Public Board Meeting

Tuesday 14 July 2026, 09:30 - 12:55

John Meikle Room, Deane House, Belvedere Road, Taunton, TA1 1HE

Somerset NHS Foundation Trust

Agenda

09:30 - 09:35
5 min

1. Welcome and Apologies for Absence

Note *Chair*

- 00 Programme for the Day - 14 July 2026 v1.3.pdf (1 pages)
- 140726 - Public Board Agenda v1.7.pdf (3 pages)

09:35 - 09:35
0 min

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

Note and Receive *Chair*

- Enclosure 01 - Register of Interests.pdf (4 pages)

09:35 - 09:35
0 min

3. Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 12 May 2026

Approve *Chair*

- Enclosure 02 - Minutes of the 12 May 2026 Public Board meeting v1.2.pdf (28 pages)

09:35 - 09:35
0 min

4. Minutes of the Somerset NHS Foundation Trust's Extraordinary Public Board meeting held on 9 June 2026

Approve *Chair*

- Enclosure 03 - Minutes of the 9 June 2026 Extraordinary Public Board meeting v2.pdf (4 pages)

09:35 - 09:35
0 min

5. Minutes of the Somerset NHS Foundation Trust's Extraordinary Public Board meeting held on 19 June 2026

Approve *Chair*

- Enclosure 04 - Minutes of the 19 June 2026 Extraordinary Public Board meeting v1.pdf (2 pages)

09:35 - 09:35
0 min

6. Action Log and Matters Arising

Review *Chair*

- Enclosure 05 - Action Log public.pdf (2 pages)

09:35 - 09:45
10 min

7. Questions from Members of the Public and Governors

Receive *Chair*

09:45 - 09:55
10 min

8. Chair's Remarks

Note *Chair*

09:55 - 10:25
30 min

9. Patient Story: Richard’s experience of Podiatry Service Transformation

Receive *Emma Davey/ Anthony Joyce/ Nikki Drake/ John Sutton/ Richard Watkins*

Enclosure 06 - Patient Story Summary July Board Meeting ED FINAL 070726.pdf (4 pages)

09:55 - 10:15
20 min

10. Chief Executive and Executive Director Report

Peter Lewis

- National and Regional Developments/ Policy Updates
- Reports and Assurance updates including:
  - Executive Committee
  - Learning from Deaths Framework: Mortality Review Progress Report (Q4)
  - Mortuary Assurance Statement (Approve)

Enclosure 07 - Chief Executive and Executive Director Report - July 2026 v2.pdf (32 pages)

10:15 - 10:25
10 min

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

Receive *Mel Iles*

10:25 - 10:40
15 min

Refreshment Break

10:40 - 11:05
25 min

12. 2026/27 Board Assurance Framework Update and Risk Appetite Review

Approve *Mel Iles*

Enclosure 08 - 2026-27 Q1 Board Assurance Framework and Risk Appetite Report - Board.pdf (8 pages)

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

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11:05 - 11:10
5 min

13. Assurance report from the People Committee meeting held on 8 June 2026

Receive *Graham Hughes*

Enclosure 09 - Assurance Report from People Committee - 8 June 2026.pdf (4 pages)

Aim 2 – Provide the best care and support to people

11:10 - 11:30
20 min

14. Integrated Performance Exception Report

Receive *Lee Cornell*

Enclosure 10 - Integrated Performance Exception Report.pdf (76 pages)

11:30 - 11:35
5 min

15. Assurance report from the Quality and Governance Assurance Committee meetings held on 29 April 2026, 27 May 2026 and 24 June 2026

Receive *Inga Kennedy*

- Enclosure 11 - Assurance Report from the QGAC Committee - 29 April 2026.pdf (4 pages)
- Enclosure 12 - Assurance Report from the QGAC Committee - 27 May 2026.pdf (4 pages)
- Enclosure 13 - Assurance Report from the QGAC Committee - 24 June 2026.pdf (4 pages)

11:35 - 11:40
5 min

16. Assurance report from the Mental Health Legislation Committee meeting held on 16 June 2026

Receive *Alexander Priest*

- Enclosure 14 - Assurance Report from the Mental Health Legislation Committee - 16 June 2026.pdf (4 pages)

11:40 - 11:50
10 min

17. Maternity & Neonatal Quarter 4 (2025/26) Quality & Safety Report

Receive *Sally Bryant*

- Enclosure 15 - Maternity & Neonatal Quarter 4 25-26 Report.pdf (9 pages)

11:50 - 12:00
10 min

18. Safe Staffing Establishment Report

Receive and Approve *Deirdre Fowler*

- Enclosure 16 - Safe Staffing Establishment Report - June 2026 Final.pdf (4 pages)

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

12:00 - 12:10
10 min

19. Finance Report (M12)

Receive *Mark Hocking*

- Enclosure 17 - Board finance Report M2 FINAL.pdf (7 pages)

12:10 - 12:15
5 min

20. Assurance Report from the Charity Committee meeting held on 21 April 2026

Receive *Graham Hughes*

- Enclosure 18 - Assurance Report from the Charity Committee - 21 April 2026.pdf (4 pages)

For Information

12:10 - 12:15
5 min

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

Receive *Chair*

12:15 - 12:15
0 min

22. Any other business

All

12:15 - 12:15
0 min

23. Risks identified

All

12:15 - 12:20
5 min

24. Evaluation of the effectiveness of the Meeting

Chair

12:20 - 12:20
0 min

25. Items to be discussed at the Confidential Board Meeting

- Minutes of the Confidential Board meeting and Extraordinary Confidential Board meetings
- Notes of the Board Seminar and Development sessions
- Healthset (Electronic Health Record)
- Minutes of the Finance Committee meetings
- Assurance Report from the Extraordinary Audit Committee meeting

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12:20 - 12:20
0 min

26. Withdrawal of Press and Public

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

12:20 - 12:20
0 min

27. Close and Date of Next Meeting

8 September 2026

Somerset NHS Foundation Trust

PROGRAMME FOR THE DAY

Board of Directors

Tuesday 14 July 2026
John Meikle Room, Deane House, Belvedere Road, Taunton, TA1 1HE

		Timing
1	**Arrival and Coffee**	**09:15 – 09:30**
2	**Public Board of Directors**	**09:30 – 12:55**
	Refreshment Break	10:55 – 11:10
3	**Lunch**	**12:55 – 13:25**
4	**Confidential Board of Directors**	**13:25 – 14:20**
5	**Refreshment Break**	**14:20 – 14:30**
6	**Seminar Session**	**14:30 – 16:35**
	Refreshment Break	15:35 – 15:45
7	**Close**	**16:35**

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

A Public meeting of the Somerset NHS Foundation Trust Board will be held on **Tuesday 14 July 2026** at **9.30 am** in the John Meikle Room, Deane House, Belvedere Road, Taunton, TA1 1HE.

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

Yours sincerely

Dr Rima Makarem
Chair

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**	Note	Chair	09:30	Verbal
2.	**Register of Interests and Declarations of Interest relating to items on the agenda**	Note and Receive	Chair		Enclosure 01
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 12 May 2026**	Approve	Chair		Enclosure 02
4.	**Minutes of the Somerset NHS Foundation Trust's Extraordinary Public Board meeting held on 9 June 2026**	Approve	Chair		Enclosure 03
5.	**Minutes of the Somerset NHS Foundation Trust's Extraordinary Public Board meeting held on 19 June 2026**	Approve	Chair		Enclosure 04
6.	**Action Log and Matters Arising**	Review	Chair		Enclosure 05
7.	**Questions from Members of the Public and Governors**	Receive	Chair	09:35	Verbal
8.	**Chair's Remarks**	Note	Chair	09:45	Verbal
9.	**Patient Story: Richard's experience of Podiatry Service Transformation**	Receive	Emma Davey/ Anthony Joyce/ Nikki Drake/ John Sutton/ Richard Watkins	09:55	Enclosure 06

		Action	Presenter	Time	Enclosure

10.	**Chief Executive and Executive Director Report**
	• National and Regional Developments/ Policy Updates
	• Reports and Assurance updates including:
	  • Executive Committee
	  • Learning from Deaths Framework: Mortality Review Progress Report (Q4)
	  • Mortuary Assurance Statement
		Approve	Peter Lewis	10:25	Enclosure 07

11.	**Update on Paediatric and Maternity Services at Yeovil District Hospital**	Receive	Mel Iles	10:45	Verbal
	Refreshment Break: 10:55 – 11:10				
12.	**2026/27 Board Assurance Framework Update and Risk Appetite Review**	Approve	Mel Iles	11:10	Enclosure 08
	Aim 5 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture				
13.	**Assurance report from the People Committee meeting held on 8 June 2026**	Receive	Graham Hughes	11:35	Enclosure 09
	Aim 2 – Provide the best care and support to people				
14.	**Integrated Performance Exception Report**	Receive	Lee Cornell	11:40	Enclosure 10
15.	**Assurance report from the Quality and Governance Assurance Committee meetings held on 29 April 2026, 27 May 2026 and 24 June 2026**	Receive	Inga Kennedy	12:00	Enclosure 11 Enclosure 12 Enclosure 13
16.	**Assurance report from the Mental Health Legislation Committee held on 16 June 2026**	Receive	Alexander Priest	12:05	Enclosure 14
17.	**Maternity & Neonatal Quarter 4 (2025/26) Quality & Safety Report**	Receive	Sally Bryant	12:10	Enclosure 15
18.	**Safe Staffing Establishment Report**	Receive and Approve	Deirdre Fowler	12:20	Enclosure 16

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

19.	**Finance Report (M2)**	Receive	Mark Hocking	12:30	Enclosure 17
20.	**Assurance Report from the Charity Committee meeting held on 21 April 2026**	Receive	Graham Hughes	12:40	Enclosure 18

For Information

21.	**Follow-up questions from Members of the Public and Governors**	Receive	Chair	12:45	Verbal
22.	**Any other business**		All		Verbal
23.	**Risks identified**		All		Verbal
24.	**Evaluation of the effectiveness of the Meeting**		Chair	12:50	Verbal

25. Items to be discussed at the Confidential Board Meeting

- Minutes of the Confidential Board meeting and Extraordinary Confidential Board meetings
- Notes of the Board Seminar and Development sessions
- Healthset (Electronic Health Record)
- Minutes of the Finance Committee meetings
- Assurance Report from the Extraordinary Audit Committee meeting

26. Withdrawal of Press and Public

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

27. Close and Date of Next Meeting 12:55

8 September 2026

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Registers of Interests
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Rima Makarem, Chair
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	Where a member of the Somerset NHS Foundation Trust Board has an Interest, or becomes aware of an Interest, which could lead to a conflict of interests in the event of the Board considering an action or decision in relation to that Interest, the Interest must be considered as a potential conflict and must be declared. The Register of Interests is part of the mechanism through which the Somerset NHS Foundation Trust Board will ensure the integrity of their decision-making processes. Board members are also required to orally declare at each meeting specific Interests in respect of items on the agenda Board members are reminded that any new or relinquished Interest should be advised to the Board and updated on the electronic database within 28 days of becoming known. Board members will be prompted at least annually to review declarations they have made and, as appropriate, update them or make a nil return. The Register as presented reflects the position as at 7 July 2026.
Recommendation	The Board is asked to: • **Note** the Register of Interests and to make any further declarations where appropriate.

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

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
Public or staff involvement or engagement has not been required for the attached report.

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

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

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

REGISTER OF INTERESTS

Trust Board as at 7 July 2026

NHS Somerset NHS Foundation Trust

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Rosie	Benneyworth	Trust Board Member	Loyalty Interests	Member	Royal College of GPs	01/07/2025		03/12/2025
Rosie	Benneyworth	Trust Board Member	Outside Employment	Interim CEO	Health Services Safety Investigations Body	01/08/2022		03/12/2025
Rosie	Benneyworth	Trust Board Member	Loyalty Interests	Chair	Symphony Healthcare Services Ltd	01/03/2026		
Darshan	Chandarana	Trust Board Member	Outside Employment	Managing Director	Neopath Ltd	01/02/2025		
Darshan	Chandarana	Trust Board Member	Outside Employment	Senior Vice President of AI	ThoughtWorks	12/01/2026		
Isobel	Clements	Director of People	Outside Employment	Governor, Board member	Weston College	22/01/2025		11/06/2026
Isobel	Clements	Director of People	Loyalty Interests	Sister-in-Law employed as Technician, Pharmacy	Somerset NHS Foundation Trust	10/09/2004		11/06/2026
Isobel	Clements	Director of People	Loyalty Interests	Nephew employed as Physiotherapist Apprentice	Somerset NHS Foundation Trust	03/05/2023		11/06/2026
Olena	Doran	Trust Board Member	Outside Employment	Professor in Biomedical Research, and Dean for Research and Enterprise	University of the West of England (UWE), Bristol	01/04/2024		11/06/2026
Deidre	Fowler	Chief Nurse	Nil Declaration			23/10/2025		
Tom	Frederick	Trust Board Member	Outside Employment	Director	Oliver Wyman	01/01/2025		
Andrew	Heron	Chief Operating Officer/Deputy Chief Executive	Loyalty Interests	Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust	Avon and West Wiltshire MH Partnership NHS Trust	17/03/2022		02/01/2026
Andrew	Heron	Chief Operating Officer/Deputy Chief Executive	Loyalty Interests	Member of the Board of Directors and line manager to the Managing Director as a wholly owned subsidiary of Somerset NHS Foundation Trust.	Symphony Healthcare Services	01/04/2024		02/01/2026
Graham	Hughes	Non Exec. Members	Outside Employment	Chairman SSL	Simply Serve Ltd	01/01/2022		11/06/2026
Melanie	Iles	Chief Medical Officer	Nil Declaration			04/11/2024		
Inga	Kennedy	Non Exec. Members	Outside Employment	Director-Trustee	The White Ensign Association	01/04/2024		29/06/2026
Peter	Lewis	Chief Executive	Loyalty Interests	Director and Management Board Member, representing Somerset NHSFT	Somerset Strategic Estates Partnership Project Company Limited	01/04/2022		19/06/2026
Peter	Lewis	Chief Executive	Loyalty Interests	Management Board Member of the Somerset Estates Partnership (SEP) Board	Somerset Estates Partnership	01/04/2023		19/06/2026
Peter	Lewis	Chief Executive	Loyalty Interests	Director, Somerset Estates Partnership Project Co Limited	Somerset Estates Partnership Project Co Limited	01/04/2023		19/06/2026
Rima	Makarem	Trust Chairman Trust Board	Outside Employment	Lay member (remunerated) since 2019	General Pharmaceutical Council	01/01/2025	31/03/2026	12/06/2025
Rima	Makarem	Trust Chairman Trust Board	Outside Employment	Chair (remunerated) since 2020	Queen Square Enterprises	01/01/2025		16/06/2026
Rima	Makarem	Trust Chairman Trust Board	Loyalty Interests	Chair (unremunerated) since 2021	Sue Ryder	01/01/2025		16/06/2026
Rima	Makarem	Trust Chairman Trust Board	Loyalty Interests	Visiting Professor	University of the West of England (UWE), Bristol	01/09/2025		16/06/2026
Rima	Makarem	Trust Chairman Trust Board	Loyalty Interests	Trustee	NHS Providers	01/06/2025		16/06/2026

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

REGISTER OF INTERESTS

Trust Board as at 7 July 2026

NHS Somerset NHS Foundation Trust

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Paul	Mapson	Non Exec. Members	Nil Declaration			31/03/2026		
Pippa	Moger	Chief Financial Officer	Outside Employment	NED SSL	Non Executive for Simply Serve Limited	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Outside Employment	SPS Board member	Member of Southwest Pathology Services (SPS) Board	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Outside Employment	Director on JV	Shepton Mallet Health Partnership	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Loyalty Interests	Step daughter employed as Ward Manager	Somerset NHS Foundation Trust	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Loyalty Interests	Son employed as Payroll lead and technical support	Somerset NHS Foundation Trust	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Outside Employment	Director of JV - SEP	Director of SEP Project Co Ltd	04/04/2025		16/06/2026
Alexander	Priest	Trust Board Member	Outside Employment	Chief Executive	Mind in Somerset	01/04/2018		24/11/2025
Jade	Renville	Director of Corporate Services	Loyalty Interests	I am Joint Director of Corporate Affairs/Services across Somerset ICB as well as Somerset NHS Foundation Trust.	NHS Somerset ICB	06/07/2024		11/06/2026
Jade	Renville	Director of Corporate Services	Loyalty Interests	Richard Huish Multi Academy Trust Director (Chair of Trust from January 2023)	Richard Huish Multi Academy Trust	01/09/2019		11/06/2026
Jade	Renville	Director of Corporate Services	Loyalty Interests	Father is Director and Owner of Renvilles Costs Lawyers	Renvilles Costs Lawyers	01/08/2003		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Company Director of PHI Ltd (Predictive Health Informatics). The Trust is a shareholder in the Company and this directorship represents the Trust in its shareholding.	Predictive Health Intelligence LTD	14/03/2022		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Wife is employed as a PA within the Neighbourhoods and Primary Care Directorate	Somerset NHS Foundation Trust	01/12/2022		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Director of SHS - a subsidiary of SFT providing primary care services	Symphony Healthcare Services	01/03/2021		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Board member of the Joint venture between Synlab uk and Somerset FT for the provision of pathology services	Somerset Pathology Services	10/01/2022		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Board member of the Somerset Estates Partnership with Prime Plc	Somerset Estates Partnership	01/04/2023		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Daughter is employed as a Healthcare assistant	Somerset NHS Foundation Trust	23/12/2020		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Shareholder Director	Simply Serve Limited	01/07/2024		11/06/2026
Owen	Woodley	Non Exec. Members	Outside	Member of the Governing Council	University of Leicester	06/03/2026		

Somerset NHS Foundation Trust

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 12 MAY 2026 IN MEETING ROOMS 1-3, WYNFORD HOUSE, LUFTON WAY, LUFTON, YEOVIL, BA22 8HR

PRESENT

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

IN ATTENDANCE

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

APOLOGIES

None

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. The Chair opened the meeting at 9:30 am and welcomed all present to the Public Board meeting, noted the extended agenda and the importance of maintaining pace throughout the session. She confirmed that there were no apologies for absence and that the meeting was quorate.

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

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

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 10 MARCH 2026

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

4. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S EXTRAORDINARY PUBLIC BOARD MEETING HELD ON 20 MARCH 2026

4.1. The minutes of the Extraordinary Public Board meeting held on 20 March 2026 were **approved** as a true and accurate record.

5. ACTION LOG AND MATTERS ARISING

5.1. The Board reviewed the Action Log and noted that a number of actions had been marked as complete, with a small number of actions remaining ongoing or not yet due. Members were invited to raise any questions or comments on the Action Log; no queries or matters arising were identified.

6. QUESTIONS FROM MEMBERS OF THE PUBLIC AND GOVERNORS

6.1. The Board received two questions from members of the public, as follows:

6.2. **Question 1 (from Gerald Smith, member of the public):**

"Despite widespread and continuing opposition to the Higman/Marden stroke reconfiguration it is anticipated to go live in August or September this year and prompts the following question in two parts as follows:

Can you announce today the date that the Yeovil HASU will close and the outsourcing and transfer of affected stroke patients to Dorchester and Taunton will begin?

Can your Board today give a categoric assurance that from the Yeovil HASU closure date the Yeovil ASU will be operating to the National Guidelines For Stroke 2023 Edition with staffing levels as set down in Table 5 of the Guidelines without exception?"

6.3. Gerald Smith also provided supporting analysis relating to stroke patient volumes and performance, highlighting concerns regarding the proportion of patients not meeting the three-hour target (see **Appendix 1**, **Appendix 2** and **Appendix 3**).

6.4. Andy Heron confirmed that the new model of care would go live, with the Hyper Acute Stroke Unit at Yeovil District Hospital scheduled to close in the first week of September. He explained that the approved business case would bring services into alignment with the 2016 national standards, representing a significant improvement. While full compliance with all aspects of the 2023 standards, particularly therapies, would not be immediately achieved across both sites, he confirmed that the Trust would be fully compliant in relation to nursing and medical staffing. He added that further work to achieve full compliance with therapy standards would be prioritised as

part of the Trust's ongoing programme of improvement.

6.5. **Question 2 (from a member of the public):**

"With some 98 patients, (2025 figures) self presenting at YDH with stoke symptoms, can you please explain in some detail the care pathway in place to determine the seriousness of cases presenting and what treatment protocols are in place, especially the most serious cases needing transport to a dedicated HASU inside the critical 90th centile window following the downgrading at YDH.

If there are no plans in place a simple, "No there aren't any plans" will suffice."

6.6. Andy Heron outlined that comprehensive pathways had been developed in partnership with the South Western Ambulance Service, Dorset County Hospital and internal clinical teams, including emergency department and imaging services. He explained that all patients presenting with suspected stroke would undergo urgent computed tomography (CT) imaging, including CT angiography and, where required, CT perfusion scanning. Patients would be discussed with the on-call stroke consultant at Taunton, with those requiring thrombolysis treated and transferred as appropriate, and those requiring mechanical thrombectomy transferred directly to specialist centres such as Southmead Hospital in Bristol.

6.7. The member of the public sought further clarification regarding the potential limitations of CT imaging in detecting certain conditions such as mid-brain bleeds and whether MRI imaging would be utilised. Mel Iles responded that advanced imaging, including perfusion scanning, supported clinical decision-making and that decisions regarding further imaging would be made by senior specialist clinicians within the established stroke network. She emphasised that the model aimed to ensure all patients received consistent, high-quality care across the county, with no reduction in the standard of treatment as a result of the service changes.

6.8. The Board **noted** the questions and responses.

7. CHAIR'S REMARKS

7.1. The Chair reflected on a busy period since the last meeting and congratulated Peter Lewis on being included in the Health Service Journal Chief Executive list for the second consecutive year.

7.2. The Board noted the recent recruitment of two Non-Executive Directors. Subject to approvals, one will commence shortly and assume the role of Chair of the Finance Committee, and the second will commence in January with a view to succeeding Paul Mapson as Chair of the Audit Committee. Thanks were expressed to all involved in the recruitment process.

7.3. The Chair advised that Non-Executive Directors had commenced thematic review of patient complaints to better understand organisational learning, patterns and trends, and reported that initial discussions with Emma Davey had been constructive.

7.4. The Chair also provided an update on external engagement activity, noting that she and Peter Lewis had recently participated in a podcast discussing integrated health

organisations, including the ambitions of integration and the challenges associated with delivering it. The recording was expected to be published in the coming weeks and would be shared more widely once available.

7.5. Finally, the Chair highlighted continued national interest in the Trust, noting that Sir Kieran Devane, Chief Executive of the NHS Alliance, was due to visit the organisation in the coming weeks. She also reported that Dame Jill Morgan was planning a future visit, reflecting the Trust's ongoing national visibility and engagement.

7.6. The Board **noted** the Chair's remarks.

8. CHIEF EXECUTIVE AND EXECUTIVE DIRECTOR REPORT

8.1. Peter Lewis introduced the report, recognising International Nurses Day and International Day of the Midwife and thanking colleagues for their continued contribution across the organisation.

8.2. He highlighted two items requiring Board approval: the NHS England Annual Self-Declaration and the Modern Slavery and Human Trafficking Act Statement for 2026/27. He also drew attention to national developments, including work on "NHS Online" as a virtual model enabling access to care pathways, noting the complexity of managing transition between virtual and face-to-face care. He referenced the publication of the Southport Inquiry, advising that the Trust would review learning and bring this back to the Board, and also noted the recent safeguarding review relating to the death of a child, confirming that an independent review had been commissioned to ensure lessons were fully understood.

8.3. In discussion, Rosie Benneyworth sought assurance on how the Trust was working with system partners to respond to learning from national inquiries, particularly in relation to mental health services. She also raised concerns regarding capacity to undertake patient safety investigations and the impact on the Trust's ability to function as a learning organisation.

8.4. In response, Peter Lewis acknowledged that while a number of staff were trained to undertake investigations, there were challenges in releasing them to do so in a timely way. Mel Iles confirmed that work was underway to strengthen prioritisation, including reinforcing expectations with service leaders, and to review whether the current distributed model or a more centralised approach would be more effective. She also highlighted improvements to oversight processes, including changes to rapid review arrangements and the need to ensure appropriate use of different investigation methods.

8.5. Deirdre Fowler emphasised that this remained a significant organisational risk and confirmed that, while some formal investigations had been paused, alternative processes such as after-action and multidisciplinary reviews continued to support learning. She advised that further updates would be provided as the revised model was developed.

8.6. The Board **approved** the NHS England Annual Self-Declaration and the Modern Slavery and Human Trafficking Act Statement for 2026/27.

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

9.1. Mel Iles provided an update on the reopening of maternity and Special Care Baby Unit services at Yeovil District Hospital, reporting that the unit had been operational for three weeks, with 45 babies born and a small number requiring Special Care Baby Unit support. She highlighted the significant preparatory work undertaken, including reuniting teams, ensuring familiarity with updated guidance and strengthening multidisciplinary team working. While early operational pressures had begun to stabilise, a further review was planned to address initial issues arising since reopening.

9.2. Mel Iles acknowledged that some longstanding cultural and behavioural challenges remained and required continued focus, supported by ongoing leadership visibility and monitoring.

9.3. In relation to paediatrics, progress against Care Quality Commission recommendations continued, with five consultant paediatricians recruited, three now in post and the remaining expected by September. Extended consultant cover was in place, supported by locum staff, and clinical leadership oversight had been strengthened. The next phase of development would focus on delivery of the paediatric assessment unit.

9.4. Mel Iles advised that the Trust's participation in the Baroness Amos review had concluded, with the final report expected shortly. Ongoing support from regional and national teams continued, and further Care Quality Commission activity at the Yeovil site was anticipated.

9.5. In discussion, Inga Kennedy emphasised the importance of maintaining leadership focus and continuing site visits, alongside addressing ongoing cultural issues. She also highlighted the importance of multidisciplinary training, noting challenges with engagement and the need for continued emphasis. Mel Iles agreed and confirmed that non-engagement would be actively followed up.

9.6. Tom Frederick welcomed the progress made and sought an update on wider regional discussions regarding sustainability of smaller units. Peter Lewis advised that discussions were ongoing but had not yet progressed to formal proposals. Andy Heron added that strengthened collaboration with Dorset County Hospital had been a positive outcome, with a commitment to maintain and build on these relationships.

9.7. The Board **noted** the update.

10. Q4 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER REPORT

10.1. Mel Iles presented the year-end Board Assurance Framework, reporting that the overall position remained stable but pressurised, with progress across strategic programmes, although several risks remained above appetite due to system-wide constraints.

10.2. Under Aim 1, population health and inequalities, progress was noted in establishing a more structured programme, with strengthened governance and early impact from diagnosis initiatives, although risks remained relating to data and system dependencies. Under Aim 7, digital innovation and research, strong delivery was reported, including progress on the Electronic Health Record, digital medicines and increasing use of Artificial Intelligence, with risk remaining above appetite due to programme scale and complexity.

10.3. Across the Framework, ongoing pressures relating to flow, workforce and financial sustainability were highlighted. It was noted that a Board Assurance Framework refresh and internal audit review would be considered at a future development session.

10.4. In discussion, Rosie Benneyworth challenged inconsistencies in smoking cessation data and raised risks associated with Artificial Intelligence. David Shannon outlined the Trust's policy and controls, supported by ongoing education. Olena Doran sought assurance on relationships with medical schools, with confirmation of ongoing engagement with Bristol, Plymouth and Exeter. Darshan Chandarana emphasised the need to provide secure internal Artificial Intelligence tools to reduce reliance on external systems. It was also noted that Artificial Intelligence was contributing to increased complaint volumes.

10.5. Mel Iles presented the Corporate Risk Register, confirming that the Trust continued to operate at a high level of risk, with 20 risks recorded. New risks included fire safety and controlled document compliance, alongside a continued focus on compound risks across flow, workforce, estates, digital and finance. The Risk Management Strategy had been approved, with training compliance at 83%.

10.6. Paul Mapson highlighted that the report reflected the prior year position and emphasised the need to reassess risks for 2026/27. Pippa Moger confirmed this would be undertaken through the Finance Committee.

10.7. The Board **noted** the Board Assurance Framework and Corporate Risk Register.

11. TERMS OF REFERENCE – ANNUAL REVIEW

11.1. The Board received an update on the annual review of the Trust's Board and Committee Terms of Reference, which had been undertaken to standardise format, structure and content in line with the agreed governance template.

11.2. It was noted that a number of revised Terms of Reference had been presented, reflecting updates agreed through Committee reviews. These included amendments to ensure alignment with best practice guidance, clarification of assurance roles, and strengthening of oversight in key areas such as quality, workforce, finance and the Healthset (Electronic Health Record) programme.

11.3. The Board was advised that the majority of Terms of Reference had been reviewed and approved through the relevant committees, with the remaining documents presented for Board approval. The work to standardise and update the documentation was welcomed and appreciation was expressed for the coordination of this exercise.

11.4. In discussion, it was noted that the definition of quality should clearly reflect patient experience alongside safety and outcomes, and assurance was provided that this was encompassed within the overarching definition used.

11.5. The Board **approved** the Terms of Reference.

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

12.1. Graham Hughes presented the report, noting that delivery of the People Strategy remained on track, with improvements in recruitment timelines, reduced agency usage, strong retention and improved mandatory training compliance.

12.2. Concerns remained regarding sickness absence, particularly stress-related absence, and its financial impact, alongside declining staff engagement and staff survey response rates.

12.3. In discussion, the Chair emphasised the importance of ensuring all staff groups, including administrative colleagues, were represented within workforce planning. Isobel Clements acknowledged this and confirmed further consideration would be given.

12.4. Darshan Chandarana challenged the reduction in staff survey response rates and asked what action was being taken to improve engagement. Isobel Clements advised that performance remained broadly in line with national levels, with work underway through local surveys while being mindful of survey fatigue.

12.5. Paul Mapson highlighted the importance of directly engaging administrative staff to better understand operational issues. Olena Doran sought assurance that the Trust was learning from best practice in other organisations. Isobel Clements confirmed that benchmarking and external collaboration were embedded, including current work on fatigue and workforce experience.

12.6. The Board **noted** the assurance report.

13. INTEGRATED PERFORMANCE REPORT

13.1. Pippa Moger presented the report, highlighting strong performance in several areas, including community waiting times, cancer diagnostics, maternity outcomes and workforce metrics such as mandatory training, retention and flu vaccination uptake.

13.2. Key areas of concern included pressures within neighbourhood services due to workforce vacancies, continued challenges in Urgent and Emergency Care despite some improvement, and a worsening position for patients with no criteria to reside. Performance in stroke and elective pathways remained mixed, with elective targets not fully achieved, although close in some areas. Diagnostics showed improvement, while cancer 62-day performance remained below target.

13.3. In discussion, Alexander Priest noted continued system-wide pressures in mental health services but highlighted that the Trust was performing comparatively well.

13.4. Rosie Benneyworth challenged whether actions to improve Accident and Emergency performance were sufficiently ambitious. Andy Heron advised that performance remained largely driven by flow and discharge challenges, with work underway through the “Every Minute Matters” programme and broader transformation initiatives. Mel Iles reinforced the focus on clinical pathways and length of stay as key drivers of improvement.

13.5. The Chair and other members reflected on the increasing size and complexity of the report and the need to balance detail with clarity. Inga Kennedy highlighted the value of the productivity data and suggested further focused discussion. **ACTION:** A Board development session on productivity to be scheduled.

13.6. The Board **noted** the Integrated Performance Report.

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

14.1. Rosie Benneyworth presented the report, highlighting concerns regarding deteriorating patient care, with metrics including National Early Warning Scores and complaints indicating areas requiring further scrutiny. This work would be progressed through the Patient Safety Committee and brought back for further review.

14.2. Mel Iles noted some recent improvement in deterioration-related metrics and confirmed that further work was being progressed through the Deteriorating Patient Committee.

14.3. Inga Kennedy provided an update from April, identifying ongoing concerns in relation to escalation of National Early Warning Scores, audit outcomes, patient flow, patients with no criteria to reside, corridor care, delayed cancer diagnoses and acute kidney injury. She highlighted a common theme relating to timely patient assessment and ensuring patients were cared for in the right place at the right time.

14.4. Inga Kennedy also raised concerns regarding a lack of clarity in the governance framework and the flow of information between committees and the Board. Mel Iles acknowledged this and confirmed that work was underway to clarify arrangements.

14.5. Pippa Moger outlined the introduction of Performance Oversight Meetings to strengthen executive visibility and oversight of service group performance across finance, quality and workforce metrics, with outputs to be reported to the Board.

