving these scores through local action. 4 listen and Learn events have taken place so far.
- 2.7 The significant impact of organisational change on wellbeing scores is noted and particularly relevant in relation to how we plan for forthcoming change.
- 2.8 Colleague Support Service 25/26 data indicates an average of 48% of referrals self-reporting workplace stress as a reason, an increase of 10% on the previous year. Self reported relational difficulties at work show an upward trend, with a 6% overall increase since 2024. Colleagues also show an upward trend in experience of Guilt at taking time off work for sickness, Workplace Trauma, and suicidality reflecting increasing complexity of experience for our colleagues.
- 2.9 The relational context of work stress continues to be indicated across increased referrals to mediation, FSUG, OH and HR and increasing complexity of cases referred.
- 2.10 Current research continues to highlight the role of leadership in shaping colleague experiences in their everyday and the importance of supporting leaders to enable sustainable changes which can support direct and indirect wellbeing in the workplace.

Local Data and Research - 'So What?'

- 2.11 S10 is the best organisational indicator of the impact of stress on the workforce. The overall data suggests approximately 21% of all sickness was as a result of psychological reasons in the last 12 months. A mean of just over 4815 FTE days were lost to S10 sickness per month in 25/26. Based on midpoint band 6 average, this equates to an approximate cost of £722,326.30 per month. This is an underestimate and does not take into account presenteeism, exacerbations of long-term conditions, MSK or unknown sickness absence reporting, impact on service delivery, team functioning or the additional costs of resolution/support services.

In addition, there appears to be a rising trend over 25/26 with emerging peaks across July-Aug, Nov-December and March. The new Data Dashboard being developed as part of the 2026 deliverables for the People Strategy will be a useful tool to identify patterns to further understand these fluctuations and identify potential solutions.

- 2.12 In Line with national research (which involved our colleagues in the participant groups), we have made recommendations for immediate and long-term improvements, which include systemic preventative action at practical, structural and policy levels:

- Prioritising improvements in working environments (inc. practical changes such as rotas, communication, rest spaces etc.)
- Reviewing the function of the Wellbeing Action Group with a view to increasing involvement of colleagues in creating local solutions to improve their wellbeing (aspects of which necessarily sit outside the remit of a wellbeing team)
- Shifting expectations towards healthcare staff attending to their own physical and mental health too - being supported to prevent ill health and reducing barriers to accessing support – e.g. walking programme with SASP
- Emphasising relationships and belonging, in intervention designs
- Reducing workplace trauma - e.g. Serious Incidents, Persistent Stressors (e.g. racism, discrimination, incivility and aggression) and Workforce Issues (availability of resources/ skillsets to meet acuity/demands of care needs).
- Collaborating with OD colleagues to design leadership interventions that support leaders and colleague groups through complex periods of transformation and change (e.g. YDH Maternity Relaunch, Neighbourhoods, Healthset)

3. Embedding a Visible Culture of Compassion to Enable Health and Wellbeing

To embed and operationalise our values of compassionate and inclusive leadership, trauma-informed care, and just and learning cultures, the organisation must not only hold the values at its heart, but also build them into its foundations through its environment, policies, procedures, and the behavioural expectations and relationships of its people. This is vital in order to support the wellbeing of the workforce now and through future challenges of transformation and forthcoming changes in strategy – for example the collaboration and build on Healthset, which begins in earnest in September 2026, and Personalised care, which relies on good working relationships

within and between teams, as well as good colleague-patient relationships to support meaningful shared decision making and choice for everyone.

Spotlight on two interventions: Developing New Leadership Approaches

3.1 New Medical Leadership Framework

The new model for medical leadership continues to be embedded. This includes a review and supported development for job planning for all teams at Clinical Service Lead level, as well as looking at the barriers to improvements and drawing on evidence based IHI Frameworks. It also has facilitated an expansion of mentorship roles for New and SAS Grade colleagues and a New Senior Doctor Induction Programme.

3.2 Compassionate Leadership Development Programme

The Compassionate Leadership Development Programme launched in October 2025 and aims to operationalise and embed Compassion as the foundation of the 3C's Leadership Framework (Compassion, Collaboration and Curiosity). The programme is designed to enhance leadership skills that support compassionate approaches to wellbeing, performance, decision-making processes and collaboration. The cultural shift is expected to underpin the development of positive, inclusive and high-performing cultures in teams and services, and is scaffolded by other compassion and inclusion orientated leadership activities, e.g. Cultural Competency training, Leadership Community of Practice, and reflective practice opportunities (1-1's, Restorative Clinical Supervision, Schwarz Rounds, Post Incident Reflective Conversations, Compassion Circles etc).

Since the launch 12, two-day trainings have been completed, with over 120 Band 7 and above leaders and managers from across all service groups in attendance (including medical colleagues). Early engagement, feedback and commitment to applying learning from attendees has been overwhelmingly positive and encouraging – we are awaiting the first impact data report. Notably, the opportunity has brought colleagues from diverse areas of work together in a face to face, psychologically safe environment, leading to open and honest conversations relating to the shared challenges of leadership in health care settings, as well as opportunities to recognise the interconnected nature of the organisation, and how silo working can lead to unintended pressures in other parts of the system. Humanising relationships between departments is likely to lead to more successful collaboration on future organisational goals. Sadly, attendance rates have been affected by continuous service pressures leading to an approximate 35% last-minute (within 24hrs) cancellation rate. This is frustrating since all sessions have been fully booked and additional colleagues have expressed a challenge in booking on. Attendance numbers inevitably have an impact on how quickly leadership cultures can be influenced and we are reviewing the programme delivery model in light of these challenges.

4. RECOMMENDATION

- 4.1 A particular challenge is the ongoing tension between service pressures and attendance to learning and development opportunities. It is apparent that

reflective, restorative and developmental spaces (including 1-1's, supervision, line management, team spaces and learning spaces) are often stood down or cancelled at short notice in the context of staffing and service pressures. Whilst understandable in many cases to prioritise immediate patient safety and clinical risk management, the unintended consequence is a struggling workforce unable to access the very structures set up to support their wellbeing and the quality of their work.

This has the potential to increase experiences of unsatisfactory delivery of care, patient safety incidents, difficult team dynamics, exhaustion, burnout, and sickness rates, thereby amplifying the pressures inherent in the system. Inevitably there will be times when safety must take precedence. However, our concern is this will become even more challenging in light of the additional demands of forthcoming organisational development (consultations digital transformation etc) that we already know will bring additional demands for colleagues. **Please could the board consider what influence they may have to raise this as an issue across their relative areas of responsibility?**



Wellbeing Guardian Report: Leading with Compassion Enabling Improved Wellbeing

Kindness, Respect, Teamwork
Everyone, Every day

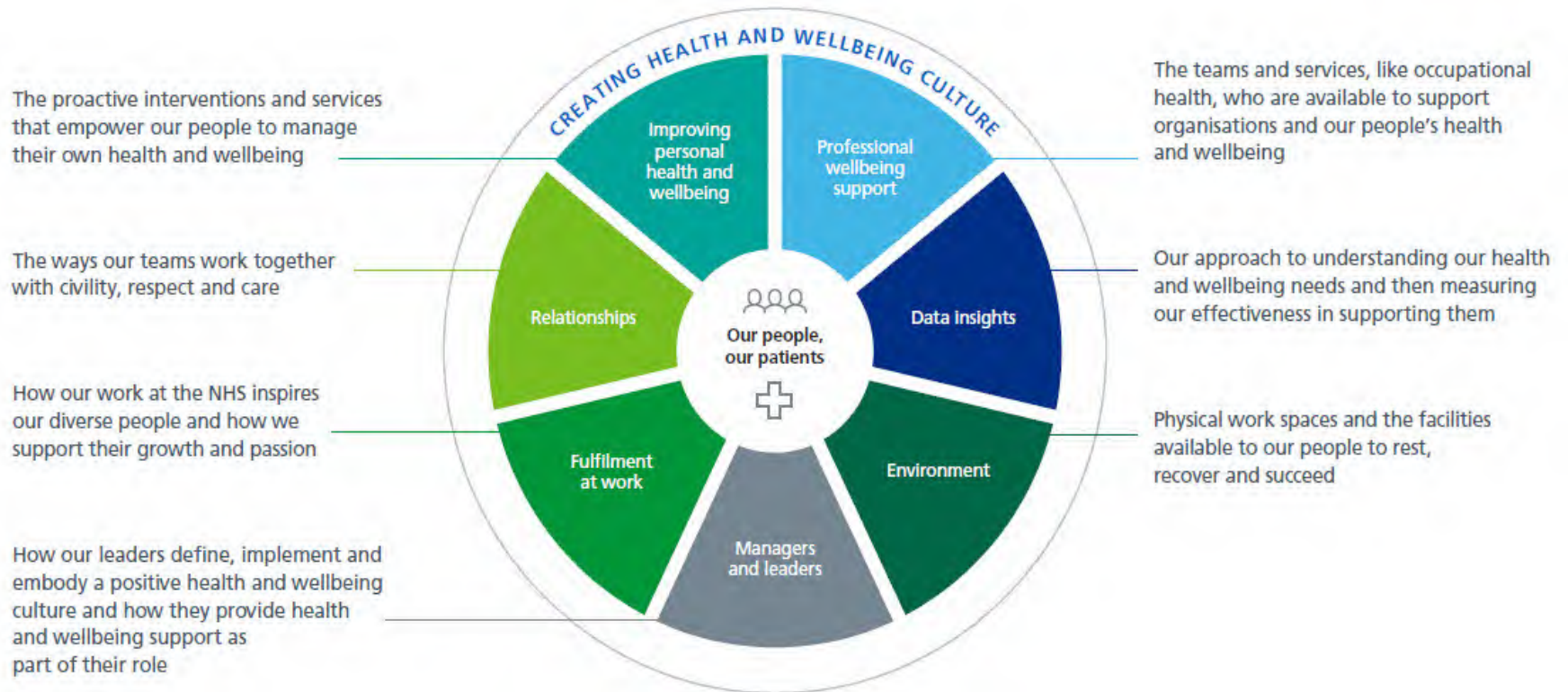
06/05/2026

Creating a Health & Wellbeing Culture

Supporting our colleagues to be in the best possible position to offer and sustain:

- Kind, Compassionate, Inclusive Environments
- Where colleagues feel a sense of belonging, being valued and cared for and take collective responsibility for their own and others wellbeing at work
- Enables colleagues to deliver kind, compassionate safe care