14.6. The Board **noted** the assurance report.

15. ASSURANCE REPORT FROM THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 17 MARCH 2026

15.1. Alexander Priest presented the assurance report, noting a positive outcome in the approval of the Section 117 Aftercare Policy, which had been developed over a number of years in partnership with system colleagues and would become increasingly important in light of evolving case law and demand.

15.2. Challenges were highlighted within the Approved Mental Health Professional Hub, where previous staffing issues had improved, but differences remained between the Trust and Local Authority regarding processes for managing referrals. It was noted that this was being addressed by the Executive team.

15.3. In discussion, Rosie Benneyworth queried concerns relating to inconsistent communication during ward rounds. Alexander Priest clarified that this related to communication with Independent Mental Health Advocates and ensuring that patients were informed of ward round timings, emphasising the impact on patient experience.

15.4. The Board **noted** the assurance report.

16. WELLBEING GUARDIAN REPORT

16.1. Graham Hughes presented the report, noting a mixed picture in the staff survey, with positive engagement in wellbeing initiatives but continued challenges, particularly in relation to stress-related sickness absence and its operational and financial impact.

16.2. In discussion, the Chair highlighted concerns regarding staff not being released for training. Isobel Clements advised that work was underway to understand the underlying causes, including service pressures and areas of higher non-attendance.

16.3. Deirdre Fowler emphasised the importance of leadership and effective roster management in enabling staff to attend training, alongside clear accountability. Isobel Clements added that greater scrutiny of sickness absence at team level was required, supported by strong and consistent leadership.

16.4. Rosie Benneyworth raised the importance of ensuring basic staff needs, including rest, nutrition and hydration, were met. It was noted that provision varied across sites and remained challenging, particularly within constrained estates and community settings.

16.5. The Board also discussed the need for appropriate and protected staff rest spaces. The Chair suggested exploring alternative use of office space to increase provision for frontline colleagues.

16.6. The Board **noted** the Wellbeing Guardian Report.

17. CORRIDOR CARE BRIEFING

17.1. Deirdre Fowler presented the briefing and outlined the significant impact of corridor care on patients and staff, noting new national expectations to achieve the “virtual elimination” of corridor care by September 2026, alongside strengthened red line standards.

17.2. A revised definition of corridor care was introduced, relating to any care delivered in non-clinical spaces without essential bedhead services or adequate privacy and dignity. Updated reporting requirements were noted, with an expectation that reported activity may increase due to clearer definitions.

17.3. Work to address corridor care was being progressed through the Urgent and Emergency Care transformation programme, focusing on reducing avoidable admissions, improving care in the first 72 hours, and strengthening discharge processes.

17.4. In discussion, Alexander Priest raised concerns regarding the continued use of unsuitable spaces. Deirdre Fowler confirmed that a detailed review of all clinical areas was underway to ensure the safest possible use of available capacity.

17.5. Paul Mapson highlighted the risk of unintended consequences, noting that efforts to reduce corridor care could result in pressures being displaced elsewhere in the system, particularly in relation to ambulance handover delays or Emergency Department performance. He emphasised the importance of maintaining oversight of the whole pathway, ensuring that improvements in one area did not inadvertently increase risk in another and that performance measures were considered in the context of overall patient safety and system flow rather than in isolation. Deirdre Fowler emphasised that decisions regarding the use of space would be based on dynamic risk assessment, with clinicians and operational teams continually assessing the safest option for patients in real time. She stressed that this would require a transparent and explicit balancing of risks, recognising that in some circumstances the least worst option may still involve suboptimal environments and that these decisions must be visible, consistent and subject to clear governance. Andy Heron emphasised the need for a whole-system approach to flow.

17.6. Rosie Benneyworth stressed the importance of maintaining a focus on patient experience and avoiding any perception of performance being managed inappropriately. Inga Kennedy highlighted the need for clarity on acceptable practice and for transparent reporting to support oversight.

17.7. The Chair challenged what would be different in addressing flow and patients with no criteria to reside. Andy Heron highlighted strengthened leadership and clinical ownership as key enablers, supported by Mel Iles, who reinforced the importance of cultural change and clinical engagement.

17.8. The Board **noted** the Corridor Care Briefing.

18. FINANCE REPORT (M12)

18.1. Pippa Moger presented the year-end financial position, reporting a £4.9 million surplus following receipt of deficit support funding (DSF) from NHS England following the redistribution of 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. She noted that while the Trust had delivered its financial plan and Cost Improvement Programme in full, only 30% of savings were recurrent, resulting in a £30 million underlying deficit carried into 2026/27.

18.2. A significant reduction in agency spend was reported compared to the previous year, although further reductions would be required in the coming year. It was also noted that a valuation adjustment had resulted in a reduction in the value of land and

buildings due to nationally prescribed indices, which would be reflected in the accounts.

18.3. The capital programme was delivered close to plan, with a small underspend, and the Trust ended the year with a strong cash position, supported by the timing of capital payments and system funding flows.

18.4. The Chair welcomed the achievement of delivering the financial plan but noted the challenges associated with non-recurrent savings and the need to maintain financial discipline going forward.

18.5. The Board **noted** the Finance Report.

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

19.1. Paul Mapson presented the assurance report and noted that the April meeting was the Committee's most significant meeting of the year, focusing on governance, annual reporting and preparation of the annual accounts.

19.2. The Committee had reviewed the Board Assurance Framework and Corporate Risk Register, noting that these related to the previous financial year and would be subject to reassessment. The Risk Management Strategy had been approved, and an internal audit of the Board Assurance Framework had been completed, which would be presented to a future Board development session.

19.3. One limited assurance report relating to dementia care had been identified and would require further focus. Counter-fraud activity was reported as satisfactory, and the Committee had noted new requirements under the Economic Crime and Corporate Transparency Act relating to the prevention of fraud.

19.4. The Head of Internal Audit had provided an opinion of "generally satisfactory with improvements required", reflecting a positive progression from previous reporting. External audit activity, including the value-for-money assessment, remained in progress.

19.5. The Committee would meet again in June to review the annual accounts and annual report, with a view to recommending approval.

19.6. The Board **noted** the assurance report.

20. GOING CONCERN STATEMENT

20.1. Pippa Moger presented the Going Concern Statement, noting the annual requirement for the Trust to assess whether it remained a going concern. She advised that, based on the approved 2026/27 budget and forecast cashflow of £47 million through to the point of signing the annual accounts, the Trust was considered to be financially sustainable over the relevant period.

20.2. The proposal had been reviewed by the Audit Committee, and no concerns had been raised.

20.3. The Board **approved** the Going Concern Statement.

21. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

21.1. The Chair invited follow-up questions from members of the public and Governors. No further questions were raised.

21.2. The Board **noted** that there were no follow-up questions.

22. ANY OTHER BUSINESS

22.1. The Chair invited any other business. It was noted that a number of Artificial Intelligence training opportunities were available, including sessions provided by NHS Alliance open to Executive and Non-Executive Directors. It was also reported that an external organisation had offered a Board development session on Artificial Intelligence, and this would be explored further with a view to bringing a session to a future Board development meeting if appropriate.

22.2. No further items of business were raised.

23. RISKS IDENTIFIED

23.1. The Board confirmed that no new risks had been identified during the meeting.

24. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

24.1. The Board reflected on the effectiveness of the meeting and agreed that there had been appropriate focus and constructive discussion across the agenda. Members noted the value of the level of detail provided, while also recognising the need to maintain a balance between depth of information and clarity of oversight.

24.2. The Board agreed that the meeting had enabled appropriate scrutiny of key issues and supported effective Board assurance.

25. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

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

26. WITHDRAWAL OF PRESS AND PUBLIC

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

27. CLOSE AND DATE OF NEXT MEETING

21.1. The meeting closed at 12.36 pm. The next meeting will take place on 14 July 2026.

APPENDIX 1

Minimum Number Stroke Patients - analysis of stroke patient numbers vs performance of Hyper Acute Stroke Unit (HASU)

NHS Somerset assert that HASUs with fewer than 600 patient admissions per year cannot perform satisfactorily to ensure good clinical outcomes. The Decision-Making Business Case (DMBC) states that:

"Areas that have centralised hyperacute stroke care into a smaller number of well-equipped and well-staffed hospitals, that includes acute stroke units of a sufficient size to ensure expertise, efficiency, and a sustainable workforce have seen the greatest improvements. When stroke care is centralised in larger units, patients have a greater likelihood of being treated more quickly and effectively so what may be lost in travel time can be more than made up by better process after arrival."

And that:

*"...to provide sufficient patient volumes to make a hyperacute stroke service clinically sustainable, to maintain expertise and to ensure good clinical outcomes, **600** stroke patient admissions per year are required. Whilst this is achieved in Musgrove Park Hospital, Yeovil District Hospital consistently falls below this level and modelling over the next ten years suggests this threshold will not be met."*

If 600 or more patients equals a better performing HASU, then it should be seen in the performance stats. Stroke units around the country are made up of Integrated Stroke Delivery Networks (ISDNs). These are regional groupings that help each other and share telemedicine duties etc. This analysis covers two ISDNs that each have a mix of urban and rural catchment areas. First the West of England ISDN, consisting of Bristol, Gloucester, Swindon, Taunton, Bath, Salisbury and Yeovil hospitals. And second, the Wessex ISDN, consisting of Dorchester, Portsmouth, Winchester, Southampton, Isle of Wight and Bournemouth hospitals.

If the ICB is correct we should see better individual performance from hospitals that have a greater number of stroke patients. The performance of all 13 hospitals was investigated, and their individual performance was compared against their individual number of stroke patients. For the claim to be true that more patients equal better outcomes , there should be a correlation between performance and the number of the stroke patients a hospital treats. Simply, the more stroke patients a hospital treats, the better performance it should achieve.

The most important hospital performance statistic is its rate of thrombolysis. About 85% of all strokes are ischaemic, when the stroke is caused by a blood clot. Thrombolysis is a powerful clot-busting medication and if the patient is treated soon enough after onset, a good recovery can be achieved. There are many reasons why thrombolysis is not administered to patients, but the most common reason is that it is too late. The national standard is that treatment should be given within 3 hours of the 999 call. But if more than 4.5 hours has elapsed, then thrombolysis could be harmful and is not administered.
In the tables below the number of patients per hospital is given, and of those, what percentage received thrombolysis. In each table the data is for 12 months which should eliminate monthly variations.
Data supplied by Sentinel Stroke National Audit Programme (SSNAP).

West of England ISDN for 12 months ending September 2025

Hospital	Bristol	Gloucester	Swindon	Taunton	Bath	Salisbury	Yeovil
Number of patients	1203	933	671	630	611	326	458
Number thrombolysed	131	97	63	63	67	29	53
% thrombolysed	10.9	10.4	9.4	10.0	11.0	9.0	11.6

Wessex ISDN for 12 months ending September 2025

Hospital	DCH	Portsmouth	Winchester	Southampton	IOW	Bournemouth
Number of patients	526	848	803	948	288	1299
Number thrombolysed	64	165	147	106	49	169
% thrombolysed	12.2	19.5	18.3	11.2	17.0	13.0

As is clear, there is no correlation between the number of patients and the rate of thrombolysis. Interestingly, the hospital with the fewest patients, the IOW, is in the top 3 performers! The hospital with the most stroke patients, Bournemouth, is 4th. Yeovil Hospital did better than Taunton Hospital despite significantly fewer patients at Yeovil.

It should be noted that the above is just one means of comparing the number of stroke patients to the performance of the hospital. But it is perhaps the most important. The treatment for stroke is time-critical and the factor which determines the clinical outcome for a stroke patient is time. Time from onset to treatment being administered. In conclusion, NHS Somerset's claim that a minimum of 600 patients per hospital is the threshold for good clinical outcome, is false.

***Analysis prepared by Quicksilver Community Group**

May 2026

APPENDIX 2

Predicted Call to Needle times for DMBC proposal to close YDH HASU using the DMBC Geospatial Evidence pack and SWAST Cat 2 Ambulance data 2025

Overview of Findings

The publication "National Stroke Service Model. Integrated Stroke Delivery Networks. May 2021" indicates **"**For patients with ischaemic stroke, systems should achieve a 90th centile call to needle time of 180 minutes." The standard applies to ischaemic stroke (blood clot) which accounts for over 85% of all strokes. Stroke treatment is time critical and delays can result in significant deterioration in the health outcomes for patients.

Currently for Somerset stroke patients taken to YDH or MPH 55% get treatment within 3 hours of the call for an ambulance. Significantly below the national standard.

If the closure of YDH HASU goes ahead this figure reduces to 45%, and specifically for those who will have to go to their nearest HASU instead of Yeovil the figure reduces to 28%.

In conclusion the current situation is appalling, but it will be made considerably worse by the decision of the ICB to close the YDH HASU.

To put this in patient numbers:

In 2025 South Western ambulance Trust conveyed 1526 Somerset stroke patients to either MPH or YDH HASU of which 838 were seen with the 3-hour window. That is 688 patients have a time compromised treatment with potential significant deterioration in their health outcomes

Under the proposal to close YDH HASU 701 would be seen within the 3-hour window. That is 838 patients have a time compromised treatment with potential significant deterioration in their health outcomes

Following the YDH closure of the 524 patients who would be re-directed elsewhere 377 patients will have a time compromised treatment (72%) with potential significant deterioration in their health outcomes.

That is a lot of patients with deteriorated health outcomes. The proposal to close the YDH HASU makes a bad situation worse when the focus should be on making the obvious improvement to timely treatment.

The final section of this report includes an analysis of the data to include potential, through unvalidated, practice improvements in door to needle processes and handover process.

These were described as plans at MPH, but no commitment could be given that similar approaches would be taken at DCH, and a SWAST pilot in Dorset, which may be taken forward to somerset in

respect of patients impacted by the closure of YDH HASU but no agreement to this has been reached at present.

Analysis

This analysis combines 2025 SWAST ambulance call to door data (obtained from FOI) with the Geospatial data presented in the DMBC appendices. It also compares results to the same analysis based on SWAST 2024 data from a previous FOI.

The DMBC geospatial evidence pack (page 170 - 202) provides a table of increasing additional ambulance travel times, (in 5-minute intervals between 0 and 35 minutes), with the number of people impacted in each interval, (page 178).

The response to an FOI request for details of analysis and modelling carried out to inform the DMBC indicated no other modelling or analysis other than that presented in the Geospatial evidence pack had been carried out.

As the geospatial evidence pack models the closure of YDH HASU the additional ambulance travel times it identifies will relate only to cases redirected following the YDH HASU closure. The table in page 178 shows there are 362 who will have additional ambulance travel time out of 996 cases across the whole county, (36%).

The mean additional travel time for these 362 cases has been calculated from the data in the Geospatial evidence pack. This is an additional 24 mins 05 seconds

An FOI response from SWAST (SWASTDAI-15930 - ##37299## - FOI MY REFERENCE GS13), provided a full year of ambulance data (2025) for call to door times, comprised of: Target Duration, On scene duration, Scene to YDH duration, and Handover duration, for all patients transported to YDH HASU. (catergory2). In addition, SSNAP data provided a mean door to needle time of 59 minutes.

SWAST provided a response to an FOI (SWAST-SSNAP DADT AS AT 22 APRIL 2025 (GP-1H), which gave the similar data for 2024

As the Geospatial evidence pack related to the patients within the geographic area of Somerset, cases with postcodes outside Somerset were removed from the SWAST data for this analysis. This yielded 524 cases, (406 for 2024).

Summary of Results

Current performance for all Somerset patients going to YDH HASU: SWAST 2025 data

Mean Total Call to Needle time	03:02:51	03:22:55(2024)

Of the 524 cases in the 2025 data 284 cases received treatment within 3 hours of the call for an ambulance (55%) - (45% in 2024)

The national target is that 90% of cases receive treatment within 3 hours of the call for an ambulance

There has clearly been some improvement in ambulance call to door times since 2024, but even with this and a HASU in both YDH and MPH there is a significant failure to meet national call to needle time expectations. This should be a major concern for NHS Somerset and the ICB, despite the efforts by SWAST to make improvements.

Predicted performance for Somerset patients after closure of YDH HASU (SWAST and Geospatial evidence pack)

Revised mean call to needle time with additional travel time: 03:26:56 (03:47:00 in 2024)

Of the 524 cases in the 2025 data 147 cases would receive treatment within 3 hours of the call for an ambulance (28%) - (20% in 2024)

The national target is that 90% of cases receive treatment within 3 hours of the call for an ambulance

The data shows 90% of patients would receive treatment within 4 hours 23 minutes.
(5 hours 15 minutes in 2024)

Under the DMBC proposals for the patients currently served by YDH HASU the percentage receiving treatment within 3 hours of the call will reduce from 55% to 28% a reduction of 27%
(45% to 20% in 2024, a reduction of 25%)

There are 362 patients in the Geospatial evidence pack cohort so a reduction of 27% represents a further 98 patients across Somerset receiving treatment outside this 3-hour target.
98 from the cohort of 996 patients across Somerset identified in the DMBC geospatial analysis represents a further 10%, (9% in 2024), of all Somerset patients served by the current 2 HASUs in the county will receive a poorer service against national standards because of the DMBC proposal.

The worsening situation from 2024 to 2025 is because the increased travel time has a bigger proportional impact on the overall ambulance call to door time as these other aspects have been improved by the ambulance service.

Nevertheless, an additional 10% reduction in numbers receiving call to treatment time within the national guidelines because of the closure of the YDH HASU, should be a significant concern to the ICB.

The current failure to meet national call to needle time expectations with a HASU in both YDH and MPH should be a major concern for the ICB. The current proposal to close the YDH HASU will make the situation worse. It must be questioned whether NHS Somerset, the ICB and Clinical Senate had been adequately served by the Geospatial evidence pack which fails to provide appropriate data to

evaluate the current situation and the impact of the proposal on travel times and call to needle time.

The Impact of the Proposals across the whole County

The SWAST 2025 data included the ambulance performance for current travel to the MPH HASU.

This was based on 1002 cases taken to the MPH HASU, yielding:

Mean door to Needle time	03:04:15
%age patients receiving door to Needle time in less than 3 hours	55%

These mean figures are very similar to the mean figures for patients transported to YDH HASU. Each element of the call to door ambulance process is also very similar irrespective of the target HASU.

Under the proposals the call to needle time will remain the same for patients transported to MPH HASU but make a significant difference to those Somerset residents currently transported to YDH HASU.

In pure number terms, of the 1526 Somerset patients reported in the SWAST data taken to MPH or YDH currently, 55% have a door to needle time of less than 3 hours.

Under the proposal to close YDH of the 1526 patients taken to their nearest HASU only 701, (45%) would be predicted to have a door to needle time of less than 3 hours, (based on the Geospatial evidence pack data).

Not only does the current proposal fail to prioritise the current significant poor performance in achieving a 3-hour call to needle time for Somerset stroke patients (currently 55%) , the proposal makes matters significantly worse where across the county only 45% of patients would receive a call to treatment within 3-hours.

This second analysis again demonstrates the significant deterioration in performance as a direct consequence of the decision to close the HASU at YDH.

The Failure of the Geospatial Evidence pack

The Geospatial evidence pack, relied on by the ICB, provided a detailed analysis of location in Somerset of patients traveling to HASUs, including analysis of demographics: over 50s, (as the most relevant target group for strokes), deprivation levels, accessibility for family and friends, access by public transport, use of private cars and various combinations.

The modelling in the DMBC appendices regarding ambulance timescales is all based on the key assumption that the time taken for a 3.00am Tuesday morning car journey is a proxy for a blue light ambulance, and this has been used to model journey times from localities within the county to predict numbers of cases which would experience additional journey times.

In response to an FOI request, **(FOI-ICB 1549),** for the details of how this proxy indicator has been validated the following statement was provide by NHS Somerset.

"There is no national data modelling available that provides blue-light ambulance journey times. Therefore the 3 am unimpeded car journey is was used as a proxy. Recent conversations have taken place with South Western Ambulance Service NHS Foundation Trust (SWAST) who have confirmed their continued support for the modelling outputs included in the Decision-Making Business Case (DMBC)".

There is no link to real life ambulance data from SWAST to provide the range of actual/predicted total journey time.

The modelling in the Geospatial Evidence pack focuses on additional journey time and gives little focus to total journey times, actual or predicted, nor, most importantly, any attempt to model call to needle time. Given the national indicator these should be expected as an essential foundation to planning.

An Alternative Approach

It would have been possible to do such a relevant analysis. The Healthcare for London planning for the re-configuration of HASU provision is a pertinent example. This involved a detailed analysis and modelling of ambulance travel times to ensure that wherever someone lives in London they will be less than 30 minutes, in a blue-light ambulance, from one of the HASUs.

This included:

· Details of 4 million ambulance journeys over three years

· Sophisticated modelling software, using real average journey times on roads, to supplement the data from the Ambulance Service.

· Specific analysis to assess the impact of the day of the week and rush hour on ambulance journey times.

The London aim was for an upper level of a 30-minute ambulance journey time as part of the 3-hour window. Achieving this upper limit reflected an actual mean journey time of 15:57 minutes. This contrasts with the mean journey time for the 406 Somerset patients who, based on the SWAST

data, have a mean journey time currently of 21:55, increasing to 46:00 with the proposed changes. This is almost 3 times the mean journey time targeted by Health Care London to achieve the required 90% 3-hour call too needle time.

The Geospatial evidence pack pages 172 and 173 provides tables embedded within the heat map of journey times. Comparison of the blue light journey time to HASU for Somerset residents (50+) shows that currently 5% have a journey time over 30 minutes, whereas with the closure of the YDH HASU this increases to 26.%. A significant increase on a critical factor.

Somerset is not London, and it is difficult to understand the consequences of these different locations without any data or evidence. However, the key difference is the approach adopted. In London actual ambulance journey times and other data and analysis which informed and were focussed on call to needle targets were central to the initial planning of the location of HASUs. In Somerset this has largely been ignored in the Geospatial evidence pack which fails to provide data to highlight the current situation and the predicted impact on journeys and call to needle time, failing to show the proposal worsens an already challenging situation.

The Failure in Somerset

1. NHS Somerset and the ICB has failed to commission or obtain evidence of real category 2 ambulance journey times from Yeovil and other areas impacted to MPH, DCH or other out county HASUs.
2. NHS Somerset and the ICB has failed to obtain any detailed modelling using real life data to identify current and predicted total journey for patients impacted by the proposed closure of the YDH HASU, including consideration of real ambulance travel times during peak hours of the week and seasonal issues related to tourism etc.
3. NHS Somerset and the ICB has failed to obtain any credible analysis, based on real data, to indicate the proportion of stroke patients affected by the closure of YDH HASU exceeding the 3-hour call to treatment window, either currently or following the closure.
4. In this respect NHS Somerset, the ICB and the Clinical Senate which endorsed the proposed closure of YDH HASU as clinically safe, must be seen as vulnerable to claims of negligence and potentially open to legal compensation claims by future patients suffering significant harm because of their delayed treatment, in addition to failing in their legal responsibility to ensure clinical safety.

Potential Mitigations

Representatives from the Quicksilver Community Group and the SFT met, (5/3/26), for discussions of concerns and to gain a greater understanding of SFTs potential mitigations to address concerns around the closure of YDH HASU.

Two areas of improved practice were noted suggesting improvements could be made in door to needle time and Handover duration.

Door to needle time

Changes in practice anticipated at HASUs could lead to improvements in door to needle time. This is based on practices developed in Northumberland where it is claimed the door to needle time practice improved by 30 minutes.

It could not be confirmed that this would be achieved in Somerset, but it was presented as the data available to indicate the scope for potential improvement.

It will be important to note the absolute door to needle time before and after changes to have some better appreciation of the degree of change which could be possible in Somerset.

(SFT cannot provide reassurance that this level of improvement would be realised in practice).

Handover duration

SWAST have been piloting Pre Hospital Video Triaging (PHVT) with Dorchester Hospital, and it is anticipated that this could lead to more efficient handovers from ambulance to hospital. **SWAST could not commit to an estimate of the time saved by this improvement.**

However, the SWAST 2025 data for patients to MPH, DCH and YDH give the following mean handover durations in minutes.

MPH	28:57
YDH	28:04
DCH	19:20

There is a consistency in the figures for MPH and YDH, and reduced figure for DCH. This could suggest the (PHVT) would account for the improvement of about 9:00 minutes.

SFT and SWAST have confirmed their intention to use PHVT for the cohort of patients affected by the closure of YDH HASU who would be taken to DCH, (although this cannot be guaranteed at present).

Amendments to the current and predicted door to needle times assuming an improvement of 39 minutes would give the following results.

Current performance for Somerset patients going to YDH HASU: SWAST 2025 data if there was a 39-minute improvement in Handover and door to Needle time

Mean Total Call to Needle time 02:23:51

Of the 524 cases in the 2025 data 438 cases received treatment within 3 hours of the call for an ambulance (84%)

The national target is that 90% of cases receive treatment within 3 hours of the call for an ambulance

90% of patients would receive treatment within 3 hours 19 mins

With the anticipated handover and door to needle practice improvements the national target would almost be achieved if the YDH HASU continues.

Predicted performance for redirected Somerset patients after closure of YDH HASU (SWAST and Geospatial evidence pack) given 39-minute improvement in Handover and door to Needle time

Revised mean call to needle time with additional travel time: 02:47:56

Of the 524 cases in the 2025 data 344 cases would receive treatment within 3 hours of the call for an ambulance (65%)

The data shows 90% of patients would receive treatment within 3 hours 43 minutes.

This performance while considerably less than if YDH HASU remains open and the improved practices are delivered, is still an improvement on the current situation.

However, as previously indicated the impact of the improved practices is not validated, nor is there any commitment that the estimates are realistic.

Most patients redirected if YDH HASU closes will go to DCH and no commitment was given that the improved door to needle practices anticipated at MPH will also be adopted by DCH (which is not in SFT).

It is also not guaranteed that the PHVT practice led by SWAST in Dorset will be extended beyond the pilot for Somerset residents.

It would seem the ICB decision to close YDH HASU, with anticipated but unvalidated mitigations is very risky to the health outcomes of those patients who will be affected. This is a significant proportion of the Somerset population 34%.

Patients treated at MPH HASU

Currently 55% of patients to MPH HASU receive treatment in 3 hours from the call.
Mean call to needle time is 03:04:15
90th Centile time is 04:06:42

If the 30 minutes improvement in door to needle time is achieved this figure improves to

78% of patients would receive treatment within 3 hours from call
Mean call to needle time becomes 02:34:15
90th centile time becomes 03:36:42

If PHVT were also adopted and the further 9 minutes could be saved
82% of patients would receive treatment within 3 hours from call
Mean call to needle time becomes 02:25:15
90th centile time becomes 03:27:42

82% of patients attending MPH would receive timely treatment
In contrast of the 34% of the population redirected following the closure of YDH HASU only 65% would receive timely treatment.

This indicted that despite the anticipated (unvalidated) efforts of SFT to mitigate the impact of extended travel following closure a further 17% would fail to receive timely treatment due to the closure of YDH HASU, whereas without the closure the percentages receiving timely treatment would be almost identical 82% and 84% - both representing a positive performance across Somerset.

These figures are based on the most optimistic view of SFT as to what might possibly be achieve through improved practice in hospital and handover.

Concerns

How viable is the anticipated time saved by changes to within hospital practice?

Both SFT and MPH would not commit to give an estimate. They merely referred to the Northumberland data as a guide. We have little information to indicate whether this can be replicated. We had no information about the door to needle duration before and after changes in Northumberland, or whether this would represent an equivalence to current and anticipated practice in Somerset.

Most importantly, SFT could not confirm that these within hospital practices planned for MPH HASU would be replicated at DCH HASU. If this is not taken on by DCH then the detrimental impact on those impacted by the closure of YDH HASU would not be partially mitigated. This would be a dire in terms of patient outcome given the increased travel time and would further extend the inequality of access to this group (34%) of Somerset residents relative to the remaining 66% served by MPH HASU.

How Viable is the anticipated time saved by changes to handover time through PHVT?

SWAST were unable to give an indication of the time saved by the improved handover practices, although we have taken an estimate-based recent data, although this could be questionable.

There was no absolute commitment that this PHVT practice would be continued beyond the pilot or extended to those disadvantaged by the closure of YDH HASU. The only commitment being that they would be the population prioritised for this practice.

If the practice in time is found to be successful it is possible that it may be extended across the whole of Somerset including MPH, further widening the inequality between the 34% and the 66% served by MPH would be extended.

Trial and proof before closure

Given that there has been considerable investment in DCH by SFT since the decision to close YDH HASU, it is a dereliction of the duty of care to patients that SFT/ICB have not used time since the decision, if not before, to fully develop these mitigations to identify if they are viable and the degree to which they do provide mitigation to extend travel time in practice.

These mitigations should be confirmed and fully established before the closure of YDH HASU goes forward.

It is interesting that while SFT intend to monitor patient outcome data following the implementation of the proposal, and there is existing data to provide a comparator, the view was given that we should expect to wait for a time before a clear picture emerges of the impact of the changes. This is not acceptable; practice changes need to be embedded before the closure if patient safety and outcomes are not to be jeopardised.

Summary

The failure of NHS Somerset, the ICB and the Clinical Senate to commission or obtain appropriate and relevant evidence of the impact of their proposals has led to a failure to consider the dire consequences on timely patient treatment for those directly affected by the potential closure of the YDH HASU, as well as failing to address the timely treatment of stroke patients across the whole of Somerset.

Similarly, the failure to implement, fully test out, and embed all mitigations to address additional travel time is a further considerable risk to patient safety and outcome.

The closure of the Yeovil HASU needs to be stopped immediately to prevent the implementation of a flawed decision, based on poor data analysis and modelling, alongside untested mitigation proposal. It will clearly lead to avoidable detrimental health outcomes for stroke patients in Yeovil and surrounding areas who will have additional delays to their time critical treatment.

The current focus of activity should be to maintain good quality HASUs at YDH, MPH, and implement time saving initiatives to bring the overall call to needle time to within the range of the national target. This analysis suggests this would be possible across Somerset with the retention of YDH HASU.

APPENDIX 3

Quicksilver Community Group
C/O 1 West Coker Road
YEOVIL, Somerset
BA20 2LX

3 May 2023

Dear Chair or Clerk of the Council,

I am writing on behalf of Quicksilver Community Group, to draw your attention to the imminent closure of the Hyper Acute Stroke Unit (HASU) at Yeovil District Hospital (YDH). The closure has been previously agreed by NHS Somerset Integrated Care Board (ICB) and is being implemented by Somerset Foundation Trust (SFT).

South Western Ambulance Service (SWAST) data shows that stroke patients from your postcode will be impacted by this closure, as they will be re-routed to alternative more distant provision, mainly Musgrove Park Hospital, (MPH), or Dorset County Hospital (DCH).

Stroke treatment is time critical and a major reason for stroke victims to not be treated is because it is too late.

Currently 520+ people every year who suffer a stroke are taken to YDH as their nearest HASU. Data provided in the SFT/ICB business case indicated there will be an average 24 minutes additional travel time for these patients going to their nearest alternative HASU.

There is a national standard that 90% of stoke patients receive treatment within 3 hours of a call for an ambulance.

Quicksilver Community Group and local GP Patient Groups have taken data directly from the ambulance and health services. Our analysis of that data indicates that of ALL Somerset stroke patients currently taken to either YDH or MPH, **only 55% get treatment within 3 hours.** A poor performance compared to the national standard.

However, with the closure of YDH HASU, only 28% of the 520+ patients per year redirected to other hospitals will receive treatment within the 3-hour window. **An appalling deterioration from the current poor performance**.

It is claimed that having fewer and larger HASUs will improve the outcomes for patients. However, recent health data for HASUs in Bristol, Gloucester, Swindon, Taunton, Bath, Salisbury, Yeovil, Dorchester, Portsmouth, Winchester, Southampton, Isle of Wight, and Bournemouth, show no correlation between size of unit and treatment outcomes.

SFT and the ICB claim that within hospital improvements could possibly save 26 minutes based on a study in Northumbria. However, these practices have not been implemented locally, and the senior Stroke Consultant at MPH could not give a confident indication that such a level of improvements could be achieved. More

worryingly, SFT have received no indication if improved practices would or could be adopted at DCH, where more patients will go, instead of YDH.

SWAST (the ambulance service), have run a pilot using Pre Hospital Video Triage with Dorchester Hospital, although no estimate of the level of improvement is available. There is no agreement, as yet, that this would be taken forward beyond the pilot or extended to Somerset in respect of patients impacted by the closure of Yeovil HASU.

The closure of the HASU at YDH leaves stroke patients in your area in a very vulnerable position. Patients who unknowingly self-present to their local hospital at YDH will have to be transferred elsewhere, incurring a further time penalty.

We call on Councils representing people in these postcode areas to make representations, individually or jointly with other Councils, to SFT and the ICB to cancel their plans for the closure of the YDH HASU. Or at the very least, postpone it until they have implemented within-hospital and handover changes, and rigorously evaluated them to ensure they fully mitigate against the additional travel time.

We hope you will be able to consider this within your council.

Thank you in anticipation.

Data sources and analyses available on request.

Ray Tostevin
chair, Quicksilver Community Group
m: 0777 171 0339
e: ray.tostevin@gmail.com

Somerset NHS Foundation Trust

EXTRAORDINARY PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRAORDINARY PUBLIC BOARD MEETING HELD ON 9 JUNE 2026 AT CHEDDON FITZPAINE MEMORIAL HALL, ROWFORD, CHEDDON FITZPAINE, TAUNTON, TA2 8JY

PRESENT

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

IN ATTENDANCE

Richard Baum	Head of Strategic Planning
Ben Edgar-Attwell	Director of Governance
Zoe Hamilton	Clinical Transformation Advisor, Improvement Team
Julie Hutchings	Board Secretary and Corporate Services Manager
Fiona Reid	Director of Communications

APOLOGIES

None

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. Rima Makarem welcomed all Board members and attendees to the Extraordinary Board meeting and confirmed that the meeting was quorate. No apologies for absence were received.

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

2.1 The Board noted the Register of Interests and confirmed that there were no additional declarations relating to the agenda.

3. FIT AND PROPER PERSON ANNUAL SUBMISSION – 2026

3.1. Mel Iles introduced the Fit and Proper Person Annual Submission for 2026 and reminded the Board of its statutory responsibility to ensure that all Board members met the requirements of the Fit and Proper Person Test. She confirmed that the annual assurance process had been completed in line with national guidance, including verification of qualifications, professional registration, employment history, and checks relating to conduct, capability and fitness to hold office. It was reported that all Board members had satisfactorily met the required standards, with no concerns identified through the assurance process.

3.2. Board members were invited to raise any questions or seek clarification on the process or outcomes. No queries were raised, and the Board expressed its assurance that the appropriate checks had been undertaken robustly and in accordance with regulatory expectations.

3.3. The Board **approved** the Fit and Proper Person Annual Submission for 2026.

4. DRAFT TRUST STRATEGY 2026-31

4.1. David Shannon introduced the Draft Trust Strategy 2026–31, supported by Richard Baum and Zoe Hamilton, explaining that the document presented to the Board represented a developed narrative aligned to the Trust's strategic aims, with further refinement required to translate these into clear priorities, deliverables and measures. He outlined that the strategy was structured around seven overarching aims, each supported by a small number of objectives and intended deliverables across years 1, 3 and 5, although further work was required to finalise metrics and baselines. He noted that this remained a complex process, particularly in moving towards more integrated, pathway-based working across services.

4.2. Richard Baum added that while there was increasing clarity around the objectives, further work was needed to define the key results and deliverables, and he invited the Board's views on the level of specificity required. Zoe Hamilton highlighted that year 1 would need to focus on establishing baseline data, including strengthening links with primary care to ensure robust system-wide measures.

4.3. In discussion, Olena Doran raised concerns regarding the lack of specificity in the proposed metrics, noting that many measures referred to increases or reductions without defined targets. She emphasised the importance of quantifiable indicators wherever possible, while also recognising that some outcomes, such as healthy life expectancy, would take longer to measure and were not wholly within the Trust's control. Rosie Benneyworth sought clarity on how the proposed metrics would align with forthcoming national frameworks, including Modern Service Frameworks, and questioned how adaptable the strategy would be as national expectations evolved.

She also highlighted the need to ensure that metrics were evidence-based and meaningful in reflecting improvements in care, particularly in community and neighbourhood models.

4.4. The Chair reflected that while the overall structure was positive, there was a risk of including too many metrics, many of which were operational rather than strategic, making it difficult to identify a clear “golden thread” through the strategy. She emphasised the importance of focusing on a smaller number of meaningful strategic outcomes, particularly those relating to population health and patient pathways, and distinguishing clearly between operational delivery measures and strategic impact. Richard Baum confirmed that the next phase of work would include developing more specific targets and refining the approach to measurement, including focusing on outcomes rather than inputs.

4.5. Inga Kennedy commented that while the structure of aims, objectives and deliverables was appropriate, the document did not yet feel fully cohesive, with some overlap and lack of alignment between the narrative and the stated aims. She noted that highlighted priorities within the narrative did not always clearly map through to the strategic aims and emphasised the importance of ensuring consistency and clarity. Owen Woodley reflected that while the strategy contained compelling elements, it lacked a clear overarching articulation of what success would look like by 2031 and suggested that a more concise and compelling statement of ambition would help engage colleagues and stakeholders. He also highlighted the need to reduce the number of priorities to a more focused set that would command organisational attention.

4.6. Further discussion reflected the balance between ambition and deliverability. Peter Lewis emphasised that the strategy needed to address the fundamental challenge of sustainability, noting that continuing with the current model of care would not be viable, and that the proposed direction would place the Trust in a better position despite the need for difficult trade-offs. Andy Heron observed that, as a comprehensive National Health Service provider, much of the “what” was externally defined, and therefore the strategy needed to focus particularly on the “how”, “where” and “when” of delivery.

4.7. Deirdre Fowler highlighted the importance of engagement and co-production with patients, communities and partners, noting that the strategy should be shaped by the population it served. She acknowledged the practical challenges of timing but encouraged the Board to take a more proactive approach to engagement. Peter Lewis responded that engagement should follow once there was sufficient Board confidence in the strategic direction, distinguishing this from formal consultation processes.

4.8. The Board also discussed the need to strengthen the visibility of key themes within the strategy, including equality, diversity and inclusion, workforce priorities, and primary care integration, noting that these were not consistently reflected across the document. Tom Frederick highlighted the importance of ensuring clearer articulation of the role of primary care, given its significance within the overall model.

4.9. The Chair summarised the discussion, noting broad support for the direction of travel, while highlighting the need for further refinement to improve clarity, focus and measurability. She proposed that the Board approve the draft content and direction of the strategy to enable further engagement with colleagues and external stakeholders, with the expectation that feedback would inform further iteration ahead of final approval in the autumn. She emphasised the importance of strengthening the clarity of the objectives, reducing complexity, and ensuring the strategy was accessible and meaningful for both colleagues and the public.

4.10. The Board **approved** the draft strategic direction and content of the Trust Strategy 2026–31, subject to further refinement, engagement and development ahead of final approval.

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

5.1. Rima Makarem advised that the focus of the Extraordinary Confidential Board meeting would be to receive a Digital, Data and Technology (DDaT) Strategy update.

6. WITHDRAWAL OF PRESS AND PUBLIC

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

7. CLOSE OF MEETING

7.1. The meeting closed at 4.10 pm.

EXTRAORDINARY PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST EXTRAORDINARY PUBLIC BOARD MEETING HELD ON 19 JUNE 2026 VIA MS TEAMS

PRESENT

Dr Rima Makarem	Chair
Rosie Benneyworth	Non-Executive Director
Darshan Chandarana	Non-Executive Director
Inga Kennedy	Non-Executive Director
Paul Mapson	Non-Executive Director
Alexander Priest	Non-Executive Director
Owen Woodley	Non-Executive Director
Peter Lewis	Chief Executive
Isobel Clements	Chief People Officer
Deirdre Fowler	Chief Nurse and Midwife
Andy Heron	Chief Operating Officer/Deputy Chief Executive
Pippa Moger	Chief Finance Officer
Jade Renville	Director of Corporate Services
David Shannon	Director of Strategy & Digital Development

IN ATTENDANCE

Julie Hutchings	Board Secretary and Corporate Services Manager
Ben Edgar-Attwell	Director of Governance
Chris Upham	Assistant Director of Finance – Financial Services

APOLOGIES

Olena Doran	Non-Executive Director
Tom Frederick	Associate Non-Executive Director
Graham Hughes	Non-Executive Director
Mel Iles	Chief Medical Officer

1. WELCOME AND APOLOGIES FOR ABSENCE

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

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

2.1 Rima Makarem advised that the focus of the Extraordinary Confidential Board meeting would be the Annual Report and Accounts.

3. WITHDRAWAL OF PRESS AND PUBLIC

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

4. CLOSE OF MEETING

4.1. The meeting closed at 10.10 am.

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETING

Minute	Action	By whom	Due date	Progress	Status
Public Board meeting held on 10 March 2026					
15.4 - Maternity & Neonatal Quarter 3 (2025/26) Quality & Safety Report	Review how delays in flow and pressures on obstetric and postnatal activity are reflected on the risk register, ensuring that any related risks are clearly captured and monitored	Deirdre Fowler/ Sally Bryant	July 2026	The risk register clearly captures delays and sustained pressures across obstetric and postnatal services due to demand, capacity, workforce, theatre, and estate constraints. Risks are well documented across maternity, neonatal, and obstetric services. Once YDH maternity services reopen, the cross-site pathway for antenatal, labour, and postnatal care during high-acuity periods will be reviewed, with potential to consolidate related issues into a single overarching risk to strengthen long-term oversight. Update: Maternity services have successfully re-opened in YDH. Following a month period of activity the service plans to review cross site pathway risks and consider need for potential consolidation of capacity and flow related risks to strengthen long term oversight.	Ongoing
Public Board meeting held on 12 May 2026					
13.5 – Integrated Performance Report	A Board development session on productivity to be scheduled.	Pippa Moger	October 2026	Item scheduled for October Board development session.	Ongoing

Somerset NHS Foundation Trust	
REPORT TO:	Public Board of Directors
REPORT TITLE:	Patient Story: Richard's experience of Podiatry Service Transformation
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and Midwife
REPORT BY:	Emma Davey, Director of Patient Experience and Engagement
PRESENTED BY:	Emma Davey, Director of Patient Experience and Engagement Anthony Joyce, Podiatry Clinical Director and Consultant Podiatric Surgeon Nikki Drake, ACP Podiatrist John Sutton, Interim Associate Director of Patient Care, Neighbourhoods Service Group
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	Storytelling remains a powerful way of bringing the patient voice into Board and connecting experience directly to service improvement and transformation. This patient story has been selected as it demonstrates how listening to patients, combined with clinical innovation and integrated working, can lead to meaningful improvements in outcomes, experience, and service efficiency. The story reflects the impact of the podiatry complex case model, which brings together multidisciplinary expertise in a single setting to deliver personalised, timely and coordinated care. This approach has transformed pathways for patients with complex foot conditions, enabling early specialist input, reducing delays, and improving quality of life. Through this model, patients experience care that is not only clinically effective but also compassionate, proactive and centred on what matters most to them, supporting independence, reducing anxiety, and enabling them to return to everyday activities. Feedback highlights that what may appear to be a minor clinical issue can have a

	significant impact on a person's ability to function, work, and live well. The transformation is also evident in system benefits, including reducing the need for ongoing interventions, improved waiting times, and more efficient use of resources, alongside enhanced colleague experience, confidence and learning. This story demonstrates how experience-led insights have supported the transition from a pilot to business as usual, embedding a more integrated, preventative and personalised model of care across community and specialist services. Richard, a service user, will be attending the Board to share his experience in person, supported by the clinical leads for the podiatry service and the Associate Director of Patient Care for the Neighbourhoods service group.
Recommendation	The Board is asked to discuss and note the report and reflect on the impact of experience-led service transformation and consider how similar approaches can be applied across pathways to improve outcomes and experience.

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

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

Details: This model supports improved clinical outcomes, enhances patient safety through earlier specialist input, and strengthens quality through personalised, coordinated care delivery

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)
This story reflects direct feedback from patients and colleagues involved in the podiatry service. It highlights the importance of capturing experience to inform service redesign and demonstrates the value of colleague insight in shaping sustainable improvements.

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]
This patient story has previously been shared through Neighbourhoods QOFP discussions and identified as a strong example of experience-led transformation suitable for Board consideration.

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

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

SOMERSET NHS FOUNDATION TRUST

PATIENT STORY

1. BACKGROUND AND PURPOSE

1.1. This patient story has been selected to illustrate how service transformation, informed by patient and colleague experience, can deliver tangible improvements in care. The podiatry complex case model demonstrates how integrated, multidisciplinary approaches can move care closer to home, reduce reliance on hospital-based pathways, and improve both patient outcomes and experience.

1.2. The story reinforces that transformation is most effective when grounded in what matters most to patients to support independence and enabling people to live well, while also creating a positive, supportive environment for colleagues to learn and deliver high-quality care.

2. KEY POINTS

2.1. Richard's experience reflects a broader shift towards earlier, more personalised and co-ordinated care through the podiatry complex case model.

2.2. Patient feedback, including experience shared through external media, highlights the significant personal impact of this care, with patients describing both the compassion of colleagues and the life-changing outcomes of treatment

2.3. The transformation has also delivered system benefits including a significant reduction in waiting times and more efficient, streamlined pathways and how integrating community and specialist expertise can improve both patient experience and service sustainability.

2.4. The Associate Director of Patient Care (ADPC) will describe how the service group has strengthened its approach to learning and including both encouraging and responding to feedback, including clearer ownership of actions, monitoring outcomes, increased accountability to ensure improvements are sustained.

3. RECOMMENDATION

3.1. The Board is asked to discuss and note the report and reflect on the impact of experience-led service transformation and consider how similar approaches can be applied across pathways to improve outcomes and experience.

DIRECTOR OF PATIENT EXPERIENCE AND ENGAGEMENT

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive and Executive Director Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Ben Edgar-Attwell, Director of Governance
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	14 July 2026

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

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

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

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
The report includes a number of references to work involving colleagues, patients and system partners.

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

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE / EXECUTIVE DIRECTOR REPORT

1 BACKGROUND AND PURPOSE

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

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

1.3 The following items require Board approval:

- Mortuary Assurance Statement for submission to NHSE.

2 NATIONAL AND REGIONAL DEVELOPMENTS / POLICY UPDATES

NATIONAL DEVELOPMENTS

Publication of the National Maternity and Neonatal Investigation (Amos Report)

2.1 On 30 June 2026, Baroness Amos published the final report of the Independent National Maternity and Neonatal Investigation, alongside individual reports for each of the twelve NHS trusts visited as part of the review, including Somerset NHS Foundation Trust. The investigation was commissioned by the Secretary of State for Health and Social Care to examine the wider maternity and neonatal system in England and to identify the changes required to improve the safety, quality and equity of care for women, babies and families.

2.2 The investigation concludes that the maternity and neonatal system is not currently delivering consistently high-quality, compassionate and equitable care and identifies a number of themes that were evident across the organisations visited. These include women and families not always feeling listened to or involved in decisions about their care, workforce and capacity pressures, inequalities in outcomes and experiences, fragmented pathways of care, poor quality estates and the need for stronger leadership, accountability and organisational culture. The report also highlights concerns regarding racism and discrimination within the maternity and neonatal system and the impact this can have on both patient experience and staff wellbeing.

2.3 The national report makes eight recommendations aimed at delivering long-term systemic and cultural change across maternity and neonatal services. In response, NHS England has announced a national 10-point improvement

plan, additional funding to support recruitment of newly qualified midwives, investment in maternity and neonatal estates, and the establishment of a national Maternity and Neonatal Commissioner. A National Maternity and Neonatal Taskforce, chaired by the Secretary of State, will oversee development of a national action plan later this year.

2.4 The Board recognises the significance of both the national and Somerset-specific reports and extends its thanks to the women, families and colleagues who shared their experiences with the investigation. The experiences described within the reports are difficult to read and we are so sorry to those who have experienced poor care, have not felt listened to, or have been harmed by services.

2.5 The Trust acknowledges that, whilst substantial work has been undertaken in recent years to improve maternity and neonatal services, including actions arising from previous CQC inspections and the safe reopening of inpatient maternity and neonatal services at Yeovil District Hospital, further improvement is required. The Trust is committed to working closely with women, families, colleagues and the Somerset Maternity and Neonatal Voices Partnership to understand the findings, respond to recommendations and continue strengthening the culture of openness, learning and compassionate care.

2.6 A detailed review of the national recommendations and the Somerset-specific findings is now underway. This will include assessment of any immediate actions required, identification of opportunities to strengthen existing improvement programmes, and consideration of how the learning should be incorporated into maternity safety, quality governance, workforce and patient experience arrangements.

NHS Reform, Governance and Legislative Change

2.7 The national policy landscape continues to evolve at pace, with significant structural reform proposed through the NHS Modernisation Bill, introduced following the King's Speech in May 2026. The Bill provides the legislative basis for major changes to NHS governance and accountability arrangements, including proposals to bring NHS England more directly within Department of Health and Social Care oversight. This represents one of the most significant reorganisations of the NHS in over a decade and is intended to support delivery of the NHS 10 Year Health Plan. While the reforms aim to strengthen national accountability and accelerate change, national commentary highlights the risk that organisational transition may divert leadership capacity away from operational delivery if not carefully managed.

2.8 Alongside this, the broader reform agenda continues to emphasise the three core strategic shifts set out in the 10 Year Health Plan: moving care from hospital to community settings, increasing digital enablement, and strengthening prevention. These priorities are now firmly embedded within national planning and performance frameworks, with increasing expectations

placed on systems and providers to demonstrate progress across all three areas concurrently.

Industrial Relations and Workforce Context

2.9 The national workforce context continues to be shaped by ongoing industrial relations activity. Planned resident doctor industrial action in June 2026 was avoided following a revised government pay offer, with members voting on proposals which include an average pay uplift of approximately 6.6% over the next year and commitments to additional training capacity. The position remains subject to the outcome of member consultation and does not fully remove the ongoing risk of disruption.

2.10 Workforce supply, retention and industrial relations therefore remain key areas of national focus, with continued recognition of the impact that workforce challenges have on operational performance, service resilience and patient experience.

NHS Staff Standards

2.11 NHS England and the Department of Health and Social Care have published the new NHS Staff Standards, which establish nationally mandated minimum expectations for employers in areas identified by staff as being most important to their experience at work. These include line management, health and wellbeing, violence prevention and reduction, sexual safety, tackling racism, and flexible working. The standards are intended to improve consistency of staff experience across the NHS and will be subject to formal performance measurement and assurance arrangements.

2.12 New NHS staff standards will require all NHS trust Board members, including Non-Executive Directors, to have publicly published SMART objectives (Specific, Measurable, Achievable, Relevant and Time-Bound) focused on tackling racism. Trusts must appoint either the CEO or COO as the senior responsible officer for this work, and leaders will be held accountable through workforce data and performance measures. Trusts' progress against these standards will influence their NHS Oversight Framework ratings, with consequences for poor performance. The guidance was introduced in response to continued evidence from the NHS Staff Survey showing higher levels of discrimination experienced by ethnic minority staff compared with white staff. This work will support the previously agreed executive inclusion objectives for 26/27 – progress on this will be reported to Executive Committee and Trust Board in the Autumn.

2.13 The Trust welcomes the introduction of the standards and will review its current baseline position, policies, arrangements and activities against the requirements to ensure robust implementation and ongoing compliance. Progress and any resulting actions will be reported through the People Committee in due course.

NHS Leadership and Management Framework

2.14 NHS England has also launched the NHS Leadership and Management Framework, which provides a consistent national approach to leadership and management development across the NHS. The framework comprises a Leadership and Management Code, a set of national leadership and management standards, and a supporting development curriculum. It has been developed to strengthen leadership capability and professional development for leaders and managers at all levels.

2.15 The Trust will undertake a review of its current leadership and management development arrangements against the framework requirements to establish a baseline position and identify any areas for further development. This work will be overseen through the People Committee, with further updates provided as implementation progresses.

Preventing Unlawful Access to Patient Records

2.16 NHS England has issued new guidance and a national awareness campaign aimed at preventing the unlawful access of patient records (Appendix 1). The communication follows a number of high-profile incidents nationally and reinforces that accessing patient information out of curiosity or for personal reasons is unlawful, can cause significant harm to patients, damages public trust, and may result in disciplinary action, dismissal, referral to professional regulators, or criminal prosecution.

2.17 The guidance sets out expectations for staff and organisations, including strengthened arrangements for education, monitoring, prevention and response. Accompanying this is a national communication campaign under the banner "Don't Let Curiosity Kill Your Career", designed to raise awareness of individual responsibilities regarding the appropriate use of patient information and the consequences of inappropriate access.

2.18 The Trust is working through a robust implementation programme to ensure compliance with the new guidance and associated expectations. This includes reviewing current arrangements, strengthening awareness and training activities, reinforcing staff responsibilities, and ensuring appropriate monitoring, audit and assurance mechanisms are in place to protect patient confidentiality, safeguard information governance standards and maintain public trust. Updates on progress will be provided through the Trust's established governance arrangements.

REGIONAL DEVELOPMENTS – SOUTHWEST

Operational Pressures and System Resilience

2.19 Across the Southwest, systems continue to experience sustained operational pressure, with demand remaining high across urgent and emergency care and elective pathways. This reflects the national position, with high levels of

activity combined with ongoing workforce and capacity constraints. Regional teams continue to maintain a strong focus on delivery against national priorities, including patient flow, discharge improvement and elective productivity.

2.20 Recent regional updates have also highlighted the impact of seasonal pressures, including a red heat-health alert in June 2026, which required coordinated system action to maintain patient safety and service continuity. This has reinforced the increasing importance of system-wide resilience planning, with a growing focus on managing non-winter pressures such as heat events and their impact on vulnerable populations and urgent care demand.

Transformation, Integration and Neighbourhood Working

2.21 There continues to be progress on the development of integrated neighbourhood models of care, aligned to national policy direction. This includes expanding multidisciplinary working across primary, community, mental health and social care services, with the aim of improving population health outcomes and reducing reliance on acute services.

2.22 There is also continued regional focus on strengthening strategic commissioning arrangements within Integrated Care Systems, in line with national expectations for ICBs to operate as more focused and data-driven commissioners. This is being supported by ongoing changes to system architecture and resource allocation, which are expected to further shape how services are planned and delivered over the coming period.

3 CORPORATE UPDATES

Triangle of Care Accreditation – External Recognition

3.1 The Trust recently submitted its annual Triangle of Care (ToC) accreditation report to the Carers Trust in March 2026. The Trust has subsequently been awarded both Triangle of Care Star 1 and Star 2 Awards for 2025/26, recognising the significant progress made in strengthening carer engagement and support across services.

3.2 The Carers Trust commended the Trust's submission, noting that the improvements made since the merger were clearly evidenced, alongside a renewed organisational focus on embedding the Triangle of Care approach. They highlighted both the challenges and opportunities presented by the scale of the Trust's integrated provision, with particular recognition of the potential to deliver more joined-up, system-wide support for carers.

3.3 The accreditation feedback also recognised the strong foundations now in place, including the development and launch of the Patient Experience and Involvement Strategy. In addition, service groups are progressing plans to establish dedicated Triangle of Care Lead roles, which will support the next

phase of improvement. This will include strengthening the network of Triangle of Care champions and expanding carer awareness training across the organisation.

3.4 The Trust will continue to work closely with the Carers Trust to review the detailed recommendations arising from the accreditation and to agree priority actions for the year ahead, ensuring sustained progress in this important area of patient and carer experience.

Our Somerset Colleague Awards (OSCAs) 2026

3.5 The Trust held the Our Somerset Colleague Awards (OSCAs) 2026, providing an opportunity to recognise and celebrate the outstanding contributions of colleagues, volunteers and partners from across the organisation. The event brought together finalists and guests to acknowledge the commitment, dedication and achievements of those who consistently demonstrate the Trust's values of Kindness, Respect and Teamwork, and who make a significant difference to the care and experience of patients and communities.

3.6 The awards reflected key organisational priorities, with strong themes emerging around person-centred care, transformation and innovation, and improving accessibility. Across all categories, nominations highlighted the breadth of work being delivered across the Trust, showcasing both individual excellence and the collective impact of multidisciplinary teams in driving improvements in quality, safety and experience.

3.7 Twelve awards were presented during the evening, including the Chair's Award, recognising exceptional contribution and leadership. Winners represented a diverse range of clinical and non-clinical roles, underlining the importance of every part of the organisation in delivering high-quality care and supporting the effective running of services.

3.8 The OSCAs continue to play an important role in recognising and valuing our colleagues, reinforcing organisational culture and supporting engagement. The event also provides an opportunity to share learning and showcase best practice, with the stories behind the nominations demonstrating innovation, compassion and commitment across the Trust.

3.9 The Trust extends its congratulations to all finalists and winners, and thanks all those involved in organising and supporting the event.

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

Assurance Report from the Executive Committee meetings held on 1 June 2026 and 6 July 2026

4.1 The Executive Committee received updates across operational performance, quality and safety, workforce, finance and organisational risk. The Committee

noted that the Trust continues to operate within a highly challenging environment, with sustained pressure across urgent and emergency care, patient flow, workforce availability and financial delivery. Whilst pressures remain significant, the Committee recognised the continued resilience of teams and the organisation's ability to maintain service delivery during periods of sustained system demand.

4.2 Operational performance and patient flow remained a major focus. The Committee reviewed the Trust's response to corridor care requirements and ongoing urgent and emergency care transformation work. Members noted that hospital occupancy remains high and that delays in discharge continue to impact flow across the organisation, particularly at Yeovil Hospital where length of stay remains significantly higher than at Musgrove Park Hospital. Work is underway to strengthen flow, improve discharge processes, reduce reliance on escalation capacity and develop a more robust approach to monitoring and reporting corridor care. The Committee emphasised the need to focus on the underlying causes of flow delays rather than solely managing their consequences.

4.3 The Committee received updates on quality and patient safety, including learning from patient safety investigations, mortality reviews and work to address delayed and missed cancer diagnoses. Particular attention was given to recurring themes relating to deteriorating patients, escalation processes, clarity of clinical responsibility and organisational learning. Members welcomed progress in strengthening governance arrangements, improving oversight of cancer pathways and addressing risks associated with patients whose care falls outside established pathways. The Committee also highlighted the need to ensure learning is translated more consistently into measurable improvement across services.

4.4 The publication of the Independent National Maternity and Neonatal Investigation (Amos Report) and the Nottingham Maternity Review was discussed. The Committee acknowledged the significance of the findings and recognised the difficult experiences described by women, families and staff. Members noted that although substantial improvement work has already been undertaken locally, including the reopening of maternity and neonatal services at Yeovil Hospital, the reports provide a further opportunity to strengthen listening, learning, culture and safety. The Committee also noted the national emphasis on maternity triage, health inequalities, racism, post-death care and organisational accountability.

4.5 The financial position remained broadly in line with plan at month two, although the Committee recognised increasing challenges in delivering the scale of savings required during 2026/27. Whilst cost improvement delivery was slightly ahead of plan, concerns were raised regarding the pace of transformational savings, continued reliance on agency staffing and the ability to achieve required reductions in temporary staffing expenditure. The Committee noted that industrial action and wider workforce pressures

continue to create additional financial risk alongside uncertainty regarding the funding of national pay awards.

4.6 Workforce sustainability remained a key area of concern. The Committee discussed staffing gaps, sickness absence, recruitment and retention challenges and the impact of operational pressures on staff wellbeing. Particular attention was given to line management and support arrangements for resident doctors, where concerns were raised regarding the consistency of sickness management, return-to-work processes and wider pastoral support. Members also reviewed the national Fair Pay for Nursing programme and preparations to undertake a large-scale review of nursing roles, ensuring alignment with national guidance whilst supporting workforce development and equality of opportunity.

4.7 The Committee reviewed the corporate risk register and Board Assurance Framework. The overall risk profile remains largely unchanged, although workforce sustainability has been escalated to corporate risk level. Analysis of risks operating above the Board's agreed risk appetite highlighted enduring concerns relating to patient flow, workforce capacity, financial sustainability, estate infrastructure and service resilience. The Committee agreed that these themes should continue to receive focused executive attention and inform future deep-dive reviews and assurance activity.

Learning from Deaths Framework: Mortality Review Progress Report (Q4)

4.8 The Quarter 4 Learning from Deaths report provides assurance regarding the Trust's arrangements for the review of deaths, identification of learning, and implementation of improvement actions across acute, community, mental health, maternity and children's services. The full report is available in the Board Reading Room.

4.9 The report highlights continued learning from mortality reviews and patient safety investigations, with recurring themes relating to the recognition and escalation of deteriorating patients, communication and documentation of Treatment Escalation Plans, clarity of clinical responsibility, safeguarding, and end-of-life decision-making. Alongside areas for improvement, reviews also identified examples of high-quality care, effective multidisciplinary working, and compassionate support to patients and families.

4.10 Independent scrutiny through the Medical Examiner service remains a key component of the Trust's Learning from Deaths arrangements. During the quarter, 601 deaths of patients across all Trust settings were referred to the Medical Examiner, with feedback from bereaved families and carers contributing significantly to the identification of potential areas for learning. Coronial activity remained high, with 54 new enquiries received during the reporting period and no Regulation 28 Reports issued.

4.11 The report also describes the implementation of revised governance arrangements aligned to the Patient Safety Incident Response Framework (PSIRF), including enhanced oversight through the Event Escalation Meeting, Event Review Meeting and Patient Safety Operational Group. These arrangements are intended to support timely identification of concerns, proportionate learning responses and stronger organisational oversight of patient safety events involving deaths.

4.12 Mortality indicators remain within the expected range at Trust level, with the Summary Hospital-level Mortality Indicator (SHMI) reported at 1.05. However, a gradual increase has been observed in recent months, particularly at Yeovil District Hospital. Further scoping work is underway through the Mortality Surveillance Group to better understand the underlying causes and determine whether any additional review or action is required. A number of diagnosis groups with above-expected mortality are also subject to detailed review, with findings to be reported through the Trust's established governance arrangements.

4.13 The Board is asked to note the continued focus on learning and improvement through the Learning from Deaths Framework and to take assurance from the arrangements in place to identify, review and respond to concerns arising from mortality reviews and patient safety investigations.

Mortuary Assurance Statement

4.14 Following publication of NHS England's letter regarding post-death care and implementation of the Fuller Inquiry recommendations (Appendix 2), NHS provider trusts are required to complete and submit a Board Assurance Statement by 31 July 2026. The completed assurance statement is attached for Board consideration and approval.

4.15 The statement provides assurance regarding the Trust's arrangements for mortuary services and the care of the deceased, including governance and leadership oversight, safeguarding responsibilities, progress against the relevant Inquiry recommendations, and compliance with national requirements relating to mortuary facilities and oversight.

4.16 The Board is asked to review and approve the attached assurance statement (Appendix 3) prior to submission to NHS England.

To:
- NHS trust:
  - chief executives
  - chief operating officers
  - data protection officers

cc.
- NHS trust:
  - people officers
  - chief digital information officers
  - chief medical officers
  - chief nursing officers
  - chief clinical information officers
  - Caldicott guardians
  - senior information risk owners
  - chairs
- NHS England region:
  - regional directors
  - chief operating officers
  - chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

7 July 2026

Dear colleagues

Patients using NHS services rightly expect their information to be kept secure by the people who treat them. This is why recent reports in the media of staff accessing patient information in unauthorised circumstances are particularly worrying for us all.

These instances may seem like benign curiosity to some, but that couldn't be further from the truth – they are harmful to patients, damage trust and, ultimately, are illegal.

The majority of NHS staff handle patient information responsibly and professionally every day. However, a small minority of individuals undermine the trust that patients place in them and cause unnecessary distress and harm by accessing records without legitimate reason. Aside from the harm caused, these staff members risk their own careers through disciplinary action, dismissal, referral to their professional regulator, and even criminal prosecution.

Every time a breach occurs there is also inevitable and lasting damage caused to public trust in the NHS overall and, specifically, our ability to safeguard people's data – something which

is critical to the long-term future of the NHS as we design technology like the Single Patient Record.

That is why today I am asking trust boards to put a renewed focus on educating staff whilst also implementing a tough approach in response to those who do breach patient trust in this way. There can be no place in the NHS for those who misuse patient information.

What we expect from all staff and trusts

All NHS staff need to understand that accessing patient information for personal reasons isn't just harmless curiosity.

We are today issuing new guidance for staff about unlawfully accessing patient medical history (see Annex A). This is accompanied by guidance for patients on how their records should be used, how they are protected and what they should do if they think their data has been accessed inappropriately (see Annex B). There is also more detailed guidance for information governance (IG) professionals on how their organisations can prevent and monitor for unlawful access to records and the steps they should take when it is identified (see Annex C).

The guidance for staff makes clear that everyone working in health and care has a professional and legal responsibility to protect people's confidential information and that accessing patient records out of curiosity or for personal reasons is illegal.

For employers, if a patient's record has been accessed without a lawful reason for doing so, they must consider reporting it to the Information Commissioner's Office (ICO) and police, both of whom have the power to pursue a criminal prosecution.