NHS Health & Wellbeing Framework



Getting the basics right

Impact of work environment and working conditions

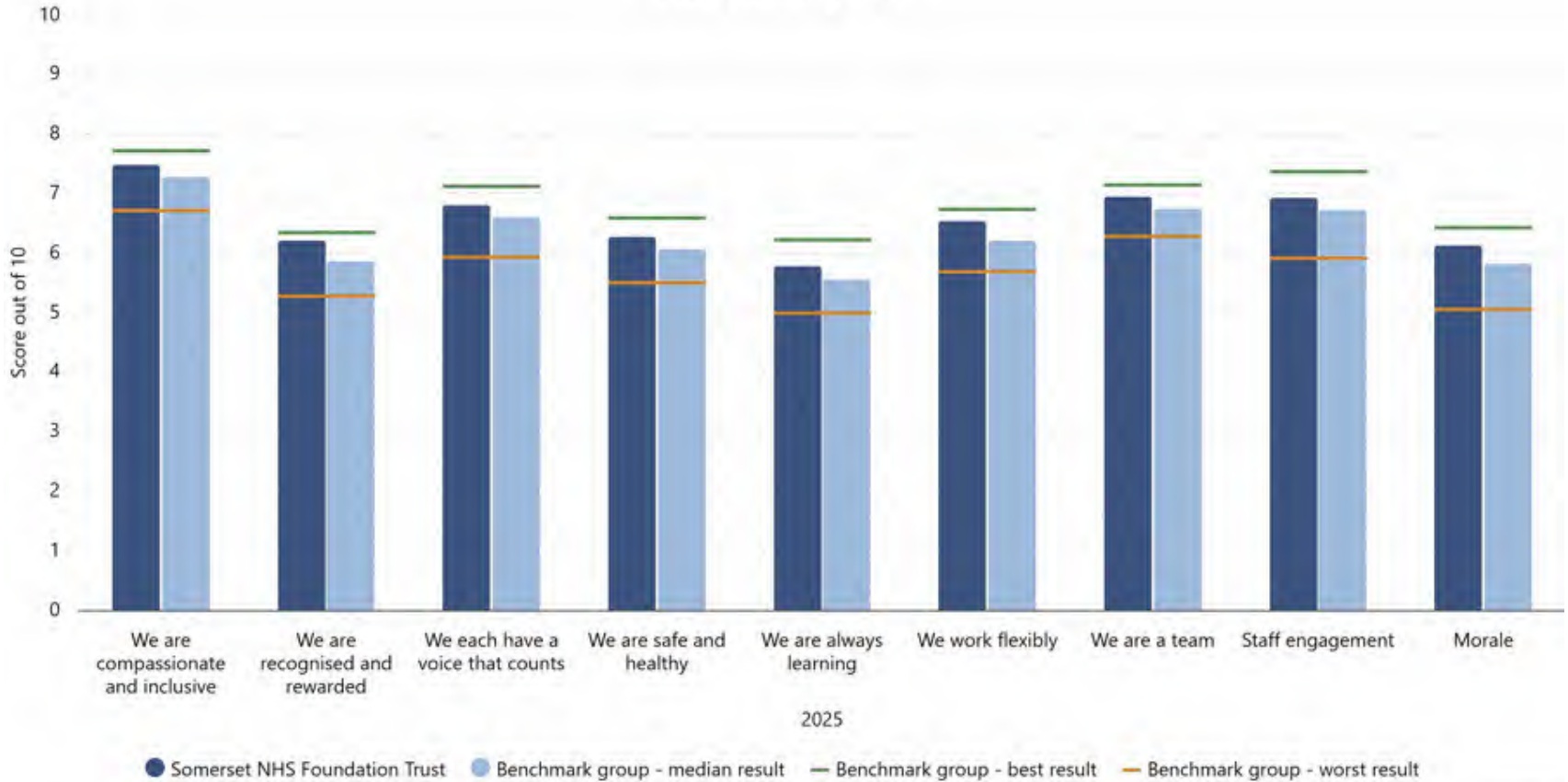




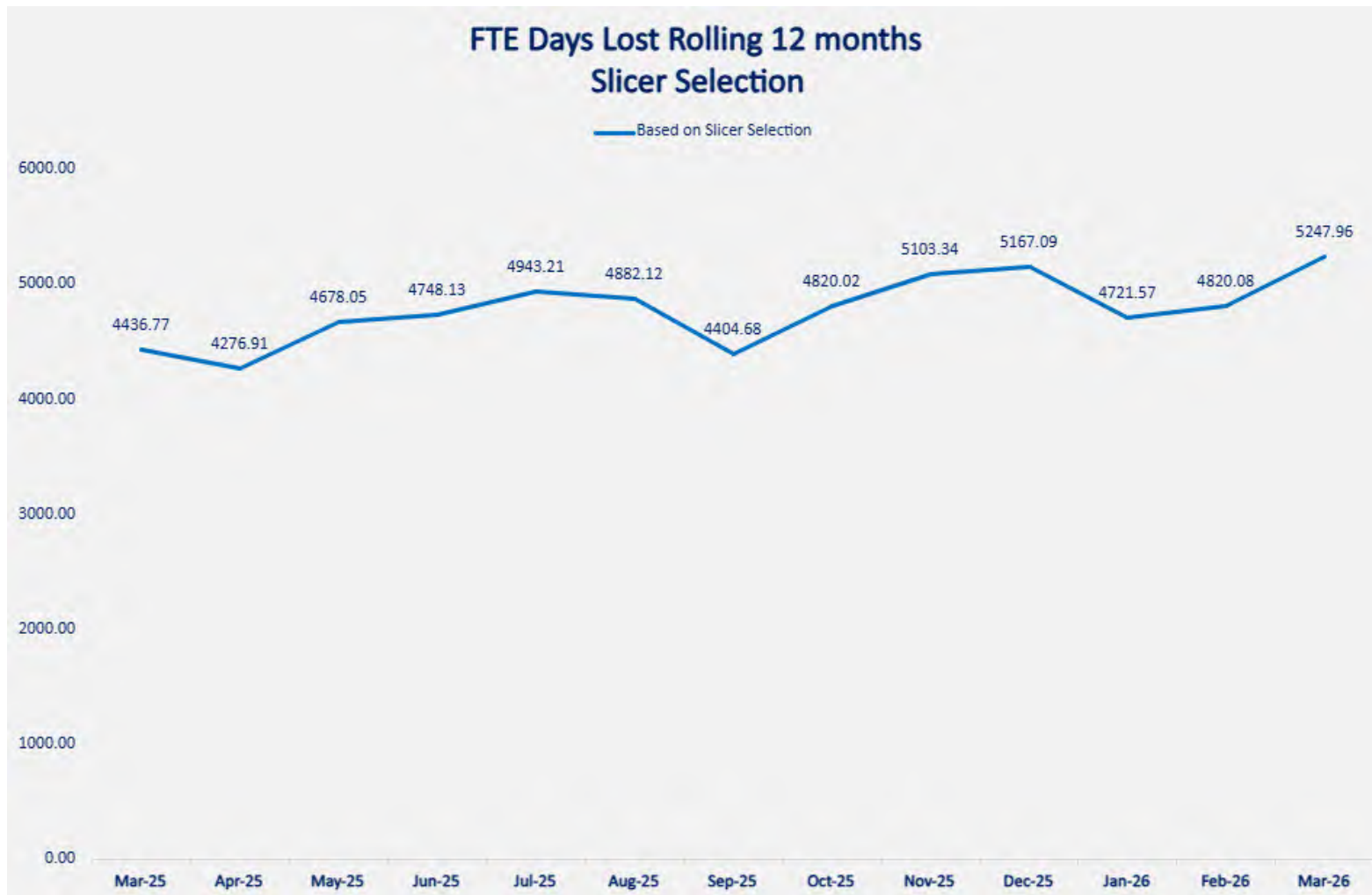
Data & Research

NHS Staff Survey 2025

Score Summary 2025

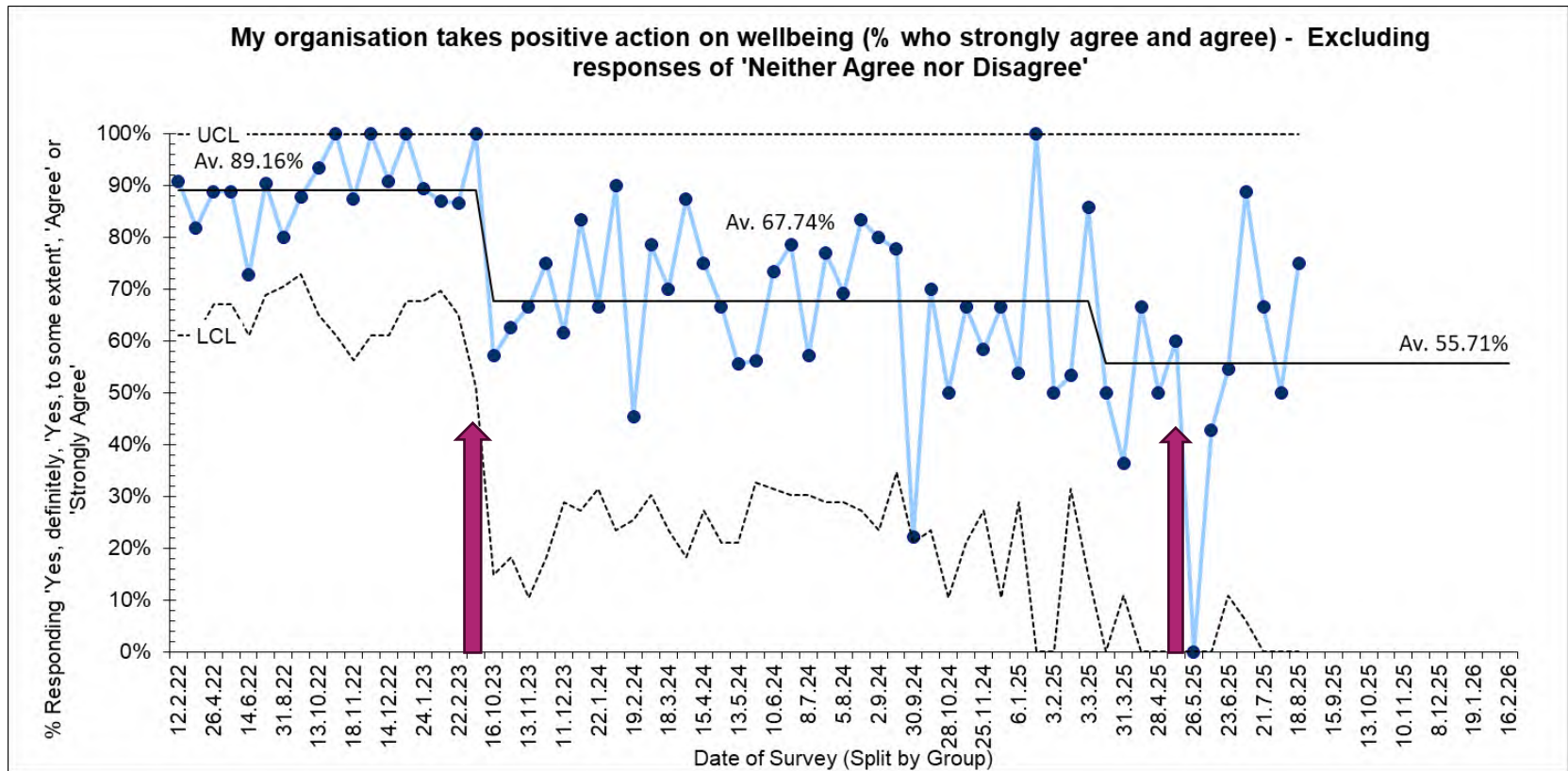


S10 Sickness Absence 25/26



Senior Drs – NHS & organisational change (Trust 59.1%)

My organisation takes +ve action on wellbeing



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Data & Research - So What?

- Cost implications:
 - FTE days lost to S10 = approximately 4815.187 per month (Apr 25- March 26)
 - Based on mid-range B6 AFC pay scales = £722,326.3 approx.
- Unknown costs:
 - Presenteeism
 - Backfill/ bank/ agency
 - Cancelled Appointments
 - Delays in service developments due to absence
 - Turnover
- Known underestimate due to:
 - limitations in sickness reporting (e.g. unknown, aggravation of LTC's etc)
 - Unknown associated costs of poor team dynamics and necessary resolution interventions

Occupational Health Overview Jan-March 26

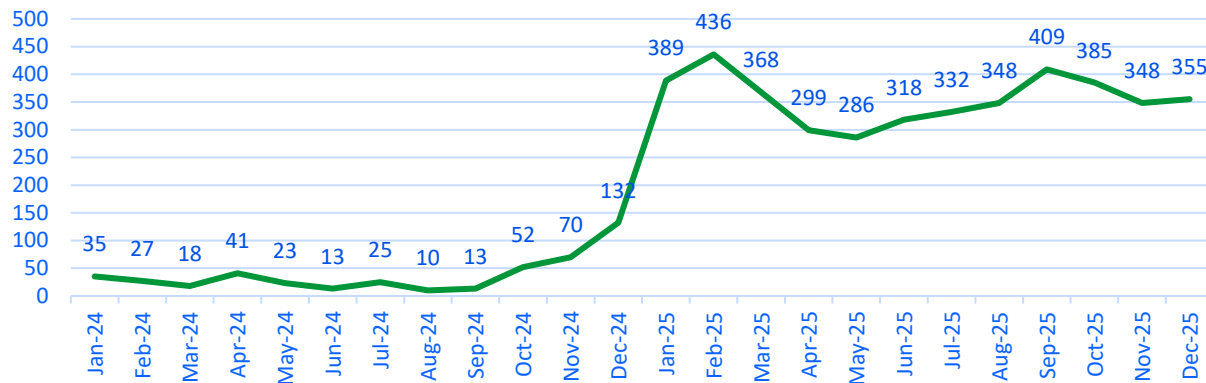


Kindness, Respect, Teamwork
Everyone, Every day

New administrative tasks for OH

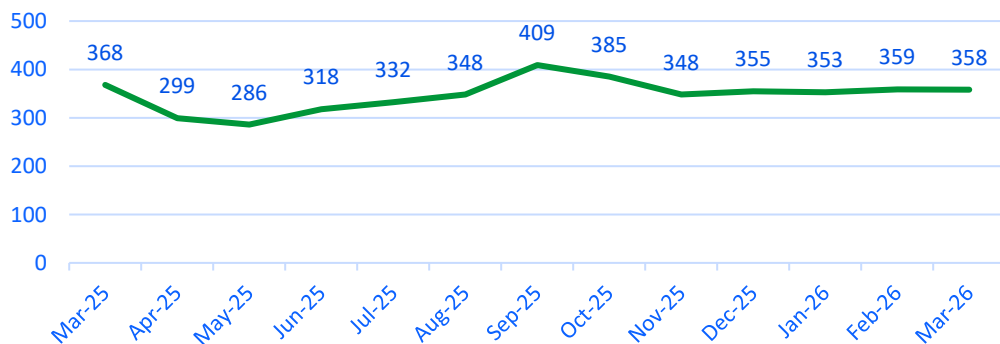
(Emails sent from OH inbox - underestimate)

2024 - 2025



- Go live date Jan 2025 with sustained activity since.
- In addition, 1141 Manual adjustments to ESR system required since June 2025 (activity recording started)

March 2025 - 2026



External pressures are beyond our
influence but.....

Workplace stress is within our gift to
proactively influence by improving
organisational culture and supporting
development of leadership skills
across the organisation

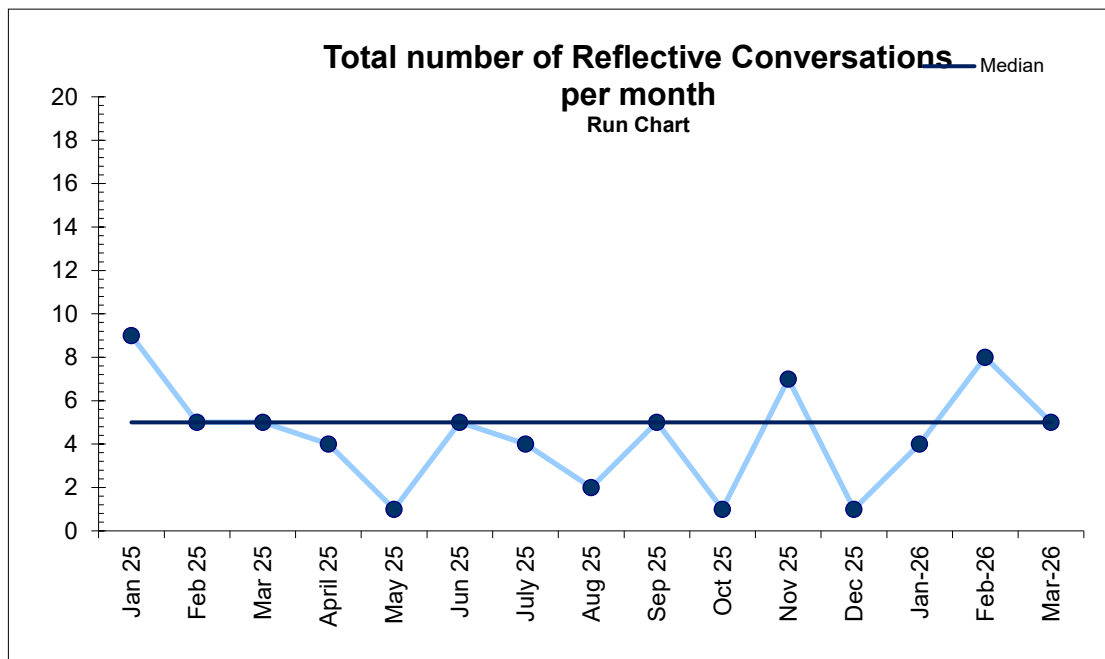
A large, stylized graphic of many birds in flight, scattered across the top and left sides of the slide. The birds are in various colors including green, blue, and purple. A dark blue horizontal bar with rounded ends spans across the middle of the slide, containing the text 'What we are already doing ...'.

What we are already doing ...

Listen & Learn in YDH themes (4 completed so far)

- Uncertainty and Future of Service / Strategic direction
- Wellbeing and Work-Life Balance
- Communication and Transparency
- Leadership and Management Structure
- Bureaucracy
- Cultural Diversity and Inclusion
- Job Planning and Meeting Overload

Post Incident Reflective Conversations



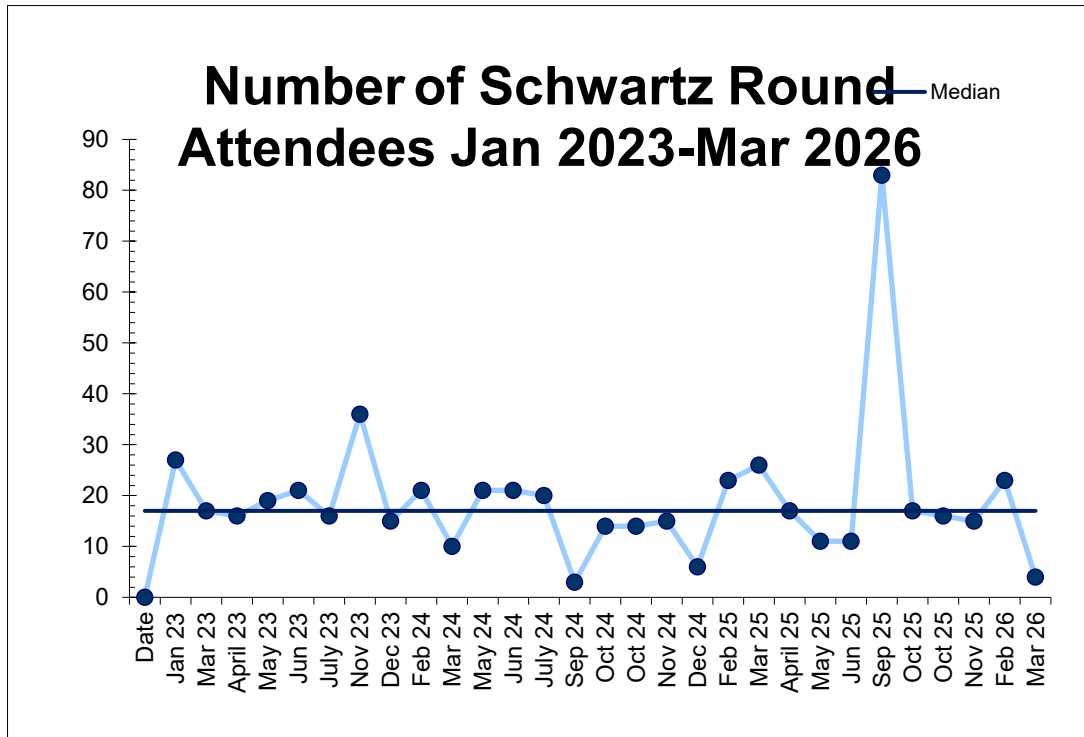
Colleague Feedback:

It provided a safe space for reflection on complex emotions, and I felt safe enough to bring things that I originally felt uncomfortable discussing.