Whilst we are determined to address the small number of cases where unlawful access takes place, we also need to focus on preventing this and the guidance for IG professionals covers how arrangements locally can be strengthened and stress-tested. Addressing unlawful access issues requires input and commitment from all areas of an organisation however, including IT teams, IG teams, HR and clinical leaders.

It is important that the content of this guidance is disseminated to staff and that consideration is given to other actions you may need to take to tackle this problem, including ensuring staff handling patient records are appropriately trained, are aware of their responsibilities and the harm that can be caused through unlawful access.

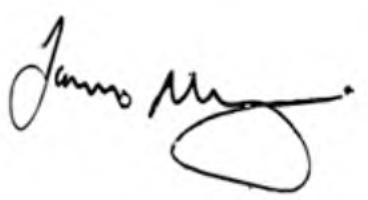
To help educate staff and enforce this messaging, a new campaign with the headline messaging warning: 'Don't let curiosity kill your career' is also being sent to trusts this week (see Annex D). The aim is to remind staff of the law and the potential impact

on patients. Making this messaging as visible as possible through posters and screensavers will support our efforts to ensure patients have the highest levels of confidence in the NHS.

Patient trust in our handling of their most sensitive data cannot be taken for granted and it is therefore critical that we both educate staff and take a hard line when their access to records falls below the standards we expect.

Thank you for joining me in ensuring that these standards are implemented across the country so we can rightly continue to build patient confidence in our use of their data.

Yours sincerely,



Sir Jim Mackey
Chief Executive Officer
NHS England

Annex A – all staff guidance
Annex B – patient guidance
Annex C – information governance guidance
Annex D – campaign brief – document attached

Data Access Creative

NHS

Is it **really** worth it?

Accessing **patient records** for **curiosity** or **personal reasons** causes harm, **is unlawful** and could **end your career**.

NHS

DON'T LET CURIOSITY KILL YOUR CAREER

Accessing patient records for curiosity or personal reasons causes harm, is unlawful and could end your career.

DON'T LET CURIOSITY KILL YOUR CAREER

Accessing patient records for curiosity or personal reasons causes harm, is unlawful and could end your career.


DON'T LET CURIOSITY END YOUR CAREER
NHS
Accessing patient records for curiosity or personal reasons causes harm, is unlawful and could end your career
NEWS
NHS staff sacked after data breach
NHS staff sacked after accessing Nottingham attack victims' records
Southport victims' medical records wrongly accessed by 48 NHS staff in 'unbelievable breach of privacy
Nurses sacked for accessing records of people killed in stabbing attacks

Is it really worth it?

Accessing patient records for curiosity or personal reasons causes harm, is unlawful and could end your career.

To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2026

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (NUH), are shocking. We must

remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, published in July 2025. The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Yours sincerely,

Duncan Burton
Chief Nursing Officer for England

Sarah-Jane Marsh
NHS England Chief Operating Officer

Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. **NHS Premises Assurance Model (PAM)** (15 April 2026)

The NHS Premises Assurance Model (PAM) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. **Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services** (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. **Insightful provider board guide** (November 2024)

Trusts are reminded that the insightful provider board guide is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the Code of governance for NHS provider trusts (March 2026) and Guidance on good governance and collaboration (April 2023).

For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. **Assessing provider capability: guidance for NHS Trust Boards** (August 2025)

Assessing provider capability: guidance for NHS trust boards provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

5. **Advanced Foundation Trust Programme** (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the Advanced Foundation Trust Programme requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per Insightful provider board guide (see entry 3).

6. **NHS Safeguarding accountability and assurance framework** (April 2026)

The NHS Safeguarding Accountability and Assurance Framework (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about

safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) Codes of Practice provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published good practice guidance for those responsible for the dignity and care of the deceased. This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

Hospice UK have several resources to support clinical and non-clinical staff in a hospice role. Their Care After Death guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit)
The full text of these recommendations can be found in the Phase 2 Report (pp.264-265).
Supporting guidance
NHS Premises Assurance Model (see entry 1 in Annex 1).
Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (see entry 2 in Annex 1).
Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)
The full text of these recommendations can be found in the Phase 2 Report (p.265).
Supporting guidance
Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)
The full text of these recommendations can be found in the Phase 2 Report (pp.265-266).
Supporting guidance
The Insightful provider board guide (see entry 3 in Annex 1).
Assessing provider capability: guidance for NHS trust boards and third-party information (see entry 4 in Annex 1).
Advanced Foundation Trust Programme (see entry 5 in Annex 1).

Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the Phase 2 Report (pp.266-267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings)

The full text of these recommendations can be found in the Phase 2 Report (pp.267-268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the Phase 2 Report (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings: Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the Phase 2 Report (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.

In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations.

Annex 3 – **Board Assurance Statement for NHS Provider Trusts.** Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.		
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.		
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.		

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency. For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.		

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date

APPENDIX 3

Annex 3 – Board Assurance Statement for NHS Provider Trusts. Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net **Assurance statement**

HTA Licenced Mortuary Response (YDH / MPH)

NHS Hospitals Recommendations from point 1 - 20

	Confirmed (yes/no)	**Additional comments or qualifications (optional)**
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	YES	The roles and responsibilities between the relevant teams responsible for mortuary care are clear and well understood. Mortuary staff roles are defined within the HTA licence, and the respective roles of the mortuary team and other services who support the care of the deceased are considered when we review concerns and incidents. Mortuary, pathology and bereavement services (including medical examiner services) are managed within the same service group, which supports consistent governance oversight. These teams work with estates, safeguarding and corporate services as needed to ensure the operation of mortuary services, in line with regulatory requirements and the Trust's governance framework. Following these recommendations, collaboration will continue to be strengthened across these teams to ensure earlier oversight, shared decision making and engagement.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	YES	Points 1-21 covered **Point 15** Report to be presented by Chief Nurse in September 2026. being drafted. • **6.8.25** Integrated Care Board (ICB) Report and meeting ref Fuller Phase 2 Trust progress against 1-21 recommendations. • **8.10.25** NHS England submission. • **21.1.26** ICB quality visit to Yeovil District Hospital/Musgrove Park Hospital Human Tissue Authority (HTA) licenced mortuaries. • **1.6. 26** Executive Board Fuller Phase 2 Update Report • **28.1. 26** Quality Assurance Group – HTA Licence Report (Annual Report) • Monthly Service Group Governance.

APPENDIX 3

In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	YES	Please see reporting schedule above. Point 15 A report will be presented by the Chief Nurse in September 2026 and is currently being drafted. The report will cover the pathway from death on the ward through to discharge from the mortuary. The Bereavement Manager, HTA Designated Individual (DI), and Mortuary Manager will complete the Dignity in Death Report.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2026/27 Board Assurance Framework Update and Risk Appetite Review
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Ben Edgar-Attwell, Director of Governance
PRESENTED BY:	Mel Iles, Chief Medical Officer
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	A revised Board Assurance Framework (BAF) has been developed following the recommendations from the recent BDO review and aligned to the Trust's emerging strategic aims and objectives. The Executive Committee has reviewed the developing framework and supported the proposed approach. The Board is asked to consider the strategic risks and proposed risk appetite levels for Strategic Aims 1 and 7, and to endorse the recommended risk appetite levels for Aims 2-6 as proposed by the relevant Board Committees. Agreed risk appetite levels will be incorporated into the final BAF.
Recommendation	The Board of Directors is asked to: • Note progress in developing the refreshed Board Assurance Framework. • Review the proposed strategic risks for Strategic Aims 1 and 7. • Approve the proposed risk appetite levels for Strategic Aims 1 and 7. • Endorse the recommended risk appetite levels for Strategic Aims 2–6.

Links to Joint Strategic Aims (Please select any which are impacted on / relevant to this paper)
☒ Aim 1 Contribute to improve health and wellbeing of population and reducing health inequalities
☒ Aim 2 Provide the best care and support to children and adults
☒ Aim 3 Strengthen care and support in local communities
☒ Aim 4 Respond well to complex needs

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

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

Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
The needs and impacts on people with protected characteristics have not been considered as part of this report but are considered as part of the mitigating actions taken at service group level.

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

Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.
Public or staff involvement or engagement has not been required for the attached report.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – eg. in Part B]
Executive Committee considered the draft Board Assurance Framework on 6 July 2026 and supported the proposed approach. Relevant Board Committees have subsequently considered and recommended risk appetite levels for Strategic Aims 2–6.

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

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

SOMERSET NHS FOUNDATION TRUST

2026/27 Q1 BOARD ASSURANCE FRAMEWORK UPDATE AND RISK APPETITE REVIEW

1. PURPOSE OF THE REPORT

1.1. To present the developing 2026/27 Board Assurance Framework to the Board of Directors, seek agreement to the proposed strategic risks for Strategic Aims 1 and 7, and consider the proposed risk appetite levels for those aims alongside the wider organisational Risk Appetite Framework for 2026/27. The paper also provides an update on progress towards implementation of the refreshed Board Assurance Framework.

2. BACKGROUND

1.1. The Trust commissioned BDO to undertake a review of the Board Assurance Framework (BAF) to assess whether it provides clear, proportionate and effective assurance to the Board regarding delivery of the Trust's strategic Aims and Objectives. The review identified strengths within the existing framework but also highlighted opportunities to improve the alignment between strategic objectives, strategic risks, controls and assurance.

1.2. A revised BAF has been developed following the recommendations arising from the recent BDO review and aligned to the Trust's emerging strategic Aims and Objectives. The updated framework provides a clearer line of sight between the Trust's strategic aims, principal strategic risks, controls and sources of assurance.

1.3. A key principle of the refresh is a move away from operational risks, which are managed through the Corporate Risk Register, towards a focus on a limited number of high-level strategic risks associated with each strategic aim.

1.4. During July 2026, Board Committees considered the proposed risk appetite levels for Strategic Aims 2–6 and recommended these for Board approval. The Board is separately asked to consider and agree the proposed risk appetite levels for Strategic Aim 1 (Contribute to improving the health and wellbeing of the population and reducing health inequalities) and Strategic Aim 7 (Deliver the vision of the Trust through innovation, research and digital transformation), both of which fall within the direct remit of the Board.

1.5. The Board is also asked to review the proposed strategic risks associated with Aims 1 and 7 and consider whether they appropriately reflect the principal threats to delivery of these strategic ambitions. The agreed risk appetite levels will be incorporated into the final version of the BAF and will provide the context against which strategic risks are assessed and monitored during 2026/27.

1.6. The Executive Committee reviewed the draft framework on 6 July 2026 and supported the proposed approach and continued development of the BAF. The

framework remains subject to further refinement of objectives, measures, controls and assurance arrangements before final presentation to the Board later in the year.

2. PROGRESS TO DATE

2.1. Good progress has been made in developing the revised BAF. This includes:

- Alignment of the BAF structure to the seven strategic Aims contained within the emerging Trust Strategy.
- Development of narrative summaries to describe the strategic intent behind each Aim.
- Drafting of principal strategic risks associated with each aim, together with corresponding controls and assurance mechanisms.
- Initial consideration of risk appetite and assurance ratings to support Board scrutiny and oversight.
- Engagement with Executive Directors regarding the proposed strategic risks and the overall framework design.

2.2. The revised framework introduces a clearer distinction between:

- Strategic aims and objectives
- Strategic risks
- Controls (what the organisation is doing to manage the risk)
- Assurance (how the organisation knows the controls are effective).

2.3. This structure is intended to support more focused Board Assurance Committee oversight and improve the quality of assurance provided to the Board.

3. RISK APPETITE

3.1. The Trust has undertaken a review of its risk appetite as part of the wider refresh of the Board Assurance Framework. Risk appetite defines the amount and type of risk the organisation is willing to accept in pursuit of its strategic objectives and provides important context for the Board's oversight of strategic risks.

3.2. Board Committees have considered the proposed risk appetite levels for Strategic Aims 2–6 and have recommended the following levels:

- Aim 2 – Provide the best care and support to people: **Open (3)**
- Aim 3 – Strengthen care and support in local communities: **Seek (4)**
- Aim 4 – Respond well to complex needs: **Seek (4)**
- Aim 5 – Support our colleagues through a compassionate, inclusive and learning culture: **Significant (5)**
- Aim 6 – Live within our means and use our resources wisely:
    - Financial Management – **Open (3)**
    - Commercial Activity – **Seek (4)**

3.3. The Board is asked to consider and agree the risk appetite levels for:

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

3.4. The principal risks associated with this aim relate to partnership working, prevention and the need to influence wider determinants of health which are not wholly within the Trust's direct control. Given the transformational nature of this aim and the reliance on system-wide collaboration, a risk appetite of **Seek (4)** (scores 15–16) is proposed, reflecting the Board's willingness to pursue innovative and collaborative approaches to improving population health and reducing health inequalities.

3.5. Strategic Risks associated with Aim 1:

3.6. Risk 1: Population Health Dependency / Partnership Risk (16)
There is a risk that improvement in population health outcomes is not achieved due to reliance on system partners and wider determinants of health outside the Trust's direct control, resulting in failure to deliver strategic aims and reputational impact.

Key Controls

- Population Health Delivery Plan aligned to JSNA and ICS priorities.
- Population Health Programme Board with cross-system membership.
- Partnership arrangements with Local Authority, ICB and VCFSE partners.
- Targeted population health programmes.
- Population health embedded within planning processes.

Sources of Assurance

- Population Health Programme Board reporting.
- Board and committee oversight.
- External benchmarking.
- System-wide reporting arrangements.

3.7. Risk 2: Targeting and prioritisation risk (12)
There is a risk that interventions are not sufficiently targeted at the most disadvantaged groups, resulting in widening health inequalities and failure to improve healthy life expectancy.

Key Controls

- Use of JSNA and health inequalities data to define priority cohorts
- Adoption of Core20PLUS5 (or equivalent) approach to reducing inequalities
- Equality Impact Assessments embedded in service redesign and transformation programmes
- Targeted service interventions (e.g. high-risk population cohorts, deprived areas)
- Collaboration with system partners to align targeting approaches

Sources of Assurance

- Routine reporting of outcomes segmented by deprivation / protected characteristics
- Committee oversight of health inequalities performance
- Review of Equality Impact Assessments through governance processes
- External assurance via CQC / NHSE where relevant
- Deep dives into areas of variation or concern

3.8. Risk 3: Prevention vs demand pressure risk (16)
There is a risk that operational and financial pressures limit capacity to move resources to support preventative activity, resulting in continued decrease in years of good health, growth in long-term conditions and demand on healthcare.

Key Controls

- Explicit inclusion of prevention within Trust strategy and operational plans
- Dedicated prevention programmes (e.g. smoking cessation, obesity, early intervention)
- Resource allocation aligned to strategic priorities (where possible)
- Integration of prevention into clinical pathways
- Workforce training and engagement in preventative approaches

Sources of Assurance

- Monitoring of activity and investment in prevention initiatives
- Review of demand trends (e.g. non-elective admissions, long-term conditions)
- Board oversight of balance between operational demand and transformation activity
- Evaluation of programme outcomes (where measurable)
- External reporting against national prevention indicators

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

3.9. Delivery of this aim requires significant organisational change, major digital investment and innovation, including implementation of the Healthset programme, wider digital transformation, adoption of AI-enabled technologies, and growth in research and innovation capability. A risk appetite of **Significant (5)** (scores 20–25) is therefore proposed, reflecting the level of ambition required to deliver the Trust Strategy whilst maintaining appropriate governance and assurance arrangements.

3.10. Strategic Risks associated with Aim 7:

3.11. Risk 1: Digital transformation delivery risk (EPR) (12)
There is a risk that major digital programmes (including Healthset) do not deliver the intended outcomes, resulting in the inability to deliver integrated care operational disruption, financial loss and fragmentation of patient records.

Key Controls
- Formal programme governance for major digital programmes
- Business cases and investment approvals
- Dedicated programme teams and leadership
- Risk and dependency management processes
- Benefits management and delivery

Sources of Assurance
- Programme reporting to Board / committees – setting up of revised Partnership Board
- Independent assurance reviews (including NHSE gateway reviews and external assurance)
- Internal audit of programme governance
- Milestone and delivery tracking

3.12. Risk 2: Technology adoption risk (12)
There is a risk that AI-enabled technologies and data-driven approaches are not adopted effectively, resulting in failure to realise informed decision-making, efficiency and quality benefits.

Key Controls
- Training and support for staff
- Change management and engagement strategies
- Iterative implementation approaches
- Integration with operational workflows
- Benefits management and delivery
- Training and development programmes (including digital, data and AI skills)

Sources of Assurance
- Monitoring of adoption and utilisation rates
- Staff feedback and satisfaction measures
- Evaluation of benefits realisation

3.13. Risk 3: Research and innovation capability risk (15)
There is a risk that the Trust does not develop a sufficiently balanced research and innovation capability, resulting in missed opportunities for improving care and attracting funding.

Key Controls
- Research strategy and partnerships with academic institutions
- Dedicated research infrastructure and teams
- Processes for identifying and adopting innovation
- Access to funding and grant programmes

Sources of Assurance

- Reporting on research activity and outputs
- Benchmarking of research performance
- Oversight via Research and Innovation Committee
- External recognition and accreditation

4. RECOMMENDATIONS

4.1. The Board of Directors is asked to:

- Note progress made in developing the refreshed Board Assurance Framework.
- Review the proposed strategic risks for Strategic Aims 1 and 7.
- Consider and approve the proposed risk appetite levels for Strategic Aims 1 and 7.
- Endorse the proposed risk appetite levels for Strategic Aims 2-6 as recommended by the relevant Board Committees.
- Note that the agreed risk appetite positions will be incorporated into the final Board Assurance Framework.

DIRECTOR OF GOVERNANCE

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 8 June 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:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	The People Committee met on 8 June 2026 and reviewed key workforce, culture and people strategy priorities. Assurance was received regarding progress with workforce transformation programmes, including Health Set, ESR2 and the Patchwork programme, alongside continued development of Aim 5 of the Trust Strategy. Service-level assurance was provided through the Mental Health and Learning Disabilities People Plan, which demonstrated positive progress in appraisal compliance, leadership development and workforce planning. A colleague story highlighted the positive impact of inclusive recruitment and employment support. Concerns remain regarding sickness absence, declining recruitment performance, workforce supply challenges in a number of hard-to-fill roles and inequalities in career progression for colleagues from ethnic minority backgrounds. These areas will continue to be monitored closely. This report provides assurance and highlights key workforce risks for Board oversight.
Recommendation	The Board is asked to **note** the assurance provided and the key risks identified, including sickness absence, recruitment performance, workforce sustainability and inclusion, and to **support** continued focus on workforce planning, colleague wellbeing and delivery of the People Strategy.

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

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

☐ Aim 2 Provide the best care and support to people

☐ Aim 3 Strengthen care and support in local communities

☐ Aim 4 Respond well to complex needs

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

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

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

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

Details: N/A

Equality

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

☒ This report has been assessed against the Trust's People Impact Assessment Tool and there are no proposals or matters which affect any persons with protected characteristics

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

Public/Staff Involvement History

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

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

Previous Consideration

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

The report is presented to the Board after every meeting.

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE MEETING HELD ON 8 JUNE 2026

1. PURPOSE

1.1. The People Committee met on 8 June 2026 to review key workforce, organisational development and strategic people 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 received assurance regarding continued delivery of key workforce transformation programmes, including Transforming People Services, implementation planning for ESR2 and progress with the Health Set programme. Members were assured regarding governance arrangements, stakeholder engagement and compliance with legislative and regulatory requirements.

2.2. The Chief People Officer's Report provided assurance that robust support arrangements remain in place for colleagues affected by changes to visa and sponsorship requirements. Assurance was also received regarding delivery of the Patchwork programme and associated improvements to rostering, workforce efficiency and pay processes.

2.3. The Committee reviewed the development of Aim 5 of the Trust Strategy and was assured regarding the focus on workforce capability, leadership, wellbeing, inclusion and the Trust's role as an Anchor Institution. Assurance was also received on the continued development of workforce reporting and inclusion metrics.

2.4. The Mental Health and Learning Disabilities Service Group People Plan provided assurance regarding staff engagement, appraisal compliance, leadership development and workforce planning. The accompanying colleague story demonstrated the positive impact of inclusive recruitment and support arrangements in enabling access to employment opportunities.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee identified several areas requiring continued focus. Sickness absence remains high, with little sustained improvement and continuing concerns regarding stress-related absence. Time to hire performance has deteriorated and remains off trajectory, with recruitment capacity and process delays contributing to performance challenges. A recruitment deep dive will be presented at the next meeting.

3.2. Members also noted continuing workforce sustainability risks, including difficulties recruiting to consultant, community nursing and other hard-to-fill posts. Concerns were raised regarding inequalities in career progression for

colleagues from ethnic minority backgrounds, with further work required to understand and address disparities.

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, recruitment challenges, workforce supply pressures and the need for robust long-term workforce planning.

4.2. Risks relating to sickness absence, particularly stress-related absence, continue to require close monitoring due to their impact on colleague wellbeing and service resilience. The Committee also noted inclusion risks relating to career progression and colleague experience, alongside the need to strengthen triangulation of workforce data, staff survey intelligence and colleague feedback to support improved assurance and decision-making.

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:	Lee Cornell, Associate Director – Planning and Performance Ian Clift, Senior Performance Manager Isobel Clements, Chief of People and Organisational Development Xanthe Whittaker, Director of Elective Care Stacy Barron-Fitzsimons, Director for Medical Services Group Sally Bryant, Director of Midwifery Leanne Ashmead, Director of Children, Young People and Families Mark Arruda-Bunker, Service Director, Mental Health and Learning Disabilities Abbie Furnival, Service Group Director – Neighbourhoods and Communities Kerry White, Managing Director – Symphony Healthcare Services Emma Davey, Director of Patient Experience and Engagement
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	Our Integrated Performance Exception Report sets out the key exceptions across a range of quality and performance measures, and the reasons for any significant changes or trends. Areas in which performance has been sustained or has notably improved include: • the percentage of patients waiting under 18 weeks from referral to be seen by our community services remains better than the target level. • patient satisfaction levels across our Symphony Healthcare practices remain high. • the percentage of patients waiting under six weeks to be seen by our community mental health services remained high.

	• overall length of stay within our adult mental health wards and PICU was below (i.e. better than) the Operational Plan for May 2026. • compliance against the A&E delivery standard in respect of patients being admitted, discharged or transferred within 12 hours of attendance. • the percentage of patients waiting no longer than 18 weeks for acute treatment was above the planned level. 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: • Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Recovery. • inappropriate Out of Area Placements for non-specialist mental health inpatient care. • compliance against the A&E delivery standard in respect of patients being admitted, discharged or transferred within four hours of attendance. • performance against the 28-day cancer Faster Diagnosis standard. • cancer 31 day wait from a Decision To Treat / Earliest Clinically Appropriate Date to First or Subsequent Treatment. • compliance in respect of the 62-day cancer standard. As set out in Appendix 3, Operational Plan Recovery Trajectories, Attendances at MPH during the period 1 January to 30 June 2026 were 2.7% higher than during the corresponding period in 2025, and attendances at YDH during the period 1 January to 30 June 2026 were 15.3% higher than during the corresponding period in 2025, giving an overall Trust-wide increase of 8.1%. The Operational Plan assumption was growth of 1%. Additionally, the SWAST report 'Somerset ICB Activity, Outcomes and THP Impact Review, May 2026' shows a growth in conveyances to MPH of 5.1%, and a growth in conveyances to YDH of 13.4%, with an overall Trust-wide growth level of 7.7%. The Operational Plan assumption was that any projected growth would be negated by work being undertaken with SWAST to reduce conveyance levels to SFT to a level no higher than the regional average.
Recommendation	The Board is asked to discuss and note the report.

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

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
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)				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

SOMERSET NHS FOUNDATION TRUST

INTEGRATED PERFORMANCE EXCEPTION REPORT: MAY 2026

TABLE OF CONTENTS

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

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

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

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

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

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

- CQIM NHS England Clinical Quality Improvement Metric
- 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
- VWOF NHS England Virtual Wards Operational Framework

CHIEF FINANCE OFFICER

NARRATIVE REPORT

NHS OVERSIGHT FRAMEWORK METRICS FOR 2026/27

The key points of note in respect of the NHS Oversight Framework metrics for 2026/27 are as follows:

The NHS Oversight Framework is the system used by NHS England to monitor, assess and support NHS organisations. Amongst its key purposes is to assess organisational performance across areas including quality of care, access targets, finance and leadership. The framework includes a set of key metrics, which are reviewed annually to ensure that they remain an accurate representation of NHS operating priorities. The metrics consider a broad range of areas to enable a balanced judgement of the range of challenges each organisation faces as well as to allow an understanding of particular areas of challenge.

There are 85 metrics underpinning the 2026/27 NHS Oversight Framework, categorised as either 'scoring' or 'contextual'. Scoring metrics are used to determine an organisation's overall segment within the NHS performance ratings, and its position within the national league table. Contextual metrics provide additional information but are not scored and do not form part of segmentation. In 2026/27, there are 42 scoring metrics which are applicable to Somerset NHS Foundation Trust (up from 25 in 2025/26), divided into seven domains, as set out below. The 23 metrics shown in bold are new scoring metrics for 2026/27.

Domain	Metrics
Population health, prevention and reducing inequality (one measure)	**1. Percentage of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service.**
Access to services (11 measures)	2. Percentage of patients waiting 18 weeks or less for care 3. Difference between planned and actual 18-week performance 4. Percentage of patients waiting over 52 weeks for care **5. Percentage of patients waiting less than 18-weeks for community care** **6. Percentage of diagnostic referrals waiting over six weeks** 7. Percentage of patients meeting the 28-day faster diagnosis standard 8. Percentage of patients treated for cancer within 62 days of referral 9. Percentage of emergency department attendances admitted, transferred or discharged within 4 hours 10. Percentage of emergency department attendances spending over 12 hours in the department

	11. Percentage of total children's and young persons' mental health patients waiting over 104 weeks for contact 12. **Percentage of people accessing mental health services with at least two contacts and a paired outcome score (all ages)**
Experience of care (six measures)	13. CQC inpatient survey satisfaction rate 14. CQC Community mental health survey satisfaction rate **15. NHS staff survey advocacy rate** **16. Mean length of stay for adult acute and psychiatric intensive care unit patients** **17. Mean length of stay for older adult mental health acute discharges** 18. **Percentage of intermediate care beds occupied by patients without criteria to reside**
Effectiveness of care (seven measures)	19. Summary Hospital Level Mortality Indicator **20. Rate of pregnant women with a delayed planned induction per 1,000 deliveries** **21. Percentage of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery** **22. Percentage of incidents managed via hear and treat or see and treat** **23. Percentage of acute adult discharges followed up within 72 hours** **24. 30-day readmission rate band - acute** 25. **14-day readmission rate - mental health**
Patient safety (six measures)	**26. Breadth and depth of clinical audit outliers** 27. Percentage of urgent crisis response patients to receive face to face care within 24 hours 28. Number of Healthcare Associated Infections (MRSA) 29. Rates of Healthcare Associated Infection (E-Coli) 30. Rates of Healthcare Associated Infection (C-Difficile) 31. NHS Staff Survey - raising concerns sub-score
Finance, productivity and innovation (five measures)	32. Planned surplus/deficit 33. Variance year-to-date to financial plan **34. Relative cost difference (National Cost Collection Index)** **35. Percentage of clinical trials set up within 150 days** 36. **Data Quality Maturity Index**
People (six measures)	37. Sickness absence rate 38. NHS staff survey engagement theme score **39. National Education and Training Survey satisfaction rate** **40. NHS staff standards score**

	41. Healthcare Worker Flu Vaccination Rate **42. Temporary staffing cost as a percentage of the total pay bill**

Six scoring metrics which were applicable to Somerset NHS Foundation Trust in 2025/26 are no longer scoring metrics in 2026/27. These are:

1. Percentage of patients waiting over 52-weeks for community services (this has been replaced by an 18-week standard).
2. Annual change in number of children and young people accessing NHS-funded mental health services.
3. Average number of days from discharge ready date to actual discharge date (this is now a scoring measure for Integrated Care Boards).
4. Percentage of mental health inpatients with >60-day length of stay (this has been replaced by two measures, relating to the mean length of stay for adults and for older adults).
5. Urgent community response two-hour performance.
6. Implied productivity growth (this has been changed from a scoring measure to a contextual measure).

The majority of the measures for 2026/27 are already included in our Integrated Performance Report. The technical guidance for the metrics is currently awaited. We will bring in any measures which are not already included, once the technical guidance is issued.

NARRATIVE REPORT

NHS ENGLAND NATIONAL PRIORITIES AND SUCCESS MEASURES FOR 2026/27

The key points of note in respect of the NHS England national priorities and success measures for 2026/27 are as follows:

NHS England's Medium-Term Planning Framework for 2026/27 to 2028/29 lists a series of key success measures for 2026/27, of which 13 apply to Somerset NHS Foundation Trust as a provider. Of these, we are performing well in respect of:

- community service waiting times: at least 78% of community health service activity occurring within 18 weeks (excludes dental).
- Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Improvement.
- improve A&E waiting times, in respect of patients admitted, discharged and transferred from ED within 12 hours with at least 96.5% of patients inside of 12 hours.
- Improve performance against the diagnostics six-week wait standard: every system delivering a minimum 3% improvement in performance or performance of 80% or better, whichever level of improvement is greater.
- improve the percentage of patients waiting no longer than 18 weeks for treatment: every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater.

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

- Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Recovery.
- inappropriate Out of Area Placements for non-specialist mental health inpatient care.
- improve A&E waiting times, with a minimum of 82% of patients admitted, discharged and transferred from ED within 4 hours in March 2027.
- improve performance against the headline 62-day cancer standard to 80% by March 2027.
- maintain performance against the 28-day cancer Faster Diagnosis standard at 80%.
- cancer 31 day wait from a Decision to Treat / Earliest Clinically Appropriate Date to First or Subsequent Treatment: every trust delivering 94% performance by March 2027.
- reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems.

- reduce the use of bank staffing, with a minimum 10% reduction on current spending across systems.

These latter two measures are covered in the Finance report.

The national reporting standard in respect of Talking Therapies patients completing a course of treatment for anxiety and depression achieving Reliable Recovery increased from 48% to 51% from April 2026. During May 2026 compliance of 45.8% was achieved, a decrease from 48.8% reported during April 2026. Four whole time equivalents (WTEs) now in post, with a further two awaiting start dates. A further four High Intensity Cognitive Behavioural Therapy trainees are due to start in December 2026. This will support a reduction in waiting times at Step 3, and shorter waiting times are known to improve outcomes and reduce drop-out rates.

As at 31 May 2026 a total of three patients remained placed out of area due to the lack of availability of suitable beds, and safety considerations. One patient placed out of area on 5 February 2026 has been assessed and accepted for medium secure care and is currently awaiting a secure bed to become available. The other two patients were repatriated on the beginning of June 2026. Out of Area usage has been affected by estates improvement works at Rydon ward, resulting in a temporary reduction of three acute beds. This work is now completed, and these additional beds became operational again from the second week of June 2026.

Compliance in respect of the A&E and UTC four-hour reporting standard decreased from 74.1% in April 2026 to 70.7% in May 2026 and remained below the Operational Plan level for May 2026 of 76.5%. A range of actions and developments are in progress to improve the position at both sites, including an additional senior house officer on nights to be trialled at MPH, ongoing weekly performance and UTC development meetings, and the creation of new digital dashboard at YDH, which shows individual patient journeys, identifying key bottlenecks for any ED stay over four hours.

Compliance reported during April 2026 in respect of the 62-day cancer standard was 71.8%, below the current national standard of 75%, and below our Operational Plan trajectory of 74.7%. The main breaches of the 62-day combined cancer standard were in urology (33% of breaches), colorectal (21%) and lung (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. Urology job planning is complete, however there have been recent departures from the team and the capacity plan is being revisited.

During April 2026, the latest validated data available, 28-day Faster Diagnosis Standard (FDS) performance was 78.6%, below the 80% national standard and below our planning trajectory of 80.2%. The highest numbers of breaches were in colorectal (26% of breaches; performance 68%), gynaecology (17%; 66%), skin (14%; 84%), breast (13%; 85%) and urology (11%; 65%), together making up 81% of breaches. Colorectal performance has been affected by waiting times for colonoscopies, which have increased due to reduced service

capacity; the reasons for longer colonoscopy waits are multifactorial but include extended leave of a locum and nurse endoscopist sickness. The Gynaecology service has been short of a consultant, following an initial inability to recruit to a post to cover maternity leave; the consultant on maternity leave usually provides a high proportion of the diagnostic capacity. Colorectal has commenced a weekly Improvement Programme; pathway analysis is underway, supported by the Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance (SWAG) and a project manager from the Trust has been secured to support.