To address the emotions that I didn't even realise I was suppressing and all the challenges that I can relates with my colleagues

It would be helpful if more of the team had attended, though we were able to reflect on this during the session and named that this reflected the culture

Schwartz Rounds: Total Attendance



“I found today’s round helpful, it made me realise that I am not alone in my imposter syndrome, that others feel the same and that actually that is okay.”—Feb 2026

“Always worth attending. Sometimes it is hard to speak openly about things that may have been on your mind for a long time, but these rounds help to break down the barriers and make it feel OK to speak up” – Feb 2026

A large, decorative graphic of numerous birds in flight, scattered across the upper and left portions of the slide. The birds are rendered in various shades of green, blue, and purple. A dark blue horizontal bar with rounded ends spans the width of the slide, partially overlapping the bottom of the bird graphic.

Compassionate Culture and Leadership

Creating a Health & Wellbeing Culture

Supporting our colleagues to be in the best possible position to offer and sustain:

- Kind, Compassionate, Inclusive Environments
- Where colleagues feel a sense of belonging, being valued and cared for and take collective responsibility for their own and others wellbeing at work
- Enables colleagues to deliver kind, compassionate safe care

Orchestrating an Organisational Shift towards Compassion

- Organisational Leadership Framework operationalised by activity at multiple levels of leadership
- Interwoven into the expectations of our 'everyday' way of doing things.
- Supported by structure, policy and action



Five pillars for medical leaders

to enable compassionate, inclusive leadership of teams.

Culture,
Connections
& Collaboration



Operations



Workforce



Quality, Safety
and Governance



Integration,
Innovation and
Improvement



Kindness, Respect, Teamwork
Everyone, Every day

[Link:
Compassionate and inclusive leadership](#)

Compassionate Leadership Development Programme



Supported by additional compassion orientated leadership practices

- Community of practice
- Mediation
- Formal Coaching and Adopting an 'Everyday Coaching Style Approach' Training
- Schwartz Rounds
- Reflective practice opportunities – including PNA led restorative clinical supervision, Balint Groups,
- Compassion Circles
- Wellbeing Conversations
- Cultural Competence and Allyship training

Our Ask





Further Reading

Senior Doctor Wellbeing & Leadership Appendices

- [Wellbeing](#)
- [somersetft.sharepoint.com/sites/intranet-keyteams/SiteAssets/Forms/AllItems.aspx?id=%2Fsites%2Fintranet-keyteams%2FSiteAssets%2FSitePages%2FPage%281%29%2Fsupport-booklet-SD-May-2025-%2Epdf&parent=%2Fsites%2Fintranet-keyteams%2FSiteAssets%2FSitePages%2FPage%281%29](#)
- [..\WSG-013 Senior Doctor Wellbeing\02. Improvement Methodology\1. Data\Anna reports\SD wellbeing report September 2024.docx](#)
- [A cross-sectional audit of the risk of burnout among senior medical staff in a UK district general hospital](#)

Compassionate Leadership

Appendices and references

- [Leadership Expectations Framework](#)
- NHS Staff Pulse Survey (2025)
- Does Employee Happiness have an Impact on Productivity? Bellet, De Neve & Ward (2019) *Saïd Business School WP 2019-13*
- West (2021) Compassionate Leadership: sustaining wisdom, humanity and presence in health and social care
- [About Schwartz Rounds - Point of Care Foundation](#)

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board Meeting
REPORT TITLE:	Corridor Care Briefing
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and Midwife
REPORT BY:	Jayne Cooper, Stacy Barron Fitzimons, Rachael Hosznyak
PRESENTED BY:	Deirdre Fowler, Chief Nurse and Midwife
DATE:	12 May 2026

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
<input checked="" type="checkbox"/> For Assurance	<input type="checkbox"/> For Approval / Decision	<input type="checkbox"/> For Information

Executive Summary and Reason for presentation to Committee/Board	<p>Corridor care represents a significant and immediate risk to patient safety, quality and dignity, and is increasingly recognised as a key indicator of whole-system flow failure. NHS England has introduced strengthened standards, a national definition, and new reporting requirements, alongside the GIRFT Corridor Care Improvement Guide, with a clear expectation that corridor care is virtually eliminated by September 2026.</p> <p>This paper is presented to the Board to provide oversight and assurance that corridor care is being addressed as a critical patient safety and system flow priority. It highlights the requirement for robust executive leadership, strengthened governance and reporting, and sets out the need for a completed gap analysis and delivery of a clear, monitored action plan aligned to national expectations.</p>
Recommendation	<p>The Trust's response to corridor care is being delivered through the Urgent and Emergency Care Transformation programme, focusing on addressing the root causes through admission avoidance, improved inpatient flow in the first 72 hours, and the <i>Every Minute Matters</i> approach. This includes embedding earlier senior clinical decision-making, strengthening multidisciplinary ownership of discharge, and reducing patients with no criteria to reside to release capacity and minimise delays. In parallel, implementation of the GIRFT Model Acute Pathway and Clinical Operational Standards supports safer, faster and more consistent patient flow, reducing unnecessary admissions and length of stay. Collectively, these actions aim to address corridor care upstream by</p>

improving system flow, supported by strengthened governance, clear escalation processes, and executive oversight to ensure corridor care is managed as a patient safety priority and progressively eliminated.

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)

- | | | | | | |
|------------------------------------|--------------------------------------|------------------------------------|----------------------------------|------------------------------|---|
| <input type="checkbox"/> Financial | <input type="checkbox"/> Legislation | <input type="checkbox"/> Workforce | <input type="checkbox"/> Estates | <input type="checkbox"/> ICT | <input checked="" type="checkbox"/> Patient Safety/ Quality |
|------------------------------------|--------------------------------------|------------------------------------|----------------------------------|------------------------------|---|

Details: N/A

Equality

The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

- This report has been assessed against the Trust's People Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
- This report has been assessed against the Trust's People Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities

Public/Staff Involvement History

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

Previous Consideration

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

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Reference to CQC domains (Please select any which are relevant to this paper)

<input checked="" type="checkbox"/> Safe	<input type="checkbox"/> Effective	<input type="checkbox"/> Caring	<input type="checkbox"/> Responsive	<input type="checkbox"/> Well Led
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Is this paper clear for release under the Freedom of Information Act 2000?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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SOMERSET NHS FOUNDATION TRUST

Corridor Care Report

1. BACKGROUND AND SITUATION

- 1.1 Corridor care represents a significant and immediate patient safety, quality and dignity risk and is increasingly recognised nationally as a marker of whole-hospital and system flow failure. Its persistence undermines public confidence, impacts staff morale, and compromises our ability to deliver safe and timely care.
- 1.2 NHS England (NHSE) has now moved from tolerance of temporary escalation practices to a clear expectation that corridor care is virtually eliminated, supported by strengthened standards, reporting and executive oversight, new national standards and reporting requirements resulting in the publication of a GIRFT Corridor Care Improvement Guide.
- 1.3 Somerset NHS Foundation Trust must now ensure robust executive and local leadership oversight, completion of a gap analysis against the GIRFT guide, and delivery of a clear, monitored action plan to eradicate corridor care.
 - On 4 March, NHSE wrote to Trust Chief Executives and Chairs outlining additional actions, red-line standards, and new reporting requirements to support the virtual elimination of corridor care by September 2026.
 - NHSE has published a new national definition of corridor care, replacing “Temporary Escalation Spaces”.
 - GIRFT has subsequently published a Corridor Care Improvement Guide to support local systems to reduce and eliminate corridor care.
 - Corridor care is now subject to new daily sitrep reporting, with national publication of data planned from May 2026, subject to data quality.

Key national red-line standards include:

- A. Ambulance handovers no longer than 45 minutes
- B. Zero tolerance for ED waits over 24 hours. Any breach must trigger an immediate whole-journey review with executive triumvirate (CMO, CNO, COO)
- C. Clear limits and escalation for corridor care. Breaches must trigger a formal RCA, reported to the CEO with learning captured

2. ASSESSMENT

2.1 The new Definition of Corridor care refers to any care delivered in a non-designated clinical space where one or more of the following cannot be met:

- Clinical safety and appropriateness
- Privacy
- Dignity (including food, water, toilet access)
- Ability to rest/sleep (e.g. lights off)
- IPC approval

A patient waiting comfortably for less than 45 minutes with a clear plan to move is not considered corridor care.

Reporting Requirements

- ED: Number of patients receiving corridor care for >45 minutes in the previous 24 hours (excluding ambulance handovers).
- Inpatient wards/other areas: Snapshot at 08:00 of patients in adult G&A areas receiving corridor care for >45 minutes.
- Data submitted via Daily Sitrep (from 6 March); Temporary Escalation Space reporting stood down.

Current Position

- Corridor care presents ongoing risks to safety, quality, dignity, and experience.
- Increased transparency and national reporting introduce reputational, regulatory, and quality risk if not proactively addressed.
- There is now a clear expectation for executive-led oversight, formal governance, and demonstrable improvement actions.
- Self assessment completed and submitted to NHSE

3. RECOMMENDATION

3.1 A wider piece of work under the Urgent and Emergency Care Transformation programme is focusing on several elements that aim to deal with the causes of the issues. The pillars being: admission avoidance, first 72 hrs as an inpatient and Every Minute Matters. The **Every Minute Matters Programme**, addresses the operational and behavioural drivers that result in corridor care by establishing reliable, early daily inpatient decision-making and discharge processes at ward level. Priority actions include:

- Earlier senior clinical decision-making embedded as a daily standard, through consistent Board → Ward → Huddle processes and earlier consultant review, enabling timely treatment plans, earlier discharge decisions and increased discharge before midday.
- Strengthened MDT ownership of discharge readiness, using a clear operating standard and ward-level accountability to identify and resolve

discharge barriers proactively, reducing late-day decision-making and avoidable inpatient delays.

- Focused and sustained reduction in patients with no criteria to reside, supported by improved MDT reliability, earlier therapy and frailty input, and proactive use of discharge routes, releasing inpatient capacity and reducing exit block that leads to corridor care.

3.2 Even modest improvements in NCTR release significant bed capacity, reduce exit block, and prevent internal corridor care forming across inpatient areas

Implementation of the Model Acute Pathway (GIRFT)

3.3 The Model Acute pathway is important because it fosters safer, faster, consistent and more efficient urgent and emergency care, with key focuses on:

3.4 Improved flow ensuring patients are in the right place at the right time in the right part of the system; Reducing bottlenecks and flow limiters. Many patients don't require admission, or can have a much shorter length of stay, if they are seen early by the right team. It also supports, continuity and coordination of care, care in the right place at the right time and 7-day working.

3.5 At Musgrove Park Hospital, there are clear, evidence-based opportunities to reduce corridor care by improving medical flow.

- Split medical take (Acute Medicine and Acute Frailty) aligns with Society for Acute medicine (SAM) and ensures assessment capacity reflects daily demand to ensure patients are seen by the right team in the first point of their care journey.
- This improves early decision-making, reduces unnecessary admissions and supports same-day discharge.
- Local data demonstrates that when the Acute Medical Unit bed base is right-sized, average AMU length of stay is reduced by approximately 10 hours, this also requires careful capacity and demand planning
- This confirms that efficiency, patient throughput and safety improve when unit configuration matches the flow model capability.

Clinical Operational Standards (GIRFT COS)

3.6 GIRFT COS consist of a set of best practice guidelines developed by the Getting It Right First Time programme to reduce unwarranted variation in NHS care. They define clear, actionable expectations for clinical and operational staff, often focusing on improving patient flow, safety, and timely, effective care by focusing on;

- Variation in clinical processes between teams
- Delays in diagnostics, treatments, follow ups.
- Inconsistent workforce models
- Sets a clear framework for expectations and patient care.

3.7 This approach addresses corridor care upstream, preventing bottlenecks rather than responding late with escalation. This approach focuses on speed, reliability and safety of flow, rather than bed expansion. With daily national reporting and increased transparency, corridor care must be governed as a patient safety priority, and an operational exception.

3.8 There is a clear expectation of:

- Defined corridor care limits
- Mandatory escalation and RCA following breaches
- Executive oversight of improvement actions and outcomes

3.9 The Board is asked to note:

- A. Reframing corridor care as a Trust wide flow priority, collectively owned at executive level and operationalised at Service Group level.
- B. The completion of a formal Trust-wide gap analysis against the GIRFT Corridor Care Improvement Guide.
- C. Approval and monitoring of mitigations, under the UEC transformation project, aligned to national standards and red lines.
- D. Strengthened governance and escalation, ensuring:
 - i. Clear corridor care limits within full capacity protocols
 - ii. Mandatory RCA and CEO oversight for breaches
- E. Ensuring data quality, reporting, and transparency is in line with new sitrep requirements.
- F. Embed corridor care as a patient safety and experience priority, with clear executive accountability.
- G. Align learning and actions at Service Group level, where opportunities arise, to support consistency and shared learning.

3.10 Proposed Trust workstreams with timeframes:

1. National definition and policy alignment
2. Reporting and data quality
3. Governance, oversight and risk management
4. Incident reporting and learning
5. Patient safety, experience and dignity
6. Operational flow improvements via UEC transformation.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Group Finance report
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Chief Finance Officer
DATE:	12 May 2026

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
<input checked="" type="checkbox"/> For Assurance	<input type="checkbox"/> For Approval / Decision	<input type="checkbox"/> For Information

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

Links to Strategic Aims (Please select any which are impacted on / relevant to this paper)
<input type="checkbox"/> Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
<input type="checkbox"/> Aim 2 Provide the best care and support to people
<input type="checkbox"/> Aim 3 Strengthen care and support in local communities
<input type="checkbox"/> Aim 4 Respond well to complex needs
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<input type="checkbox"/> 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)					
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Details: N/A

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

Not applicable

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

Monthly report

Reference to CQC domains (Please select any which are relevant to this paper)

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Is this paper clear for release under the Freedom of Information Act 2000?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT

1. SUMMARY

- 1.1 In March, the Trust recorded a surplus of £7.371m, this was £4.933m favourable to plan for the month. Cumulatively, the Trust is £4.933m favourable to the annual plan.
- 1.2 NHS England has decided to redistribute any Deficit Support Funding (DSF) foregone by systems that did not deliver their plans this year to those providers that did so, as long as those providers are part of a system that delivered plan and have also submitted a balanced plan for 2026/27, for SFT this value is £4.915m. As the funding from which the bonus will be paid was originally intended to fund system deficits, the money has to flow to the bottom line of the Trust, thus creating a surplus to make sure that the NHS overall meets its financial targets, and so cannot be spent. However the DSF bonus will be cash-backed, so will provide us with additional cash.
- 1.3 The financial performance of services was slightly improved overall compared with previous months. However, pressures continued within many of our clinical services, particularly within the Children, Young People & Families, Surgery and Medical service groups – this has been a consistent issue throughout the year. If we exclude the bonus DSF funding, we have achieved our plan as forecast.
- 1.4 March agency expenditure was £0.977m, this was £0.568m below February expenditure. Cumulatively, expenditure is £11.215m lower than in 2024/25 and represents a 39% reduction.
- 1.5 CIP was delivered in March in line with our forecasts which is positive. Our overall plan was achieved and of this c30% was recurrent. While this has matched our forecast levels it remains disappointing and is well below that planned at the start of the year. Work is well underway to develop robust plans that will achieve both a much higher level of overall efficiency and recurrent savings in 2026/27.
- 1.6 The Trust recorded an I&E impairment of £20.1m in the month resulting from the desktop valuation of the Trust's land and buildings undertaken by the Trust valuers as part of the year end accounts process. This reflects the reduction in market value of assets. This is below the line and therefore disregarded in the assessment of financial performance by NHSE. In addition, further impairments of £14.4m were charged to the revaluation reserve (as these impairments can be offset against previous upward movements in asset value).

2. INCOME AND EXPENDITURE

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

Table 1: Income and Expenditure Summary March

Statement of Comprehensive Income	Annual Budget £000	Current Month 12			Year to date		
		Budget £000	Actual £000	Fav./ (Adv.) Variance £000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	1,047,648	91,817	107,997	16,180	1,047,647	1,086,180	38,533
Other Operating Income	78,748	6,830	46,893	40,063	78,747	125,335	46,588
Total operating income	1,126,396	98,647	154,890	56,243	1,126,394	1,211,515	85,121
Operating expenses							
Employee Operating Expenses	(773,211)	(64,357)	(113,343)	(48,986)	(773,211)	(838,573)	(65,361)
Drugs Cost: Consumed/Purchased	(83,283)	(7,380)	(7,760)	(380)	(83,283)	(86,192)	(2,909)
Clinical Supp & Serv Exc-Drugs	(77,656)	(8,482)	(9,374)	(892)	(77,656)	(85,827)	(8,171)
Supplies & Services - General	(32,732)	(3,283)	(3,405)	(122)	(32,732)	(38,050)	(5,318)
Other Operating Expenses	(151,245)	(11,754)	(33,119)	(21,365)	(151,245)	(168,255)	(17,011)
Total operating expenses	(1,118,127)	(95,255)	(167,001)	(71,746)	(1,118,127)	(1,216,896)	(98,770)
Operating Surplus/Deficit	8,269	1,392	(12,110)	(15,503)	8,267	(5,381)	(13,648)
Finance Expense	(14,169)	(1,201)	(636)	(566)	(14,169)	(12,968)	1,202
Finance Income	3,518	285	(159)	(445)	3,518	2,149	(1,368)
Other	0	(1)	(1)	(0)	2	(1)	(1)
Overall Surplus/(Deficit)	(2,383)	2,475	(12,906)	(15,382)	(2,383)	(16,210)	(13,828)
Depr On Donated Assets	1,216	102	94	(8)	1,216	1,381	165
Donated Assets Income	(1,412)	(353)	(42)	311	(1,412)	(505)	847
Amortisation	0	0	3	3	0	36	36
PFI UK GAAP Adjustments	2,579	214	111	(103)	2,579	180	(2,399)
Impairments	0	0	20,112	20,112	0	20,112	20,112
Adjustments to control total	2,383	(137)	20,277	20,314	2,383	21,144	18,761
Adjusted Financial Performance	0	2,438	7,371	4,933	0	4,983	4,933

2.2 Total agency and locum costs in month were £2.024m, this is an increase of £0.109m compared with February. Agency costs were £0.568m lower than in February at £0.977m. There was a decrease of £0.629m in medical agency and a £0.0103m increase in nursing agency.

2.3 The spike in other substantive staff costs in March is driven by the additional 9.4% employer superannuation costs of c£46m which are paid each month by NHSE and transferred to organisations in March (these are fully funded by additional income). This effects substantive costs only.

2.4 Further information is set out in Tables 2 and 3 below:-

Table 2: Pay expenditure information

2025/26 Monthly Pay Expenditure analysis	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	2025/26 In Month Budget	F/(A) Variance £000	2025/26 Total YTD Budget	F/(A) Variance £000		
Temporary staff																		
Bank Staff	2,083	2,224	2,055	2,127	2,253	2,072	2,061	2,108	1,985	2,126	2,183	2,881	1,815	(1,068)	26,159	21,254	(4,635)	
Medical Agency	1,251	1,178	1,175	1,167	1,082	1,107	1,128	922	1,117	1,013	1,135	506	695	189	12,782	10,832	(1,950)	
Medical Locums	846	800	816	808	808	963	755	797	849	1,533	658	370	1,047	895	(152)	10,244	11,293	1,049
Nursing Agency	406	317	315	364	321	285	79	307	252	349	306	409	280	(128)	3,710	2,957	(753)	
Other Agency	170	168	118	119	97	92	102	72	88	24	103	62	149	87	1,215	1,839	725	
Total Temporary Staff	4,756	4,687	4,480	4,583	4,716	4,313	4,167	4,258	4,975	4,171	4,098	4,905	3,832	(1,073)	54,109	48,545	(5,565)	
Nursing	16,525	16,473	16,457	16,715	15,960	18,563	16,307	16,772	16,892	16,871	16,784	16,628	17,228	402	196,926	206,963	8,038	
Support to Nursing	6,368	6,342	6,372	6,020	6,486	6,153	5,939	5,890	5,924	5,947	5,888	6,486	5,551	(935)	73,818	68,022	(5,796)	
Medical	13,858	13,752	13,742	14,734	14,699	14,710	14,444	14,640	14,163	14,166	14,688	14,184	13,676	(509)	175,150	159,515	(15,635)	
AHP's	9,526	9,523	9,533	9,691	9,919	9,787	9,696	9,761	9,702	9,758	10,128	9,798	8,598	(1,200)	116,822	116,254	(568)	
Infrastructure Support	10,548	10,483	10,696	10,604	10,749	10,484	10,934	10,912	10,554	10,037	10,587	10,645	11,272	627	127,233	125,016	(2,217)	
Other	4,011	4,184	4,113	4,635	4,231	3,319	3,678	3,779	3,782	3,718	3,560	50,499	4,201	(46,299)	92,511	48,895	(43,615)	
Substantive Staff	60,835	60,756	60,896	62,398	62,044	61,019	60,997	60,755	60,819	60,497	65,004	108,438	60,524	(47,913)	784,457	724,667	(59,791)	
Total All Staff	85,592	85,443	85,376	86,983	86,760	85,333	85,164	85,013	85,794	84,668	89,102	113,343	64,357	(48,986)	838,567	773,211	(65,356)	
% Temporary	7.25%	7.16%	8.85%	8.84%	7.06%	6.60%	8.39%	6.53%	7.56%	6.43%	5.93%	4.33%	5.95%		6.43%	6.28%		