The reported compliance in respect of cancer 31-day waits from a Decision To Treat / Earliest Clinically Appropriate Date to First or Subsequent Treatment for April 2026 was 91.9%, below the national reporting standard of 96% and also below the Operational Plan of 93.7%. There has been an increase in breaches of the 31-day standard for skin patients due to a significant early surge in suspected cancer referrals in the last four months, which we usually only start to see in May 2026. This is possibly related to the extended period of good weather last year. An insourcing provider is being used to provide additional capacity within the dermatology service; a locum has also been appointed and will start in June 2026; the consultant who is on extended absence will return in July 2026.

Response

Talking Therapies – National priorities in 2026/27 are to improve the percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Recovery, to achieve a minimum of 51% compliance.

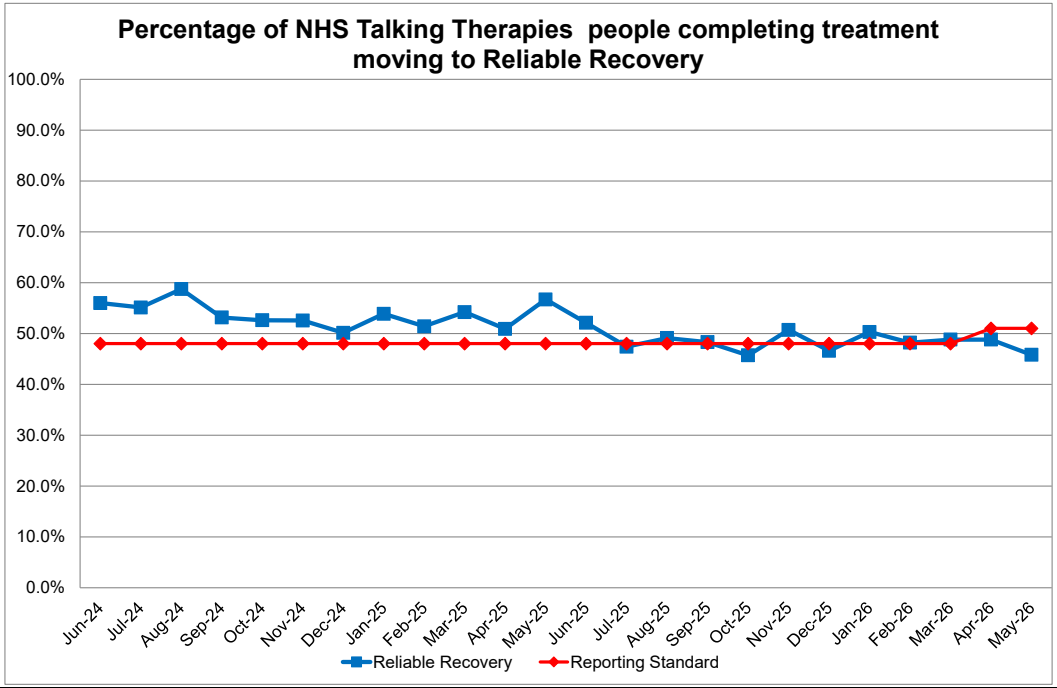
Current performance (including factors affecting this)

- During May 2026, of a total of 378 patients discharged, 173 were recorded as moving to Reliable Recovery, a rate of 45.8%.
- From 1 April 2026 the national reporting standard increased from 48% to 51%.

Focus of improvement work

- Increase workforce at Step 3 with expansion monies. Four whole time equivalents (WTEs) now in post, with a further two awaiting start dates. A further four High Intensity Cognitive Behavioural Therapy trainees are due to start in December 2026.
- Health inequalities need to nbe addressed to improve referral rates in respect of over 65s. Work is planned to commence with the Primary Care Networks regarding over 65s, as this group prefer a referral by a health care professional rather than self-referral. A meeeting with the Integrated Care Board GP Support Unit is planned for 18 June 2026 to assist with GP engagement.
- Recovery focused supervision for all staff, with bespoke training for supervisors on the importance of outcome measures. Training is planned to commence August 2026.
- The numbers waiting are already reducing and it is anticipated that the reporting standard will be achieved over the next six months when the actions detailed above are delivered. Reducing waiting times is known to have a positive impact on Recovery.

Line Chart



How do we compare

National average performance for providers was 48.2% in April 2026, the latest data available. Our performance was 48.8%.

Performance over the last six months

Area	Dec	Jan	Feb	Mar	Apr	May
Compliance	46.6%	50.3%	48.2%	48.8%	48.8%	45.8%

Safe

Out of Area Placements – The aim is to eliminate the placing people out of area for non-specialist acute mental health inpatient care due to local bed pressures.

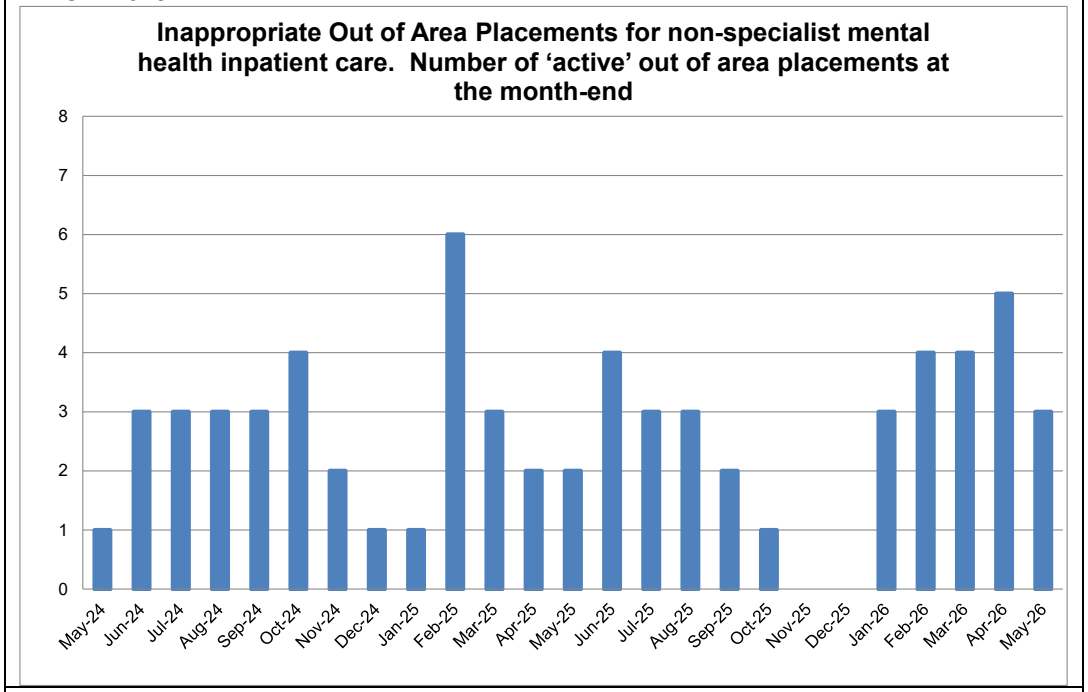
Current performance (including factors affecting this)

- As at 31 May 2026 a total of three patients remained placed out of area due to the lack of availability of suitable beds, and safety considerations.
- One patient, placed out of area on 5 February 2026 has been assessed and accepted for medium secure care and is currently awaiting a secure bed to become available
- The other two patients were repatriated on the beginning of June 2026.

Focus of improvement work

- Out of Area usage has been affected by estates improvement works at Rydon ward, resulting in a temporary reduction of three acute beds. This work is now completed, and these additional beds became operational again from the second week of June 2026.
- A full review of all current meetings and processes is being undertaken to refocus attention on bed flow, and ensure these are more action and person focused. The Service Group Director or their Deputy will chair the Clinically Ready for Discharge (CRFD) meetings to improve focus and escalation of challenges, to be implemented by the end of June 2026.
- A new patient flow dashboard has been created with 'Live' data to increase the visibility of those with a long length of stay, to target input and clinical decision-making.
- The Associate Medical Director and Inpatient Clinical Director are supporting new inpatient consultants in decision-making and risk-based decisions to support community care and improve flow.

Line Chart



How do we compare

Data published by NHS Digital shows that we continue have lower levels of out of area placements for non-specialist acute mental health inpatient care than other providers of mental health services nationally.

Performance over the last six months

Area	Dec	Jan	Feb	Mar	Apr	May
Reported number	0	3	4	4	5	3

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 82% of patients will wait less than four hours in the Emergency Department, by March 2027.

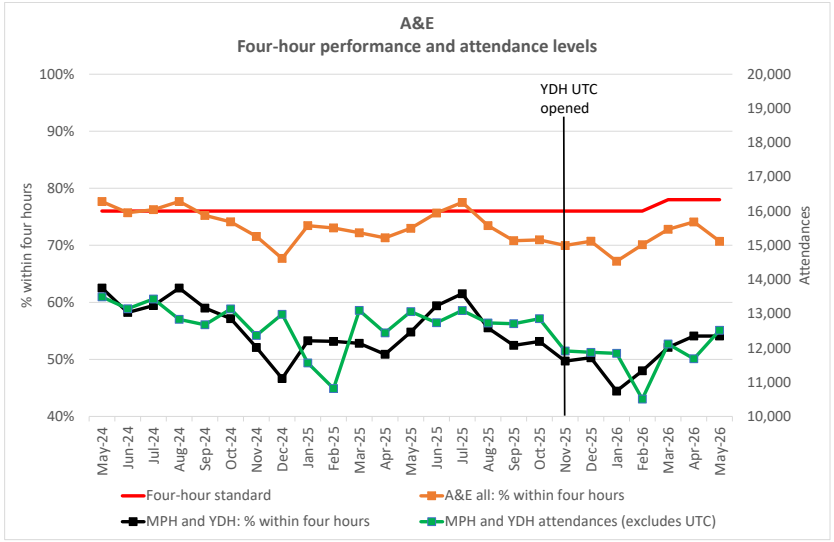
Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 48.6% during May 2026, down from 54.1% in April 2026. With Urgent Treatment Centres (UTCs) compliance included at 97.5%. Overall compliance was 70.7%, below the 76.5% Operational Plan standard to be achieved in May 2026.
- Compliance in respect of our two A&E departments was:
    - Musgrove Park Hospital (MPH): 48.0%.
    - Yeovil District Hospital (YDH): 49.5%.
- In May 2026 a total of 1,469 out of 1,524 patients (96.4%) were discharged, admitted or transferred with four hours at the YDH UTC.
- Between 1 and 31 May 2026, 96.5% of patients spent less than 12 hours in the EDs, above the Operational Plan standard for May 2026 of 94.7% or more.

Focus of improvement work

- **Both**
    - Weekly performance meetings are being held with the deputy director of medicine.
    - A review has been undertaken of performance against the four-hour standard for paediatric patients.
    - Work is underway to develop a root cause analysis process for stays longer than 24 hours.
    - Progress in the violence and aggression banning process – three letters sent at MPH.
- **MPH:**
    - An additional senior house officer on nights is to be trialled during the week commencing 29 June 2026, from 10pm-6am, driven by support managers to ensure a continuous improvement approach.
    - Weekly UTC development meetings are ongoing – approaching final model decisions, following amendment after assessment of financial feasibility.
    - New consultants will start in post in August and September 2026.
    - Trialling new role labels for EPIC/RESUS and Paediatrics to support the identification of lead roles.
- **YDH:**
    - New bariatric weighing scales installed in YDH to reduce delays in patient assessment.
    - SDEC has moved to a digital referral system to reduce unnecessary conversations and smooth the referral process.
    - Amended nursing numbers approved and within standard staffing numbers.
    - The new SDEC unit manager has started, to support flow and efficiency.
    - A new digital dashboard has been created, which shows individual patient journeys, identifying key bottlenecks for any ED stay over four hours.
    - Three trust fellows and two SAS are starting within the next three weeks; a further one trust fellow and one SAS within the next three months. A further advert for two SAS is now live.

Line Chart



How do we compare

In May 2026, the national average performance for Trusts with a major Emergency Department was 61.9%. Our performance was 48.6%. We were ranked 110 out of 121 trusts. With Urgent Treatment Centre attendances included, we were ranked 81 with performance of 70.7%. National average performance was 73.6%.

Recent performance

Area	Dec	Jan	Feb	Mar	Apr	May
A&E only	50.3%	44.5%	48.0%	52.1%	54.1%	48.6%
Including UTC	70.7%	67.2%	70.1%	72.8%	74.1%	70.7%

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 for at least 85% of patients to be treated within 62 days of referral. The 28-day Faster Diagnosis is the first part of the 62-day pathway.

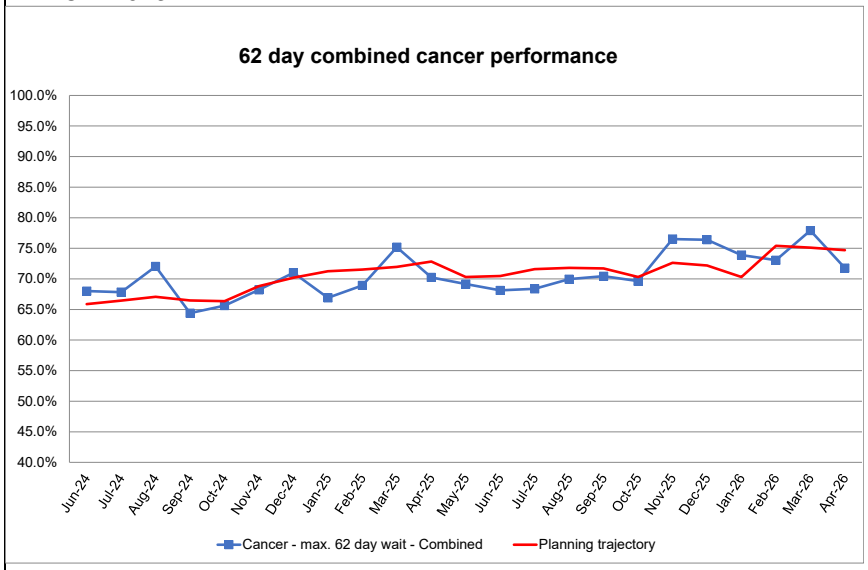
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 71.8% in April 2026, which is below the current national standard of 75%, and below our Operational Plan trajectory of 74.7%.
- The main breaches of the 62-day combined cancer standard were in urology (33% of breaches), colorectal (21%) and lung (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 colonoscopy waits, as well as insufficient theatre capacity to meet bulges in demand for surgery consistently.
- The lung breaches are multifactorial, with some related to the extensive diagnostic work-up required for surgical treatment in Bristol.
- Eighteen GP-referred patients were treated in April 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.
- Colorectal 62-day waiting times are heavily affected by the diagnostic phase of the pathway, the actions for which are set out in the 28-day Faster Diagnosis Standard report.
- 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 70.0% in April 2026, the latest data available. Our performance was 71.8%. We were ranked 71 out of 144 trusts.

The target for the end of March 2026 became 75%, although the national standard remains 85%.

Recent performance

62-day GP cancer performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
% Compliance	76.5%	76.4%	73.7%	73.1%	77.9%	71.8%
Trajectory	72.6%	72.2%	70.3%	75.4%	75.1%	74.7%

Responsive

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

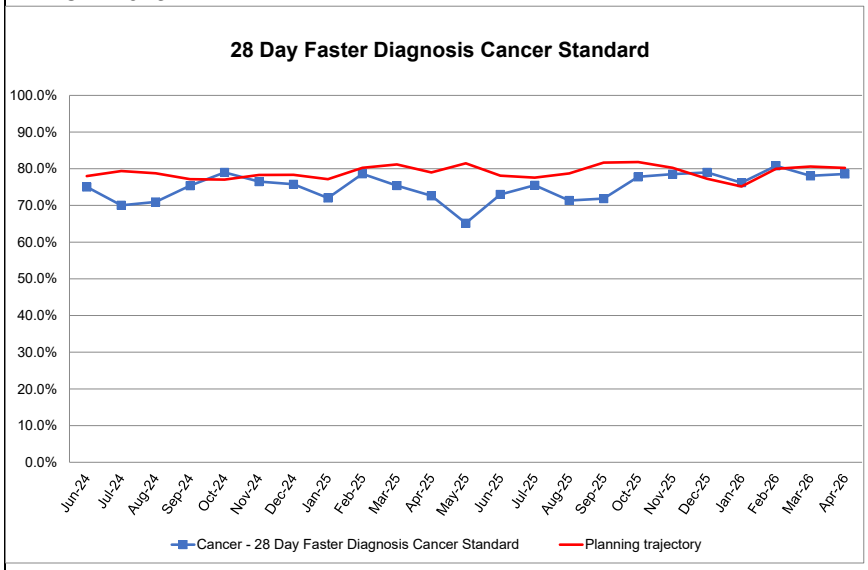
Current performance (including factors affecting this)

- The percentage of patients diagnosed with a cancer or given a benign diagnosis within 28 days of referral was 78.6% in April 2026, below our Operational Plan trajectory and also below the national standard of 80%.
- The highest numbers of breaches were in colorectal (26% of breaches; performance 68%), gynaecology (17%; 66%), skin (14%; 84%), breast (13%; 85%) and urology (11%; 65%), together making up 81% of breaches.
- Colorectal performance has been affected by waiting times for colonoscopies, which have increased due to reduced service capacity; the reasons for longer colonoscopy waits are multifactorial but include extended leave of a locum and nurse endoscopist sickness.
- The Gynaecology service has been short of a consultant, following an initial inability to recruit to a post to cover maternity leave; the consultant on maternity leave usually provides a high proportion of the diagnostic capacity.

Focus of improvement work

- Colorectal has commenced a weekly Improvement Programme; pathway analysis is underway, supported by the Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance (SWAG) and a project manager from the Trust has been secured to support.
- GP request straight to CT colon/CT is going to be implemented, to enable faster direct access to relevant diagnostic tests for colon cancer.
- Work continues to try to reduce colonoscopy waiting times, including additional sessions being established; Additional CT colon capacity is being provided at Taunton and Yeovil Community Diagnostic Centres.
- Gynaecology continues to pilot the WID-Easy high vaginal swab, which should reduce the time to diagnose endometrial cancer to 72 hours; the signs are that waiting times are improving.
- Please also see the Cancer report.

Line Chart



How do we compare

National average performance for providers was 75.9% in April 2026, the latest data available. Our performance was 78.6%. We ranked 66 out of 140 providers.

Recent performance

Performance in recent months was as follows:

28-day GP cancer performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
Trajectory	80.3%	77.3%	75.1%	80.0%	80.6%	80.2%
Compliance	78.5%	79.0%	76.2%	80.8%	78.1%	78.6%

Responsive

31-day decision to treat to cancer treatment is a measure of the length of wait from the patient agreed decision to treat, through to treatment. The standard is for at least 96% of patients to be treated within 31 days of a decision to treat. This target includes first and subsequent treatments for cancer.

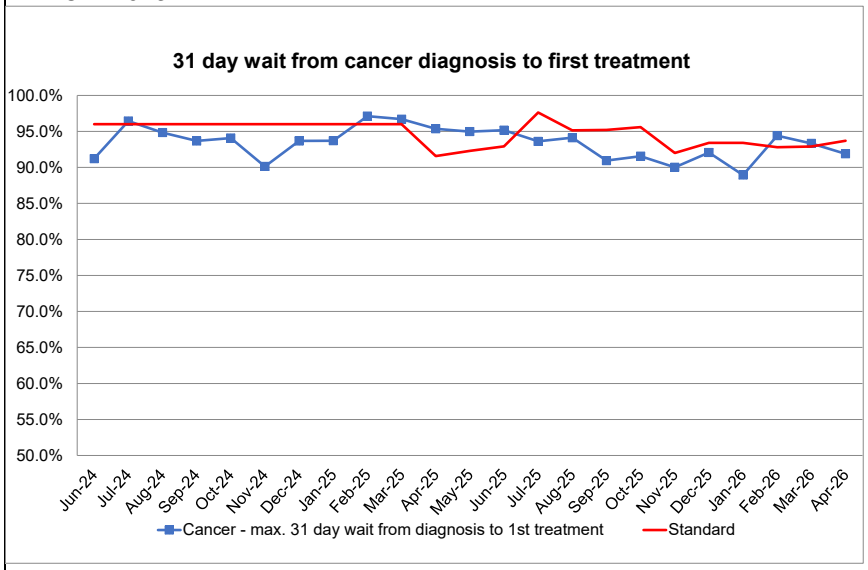
Current performance (including factors affecting this)

- Performance against the 31-day first combined treatment standard was 91.9% in April 2026 below both the 96% national standard and the Operational Plan trajectory of 93.7%.
- There were 51 breaches of the standard, of which 20 (39% of breaches) were for skin and ten (20%) were for breast. There were smaller volumes of breaches across a range of tumour sites.
- There has been an increase in breaches of the 31-day standard for skin patients due to a significant early surge in suspected cancer referrals in the last four months, which we usually only start to see in May 2026. This is possibly related to the extended period of good weather last year.
- One consultant retired from the skin service in December 2025, and there has also been an unexpected extended absence.
- 37 of the 51 breaches of the 31-day standard involved surgical treatments; performance against the 31-day decision to treat standard is also heavily affected by bulges in demand, which we see in skin but also in other tumour sites.

Focus of improvement work

- An insourcing provider is being used to provide additional capacity within the dermatology service; a locum has also been appointed and will start in June 2026; the consultant who is on extended absence will return in July 2026.
- We are exploring the use of Artificial Intelligence based systems to support the triage of referrals for suspected skin cancer, to enable patients with the highest risk of cancer to be prioritised.
- Theatre sessions continue to be booked flexibly, with slots protected for cancer surgery; these slots are filled with routine long waiters closer to the date, if not needed to meet demand following the latest week's Multi-Disciplinary Team decisions and subsequent cancer clinic attendances.

Line Chart



How do we compare

National average performance for providers was 91.5% in April 2026, the latest data available. Our performance was 91.9%. We ranked 101 out of 140 providers.

Recent performance

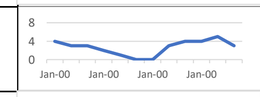
Performance in recent months was as follows:

31-day GP cancer performance

Area	Nov	Dec	Jan	Feb	Mar	Apr
Trajectory	92.0%	93.4%	93.4%	92.8%	92.9%	93.7%
Compliance	90.0%	92.1%	89.2%	94.4%	93.3%	91.9%

SOMERSET NHS FOUNDATION TRUST

NHS ENGLAND MEDIUM-TERM PLANNING FRAMEWORK FOR 2026/27 to 2028/29: NATIONAL PRIORITIES AND SUCCESS MEASURES FOR 2026/27

No.	Priority	Success Measure	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
NP1		Community service waiting times: at least 78% of community health service activity occurring within 18 weeks (excludes dental)	1,2,3	95.6%	96.4%	95.8%	95.7%	94.3%	93.9%	93.9%	95.8%	90.8%	89.1%	88.2%	91.4%	From April 2026 >78% = Green <78% = Red		
NP2	Improve mental health and learning disability care	Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Improvement	1,2,3	74.2%	70.0%	74.3%	70.8%	70.9%	74.1%	69.6%	76.5%	72.2%	69.9%	71.2%	71.2%	From April 2026 >=69%= Green <69% =Red		
NP3		Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Recovery	1,2,3	52.1%	47.4%	49.1%	48.3%	45.7%	50.7%	46.6%	50.3%	48.2%	48.8%	48.8%	45.8%	From April 2026 >=51%= Green <51% =Red		
NP4		Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end	1,2	4	3	3	2	1	0	0	3	4	4	5	3	=<1= Green >1 = Red		
NP5	Improve A&E waiting times	Improve A&E waiting times, with a minimum of 82% of patients admitted, discharged and transferred from ED within 4 hours in March 2027: **Trust-wide performance**	2	75.7%	77.5%	73.5%	70.8%	71.0%	70.0%	70.7%	67.2%	70.1%	72.8%	74.1%	70.7%	From April 2026 >=trajectory = Green <trajectory = Red		
NP6		Improve A&E waiting times, with a higher proportion of patients admitted, discharged or transferred from ED and UTCs within 12 hours across 2026/27 - **Trust-wide performance**	2	97.1%	97.4%	97.5%	97.4%	97.2%	97.2%	97.1%	96.8%	96.7%	96.7%	96.8%	96.5%	From April 2026 >=trajectory = Green <trajectory = Red		
NP7	Reduce the time people wait for elective care	Improve performance against the diagnostics six-week wait standard: every system delivering a minimum 3% improvement in performance or performance of 80% or better, whichever level of improvement is greater	1,2	78.7%	79.6%	78.4%	79.7%	81.3%	77.7%	72.5%	73.0%	79.1%	80.7%	78.0%	79.6%	From April 2026 >=trajectory = Green <trajectory = Red		
NP8		Improve performance against the headline 62-day cancer standard to 80% by March 2027	1,2	68.1%	68.4%	70.0%	70.4%	69.6%	76.5%	76.4%	73.7%	73.1%	77.9%	71.8%	Data not yet due	Above trajectory >=75% = Green Above trajectory but <75% = Amber Below trajectory = Red		
NP9		Maintain performance against the 28-day cancer Faster Diagnosis Standard at 80%	1,2	73.0%	75.5%	71.3%	71.9%	77.8%	78.5%	79.0%	76.2%	80.8%	78.1%	78.6%	Data not yet due	Above trajectory or >= 80% = Green Above trajectory but < 80% = Amber below trajectory = Red		
NP10		Cancer 31 day wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment: every trust delivering 94% performance by March 2027	1,2	95.2%	93.6%	94.1%	90.9%	91.6%	90.0%	92.1%	89.2%	94.4%	93.3%	91.9%	Data not yet due	Above trajectory >=94% = Green Above trajectory but < 94% = Amber below trajectory = Red		
NP11		Improve the percentage of patients waiting no longer than 18 weeks for treatment: every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%)	1,2	65.8%	63.9%	62.2%	62.5%	62.5%	62.3%	62.4%	61.8%	63.1%	65.4%	65.8%	65.6%	From April 2026 >=trajectory = Green <trajectory = Red		
NP12	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	-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	-29.4% £1,290K	-20.7% (£2,767K	>=30% reduction= Green >=25% - <30% reduction =Amber <25% reduction =Red		
NP13		Reduce use of bank staffing, with a minimum 10% reduction on current spending across systems	6	New measure from April 2026. Exceptions reported in the Finance report.										63.0% higher than plan	62.8% higher than plan	>=10% reduction= Green >=5% - <30% reduction =Amber <5% reduction =Red		

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

- Urgent care performance remains strong, with continued high delivery against the 4-hour standard within Urgent Treatment Centres and sustained performance of the Urgent Community Response (UCR) service, demonstrating effective system access and responsiveness.
- Progress continues against elective recovery, with community waiting times largely maintained within acceptable thresholds and no long waits (52+ weeks) reported, reflecting sustained focus on backlog management.
- Patient safety performance remains strong overall, with no reported MRSA or E. coli infections and stable low levels of C. difficile, alongside continued learning through governance processes.
- Community services are continuing to deliver effective admission avoidance, with strong utilisation of rapid response pathways supporting patients to remain at home and reducing demand on acute services.
- Performance against the UCR two-hour standard remains strong, with an integrated approach with rapid response and the district nurses supporting this.
- Workforce and operational performance remain stable, with high levels of mandatory training compliance maintained and agency spend controlled in line with financial plan.
- RTT performance for the chronic pain service has seen some recovery.
- Numbers of people waiting for community beds remain low (for example, on 28 June 2026, 14 people were waiting: three at YDH, seven at MPH, four other).

Challenges

- With 10.0 whole time equivalent (WTE) Emergency Nurse Practitioner (ENP) vacancies (26%) across our community UTCs and a 10% sickness absence rate during June 2026, our ability to keep all units open has been severely affected, with reduced hours or full-day closures most frequently seen in Burnham-on-Sea and Shepton Mallet. Minehead is a developing issue. along with Bridgwater.

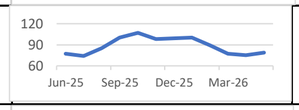
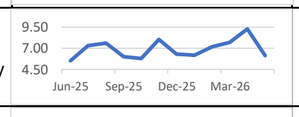
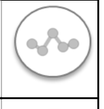
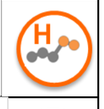
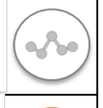
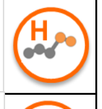
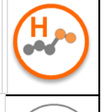
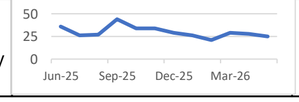
- Delivery of elective and RTT performance remains variable across services, with pain pathways continuing to operate below trajectory for the May 2026 return.
- Community hospital flow remains a challenge, with length of stay above target and delays in discharge (including patients with no reason to reside) affecting bed availability and flow.
- Pressure ulcer performance shows variation, with periods of deterioration against expected thresholds, requiring a continued focus on prevention and consistency of practice.
- Access to some community services has deteriorated, particularly within MSK and podiatry, where increasing demand and workforce pressures are affecting waiting times, although there has been an upturn in performance during the latest month.
- Hospital at Home continues to be under-utilised relative to plan, limiting its potential to support admission avoidance and system flow.
- Workforce improvements are required in specific areas, including appraisal rates, safeguarding compliance, and rostering efficiency, where performance is below expected standards.
- Some onboarding challenges are beginning to be addressed in the service group, with recruitment.

Actions to Address Underperformance:

- A workforce plan for community UTCs is currently in development and we are scoping options with Primary Care Network partners for increased sustainability whilst we achieve that workforce plan.
- Continued focus on elective recovery plans, including targeted pathway support and productivity improvements within pain is yielding improvements in triage turnaround times.
- Strengthening of discharge pathways and system working to reduce length of stay and improve patient flow through community hospital beds. There is currently a Pathway 2 test and learn to speed up transfer of patients from referral.
- Workforce actions are in development to address pressures in MSK and podiatry.
- A strong focus on our people metrics continues, in sector business and performance meetings
- Further development of Hospital at Home workforce plan with adverts for a senior ACP and scoping options to attract a consultant to the service following an unsuccessful advertisement.