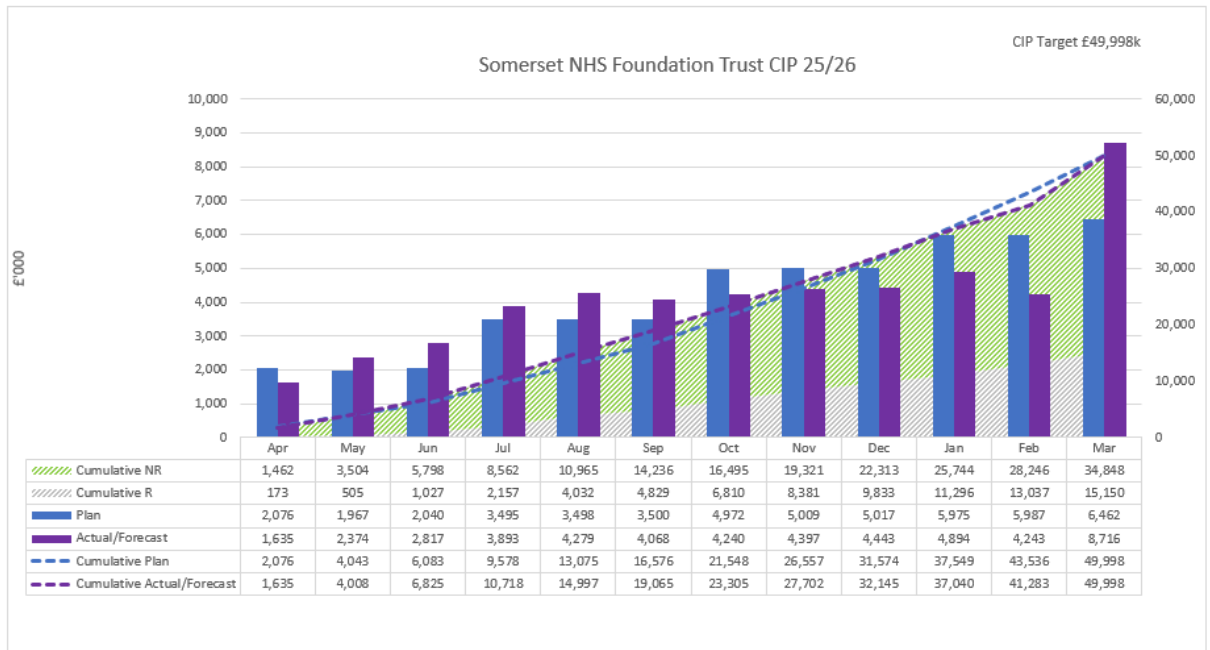
Table 3: WTE information

2025/26 Monthly Workforce analysis	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	In Month WTE	In Month Budget WTE	F/(A) Variance WTE
Temporary staff															
Bank Staff	572.82	503.68	461.20	534.77	515.78	495.96	489.04	489.45	461.36	491.54	500.37	556.53	556.53	477.44	(79.09)
Medical Agency	57.89	55.77	55.19	56.24	50.27	50.74	48.00	48.69	49.73	45.28	44.80	47.50	47.50	38.07	(9.43)
Medical Locums	48.91	45.94	47.85	47.33	45.45	43.49	49.88	44.29	47.60	58.59	46.96	66.85	66.85	76.34	9.49
Nursing Agency	58.76	56.94	41.37	54.17	47.42	41.23	49.60	41.04	41.94	45.84	46.67	48.40	48.40	42.52	(5.88)
Other Agency	42.53	35.57	29.31	23.27	19.17	21.36	15.98	9.83	13.52	6.27	10.31	8.90	8.90	31.28	22.38
Total Temporary Staff	780.91	697.90	634.92	715.78	678.09	652.78	652.50	633.30	614.15	647.52	649.11	728.18	728.18	665.65	(62.53)
Nursing	3,515.03	3,505.84	3,502.40	3,475.99	3,485.50	3,518.73	3,527.99	3,537.51	3,534.52	3,516.68	3,517.16	3,499.91	3,499.91	3,447.65	(52.26)
Support to Nursing	2,008.96	1,990.93	1,995.47	1,989.30	1,984.46	1,910.43	1,881.38	1,867.88	1,860.25	1,854.45	1,846.69	1,869.95	1,869.95	1,795.35	(74.60)
Medical	1,215.27	1,218.17	1,210.91	1,215.12	1,268.22	1,274.89	1,274.20	1,276.42	1,265.71	1,264.41	1,275.83	1,267.59	1,267.59	1,293.10	25.51
AHP's	1,623.27	1,617.72	1,625.00	1,612.73	1,634.40	1,650.36	1,648.79	1,641.49	1,651.48	1,653.52	1,649.63	1,645.29	1,645.29	1,741.21	95.92
Infrastructure Support	2,743.25	2,766.59	2,767.95	2,771.36	2,758.36	2,760.38	2,764.96	2,768.71	2,736.51	2,737.58	2,742.18	2,724.42	2,724.42	2,851.17	126.75
Other	1,291.31	1,234.14	1,227.20	1,234.78	1,222.60	1,206.86	1,215.86	1,218.54	1,210.23	1,204.79	1,205.72	1,207.22	1,207.22	1,316.35	109.13
Substantive Staff	12,337.09	12,333.38	12,328.93	12,299.28	12,353.55	12,321.65	12,313.18	12,310.54	12,258.69	12,231.42	12,237.19	12,214.38	12,214.38	12,444.83	230.45
Total All Staff	13,118.00	13,031.28	12,963.85	13,015.06	13,031.64	12,974.43	12,965.68	12,943.84	12,872.84	12,878.94	12,886.30	12,942.56	12,942.56	13,110.48	167.92
% Temporary	5.95%	5.36%	4.90%	5.50%	5.20%	5.03%	5.03%	4.89%	4.77%	5.03%	5.04%	5.63%	5.63%	5.08%	

3. COST IMPROVEMENT PROGRAMME

3.1 In March, total savings of £8.716m were delivered, this was £2.253m favourable to plan for the month. In total, savings of £49.998m have been delivered which is original planned level. Of these, £15.150m (30%) has been recurrent in nature and although this is consistent with forecasts, it falls somewhat below our original expectations. Further analysis is shown in the chart below: -

Chart 1: CIP Plan 2025/26

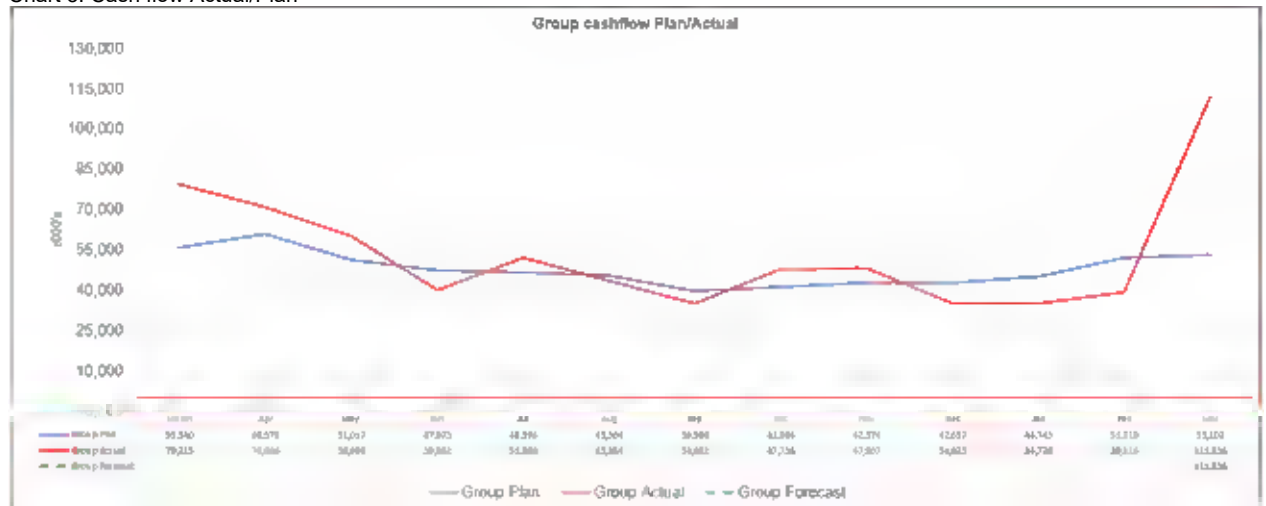


4. CASH

4.1 Cash balances at 31 March were £111.836m; £59m higher than plan, largely due to capital expenditure incurred and not yet settled (capital creditors £42.3m) and a £28.1m cash balance held on behalf of partner Trusts for EHR supplier payments under the Trust's role as lead provider.

4.2 The group cashflow position is shown below:-

Chart 3: Cash flow Actual/Plan



5. STATEMENT OF FINANCIAL POSITION

Feb-26	Mar-26	Movement		Mar-25	Mar-26	Movement in Year
£000	£000	£'000		£000	£000	£000
48,724	70,958	22,234	Intangible Assets	35,549	70,958	35,409
422,495	420,594	(1,902)	Property, plant and equipment, other	407,874	420,594	12,720
27,220	26,626	(594)	On SoFP PFI assets	29,141	26,626	(2,515)
85,596	87,482	1,886	Right of use assets	89,834	87,482	(2,352)
14	14	0	Investments	14	14	0
14	14	0	Other investments/financial assets	14	14	0
3,271	3,340	70	Trade & other receivables > 1yr	3,063	3,340	277
587,334	609,028	21,694	Non-current assets	565,489	609,028	43,539
13,087	13,022	(64)	Inventories	11,281	13,022	1,741
29,743	10,586	(19,157)	Trade and other receivables: NHS receivables	5,338	10,586	5,248
34,662	22,684	(11,977)	Trade and other receivables: non-NHS receivables	18,796	22,684	3,889
0	0	0	Non current assets held for sale	496	0	(496)
39,116	111,836	72,721	Cash	79,215	111,836	32,622
116,607	158,129	41,522	Total current assets	115,126	158,129	43,003
(114,806)	(134,716)	(19,909)	Trade and other payables: non-capital	(101,088)	(134,716)	(33,628)
(11,336)	(42,354)	(31,018)	Trade and other payables: capital	(18,183)	(42,354)	(24,171)
(25,924)	(12,074)	13,851	Other liabilities	(18,455)	(12,074)	6,382
(12,451)	(12,695)	(244)	Borrowings	(16,046)	(12,695)	3,351
(8,614)	(8,908)	(294)	Provisions < 1yr	(9,440)	(8,908)	533
(173,131)	(210,746)	(37,615)	Current liabilities	(163,213)	(210,746)	(47,533)
(56,524)	(52,617)	3,907	Net current assets	(48,087)	(52,617)	(4,530)
(109,456)	(112,107)	(2,650)	Borrowings > 1yr	(112,989)	(112,107)	882
(2,668)	(2,725)	(57)	Provisions > 1yr	(2,871)	(2,725)	145
(1,186)	(1,164)	22	Other liabilities > 1Yr	(1,423)	(1,164)	259
(113,311)	(115,996)	(2,686)	Total long-term liabilities	(117,282)	(115,996)	1,286
417,499	440,415	22,916	Net assets employed	400,120	440,415	40,295
			Financed by:			
420,284	466,225	45,941	Public dividend capital	399,414	466,225	66,811
71,459	60,819	(10,641)	Revaluation reserve	73,581	60,819	(12,762)
(3,702)	(3,702)	0	Other reserves	(354)	(3,702)	(3,348)
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(68,792)	(81,325)	(12,533)	I&E reserve	(70,733)	(81,325)	(10,592)
			Other's equity			
722	871	149	Non-controlling Interest	683	871	187
417,499	440,415	22,916	Total financed	400,120	440,415	40,295

5.1 Trade and other payables-capital in month movement is driven by increased capital spend with payment expected in April (£20.2m relates to the Trust EHR system), corresponding entries in cash.