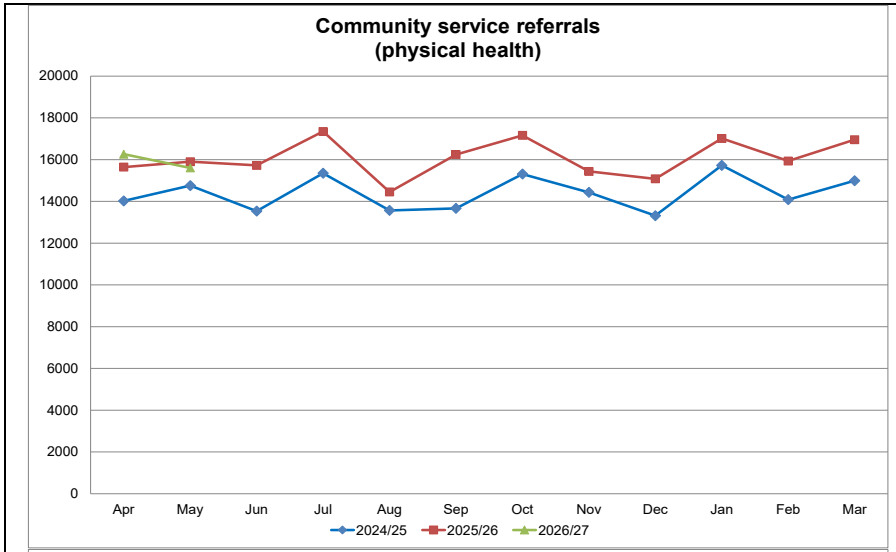
SOMERSET NHS FOUNDATION TRUST

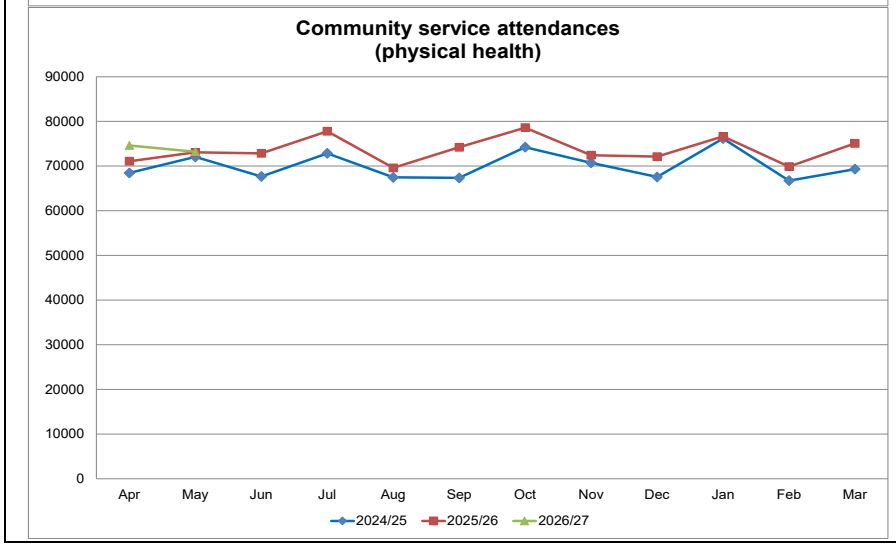
NEIGHBOURHOODS AND COMMUNITY SERVICES

No.	Description	Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
NC1	Mental health referrals offered first appointments within 6 weeks Older Persons mental health services	ICB	1,2,3	100.0%	96.8%	97.2%	99.0%	97.9%	95.8%	97.1%	95.7%	94.5%	90.7%	92.6%	94.9%	>=90%= Green >=80% - <90% =Amber <80% =Red		
NC2	Intermediate Care - Patients all ages discharged home from acute hospital beds on pathway 0 or 1	HDS	1,2,3	94.9%	94.5%	95.3%	95.3%	93.8%	95.2%	95.0%	94.1%	94.3%	94.3%	93.9%	Data awaited	>=95%= Green >=85% - <95% =Amber <85% =Red		
NC3	Urgent Community Response: percentage of patients seen within two hours	NHSC	1,2,3	92.6%	93.5%	92.0%	92.7%	91.2%	93.9%	91.9%	91.6%	93.4%	93.6%	94.3%	Data not yet due	>=70%= Green >=60% - <70% =Amber <60% =Red		
NC4	Hospital at Home - Caseload Size	VWOF	1,2,3	77	74	85	100	107	98	99	100	89	77	75	79	>167 = Green >134 - <167 =Amber <134 =Red		
NC5	Hospital at Home - Admissions	VWOF	1,2,3	242	289	288	308	364	304	313	342	254	251	227	247	>419 = Green >377 - <419 =Amber <377 =Red		
NC6	Total number of patient falls - community hospitals	NHSC	2	29	39	38	27	27	36	28	29	30	36	40	26	Monitored using Statistical Process Control rules. Report by exception.		
NC7	Rate of falls per 1,000 occupied bed days - community hospitals	NHSC	2	5.52	7.32	7.62	5.99	5.78	8.06	6.29	6.16	7.16	7.71	9.28	6.14	Monitored using Statistical Process Control rules. Report by exception.		
NC8	Community hospitals - number of pressure ulcers	NHSC	2	1	4	7	5	5	5	11	12	3	7	8	Data not yet due	From April 2026 <=5 = Green >5 = Red		
NC9	Community hospitals - rate of pressure ulcer damage per 1,000 occupied bed days	NHSC	2	0.19	0.75	1.40	1.11	1.07	1.12	2.47	2.55	0.72	1.50	1.86	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC10	District nursing - number of pressure ulcers	NHSC	2	56	59	72	66	77	74	64	99	91	88	117	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC11	Rate of pressure ulcer damage per 1,000 district nursing contacts	NHSC	2	1.72	1.78	2.32	2.08	2.37	2.32	2.00	3.05	2.98	2.88	3.72	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC12	Total number of medication incidents in a community setting	NHSC	2	36	26	27	44	34	34	29	26	21	29	28	25	Monitored using Statistical Process Control rules. Report by exception.		

Operational context

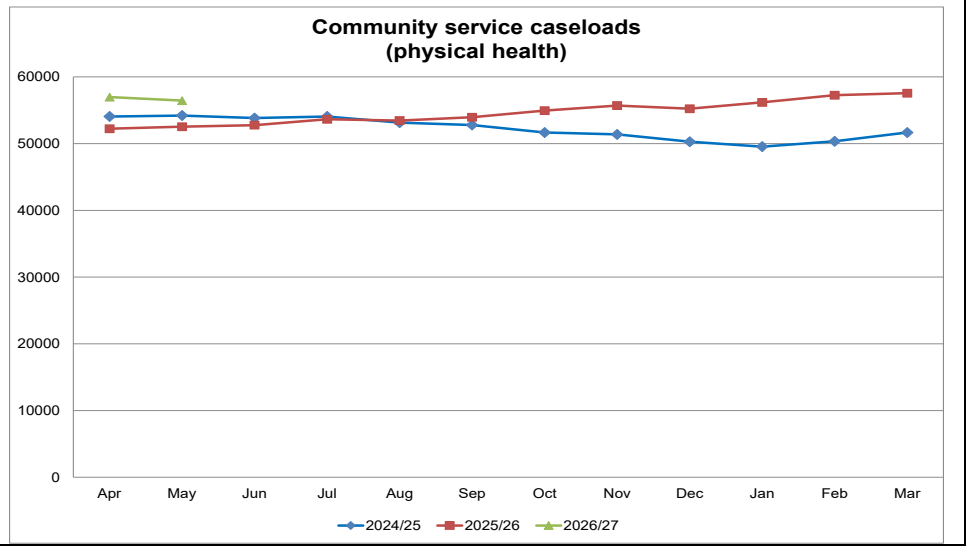
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





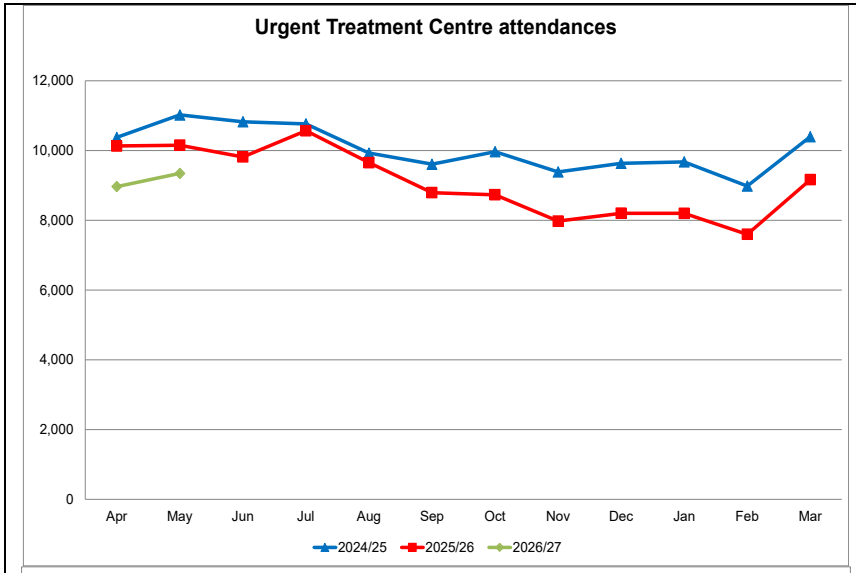
Summary:

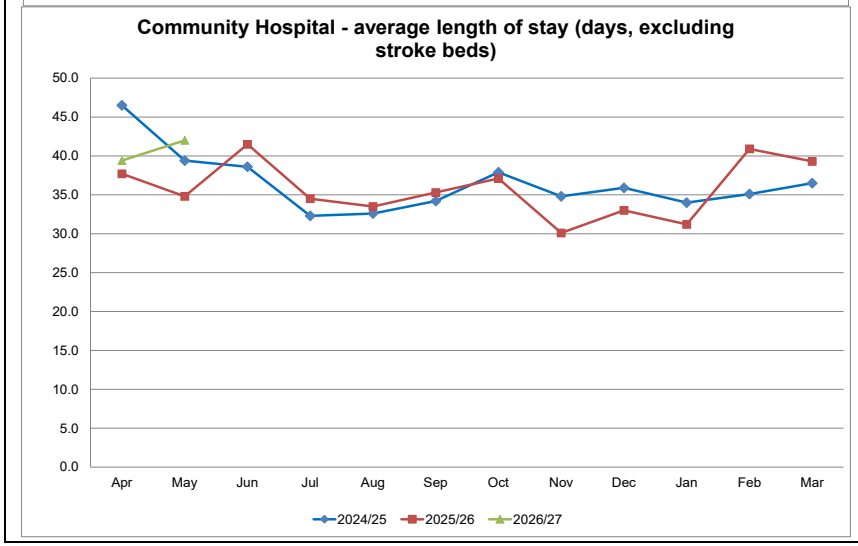
- Direct referrals to our community physical health services between 1 April and 31 May 2026 were 1.0% higher than the same months of 2025 and 10.7% higher than the same months of 2024.
- Attendances for the same reporting period were 2.5% higher than the same months of 2025 and 5.2% higher than the same months of 2024.
- Community service caseload levels as at 31 May 2026 were 7.4% higher than as at 31 May 2025, and 4.1% higher than as at 31 May 2024.



Operational context

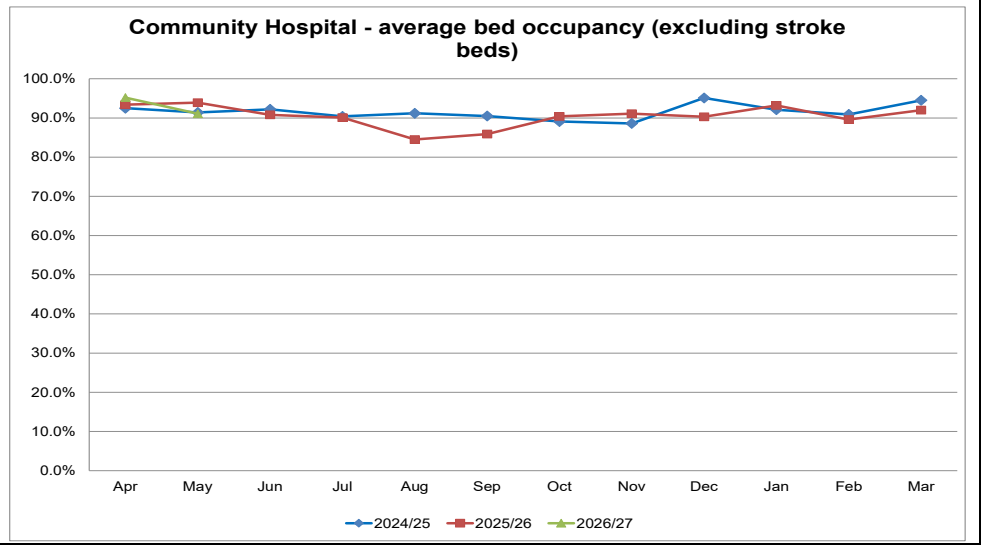
Community Physical Health: This section of the report provides a high-level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





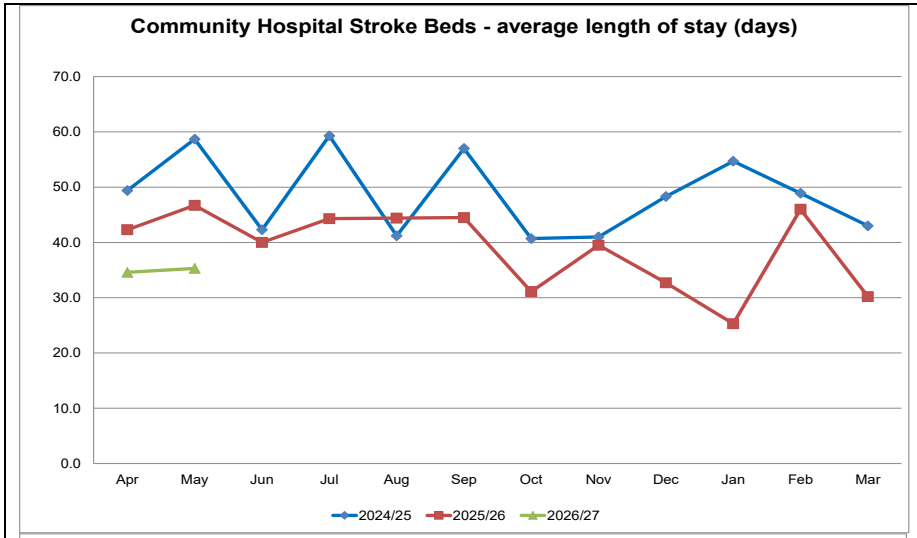
Summary:

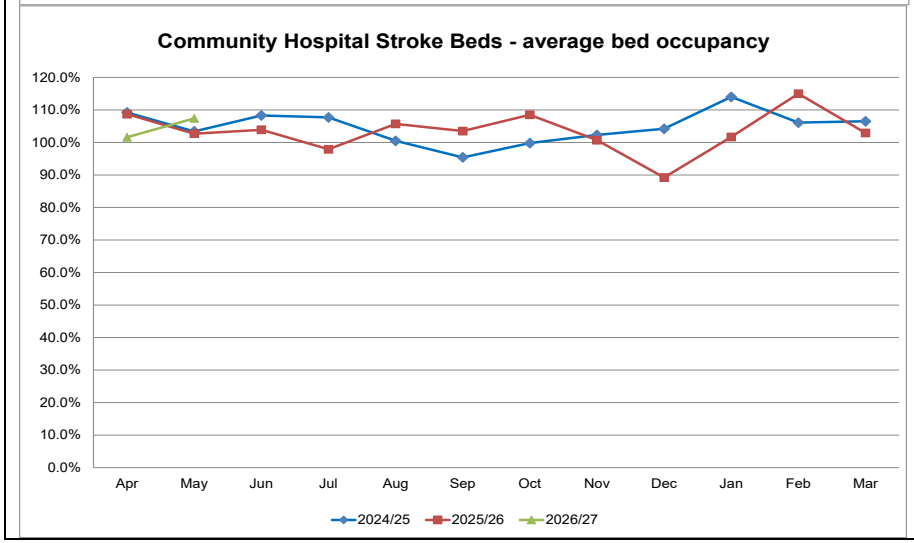
- Between 1 April and 31 May 2026, the number of Urgent Treatment Centre (UTC) attendances (excluding the YDH UTC) was 9.7% lower than the same months of 2025 and 14.4% lower than the same months of 2024. During May 2026, 97.7% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 78%.
- The average length of stay for non-stroke patients in our community hospitals in May 2026 was 42.0 days; an increase compared to April 2026. During May 2026 four 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 May 2026 was 36.6 days, compared to 47.0 days for the 12-month period ending 31 May 2025.
- The community hospital bed occupancy rate for non-stroke patients in May 2026 decreased to 91.1%, from 95.2% in April 2026.



Operational context

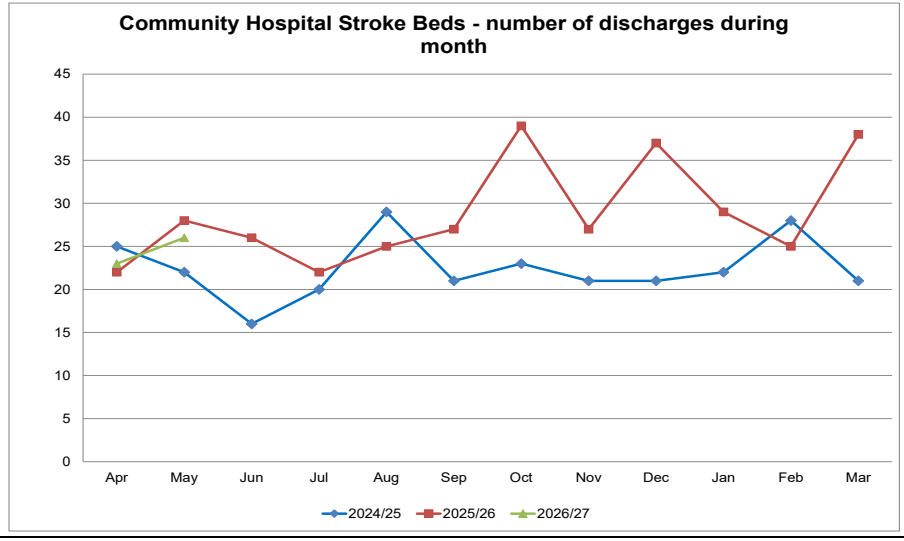
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay for stroke patients in our community hospitals in May 2026 increased to 35.3 days, from 34.6 days in April 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 May 2026 was 36.1 days, compared to 35.4 days for the 12-month period ending 31 May 2025.
- Stroke bed occupancy in May 2026 increased compared to April 2026.
- During May 2026 there were 26 discharges of stroke patients, compared to 23 during April 2026.



NARRATIVE REPORT

SYMPHONY HEALTHCARE SERVICES

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

What is Going Well

- **Document Backlog**
  We are pleased to report that the documents are now within protocol (10 working days) and have remained that way for several weeks. The Care Quality Commission (CQC) and the Integrated Care Board (ICB) will review again in three months' time and if the documents remain within protocol they will commence the review to remove the breach notice.

- **Average time for calls (S7)**
  Average call waiting times reduced for the fourth consecutive month to close to the internal target of four minutes. As highlighted last month, this is primarily due to the improvements in the South Somerset West Primary Care Network (PCN) Contact Hub.

What Requires Improvement and Planned Actions

- **GP vacancy rate (S4)**
  The increase in the GP vacancy rate to 17% appears concerning; however, a detailed review has been undertaken to understand the underlying factors and this analysis provides reassurance that significant progress has already been made in recruiting to these vacancies. Based on confirmed appointments and candidates currently progressing through the recruitment pipeline, the vacancy rate is forecast to reduce to approximately 8% as new starters join the organisation, with further GP recruitment activity ongoing.

  Since January 2026, a total of 12 GPs have resigned or retired. Organisational change associated with the merger programme was identified as a contributing factor by three departing GPs. The majority of the remaining departures were attributed to relocation for family reasons. The departures from the Crewkerne and Buttercross practices occurred within a relatively short timeframe and combined with the merger that commenced in June 2026, have created additional operational pressure. However, the recruitment activity undertaken to date has positioned the organisation well to address these vacancies and strengthen workforce resilience over the coming months. A summary of the reasons for departure is set out below:

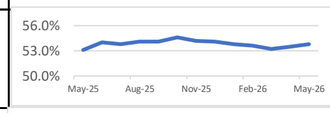
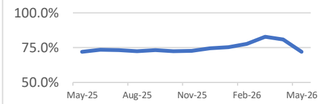
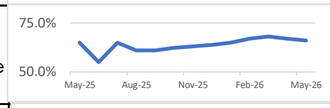
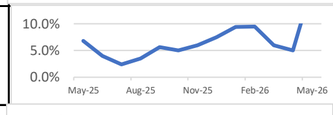
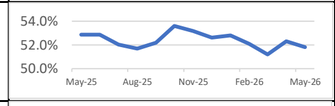
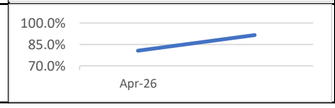
Practice	Reason
Crewkerne 1	Wanted to become a Partner; remains working with Symphony on our internal bank one day a week.
Crewkerne 2	Relocation.
Crewkerne 3	Relocation.
Crewkerne 4	No longer wants to work within the NHS and moving to pure private health work.
Buttercross 1	Relocation; also merger working not agreeable
Buttercross 2	Specialisation focus (dermatology).
Symphony North	Specialisation focus (paediatrics) remaining working with Symphony. Merger working not agreeable.
Symphony North	Merger working not agreeable.
Symphony North	Relocation
Oaklands	Relocation
Oaklands	Relocation
Warwick	Retirement

Other updates

- **Seen within two weeks of request (S9)**
  As part of ongoing changes to data collection, this target has been revised to align with the national performance standard, which requires 90% of urgent patients to be seen on the same day.
- The contract merger into Symphony South commences in June 2026; the main property issues that have stalled this have now been resolved.
- Shortlisted for an Our Somerset Colleague Award (OSCA) with the offer into the community with the peri-op team.

SOMERSET NHS FOUNDATION TRUST

SYMPHONY HEALTHCARE SERVICES

No.	Description	Source	Links to strategic aims	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
S1	Dementia diagnosis rates for patients aged 65 years plus	OPG	1,3,4	53.1%	54.0%	53.8%	54.1%	54.1%	54.6%	54.2%	54.1%	53.8%	53.6%	53.2%	53.5%	53.8%	>=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	72.0%	73.5%	73.3%	72.4%	73.1%	72.3%	72.7%	74.4%	75.2%	77.8%	82.8%	80.8%	72.0%	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%	55.0%	65.0%	61.0%	61.0%	62.3%	63.1%	63.9%	65.0%	67.0%	68.1%	67.0%	66.0%	>=50%= Green >=40% - <50% =Amber <40% =Red. Target to be achieved by year end		
S4	GP Vacancy rate	SHS	6	6.8%	4.0%	2.4%	3.5%	5.6%	5.0%	6.0%	7.5%	9.4%	9.5%	6.0%	5.0%	17.0%	=<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%	75.3%	76.4%	77.4%	78.9%	81.5%	83.7%	86.8%	90.6%	93.9%	76.0%	77.0%	Profiled target: 95% by year end		
S6	Patient satisfaction rate	SHS	2,3	91.8%	89.7%	92.1%	90.4%	91.1%	93.8%	90.8%	92.7%	92.4%	91.3%	90.9%	91.5%	90.9%	>=85%= Green >=75% - <85% =Amber <75% =Red		
S7	Average time for calls in the queue	SHS	2,3	05:52	05:23	04:45	05:12	06:58	07:36	07:30	07:15	07:27	06:57	05:23	04:49	04:38	=<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	52.9%	52.9%	52.0%	51.7%	52.2%	53.6%	53.2%	52.6%	52.8%	52.1%	51.2%	52.3%	51.8%	>=50%= Green >=40% - <50% =Amber <40% =Red		
S9	Percentage of requests deemend "clinically urgent" seen on the same day	SHS		New reporting criteria											80.6%	91.5%	>=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 are as follows:

What is going well

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 May 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 remain well above the compliance standards, and the numbers of ligatures remain low compared to historical averages.

Talking Therapies compliance against the six-week waiting times standard fell back below the 75% national standard in February 2026 and so remained during April 2026, the latest validated data available. This dip in compliance was mainly due to the reduction in activity over the Christmas and New Year period. It is expected that compliance will be restored over forthcoming months as actions and initiatives embed.

Staffing metrics continue to demonstrate good performance. Although appraisal rates decreased from 88.6% as at 30 April 2026 to 87.9% as at 31 May 2026, this was significantly above the Trust average of 79.9%. Mandatory training for the Service Group increased slightly to 93.8% as at 31 May 2026 from 93.7% as at 30 April 2026.

The Community Mental Health Service transformation programme has started, with four engagement events with Lived Experience Partners, and those who use services to gather their feedback, and in-person team briefings by the Service Group Director with three of the four locality teams. Two listening events with all Community Mental Health Service staff will take place in June 2026.

What is going less well

Bed demand and flow have continued to be challenging, with high numbers of patients needing social care input. Following escalations to the Local Authority, input and activity have improved but discharges of long-stay patients are now contributing to the increased length of stay, as reflected within reporting metric MH11 relating to older person wards.

Bed flow was further exacerbated by the temporary reduction of three acute beds whilst the Rydon ward environmental improvement works was being undertaken, There has continued to be a need to use inappropriate Out of Area or Out of placements, with three people placed out of area at the month end, a reduction from five as at 30 April 2026.

The Employment Support Service continues to fall below the standard for the percentage of people supported into work. Targeted work is being undertaken in one locality team, who are not in line with the Individual Placement and Support (IPS) Fidelity Model, and once this work is complete, it is expected that the overall compliance will significantly improve.

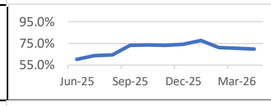
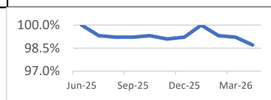
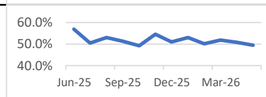
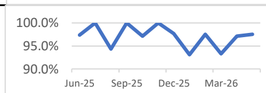
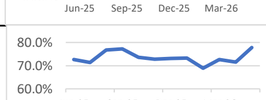
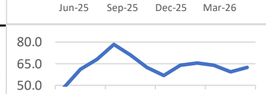
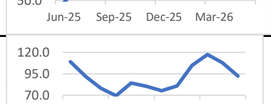
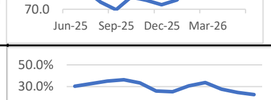
During May 2026 the number of restraints on our mental health wards increased from 20 during April 2026 to 62 during May 2026. The topic lead has been implementing various actions to improve awareness and practice including a significant change in training and practice (QI Project) that has seen a major reduction in floor restraints by using Safety Pods Proactive. The previous Proactive Care and Reducing the Use of Force (Practice) Policy 2022 V7 has been split into two documents: a focused Proactive Care Seclusion Policy and a new overarching Proactive Care Model and Reducing Use of Force Strategy, currently being developed and due to be completed by 31 August 2026. A reporting portal dashboard is also in development to provide proactive timely information and is planned to be rolled out by the end of August 2026.

Focus of improvement work

Community Services
Pre-engagement work has continued for the start of the community mental health services transformation project, which has been received well. Formal workshops for Lived Experience Partners have taken place in April and May 2026, with staff engagement events scheduled. Discussions have also taken place with the Open Mental Health Partnership Board to inform them of the plan and seek support for re-visiting the whole community model and ways of working. The aims of the project 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.

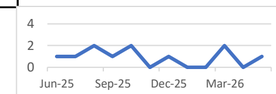
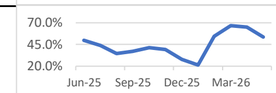
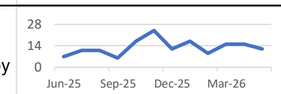
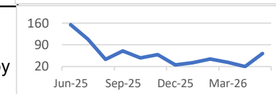
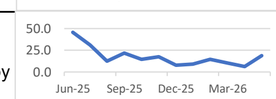
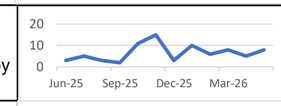
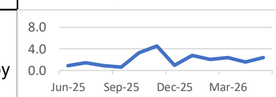
SOMERSET NHS FOUNDATION TRUST

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description		Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
MH1	Mental health referrals offered first appointments within 6 weeks	Adult mental health services	ICB	1,2,3	92.1%	97.1%	98.2%	91.9%	92.2%	93.8%	92.0%	90.7%	97.4%	94.6%	94.4%	97.6%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
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%			P
MH3	Percentage of women accessing specialist community Perinatal Mental Health service - 12 month rolling reporting		LTP	1,2	657	655	642	658	658	653	668	702	726	709	709	713	>=640 = Green <640 = Red		P
MH4	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		NHSC	1,2,3	83.3%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>=60%= Green <60% =Red		P
MH5	Talking Therapies RTT : percentage of people waiting under 6 weeks		NHSC	1,2,3	60.3%	63.6%	64.3%	73.1%	73.7%	73.1%	74.1%	77.7%	71.2%	70.5%	69.7%	Data not yet due	>=75%= Green <75% =Red		F
MH6	Talking Therapies RTT: percentage of people waiting under 18 weeks		NHSC	1,2,3	100.0%	99.3%	99.2%	99.2%	99.3%	99.1%	99.2%	100.0%	99.3%	99.2%	98.7%	Data not yet due	>=95%= Green <95% =Red		P
MH7	Talking Therapies Recovery Rates		NHSC	1,2,3	56.9%	50.4%	53.1%	51.3%	49.2%	54.6%	50.9%	53.1%	50.1%	51.8%	50.8%	49.4%	>=50%= Green <50% =Red		P
MH8	Adult mental health inpatients receiving a follow up within 72 hours of discharge		NHSC	1,2	97.4%	100.0%	94.3%	100.0%	97.1%	100.0%	97.7%	93.1%	97.5%	93.3%	97.1%	97.5%	>=80%= Green <80% =Red		P
MH9	Percentage of urgent crisis response patients to receive face to face care within 24 hours		NHSC	1,2	72.7%	71.4%	76.8%	77.2%	73.7%	72.9%	73.1%	73.2%	68.9%	72.6%	71.5%	77.8%	TBC		
MH10	Overall Length of stay - Reduce average LOS by March 2027 - Adult awards and PICU only		PAF	2,6	48.2	61.0	68.1	78.4	71.2	62.5	56.7	63.9	65.4	64.1	59.5	62.5	From April 2026 at or below trajectory = Green above trajectory = Red		P
MH11	Overall Length of stay - Reduce average LOS by March 2027 - Older Persons wards only		PAF	2,6	109.2	91.8	78.2	69.5	84.2	80.3	75.4	81.0	104.8	117.5	107.8	92.3	From April 2026 at or below trajectory = Green above trajectory = Red		F
MH12	Percentage of adult inpatients discharged with a length of stay exceeding 60 days		NOF, PAF	2,3	30.2%	32.6%	34.8%	36.2%	33.3%	25.8%	25.0%	30.6%	33.7%	27.3%	24.4%	22.4%	SPC <=29.8% = Green >29.8% = Red		
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	91.3%	90.2%	90.1%	91.2%	91.2%	91.0%	90.6%	91.1%	90.8%	91.2%	90.3%	90.2%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
MH15	Number of people accessing community mental health services with serious mental illness - rolling 12 month number.		NOF, PAF	1,2,3,4	9,977	10,113	10,141	10,143	10,255	10,202	10,227	10,276	10,349	10,439	10,415	10,305	No stated target		

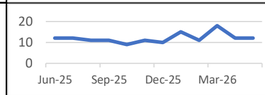
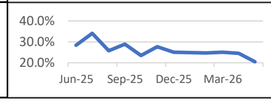
SOMERSET NHS FOUNDATION TRUST

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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	1	2	1	2	0	1	0	0	2	0	1	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	98.0%	99.0%	98.2%	97.6%	97.6%	97.1%	97.0%	97.7%	97.4%	97.7%	96.6%	91.8%	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%	44.0%	34.6%	37.0%	41.4%	39.3%	28.0%	21.4%	54.5%	66.7%	65.2%	53.8%	SPC <=60.9% = Green >60.9% = Red		
MH19	Total number of patient falls - mental health inpatient wards	NHSC	2	7	11	11	6	17	24	12	17	9	15	15	12	Monitored using Statistical Process Control rules. Report by exception.		
MH20	Rate of falls per 1,000 occupied bed days	NHSC	2	2.1	3.2	3.1	1.9	5.1	7.3	3.7	5.2	3.0	4.5	4.7	3.6	Monitored using Statistical Process Control rules. Report by exception.		
MH21	Restrictive Interventions - total number of incidents	NOF, NHSC	2	155	108	43	70	48	58	25	32	44	34	20	62	Monitored using Statistical Process Control rules. Report by exception.		
MH22	Restrictive Interventions per 1,000 occupied bed days	NHSC	2	45.7	31.2	12.3	21.8	14.4	17.6	7.8	9.0	14.8	10.3	6.3	18.6	Monitored using Statistical Process Control rules. Report by exception.		
MH23	Number of prone restraints	NHSC	2	3	5	3	2	11	15	3	10	6	8	5	8	Monitored using Statistical Process Control rules. Report by exception.		
MH24	Prone restraints per 1,000 occupied bed days	NHSC	2	0.9	1.4	0.9	0.6	3.3	4.5	0.9	2.8	2.0	2.4	1.6	2.4	Monitored using Statistical Process Control rules. Report by exception.		
MH25	Total number of medication incidents in a mental health setting	NHSC	2	18	16	21	15	3	8	10	12	13	11	17	16	Monitored using Statistical Process Control rules. Report by exception.		
MH26	Ligatures: Total number of incidents	NHSC	2	126	89	133	54	15	10	15	7	15	5	9	17	Monitored using Statistical Process Control rules. Report by exception.		
MH27	Number of ligature point incidents	NHSC	2	1	1	0	0	0	0	0	0	2	0	0	1	Monitored using Statistical Process Control rules. Report by exception.		
MH28	Violence and Aggression: Number of incidents patient on patient (inpatients only)	NHSC	2	1	1	2	3	3	0	6	5	1	4	3	4	Monitored using Statistical Process Control rules. Report by exception.		
MH29	Violence and Aggression: Number of incidents patient on staff	NHSC	2	12	14	24	20	13	19	15	13	14	11	17	15	Monitored using Statistical Process Control rules. Report by exception.		
MH30	Number of Type 1 -Traditional Seclusion	NHSC	2	7	9	11	9	22	24	20	21	19	14	16	14	Monitored using Statistical Process Control rules. Report by exception.		