5.2 I&E reserve and revaluation reserve in month movements are driven by the £20.1m impairment and £10.6m revaluation decrease resulting from the annual valuation of the Trusts' land and buildings by our external valuer.

6. CAPITAL

6.1 Total capital expenditure was £118.078m at the end of March against a revised plan of £119.841m. There have been significant changes over the course of the year due to a combination of approving new areas of expenditure as schemes slipped and in response to additional funding allocations.

6.2 Total reported CDEL expenditure to the end of March amounted to £116.792m against a plan of £116.819m, underspending by £0.027m.

- 6.3 Delivery of a complex programme such as this is another huge achievement and the result of significant planning and hard work of many colleagues. A summary at overall programme level, together with the outturn position is shown in the table below:

Table 4: Capital Programme Summary

Scheme Type	Initial Annual Plan	Updated Internal Annual Plan	Actual Spend Year to Date	Variance to Internal Plan
	£'000	£'000	£'000	£'000
Local Funded Schemes	38,851	39,211	42,343	(3,132)
IFRS 16 "Leases"	5,668	10,797	7,638	3,159
National Programmes	56,593	66,811	66,811	0
CDEL Total Expenditure	101,112	116,819	116,792	27
Charity/Grant	1,410	2,644	938	1,706
PFI Funded/IFRIC 12	378	378	348	30
Total	102,900	119,841	118,078	1,763

7. CONCLUSION & RECOMMENDATION

- 7.1 The Trust has delivered the 2025/26 financial plan. This has resulted in the Trust being eligible to receive a bonus of £4.9m in deficit support funding reallocated by NHSE.
- 7.2 The successful delivery of the full efficiency programme, together with a 39% reduction in agency expenditure are significant achievements, especially when viewed against the backdrop of the operational pressures that have been present during the year.
- 7.3 Our financial performance has been supported by non-recurrent resources and additional funding which is not sustainable. The plan for 2026/27 requires a step change in our delivery of recurrent efficiencies through our transformation programme combined with adherence to service level financial plans and further reductions in temporary staffing.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Audit Committee meeting held on 22 April 2026
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer Jade Renville, Director of Corporate Services
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Paul Mapson, Chair of the Audit Committee
DATE:	12 May 2026

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
<input checked="" type="checkbox"/> For Assurance	<input type="checkbox"/> For Approval / Decision	<input type="checkbox"/> For Information

Executive Summary and Reason for presentation to Committee/Board	<p>The Audit Committee met on 22 April 2026 and reviewed the Quarter 4 Board Assurance Framework and Corporate Risk Register, the Risk Management Strategy 2026–2029, internal and external audit updates, counter fraud activity, limited assurance reviews and a range of governance and financial control items.</p> <p>Assurance was received on the overall effectiveness of the Trust’s risk management and assurance arrangements, progress with internal and external audit delivery and proactive fraud prevention activity. The Committee noted that the year-end risk profile remains high, reflecting sustained operational and financial pressures, alongside evidence of progress in service recovery, digital programmes and the maturity of risk management arrangements. This report provides assurance to the Board and highlights key risks requiring Board oversight.</p>
Recommendation	<p>The Board is asked to note the assurance provided and the key risks identified, including those relating to strategic risks above appetite, information governance, limited assurance audit findings, governance effectiveness and fraud prevention activity, and to support ongoing work to strengthen internal control, risk management and assurance across the Trust.</p>

Links to Strategic Aims (Please select any which are impacted on / relevant to this paper)	
<input type="checkbox"/>	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)

- | | | | | | |
|---|--------------------------------------|------------------------------------|----------------------------------|------------------------------|---|
| <input checked="" type="checkbox"/> Financial | <input type="checkbox"/> Legislation | <input type="checkbox"/> Workforce | <input type="checkbox"/> Estates | <input type="checkbox"/> ICT | <input type="checkbox"/> Patient Safety/Quality |
|---|--------------------------------------|------------------------------------|----------------------------------|------------------------------|---|

Details: N/A

Equality
The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics

- This report has been assessed against the Trust’s People Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics
- This report has been assessed against the Trust’s People Impact Assessment Tool and there are proposals or matters which affect any persons with protected characteristics and the following is planned to mitigate any identified inequalities

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

Staff involvement takes place through the regular service group and topic updates.

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

The report is presented to the Board after every meeting.

Reference to CQC domains (Please select any which are relevant to this paper)

- | | | | | |
|-------------------------------|------------------------------------|---------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Safe | <input type="checkbox"/> Effective | <input type="checkbox"/> Caring | <input type="checkbox"/> Responsive | <input checked="" type="checkbox"/> Well Led |
|-------------------------------|------------------------------------|---------------------------------|-------------------------------------|--|

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MEETING OF THE AUDIT COMMITTEE HELD ON 22 APRIL 2026

1. PURPOSE

- 1.1 The Audit Committee met on 22 April 2026 to review the effectiveness of internal control, risk management, governance and assurance arrangements across the Trust. This report provides assurance to the Board on matters discussed, highlights areas of concern, and identifies risks requiring escalation or continued oversight.

2. ASSURANCE RECEIVED

- 2.1. The Committee reviewed the Quarter 4 Board Assurance Framework (BAF) and Corporate Risk Register and noted that the overall risk profile at year end remains broadly consistent with Quarter 3, with a number of strategic aims continuing to sit above risk appetite. These largely reflect sustained pressures relating to urgent care demand and flow, workforce sustainability, digital infrastructure, financial position and estates. The Committee noted genuine progress in several areas, including strengthening paediatric medical staffing, successful reopening of the Yeovil maternity unit, expansion of Hospital at Home and virtual models, and continued progress with digital programmes including EHR and Copilot.
- 2.2. The Committee received assurance from the Risk Management Strategy 2026–2029, which was approved, noting its focus on increasing maturity, managing compound risks and improving horizon scanning. The Committee emphasised the importance of clear and accessible communication of the strategy to support engagement across the organisation.
- 2.3. The Committee considered reports from Internal Audit, noting good overall progress against the 2025/26 plan and continued constructive engagement from services. The BAF assurance review provided moderate assurance and confirmed that while a Board Assurance Framework is in place, further development is required to ensure clearer distinction between strategic and operational risk, stronger articulation of controls and mitigations, and improved consideration of interdependencies. This will inform future Board development and strategy work. The Dementia Care audit, which received limited assurance, was identified as a particular concern and will be escalated through appropriate assurance routes.
- 2.4. The Committee received reassurance from External Audit, noting that planning for the 2024/25 year-end audit is well progressed with no emerging concerns. The Audit Plan and Value for Money Risk Assessment were reviewed, with minor factual amendments requested ahead of finalisation.
- 2.5. The Counter Fraud progress reports provided assurance regarding proactive and reactive fraud activity, with a high recovery rate of identified losses, positive feedback from the NHS Counter Fraud Authority engagement visit, and approval of the 2026/27 Counter Fraud Workplan.
- 2.6. Assurance was also received on the oversight of limited assurance audits, losses and special payments, single tender actions, and national cost collection arrangements, with appropriate governance and follow-up in place.

3. AREAS OF CONCERN OR FOLLOW UP

- 3.1. The Committee noted recurring themes from limited assurance audits, particularly the need to ensure that actions are embedded in practice and supported by strong local governance. Concerns were raised regarding information governance risks linked to Subject Access Request backlogs and potential ICO enforcement action, alongside the need for continued focus on digital transformation, cyber assurance and AI governance.
- 3.2. The Committee highlighted the Dementia Care limited assurance findings as requiring particular attention, given gaps in screening, training and governance arrangements. The increasing scale and complexity of risk in the context of the new financial year was also noted, with recognition that financial pressures may exacerbate workforce, quality and operational risks if not carefully managed.

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

- 4.1. The Committee agreed that several strategic risks within the BAF remain above the Trust's risk appetite, including those relating to workforce sustainability, digital transformation, estates condition, urgent care demand and financial resilience. The Committee highlighted the potential for compound risk across financial, workforce and operational pressures.
- 4.2. Limited assurance audit findings, particularly in relation to dementia care, clinical supervision and PSIRF, will continue to be escalated through the relevant Board assurance committees. The Committee also noted the implications of the new "failure to prevent fraud" offence and confirmed the importance of maintaining strong fraud prevention and oversight arrangements.