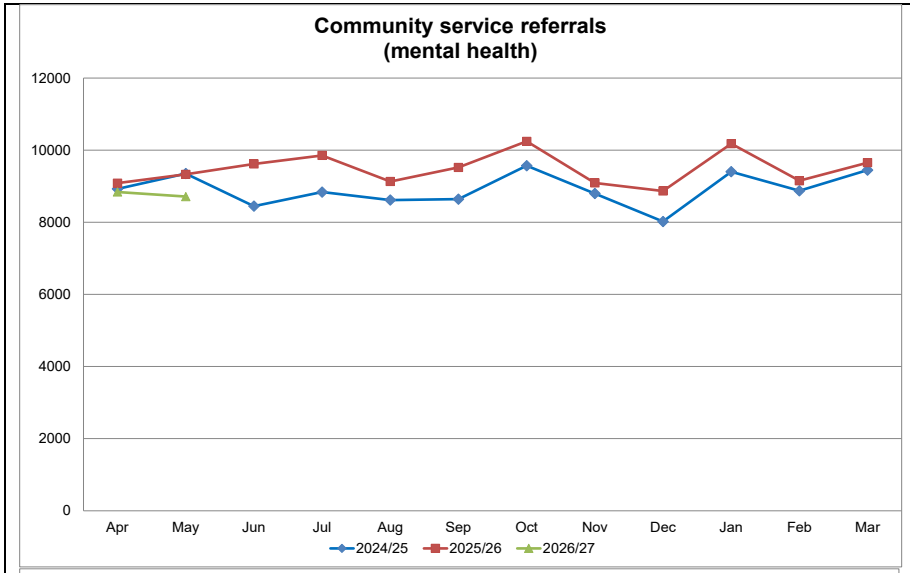
SOMERSET NHS FOUNDATION TRUST

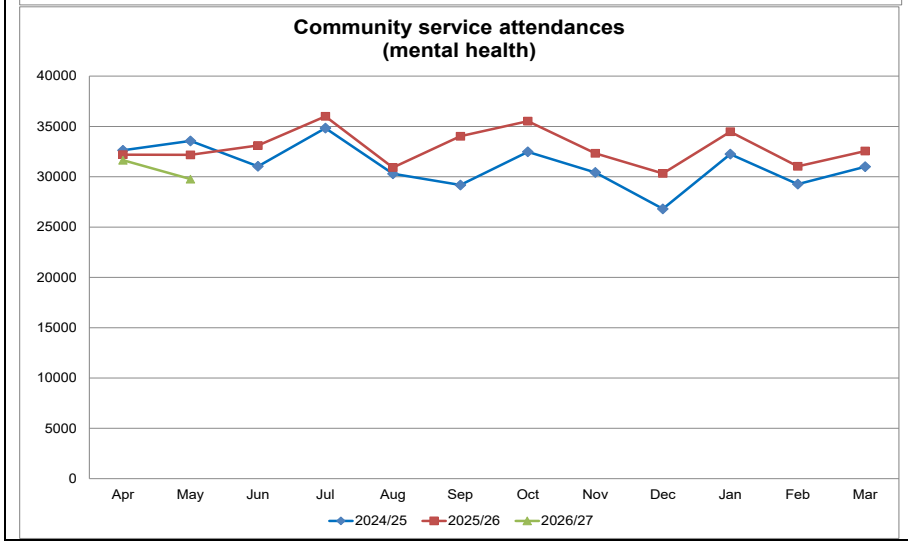
MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
MH31	Number of Type 2 -Short term Segregation	NHSC	2	1	0	0	1	0	1	2	7	0	1	2	0	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	12	12	11	11	9	11	10	15	11	18	12	12	<30 days = Green >30 days =Red		
MH33	Employment Support service - Percentage of clients supported into work (rolling 12 months)	NHSC	2	28.4%	34.1%	25.8%	29.0%	23.4%	27.8%	25.0%	24.8%	24.7%	25.0%	24.5%	20.5%	>=40% = Green >=30% and <40% =Amber <30% =Red		

Operational context

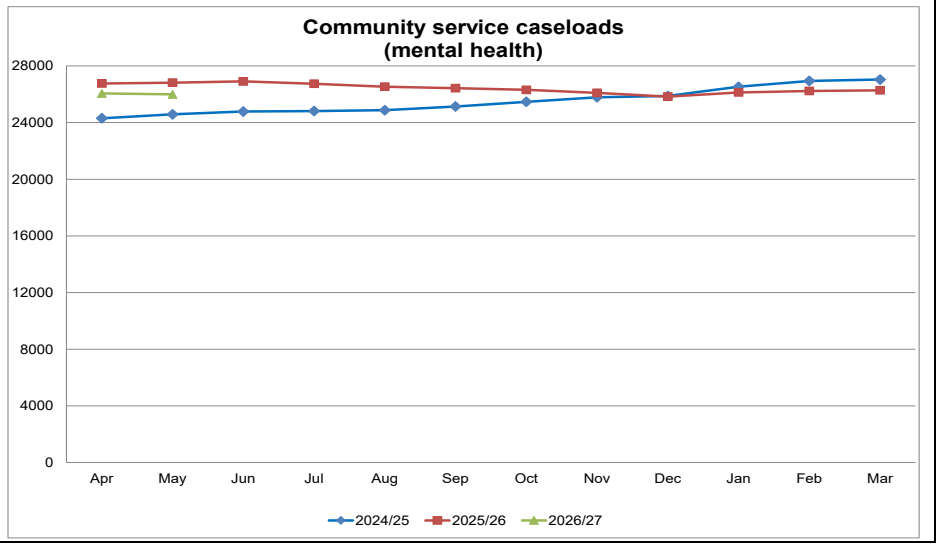
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





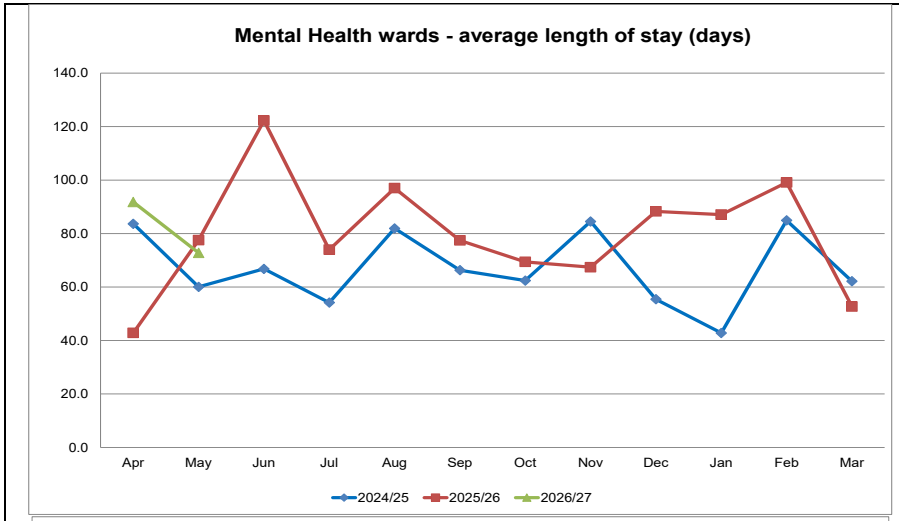
Summary:

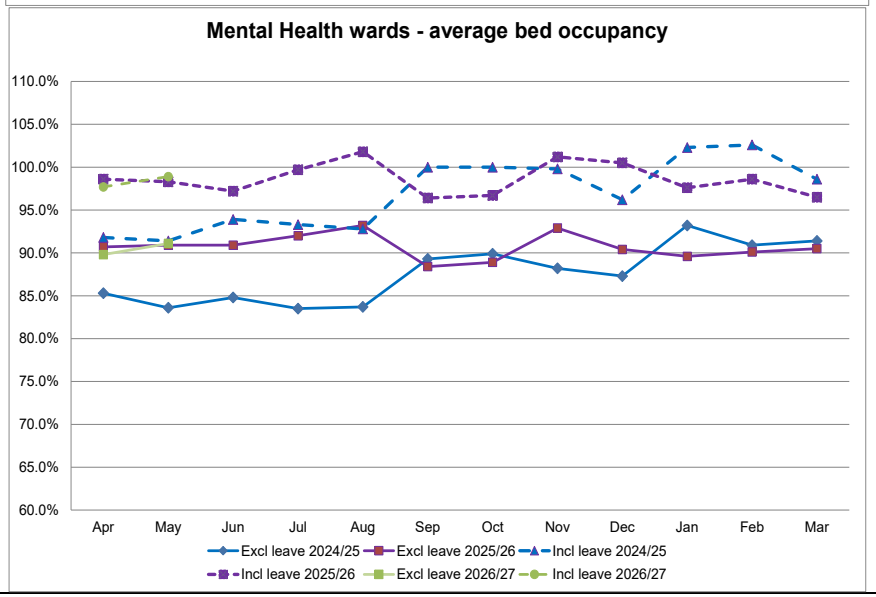
- Direct referrals to our community mental health services between 1 April and 31 May 2026 were 4.7% lower than the same months of 2025 and 4.0% lower than the same months of 2024.
- Attendances for the same reporting period were 4.6% lower than the same months of 2025 and 7.2% lower than the same months of 2024.
- Community mental health service caseloads as at 31 May 2026 3.1% lower than as at 31 May 2025 but were 5.7% higher than as at 31 May 2024.



Assurance and Leading Indicators

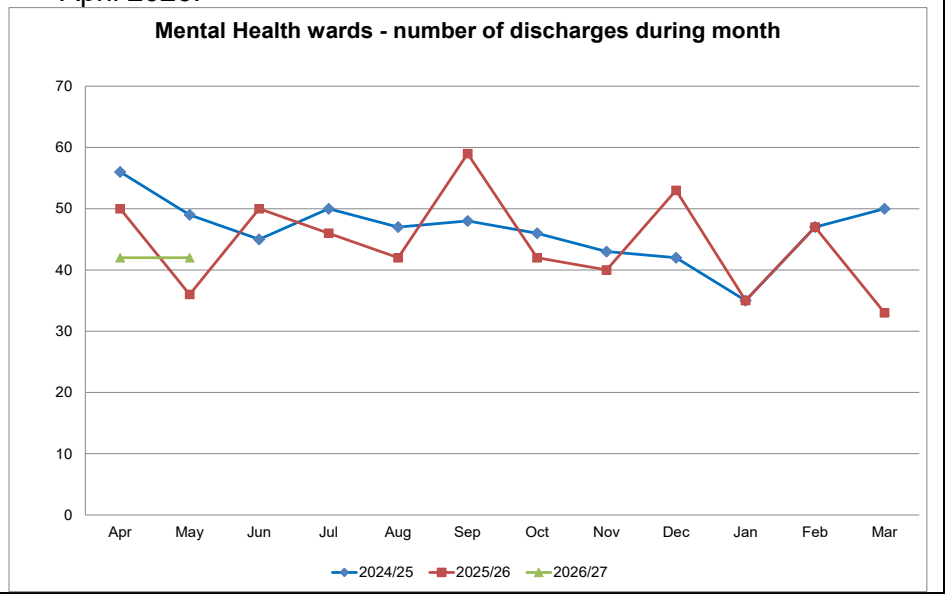
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay across all of our mental health wards in May 2026 was 72.8 days, significantly down from 91.2 days in April 2026. During May 2026, 10 patients were discharged with lengths of stay of 100 days or more, including one patient discharged from Willow Ward One, our rehabilitation unit, who had a length of stay of 510 days. The rolling 12-month average length of stay for the period ending 31 May 2026 was 75.5 days, compared to 63.8 days for the 12-month period ending 31 May 2025.
- The mental health bed occupancy rates excluding leave and including leave increased compared to April 2026.
- A total of 42 patients were discharged in May 2026, the same as in April 2026.



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 May 2026, performance for ambulance handovers taking more than 15 minutes declined at the MPH site, increasing from 55.4% in April 2026 to 57.4% in May 2026, although this was better than the Operational Plan trajectory of 63% or less. A slight improvement was seen at YDH with the percentage taking more than 15 minutes reducing from 90.5% during April 2026 to 88.6% in May 2026.

The Trust-wide average ambulance handover time in May 2026 was 22.4 minutes (19.6 minutes at MPH and 27.4 minutes at YDH), against an Operational Plan standard of 25.4 minutes or less.

Front Door

In May 2026, both Emergency Departments (EDs) continued to see exceptional increases in attendances, compared to 2025. Trust-wide growth in ED attendances in May 2026 was 7%; the Trust-wide number of admissions also increased, by 3.8%. For the calendar year to date, compared to the previous year, our ED front door demand has increased by 8%.

	MPH ED Attendance	MPH ED Admissions	MPH ED Breaches (Over 4 hrs)	YDH ED Attendance (including the UTC)	YDH ED Admissions	YDH ED Breaches (Over 4 hrs)	Community MIU/UTC Attendance (Unplanned)	Community MIU/UTC Breaches (Over 4 hrs)
May 2026 to May 2025 difference: increase / (reduction)	94	112	168	871	8	416	(879)	(53)
%	1.2%	5.9%	4.4%	15.8%	0.7%	19.9%	(9.1%)	(21.5%)

The front door continues to see consistent pressure, particularly at YDH, where there continues to be a significant month-on-month rise in ED attendances; for May 2026 this represents a 15.8% increase compared to May 2025. However, our EDs are working hard to turn patients around at the front door, as is demonstrated by a lower rate of admissions at YDH. Four-hour performance in May 2026 declined compared to the previous month and also compared to performance in May 2025.

Focus of improvement work:

- The Trust continues to work with colleagues from South Western Ambulance Service NHS Foundation Trust (SWAST) to support a reduction in the levels of conveyances to hospital, in addition to supporting the Integrated Care Bard (ICB) to improve 'call before conveyance' rates.
- YDH development of a Paediatric Assessment Unit (PAU) to support timely paediatric care, and a refocus on pathways and escalation on the MPH site.
- 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 May 2026, the percentage of occupied bed days lost due to patients not meeting the criteria to reside was 22.5% at MPH and 24.5% at YDH. This remains significantly above the system plan ambition for NCTR. The average Length of Stay (LOS) at MPH maintained at 6.3 days, but reduced at YDH to 9.4 days, from 9.6 days in April 2026. Despite the challenges, SFT continues to perform well in discharging over 85% of our patients on a Pathway 0; for May 2026, this was 87.3% at MPH and 85.7% at YDH.

Focus of improvement work

- A continued drive to improve hospital-related delays as well as continued focused work on board rounds and criteria-led discharge through the Getting it Right First Time (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

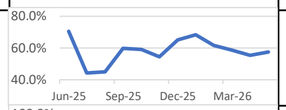
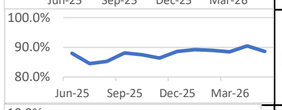
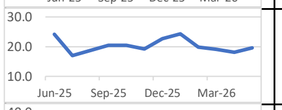
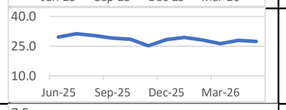
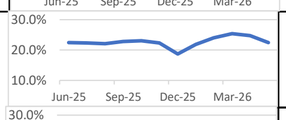
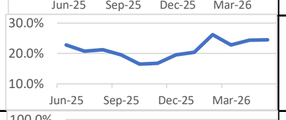
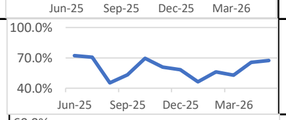
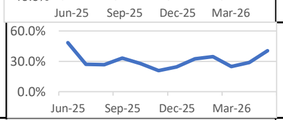
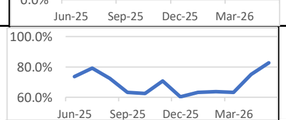
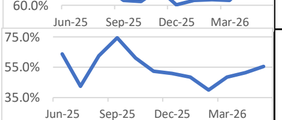
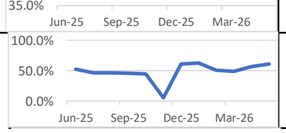
The percentage of patients admitted to a stroke ward within four hours continued to improve at MPH during May 2026, with performance of 67.3%, and at YDH reached the highest level since June 2025, with performance of 40.5%. The YDH stroke ward continues to experience a significant level of patients who are delayed waiting on ward care. The percentage of patients assessed by a specialist consultant in stroke was 68.3% at YDH and 57.1% at MPH.

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.

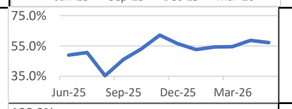
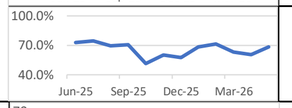
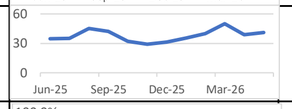
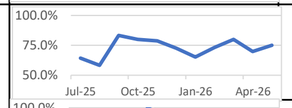
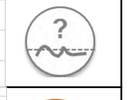
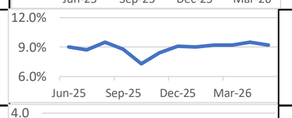
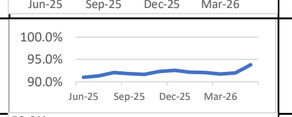
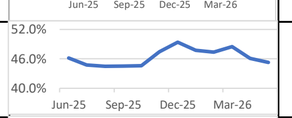
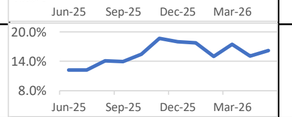
SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
UEC1	Percentage of ambulance handovers over 15 minutes	MPH	NHSC	2	70.5%	44.3%	44.9%	59.8%	59.1%	54.5%	65.1%	68.5%	61.6%	58.8%	55.4%	57.4%	From April 2026 >=trajectory = Green <trajectory = Red		
UEC2		YDH			88.0%	84.5%	85.2%	88.1%	87.5%	86.4%	88.6%	89.2%	88.9%	88.5%	90.5%	88.6%			
UEC3	Percentage of ambulance handovers over 45 minutes	MPH	NHSC	2	8.0%	2.7%	5.6%	5.3%	4.9%	4.7%	8.0%	10.0%	3.8%	2.6%	1.7%	4.2%			
UEC4		YDH			13.5%	13.9%	12.2%	11.8%	10.1%	4.9%	9.7%	12.1%	9.2%	6.1%	8.4%	7.0%			
UEC5	Ambulance - Average handover times (minutes)	MPH	NHSC	2	24.1	17.0	18.7	20.5	20.4	19.2	22.7	24.3	19.9	19.1	18.1	19.6			
UEC6		YDH			29.5	31.2	30.3	28.9	28.5	25.1	28.3	29.3	28.0	26.2	28.0	27.4			
UEC7	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	6.7	6.3	6.6	6.6	6.6	6.8	6.1	6.5	7.2	6.5	6.3	6.3	Monitored using Statistical Process Control rules. Report by exception.		
UEC8		YDH			8.9	9.1	8.3	8.8	9.6	8.5	9.3	9.2	9.0	9.5	9.6	9.4			
UEC9	Patients not meeting the criteria to reside: percentage of occupied bed days lost	MPH	SFT	2,6	22.5%	22.3%	22.1%	22.8%	23.0%	22.3%	18.7%	21.9%	24.0%	25.4%	24.7%	22.5%	<=9.8%= Green >15% =Red		
UEC10		YDH			22.8%	20.7%	21.3%	19.6%	16.5%	16.8%	19.5%	20.4%	26.2%	22.8%	24.4%	24.5%			
UEC11	Percentage of Stroke Patients directly admitted to a stroke ward within four hours	MPH	NSG	1,2,4	72.2%	70.8%	45.3%	53.3%	69.6%	60.7%	58.3%	46.2%	56.2%	52.9%	65.5%	67.3%	>=90%= Green >=75% - <90% =Amber <75% =Red		
UEC12		YDH			48.4%	27.0%	26.5%	33.3%	27.8%	20.8%	24.3%	32.3%	34.6%	25.0%	28.9%	40.5%			
UEC13	Percentage of patients spending >90% of time in stroke unit - acute services	MPH	NSG	1,2,4	73.6%	79.1%	72.3%	63.3%	62.5%	70.7%	60.3%	63.3%	63.8%	63.3%	75.0%	82.7%	>=80%= Green >=70% - <80% =Amber <70% =Red		
UEC14		YDH			63.8%	42.5%	62.5%	74.4%	61.0%	52.4%	50.9%	48.6%	40.0%	48.6%	51.4%	55.6%			
UEC15	Percentage of patients scanned within 20 minutes of clock start	MPH	NSG	1,2,4	52.7%	46.3%	46.2%	46.0%	44.7%	5.4%	60.9%	62.7%	50.9%	49.1%	56.9%	60.7%	>=32%= Green >=27% - <32% =Amber <27% =Red		

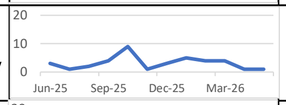
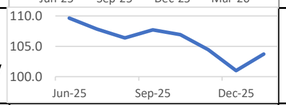
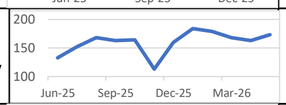
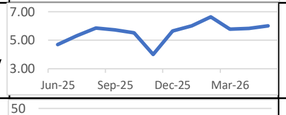
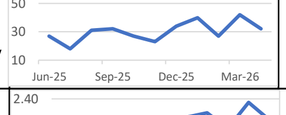
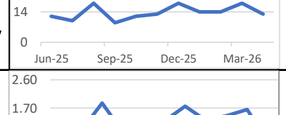
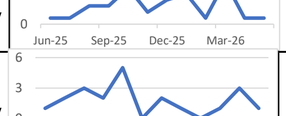
SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
UEC16	Percentage of patients scanned within 20 minutes of clock start	YDH	NSG	1,2,4	33.3%	51.1%	19.4%	24.4%	21.6%	24.0%	17.8%	5.3%	14.3%	26.3%	23.3%	17.1%	>=32%= Green >=27% - <32% =Amber <27% =Red		
UEC17	Percentage of patients assessed by a Stroke Specialist Consultant within 14 hours of clock start	MPH	NSG	1,2,4	49.1%	50.7%	35.4%	46.0%	53.2%	62.1%	56.5%	52.5%	54.4%	54.5%	58.6%	57.1%	>=70%= Green >=60% - <70% =Amber <60% =Red		
UEC18		YDH			72.7%	74.5%	69.4%	70.7%	51.4%	60.0%	57.4%	68.4%	71.4%	63.2%	60.5%	68.3%			
UEC19	Stroke: Median number of minutes of total therapy received per inpatient day	MPH	NSG	1,2,4	41	57	45	30	28	54	59	55	61	57	54	56	>=42= Green >=32 - <42 =Amber <32 =Red		
UEC20	Stroke: Median number of minutes of total therapy received per inpatient day	YDH	NSG	1,2,4	35	35	45	42	32	29	31	36	40	50	39	41	>=42= Green >=32 - <42 =Amber <32 =Red		
UEC21	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	64.7%	64.3%	58.3%	83.3%	80.0%	78.6%	72.7%	65.2%	73.3%	80.0%	70.0%	75.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
UEC22	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH			90.0%	90.6%	92.0%	88.9%	100.0%	97.1%	79.4%	90.0%	90.3%	88.2%	88.9%	96.6%			
UEC23	Percentage of emergency patients screened for sepsis - Emergency Departments				100.0%	100.0%	100.0%	66.7%	52.5%	69.7%	66.7%	70.7%	58.6%	62.5%	46.2%	71.7%			
UEC24	Percentage of patients admitted as an emergency within 30 days of discharge		NOF, PAF	2,3	9.0%	8.7%	9.5%	8.8%	7.3%	8.4%	9.1%	9.0%	9.2%	9.2%	9.5%	9.2%	To be confirmed.		
UEC25	Average number of days between planned and actual discharge date		NOF, PAF	2,3	2.6	2.6	2.5	2.3	2.4	2.2	2.2	1.7	1.5	1.7	1.2	1.7	To be confirmed.		
UEC26	Monthly number of inpatients to suffer a new hip fracture		PAF	2	1	1	0	1	0	3	1	1	0	1	0	0	To be confirmed.		
UEC27	Percentage of mental health patients spending under 12 hours in A&E		PAF	2,3	91.0%	91.3%	92.1%	91.8%	91.7%	92.3%	92.6%	92.1%	92.0%	91.7%	92.0%	93.8%	From April 2026 >=trajectory = Green <trajectory = Red		
UEC28	Percentage of over 65s attending emergency departments to be admitted		PAF	2,3	46.2%	44.7%	44.5%	44.5%	44.6%	47.4%	49.4%	47.8%	47.4%	48.5%	46.1%	45.3%	To be confirmed.		
UEC29	Percentage of under 18s attending emergency departments to be admitted		PAF	2,3	12.2%	12.2%	14.1%	14.0%	15.4%	18.7%	18.0%	17.8%	15.0%	17.5%	15.1%	16.2%	To be confirmed.		
UEC30	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.		

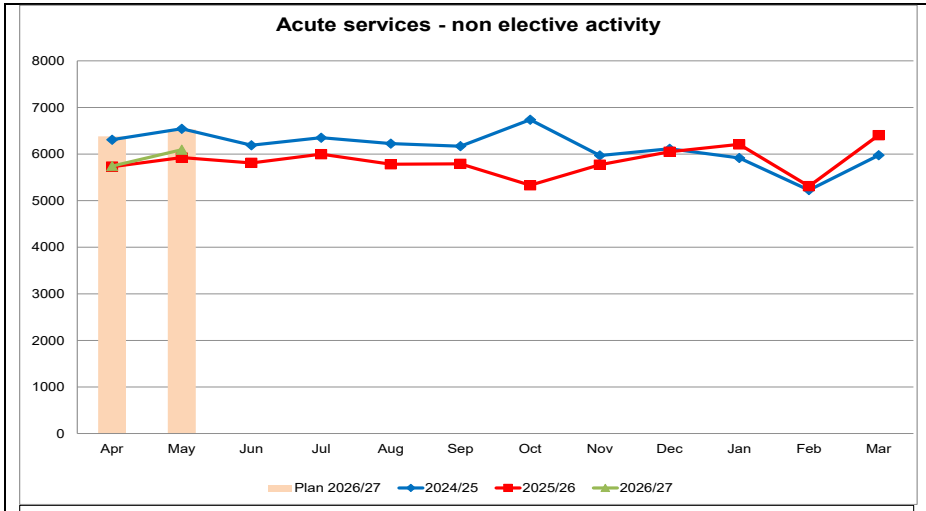
SOMERSET NHS FOUNDATION TRUST

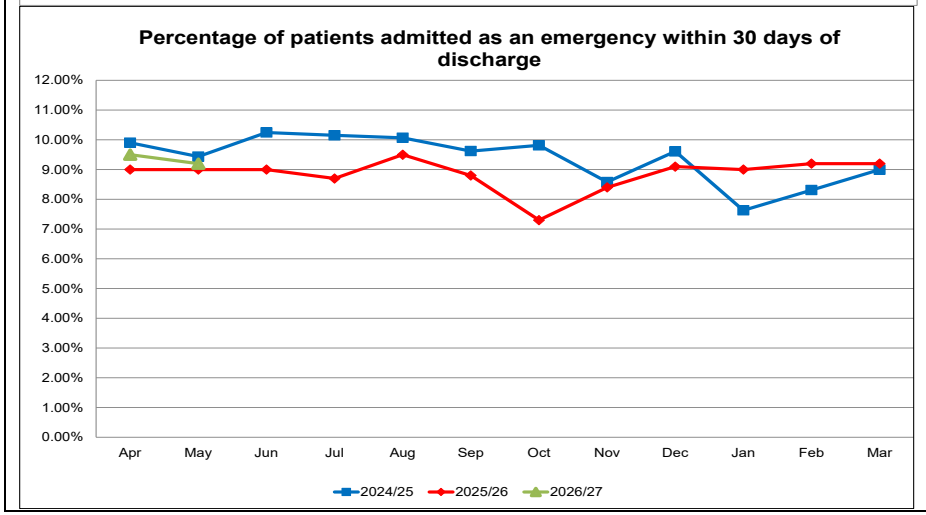
URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
UEC31	Average daily number of medical and surgical outliers in acute wards during the month	MPH	NHSC	2	3	1	2	4	9	1	3	5	4	4	1	1	Monitored using Statistical Process Control rules. Report by exception.		
UEC32		YDH	NHSC	2	15	18	11	9	9	9	9	10	7	9	9	10	Monitored using Statistical Process Control rules. Report by exception.		
UEC33	Number of patients transferred between acute wards after 10pm	MPH	NHSC	2	75	83	82	103	61	67	78	143	102	80	42	67	Monitored using Statistical Process Control rules. Report by exception.		
UEC34		YDH	NHSC	2	98	109	133	92	137	104	175	138	120	130	125	136	Monitored using Statistical Process Control rules. Report by exception.		
UEC35	Summary Hospital-level Mortality Indicator (SHMI)		NOF, NHSC	2	109.6	107.8	106.4	107.7	107.0	104.4	101.0	103.7	Data not yet due - February 2026 to be reported after May 2026				Monitored using Statistical Process Control rules. Report by exception.		
UEC36	Total number of patient falls - acute services		NHSC	2	133	152	168	163	164	113	160	184	179	168	163	173	Monitored using Statistical Process Control rules. Report by exception.		
UEC37	Rate of falls per 1,000 occupied bed days - acute services		NHSC	2	4.70	5.32	5.86	5.72	5.53	4.00	5.66	6.02	6.64	5.77	5.82	6.02	Monitored using Statistical Process Control rules. Report by exception.		
UEC38	Number of pressure ulcers	MPH	NOF, NHSC	2	27	18	31	32	27	23	34	40	27	42	32	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC39	Rate of pressure ulcer damage per 1,000 occupied bed days	MPH	NOF, NHSC	2	1.46	0.96	1.63	1.70	1.40	1.27	1.89	2.01	1.56	2.30	1.81	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC40	Number of pressure ulcers	YDH	NOF, NHSC	2	12	10	18	9	12	13	18	14	14	18	13	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC41	Rate of pressure ulcer damage per 1,000 occupied bed days	YDH	NOF, NHSC	2	1.22	1.01	1.86	0.93	1.15	1.28	1.76	1.31	1.45	1.66	0.63	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
UEC42	No. ward-based cardiac arrests - acute wards	MPH	NHSC	2	1	1	3	3	6	2	4	5	1	7	1	1	Monitored using Statistical Process Control rules. Report by exception.		
UEC43	No. ward-based cardiac arrests - acute wards	YDH	NHSC	2	1	2	3	2	5	0	2	1	0	1	3	1	Monitored using Statistical Process Control rules. Report by exception.		
UEC44	Total number of medication incidents	MPH	NHSC	2	80	92	88	67	113	105	103	99	72	81	93	63	Monitored using Statistical Process Control rules. Report by exception.		
UEC45	Total number of medication incidents	YDH	NHSC	2	42	46	54	50	47	45	33	47	41	40	36	37	Monitored using Statistical Process Control rules. Report by exception.		

Operational context

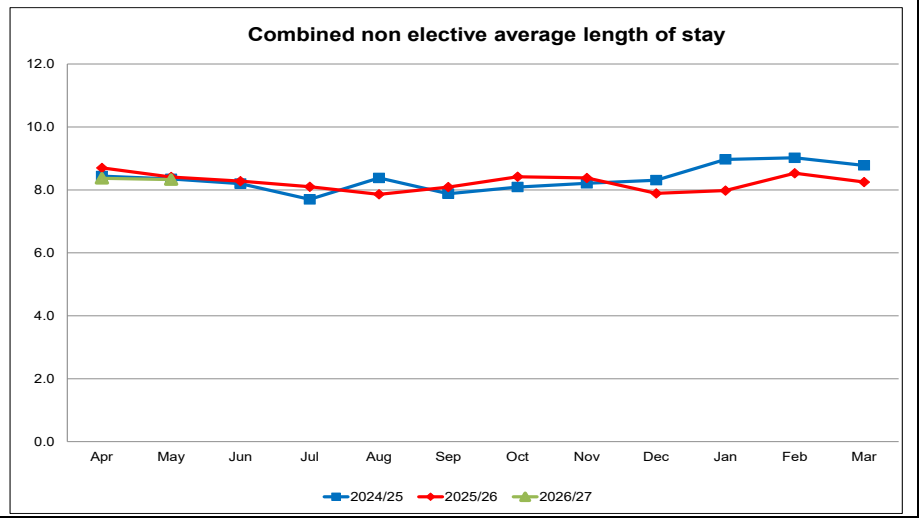
Acute services: This section of the report provides a summary of the levels of non-elective activity, emergency readmissions within 30 days, and non-elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- Between 1 April and 31 May 2026, non-elective admissions decreased by 1.6% compared to the same months of 2025 and decreased by 7.9% compared to the same months of 2024. Activity for 1 April and 31 May 2026 was 8.3% below the planned level.
- Between 1 April and 31 May 2026, emergency readmissions totalled 2,326, 1.6% higher than the same period in 2025, when there were 2,289 readmissions.
- The trust-wide monthly non-elective average length of stay decreased in May 2026 to 8.3 days, from 8.4 days in April 2026.