Paul Mapson
CHAIR OF THE AUDIT COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Going Concern Statement
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Chris Upham, Assistant Director of Finance - Financial Services
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	12 May 2026

Purpose of Paper/Action Required (Please select any which are relevant to this paper)		
<input type="checkbox"/> For Assurance	<input checked="" type="checkbox"/> For Approval / Decision	<input type="checkbox"/> For Information

Executive Summary and Reason for presentation to Committee/Board	<p>International Accounting Standard 1 Presentation of financial statements (IAS 1) requires management to make an assessment of an entity's ability to continue as a going concern when preparing that entity's financial statements.</p> <p>This report provides the Board with an overview of their responsibilities and evidence to support the going concern assessment in respect of Somerset NHS Foundation Trust.</p>
Recommendation	<p>The Board is asked to review and approve the application of the Going Concern concept to the preparation of the Somerset NHS Foundation Trust 2025/26 accounts as recommended by the Audit Committee.</p>

Links to Joint Strategic Aims (Please select any which are impacted on / relevant to this paper)	
<input type="checkbox"/>	Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
<input type="checkbox"/>	Aim 2 Provide the best care and support to people
<input type="checkbox"/>	Aim 3 Strengthen care and support in local communities
<input type="checkbox"/>	Aim 4 Respond well to complex needs
<input type="checkbox"/>	Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
<input checked="" type="checkbox"/>	Aim 6 Live within our means and use our resources wisely
<input type="checkbox"/>	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)

<input checked="" type="checkbox"/> Financial	<input type="checkbox"/> Legislation	<input type="checkbox"/> Workforce	<input type="checkbox"/> Estates	<input type="checkbox"/> ICT	<input type="checkbox"/> Patient Safety/ Quality
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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

- | |
|--|
| <input checked="" type="checkbox"/> 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 |
| <input type="checkbox"/> 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)

None

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]

None

Reference to CQC domains (Please select any which are relevant to this paper)

<input type="checkbox"/> Safe	<input type="checkbox"/> Effective	<input type="checkbox"/> Caring	<input type="checkbox"/> Responsive	<input checked="" type="checkbox"/> Well Led
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Is this paper clear for release under the Freedom of Information Act 2000?

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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SOMERSET NHS FOUNDATION TRUST

GOING CONCERN REPORT

1. INTRODUCTION

1.1 International Accounting Standards (IAS1) require the directors to assess, as part of the account's preparation process, the Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust Annual Reporting Manual paragraph 2.14:

"The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern."

1.2 Whilst it is unlikely that an NHS body will be determined not to be a going concern, this interpretation does not exempt the management of NHS bodies from undertaking a going concern review.

1.3 The Trust's external auditors will seek evidence to support their evaluation of management's going concern assessment and any disclosures in the financial statements. They need to conclude whether there is material uncertainty relating to the entity's ability to continue as a going concern. Where the auditor concludes that they are satisfied that the accounts should be prepared on a going concern basis but there are material uncertainties relating to the entity's ability to continue as such then they will report this using an emphasis of matter paragraph in their audit report.

2. GOING CONCERN ASSESSMENT

2.1 IAS 1 states the review should consider as much information about the future as possible but should look ahead at least 12 months from the end of the reporting period. In practice our auditors like the review to consider at least 12 months from the signing of the accounts, scheduled for 19 June 2026.

2.2 The going concern assessment should include a review of:

Financial Conditions	<ul style="list-style-type: none">• inability to meet the planned annual financial targets• the need to use a working capital facility to meet future obligations when they fall due• any necessary working capital/loan facilities have not been agreed• existence of significant operating losses, historical and projected• anticipated or actual major loss of commissioner income• major cost improvement programme with high risk of non-achievement• major losses or cash flow problems which have arisen since the balance sheet date
Operating Conditions	<ul style="list-style-type: none">• loss of key management without replacement• loss of key staff without replacement and/or industrial relation difficulties• significant failure to achieve Care Quality Commission standards resulting in any restrictions on services provided

	<ul style="list-style-type: none"> fundamental changes in the market or technology to which the Trust is unable to adapt adequately
Other Conditions	<ul style="list-style-type: none"> serious non-compliance with regulatory or statutory requirements pending legal or regulatory proceedings against the Trust that may, if successful, result in claims that are unlikely to be satisfied changes in legislation or government policy expected to adversely affect the Trust issues which involve a range of possible outcomes so wide that an unfavourable result could affect the appropriateness of the going concern basis significant concerns about finance or quality raised by regulators

2.3 Directors should request and consider evidence to support their assessment including identifying any potential remedial actions that may need to be addressed, to support their conclusion prior to their approval of financial statements. Evidence to consider may include:

Forecasts & budgets	<ul style="list-style-type: none"> budget covering at least up to 12 months from the date of the approval of the financial statements cash flow forecasts covering at least up to 12 months from the date of the approval of the financial statements and providing monthly balances for the period to the end of the financial year, reflecting agreed commissioning contracts critical assumptions underlying forecasts and budgets commissioning intentions, agreement of contract activity CIP risk rating capital programme cash flow forecasts and financing sources an adequate matching of projected cash inflows with projected cash outflows including all liabilities and other commitments
Access to funding	<ul style="list-style-type: none"> availability of an agreed financing facility if required cash resources available to the Trust compared to the Trust's expected cash requirements
Medium & long-term plans	<ul style="list-style-type: none"> medium or long-term plans that give an indication in general terms of how the directors expect the Trust's business to fare
Health services & markets	<ul style="list-style-type: none"> the economic environment within which the Trust operates & any economic, political or other factors which may cause the health market to change
Contingent liabilities	<ul style="list-style-type: none"> potential cash outflows during the review period relating to legal proceedings, environmental costs and service liability
Financial & operational risk management	<ul style="list-style-type: none"> key risks identified by the Trust in its Risk Register counterparty risks that arise from concentration on key suppliers or commissioners who may themselves be facing financial difficulty

Sensitivity analysis & stress testing	<ul style="list-style-type: none"> critical assumptions that underlie the budgets and forecasts the extent to which cash flows vary with changes in assumptions
Systems Controls	<ul style="list-style-type: none"> Head of Internal Audit Opinion

- 2.4 The evidence considered has been contained within the monthly finance reporting to Finance Committee and Board. The Trust 2026/27 Financial Plan was approved by the Board on 10 February 2026 which encompassed guidance from NHS England for 2026/27.
- 2.5 Having due consideration to the relevant conditions and having performed the assessment utilising the evidence outlined above, the Directors need to evaluate which one of three potential conclusions is appropriate to the specific circumstances of the Trust. The Directors may conclude one of the following:
- i) there are no material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern;
 - ii) there are material uncertainties related to events or conditions that may cast significant doubt about the Trust's ability to continue as a going concern, but the going concern basis remains appropriate;
 - iii) use of the going concern basis is not appropriate.
- 2.6 Directors should request and consider evidence to support their assessment including identifying any potential remedial actions that may need to be addressed, to support their conclusion prior to their approval of financial statements. Evidence to consider may include:

2025/26 Going Concern Assessment

Conditions	Criteria	Evidence
Financial	<ol style="list-style-type: none"> 1. meeting the planned annual financial targets 2. any necessary interim financing facilities are agreed 3. existence of significant operating losses, historical and projected 4. anticipated or actual major loss of commissioner income 5. major cost improvement programme with high risk of non-achievement 6. major losses or cash flow problems which have arisen since the balance sheet date 	<ol style="list-style-type: none"> 1. Financial performance achieved during 2025/26 in line with plan. 2. None required. 3. None. 4. Nothing anticipated outside of plan. 5. CIP plans in progress and confident of plan delivery. 6. Not anticipated.
Operating	<ol style="list-style-type: none"> 7. loss of key management without replacement 8. loss of key staff without replacement and/or industrial relation difficulties 9. significant failure to achieve Care Quality Commission standards resulting in any restrictions on services provided 10. fundamental changes in the market or technology to which the Trust is unable to adapt adequately 	<ol style="list-style-type: none"> 7. None anticipated. 8. Not expected. 9. None. 10. Not anticipated.
Other	<ol style="list-style-type: none"> 11. serious non-compliance with regulatory or statutory requirements 12. pending legal or regulatory proceedings against the Trust that may, if successful, result in claims that are unlikely to be satisfied 13. changes in legislation or government policy expected to adversely affect the Trust 14. issues which involve a range of possible outcomes so wide that an unfavourable result could affect the appropriateness of the going concern basis 15. significant concerns about finance or quality raised by regulators 	<ol style="list-style-type: none"> 11. None. 12. None. 13. None expected. 14. None expected. 15. None.

3. CONCLUSION & RECOMMENDATION

- 3.1 The Trust has submitted detailed financial plans for the financial year to NHS England for 3 years to March 2029 (Appendix 1: showing significant cash reserves available to support the Trust's continued activities). Based on current assumptions,

it is unlikely that the Trust will require additional cash support in the form of interim revenue loan support from the Department of Health and Social Care.

- 3.2 For these reasons and based on the assessment above, the Directors consider it appropriate to continue to adopt the going concern basis in preparing the accounts.
- 3.3 The Board is requested to approve the application of Going Concern following recommendation from Audit Committee.

CHIEF FINANCE OFFICER

Appendix 1

Monthly cash flow forecast	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-27	May-27	Jun-27
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Opening Cash Balance	68,436	104,855	90,892	63,980	81,208	62,894	49,711	67,831	52,417	36,676	57,625	59,273	75,134	75,807	69,974
Surplus/(Deficit) from operations	(4,702)	(2,381)	(3,803)	(396)	(2,988)	(1,110)	1,703	(1,033)	1,930	9,705	4,322	11,328	(4,702)	(2,381)	(3,803)
Non-cash flows in operating surplus/(deficit)	4,173	4,173	3,972	4,173	4,173	3,972	4,173	4,173	3,972	4,173	4,173	3,972	4,173	4,173	3,972
Operating cash flows before movements in working capital	(529)	1,792	169	3,777	1,185	2,862	5,876	3,140	5,902	13,878	8,495	15,300	(529)	1,792	169
Increase/(decrease) in working capital	40,954	(13,333)	(22,552)	18,165	(16,272)	(5,278)	16,617	(15,674)	(16,615)	11,445	(3,988)	10,602	5,208	(5,203)	(18,161)
Net cash inflow/(outflow) from operating activities	40,425	(11,541)	(22,383)	21,942	(15,087)	(2,416)	22,493	(12,534)	(10,713)	25,323	4,507	25,902	4,679	(3,411)	(17,992)
Capital expenditure	(2,049)	(1,949)	(3,694)	(2,753)	(2,753)	(5,276)	(5,527)	(5,527)	(7,308)	(5,529)	(5,769)	(7,741)	(2,049)	(1,949)	(3,694)
Investing activities	177	177	177	177	177	177	177	177	177	177	177	177	177	177	177
Net cash inflow/(outflow) before financing	38,553	(13,313)	(25,900)	19,366	(17,663)	(7,515)	17,143	(17,884)	(17,844)	19,971	(1,085)	18,338	2,807	(5,183)	(21,509)
Net cash inflow/(outflow) from financing activities	(2,134)	(650)	(1,012)	(2,138)	(651)	(5,668)	977	2,470	2,103	978	2,733	(2,477)	(2,134)	(650)	(1,012)
Net increase/(decrease) in cash and cash equivalents	36,419	(13,963)	(26,912)	17,228	(18,314)	(13,183)	18,120	(15,414)	(15,741)	20,949	1,648	15,861	673	(5,833)	(22,521)
Closing cash balance	104,855	90,892	63,980	81,208	62,894	49,711	67,831	52,417	36,676	57,625	59,273	75,134	75,807	69,974	47,453