NARRATIVE REPORT

ELECTIVE CARE SERVICES

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

1) The percentage of patients receiving the diagnostic test they need within six weeks of the request being made was 79.6% at the end of May 2026, compared with 78.0% at the end of April 2026. The number of patients waiting over six weeks for a diagnostic test decreased in the period, from 2,788 in April 2026 to 2,522 in May 2026 and was very similar to plan (2,500). The total waiting list size was also higher than plan (12,369 versus a plan of 11,590). Although above plan, the total number of patients awaiting a scan reduced between April and May 2026 despite a loss of capacity due to bank holidays. The main reasons for the six week wait backlogs continue to be capacity shortfalls related to staff vacancies and sickness.
Additional actions being taken in the coming months include:

- Completion of the Bridgwater Diagnostic Centre (June 2026, although opening in August 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.

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

	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
MRI	148	130	96	136	88	105	143	262	206	221	320	252
CT	343	335	293	278	252	212	239	167	79	40	20	16
Ultrasound	988	473	191	141	61	91	70	91	71	121	372	337
Barium Enema	30	23	21	21	12	19	10	4	4	18	18	15
DEXA	126	193	243	309	337	355	387	360	234	150	148	145
Audiology	92	163	111	120	79	117	239	161	148	92	166	277
Echo	254	256	328	142	130	296	564	757	639	766	654	427
Neurophysiology	46	25	28	62	26	35	50	33	16	37	75	74
Sleep studies	130	86	53	14	8	20	6	22	15	19	4	8
Urodynamics	35	36	24	26	30	25	58	65	68	68	58	52
Colonoscopy	258	326	447	442	465	520	618	628	501	460	322	251
Flexi sigmoid.	109	139	215	222	224	225	247	263	181	163	189	205
Cystoscopy	16	30	16	19	19	27	27	22	26	16	14	4
Gastroscopy	280	231	324	332	398	538	523	409	291	348	428	459

2) The RTT plan has been re-set as part of the medium-term plan for the next three years. Current performance against the core RTT target is as follows:
    - 18-weeks RTT (actual 65.6%; plan 63.5%).

Alongside this headline target, there are several supporting metrics which the Trust continues to monitor. These are as follows:

- First OPA within 18 weeks (actual 73.9%; plan 72.0%)
- 52-week waits (actual 2.4% of total waiting list; plan 1.4% or less).
- 65-week waits (37 against a national requirement of zero).

18-week RTT performance (i.e. the percentage of patients waiting under 18 weeks on a Referral to Treatment pathway), is better than plan, as is the percentage of patients waiting under 18 weeks for a first outpatient appointment. This is mainly due to the additional insourcing capacity we established in Quarter 4 of 2025/26, but also the positive impacts of Advice & Refer, with fewer patients having been referred due to advice and guidance given to GPs to support patient management in primary care, and fewer patients now waiting over 18 weeks. The total waiting list size is, however, significantly above plan (54,011 versus a plan of 51,346). The reasons for this are multifactorial but include:

- the plan being set at a point where we were seeing a dramatic reduction in total waiting list size, with the combined impacts of Advice & Refer reduction in clock starts, and additional capacity established, which have not been sustained.
- a seasonal rise in referrals, especially referrals for suspected skin and urological cancer, and additions to the RTT waiting list due to addressing some of the Advice & Refer triage backlogs which have built-up after the resident doctor strikes.
- a small reduction in treatment capacity (i.e. RTT clock stops) due to bank holidays and associated annual leave.
- a reduction in RTT pathway validation due to vacancies in the team.
- several consultant vacancies in high volume specialties including neurology (now filled but not yet in post) and urology.

The numbers of over 52 and over 65-week waiters have increased slightly across the last three months. Actions to reduce the longest waiting patients include:

- fifteen additional theatre sessions being established each week from the beginning of September 2026, covering orthopaedics, ENT, upper GI and urology.
- additional weekend operating sessions being run from April to August 2026, across a range of specialties including orthopaedics and upper GI.

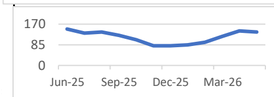
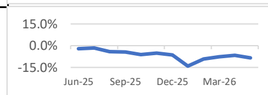
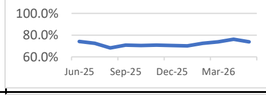
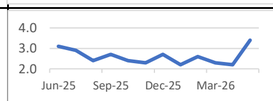
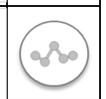
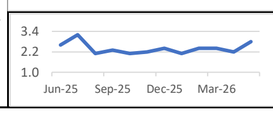
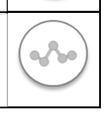
- continued outpatient appointment insourcing in ENT and orthopaedics.
- continued weekend orthopaedic surgery insourcing.
- clinical vacancies appointed to including consultant neurologists, consultant orthopaedic surgeons, ENT and Maxillofacial NHS locums and a urology specialty doctor.

In 2025/26 a new governance structure was established to provide senior oversight for RTT delivery, which continues to be taken forward in 2026/27. This included weekly reviews of patients at risk of breaching 65 weeks at each month-end, chaired by the Chief Operating Officer, with the Director of Elective Care and relevant Service Group Directors in attendance. A monthly elective performance and productivity review meeting is being established, which will again be chaired by the Chief Operating Officer, replacing the challenged specialty review meetings which were in place. In addition, bi-monthly review meetings are in place for the highest risk specialties, and the plans continue to be updated with new actions identified. These meetings are chaired by the Director of Elective Care. The themes for the main actions to improve RTT performance are as follows:

- Continued implementation of the Advice & Refer (Cinapsis) advice & guidance (A&G) platform, which will enable enhanced referrals for all routine GP requests for secondary care opinion. In addition to sixteen specialties already live with written A&G, work is ongoing on the pathway design and onboarding process for Paediatrics, Respiratory and General Surgery. A single point of access is also being developed for the Ophthalmology service, incorporating optometrist direct referral. Additional services going live will further reduce the number of patients needing to have an outpatient appointment. However, in the short term 18-week and first appointments within 18 weeks, performance is being affected because 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).
- 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.
- Clinic template standardisation and increased utilisation, including the development of a machine learning DNA predictor tool to support the backfilling of predicted underutilised clinics.

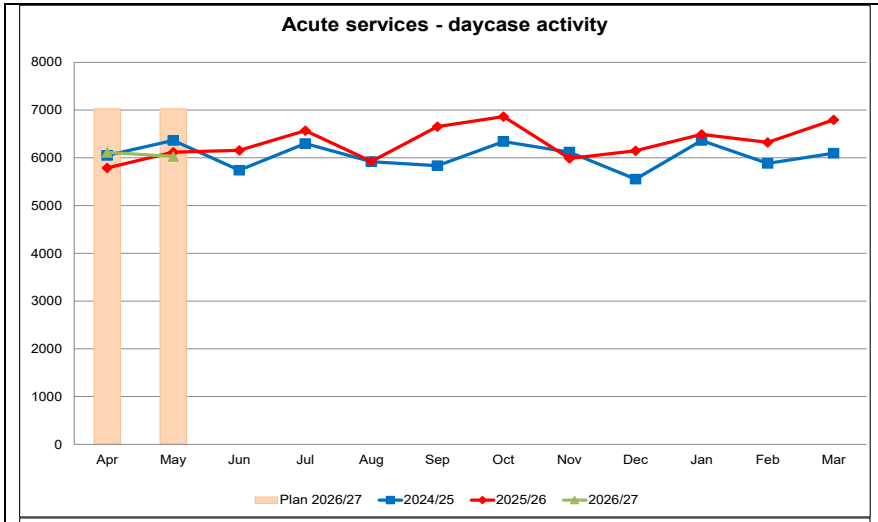
SOMERSET NHS FOUNDATION TRUST

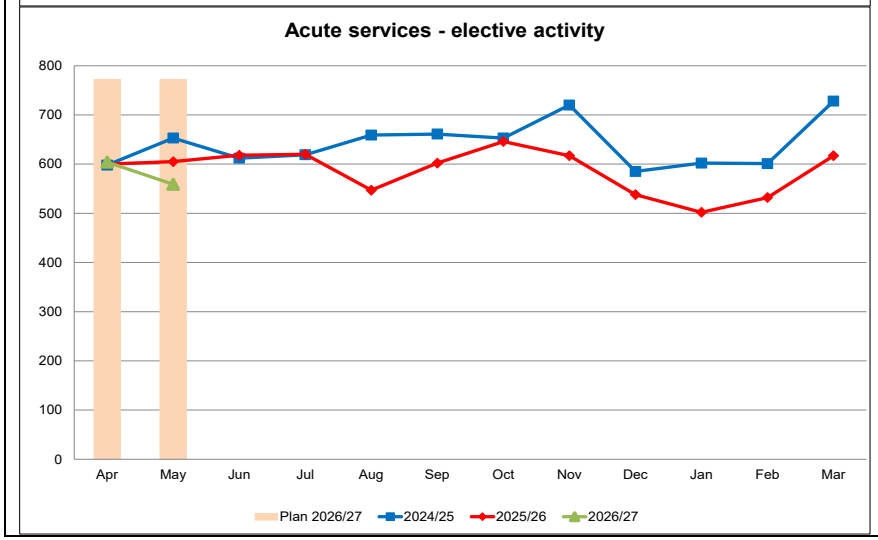
ELECTIVE CARE

No.	Description		Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
EC1	Reduce the proportion of people waiting over 52 weeks for treatment to zero March 2027		OPG	1,2	2.8%	3.0%	3.2%	3.0%	2.7%	2.3%	2.4%	2.2%	2.1%	2.0%	2.1%	2.4%	From April 2026 <=trajectory = Green >trajectory = Red		
EC2	52 week RTT breaches - Patients of all ages		OPG		1,588	1,749	1,826	1,740	1,575	1,313	1,290	1,195	1,111	1,028	1,135	1,304	From April 2023 At or below trajectory = Green Above trajectory = Red		
EC3	52 week RTT breaches - Patients aged under 18		OPG		150	133	138	124	106	81	81	84	96	120	142	138			
EC4	65 week RTT breaches - Patients of all ages		NHSC		108	136	149	157	141	79	18	11	26	17	23	37			
EC5	Referral to Treatment (RTT) incomplete pathway waiting list size - all ages		NHSC	1,2	57,440	57,905	57,715	57,935	58,068	56,659	53,781	53,143	52,985	52,302	53,891	54,011			
EC6	Referral to Treatment (RTT) incomplete pathway waiting list size - under 18		NHSC		4,312	4,160	4,027	3,967	4,005	3,918	3,820	3,762	3,803	3,868	4,098	4,013	From April 2025 at or below trajectory = Green above = Red		
EC7	Rate of annual growth in under 18s elective activity - Rolling 12 months comparison of previous 12 months		NOF, PAF		-2.1%	-1.6%	-4.0%	-4.5%	-6.1%	-5.1%	-6.3%	-14.1%	-9.3%	-7.6%	-6.7%	-8.4%	To be confirmed		
EC8	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				74.1%	72.3%	68.2%	70.6%	70.3%	70.7%	70.3%	70.2%	72.4%	73.9%	76.2%	73.9%	Per the planning trajectory, culminating in 80.0% in March 2027.		
EC9	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	3.1	2.9	2.4	2.7	2.4	2.3	2.7	2.2	2.6	2.3	2.2	3.4	Monitored using Statistical Process Control rules. Report by exception.		
EC10		YDH			2.6	3.2	2.1	2.3	2.1	2.2	2.4	2.1	2.4	2.4	2.2	2.8			

Operational context

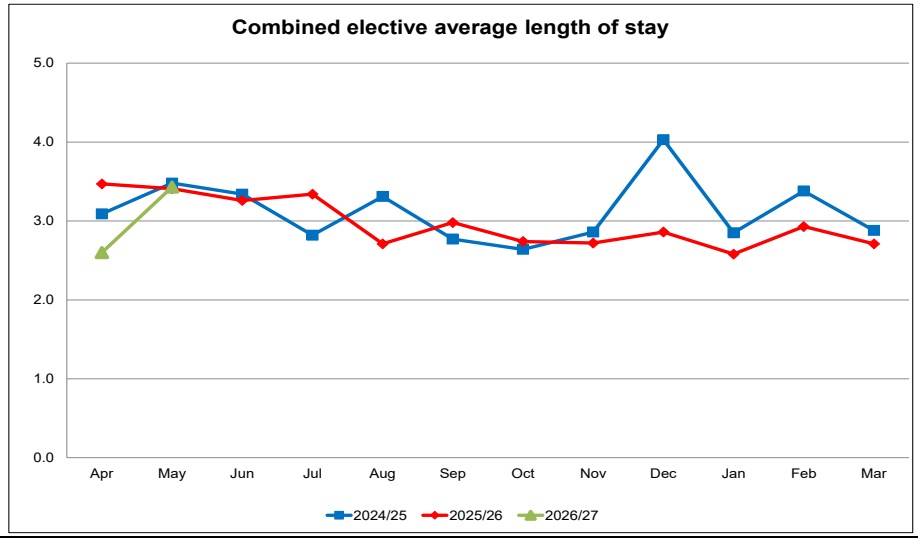
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





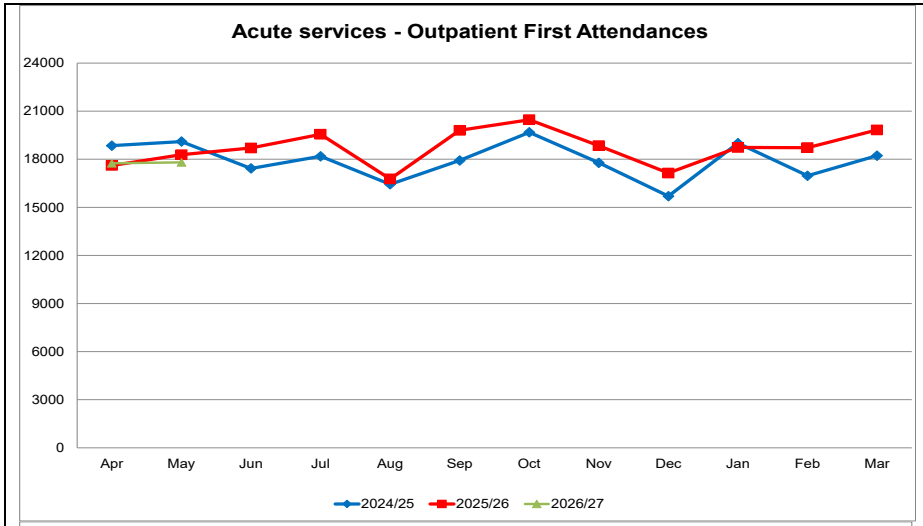
Summary:

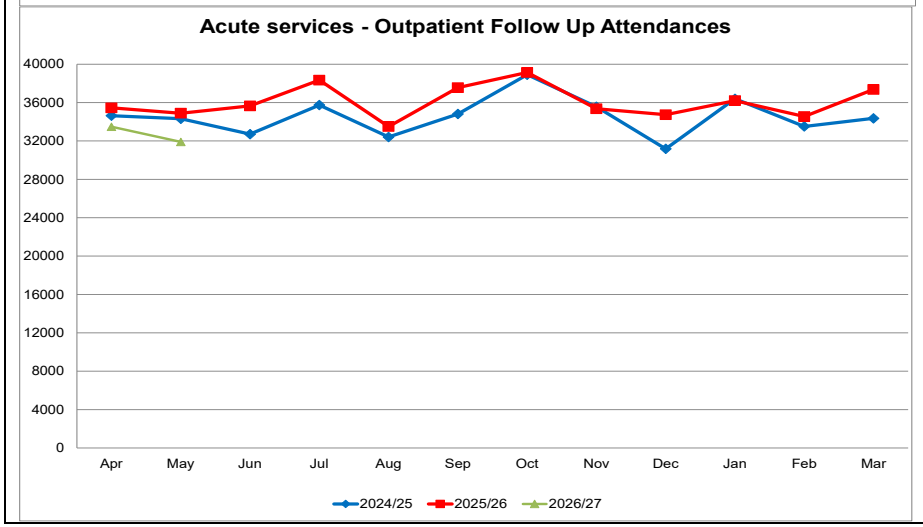
- The number of day cases undertaken by our acute services between 1 April and 31 May 2026 increased by 2.0% compared to the same months of 2025 but decreased by 2.2% compared to the same months of 2024. Activity for the year to date was 13.6% below the current year plan.
- Over the same period, elective admissions were 3.5% lower than the corresponding months of 2025 and 7.0% lower compared to the same months of 2024. Activity for the year to date was 24.7% below the current year plan.
- The trust-wide monthly elective average length of stay was 3.4 days in May 2026, an increase from 2.6 days in April 2026.



Operational context

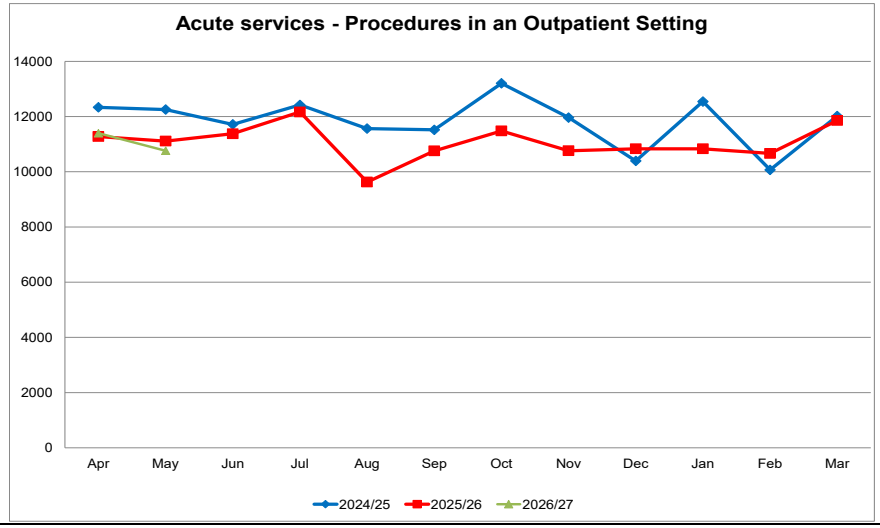
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- The number of first outpatient attendances undertaken by our acute services between 1 April and 31 May 2026 decreased by 1.0% compared to the same months of 2025 and were 6.3% lower than the same months of 2024.
- Over the same period, follow up outpatient attendances were 7.1% lower than the corresponding months of 2025 and 5.2% lower than the same months of 2024.
- Between 1 April and 31 May 2026, the reported number of procedures undertaken within an outpatient setting decreased by 1.0% compared to the same months of 2025 and were 9.9% lower than the same months of 2024. The backlog in respect of coding means that the current numbers 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 78.6% in April 2026, below the national standard (80.0%), and below our planning trajectory of 80.2%. Two tumour sites, Colorectal and Gynaecology were the main contributors to the breaches of the standard in April 2026 as shown in Table 1 below, together making up 43% of breaches.

Table 1. Top five tumour sites contributing to current FDS performance in breach number terms, and in the previous month.

Tumour sites	Breaches (Mar 26)	Performance (Mar 26)	% of breaches (Mar 26)	Breaches (Apr 26)	Performance (Apr 26)	% of breaches (Apr 26)
Colorectal	206	62%	33%	153	68%	26%
Gynaecology	87	66%	14%	99	66%	17%
Skin	79	86%	13%	79	84%	14%
Breast	36	93%	6%	74	85%	13%
Urology	100	63%	16%	65	74%	11%

FDS performance has been affected by very high levels of skin suspected cancer referrals, with skin otherwise usually performing above 90%. Longer than optimal endoscopy waiting times have also been a factor, which is impacting on colorectal performance, and a significant shortfall in capacity in the gynaecology service due to insufficient cover for maternity leave, and sickness in recent months has also increased waiting times. The main actions being taken are:

Colorectal:

- Weekly Colorectal Improvement Programme established to re-visit and continue the 100 Day Challenge work.

- Project Manager secured to support pathway improvement work (returns from maternity leave July 26).
- Pathway analysis being undertaken, supported by SWAG; the analysis of the pathways will help to identify bottlenecks and issues which will then be used by the Improvement Group.
- Straight to CT/CTC pathway for GPs being implemented.
- Progressing discussions on the implementation of ColoFIT, which uses patient specific factors to refine the risk calculation and reduce the need for a colonoscopy to be undertaken in some patients.
- Review and refinement of the GA colonoscopy pathway at YDH to reduce delays.
- Additional endoscopy sessions established by offering enhanced rates: 200 additional slots over the next two months.
- Surgical Centre (King's Building) opening in September 2026, which will provide more flexibility in the physical space to carry out lists.
- Recruitment to booking team vacancies, moving to a central workforce to flex across the two sites.

Gynaecology:

- A pilot of WID-easy high vaginal swabs has now been running for three months, 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.

2) 62-day referral to cancer treatment performance was 71.8% in April 2026, below the current national standard of 75% and our planning trajectory of 74.7%. Draft May 2026 performance represents a deterioration in performance on the April 2026 position. Colorectal and urology are the main tumour sites contributing to breaches.

   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 Head & Neck (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 has been established; a new straight to Maxillo Facial pathway and consultant supervised GP with Extended Roles plastics lists for the less complex cases, is being considered; a summer resilience plan has been developed, although demand is running very high.
- 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.

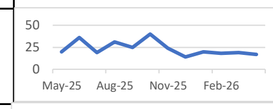
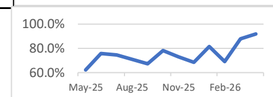
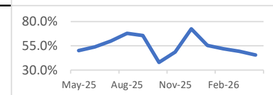
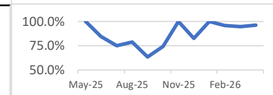
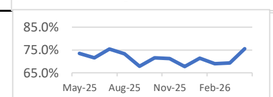
Table 2. 62-Day Cancer performance August 2024 to April 2026.

	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	Apr 26
Trajectory (%)	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	74.7
Actual (%)	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	77.9	71.8

3) 31-day decision to treat to treatment performance was below the 96% April 2026 standard, at 91.9%, and below the planning trajectory of 93.7%. Almost 40% of the breaches of the 31-day standard were in skin and related to the very high levels of referral seen in Quarter 4 of 2025/26. This unseasonally high level of referral growth may be related to the extended period of hot weather experienced in the South West in 2025. The dermatology service has also had a reduction in capacity following a consultant departure. The Trust's insourcing provider is increasing the capacity it provides and artificial intelligence support for the triaging of referrals is being considered to enable patients with the highest risk of cancer to be prioritised.

SOMERSET NHS FOUNDATION TRUST

CANCER SERVICES

No.	Description	Source	Links to strategic aims	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Thresholds	Trend	Variation / Assurance
C1	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104	OPG	1,2	20	36	19	31	25	40	24	14	20	18	19	17	0= Green >0 = Red		
C2	Cancer: 62-day wait from referral to treatment for urgent referrals – Breast	OPG	1,2	62.2%	75.9%	74.6%	70.9%	67.3%	78.1%	73.1%	68.4%	81.5%	69.0%	87.8%	91.9%	At or above trajectory =Amber and below trajectory =Red		
C3	Cancer: 62-day wait from referral to treatment for urgent referrals – Colorectal	OPG	1,2	50.0%	53.8%	60.0%	67.8%	65.6%	37.9%	48.5%	72.5%	55.3%	51.9%	49.4%	45.5%	At or above trajectory =Amber and below trajectory =Red		
C4	Cancer: 62-day wait from referral to treatment for urgent referrals – Gynaecology	OPG	1,2	100.0%	80.0%	62.5%	75.0%	72.7%	86.4%	57.1%	94.4%	81.8%	50.0%	75.0%	83.3%	At or above trajectory =Amber and below trajectory =Red		
C5	Cancer: 62-day wait from referral to treatment for urgent referrals – Haematology	OPG	1,2	100.0%	84.6%	75.0%	78.9%	63.4%	74.4%	100.0%	82.6%	100.0%	95.8%	94.8%	96.2%	At or above trajectory =Amber and below trajectory =Red		
C6	Cancer: 62-day wait from referral to treatment for urgent referrals – Head and Neck	OPG	1,2	72.7%	91.7%	52.6%	51.4%	68.8%	67.5%	77.8%	61.3%	77.8%	66.7%	78.6%	74.6%	At or above trajectory =Amber and below trajectory =Red		
C7	Cancer: 62-day wait from referral to treatment for urgent referrals – Lung	OPG	1,2	75.5%	60.0%	57.6%	66.7%	68.1%	69.6%	100.0%	86.9%	40.0%	45.2%	79.7%	48.9%	At or above trajectory =Amber and below trajectory =Red		
C8	Cancer: 62-day wait from referral to treatment for urgent referrals – Other	OPG	1,2	100.0%	69.2%	92.3%	86.7%	77.8%	61.5%	58.8%	100.0%	87.5%	76.5%	100.0%	100.0%	At or above trajectory =Amber and below trajectory =Red		
C9	Cancer: 62-day wait from referral to treatment for urgent referrals – Skin	OPG	1,2	91.6%	92.0%	81.4%	83.1%	82.3%	76.3%	89.7%	81.1%	85.1%	89.3%	87.6%	84.4%	At or above trajectory =Amber and below trajectory =Red		
C10	Cancer: 62-day wait from referral to treatment for urgent referrals – Upper GI	OPG	1,2	82.1%	69.2%	66.7%	95.8%	63.8%	77.8%	86.2%	56.7%	76.6%	88.9%	82.3%	75.0%	At or above trajectory =Amber and below trajectory =Red		
C11	Cancer: 62-day wait from referral to treatment for urgent referrals – Urology	OPG	1,2	39.9%	40.7%	58.3%	52.7%	64.8%	55.0%	68.3%	55.2%	68.8%	67.5%	65.3%	63.9%	At or above trajectory =Amber and below trajectory =Red		
C12	Cancer: Percentage of all cancers diagnosed that are diagnosed at stage 1 or 2 (75% to be achieved by 2028)	PAF	1,2	73.4%	71.6%	75.3%	73.4%	67.9%	71.6%	71.2%	67.7%	71.3%	69.0%	69.2%	75.5%	>=60.1%= Green >=55.1% to <60.1% = Amber <55.1% =Red		

NARRATIVE REPORT

MATERNITY SERVICES

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

Services continue to operate on both sites, with all operations functioning as they were prior to the temporary suspension of inpatient services at YDH.

Further progress has been made towards the implementation of a county-wide model for elective caesarean section pathways. This includes the introduction of a shared booking diary across sites, enabling improved co-ordination of capacity and demand. This approach is designed to enhance choice, optimise the use of available theatre capacity, and support equitable workload distribution across the system.

The model also enables prioritisation based on clinical need, ensuring that women requiring higher levels of clinical support are appropriately allocated, while maintaining safe, timely access for all. Overall, this represents a significant step forward in standardising pathways across the county, improving patient experience, and strengthening system-wide resilience.

The service has identified a proportionately low number of RADARs being submitted from the YDH site. The Perinatal governance team are closely monitoring this and have proactively undertaken work to support colleagues' confidence and ability to submit RADARs using local leaders to embed improvements.

During May 2026 there was one reported Hypoxic Ischaemic Encephalopathy (HIE) case (rates are reported per 1,000 births). This incident was a concealed pregnancy, and was admitted to maternity via ED. The case has been reviewed internally and was referred to Maternity and Newborn Safety Investigations (MNSI) for investigation. The parents declined and therefore MNSI rejected the case. There were no concerns raised over the care.

The themes of reported incidents for May 2026 were:

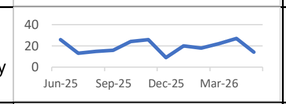
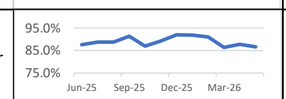
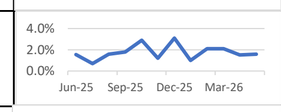
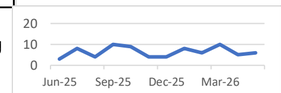
- Pathways for following up results throughout the perinatal pathway.
- Staffing continues to be challenging in both the acute setting and in community services; recruitment is in progress.

- Risk assessments being completed (e.g. Postpartum haemorrhage [PPH] risk assessment).

We remain in the improvement phase of the Maternity and Neonatal Improvement Support Team (MNIST) programme and the launch of the plan for the public, in collaboration with our Maternity & Neonatal Services user Voices Partnership (MNVP), was held on 9 May 2026 in Yeovil.
The service leads are actively supporting colleagues following the national publication of the Ockenden report and await the publication of the Trust and national Amos findings. Preparations for colleague support over the next few weeks have been put into place.

SOMERSET NHS FOUNDATION TRUST

MATERNITY SERVICES

No.	Description	Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
M1	Babies readmitted to hospital who were under 30 days	CQIM	2	0	0	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	26	13	15	16	24	26	9	20	18	22	27	14	Monitored using Statistical Process Control rules. Report by exception.		
M3	Percentage of babies where breast feeding was initiated	CQIM	1,2	87.6%	88.7%	88.8%	91.3%	86.9%	89.2%	92.0%	91.9%	91.1%	86.4%	87.8%	86.6%	>=80%= Green >=75% - <80% =Amber <75% =Red		
M4	Percentage of babies with an APGAR score between 0 and 6	CQIM	1,2	1.6%	0.7%	1.6%	1.8%	2.9%	1.2%	3.1%	1.0%	2.1%	2.1%	1.5%	1.6%	=<1%= Green >1% - =<2% =Amber >2% =Red		
M5	Women who had a 3rd or 4th degree tear at delivery	CQIM	2	3	8	4	10	9	4	4	8	6	10	5	6	To be confirmed, following benchmarking against regional performance.		
M6	Women who had a postpartum haemorrhage (PPH) of 1,500ml or more	CQIM	2	10	6	15	9	10	8	9	6	8	8	10	10	To be confirmed, following benchmarking against regional performance.		
M7	Women who were current smokers at booking appointment	CQIM	1,2	7.0%	5.9%	6.4%	6.7%	5.2%	4.5%	1.5%	7.1%	4.8%	4.9%	7.4%	5.8%	No target level.		
M8	Women who were current smokers at delivery	CQIM	1,2	5.4%	6.8%	6.6%	4.2%	6.8%	3.7%	5.0%	8.2%	3.5%	5.9%	4.2%	3.8%	=<10%= Green >10% - =<12% =Amber >12% =Red		
M9	No. of still births	CQIM	2	1	0	0	0	0	1	0	0	0	2	1	0	Monitored using Statistical Process Control rules. Report by exception.		
M10	No. of babies with Hypoxic Ischaemic Encephalopathy Diagnosis (rate per 1,000 births)	CQIM	2	0.0	0.0	0.0	0.0	0.0	0.0	7.6	0.0	0.0	0.0	0.0	3.9	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%			Quarterly reporting		>=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
Urgent referrals: As at 31 May 2026 the three-month rolling compliance decreased to 83.3%; one breach was recorded in March 2026.
Routine referrals: Compliance increased to 98.3% as at 31 May 2026.
Demand and complexity continue to increase, with a rising prevalence of Avoidant/Restrictive Food Intake Disorder (ARFID) presentations, requiring adaptation of clinical pathways. A higher proportion of cases being triaged as urgent continues to affect routine capacity and overall service flow.
Key areas of focus include:

- Embedding revised pathways to support clinically appropriate triage.
- Implementing updated GP Advice and Guidance (now in ICB Quality Assurance).
- Continuing service model development to support sustainable performance improvement.

Children and Young People's Community Mental Health service
Access performance dipped slightly below the 90% standard to 89.6% following a sustained period of compliance, reflecting the impact of continued high demand and workforce pressures. However, 18-week performance remains compliant, although progress has plateaued, indicating limited headroom within current capacity.
Demand continues to rise, with referrals running significantly above baseline and a sustained increase in access, with 6,013 children and young people seen in the 12 months to May 2026 (up from 5,315 in the 12 months to May 2025).
Key pressures include:

- Sustained high demand affecting routine access and service flow.
- Workforce challenges, including sickness and vacancies.
- Limited additional capacity constraining further improvement.

Areas of focus include:

- Maintaining access performance while managing continued demand growth.
- Supporting workforce stability and resilience.
- Progressing expansion of Mental Health Support Teams in schools and colleges to support core CAMHS capacity and sustainability.

Primary Care Dental Service

Progress continues across Somerset and Dorset, with sustained improvement in Somerset waiting lists and early gains emerging in Dorset, although overall performance remains constrained by system capacity, particularly within general anaesthetic (GA) pathways.

Current position (combined Dorset and Somerset):

- General waiting list: 2,956 patients (62.2% >18 weeks; 16.9% >52 weeks).
- Adult GA: 38 patients (53% >18 weeks; 13% >52 weeks).
- Paediatric GA: 515 patients (64.3% >18 weeks; 6.5% >52 weeks).
- Minor Oral Surgery: 304 patients (48% >18 weeks; no patients >52 weeks).

Progress since last report:

- Somerset continues to deliver reductions across most waiting lists, maintaining the recovery trajectory.
- 52-week waits had reduced significantly over the year; however, there has been a recent increase to 501 patients (from 431 in April), reflecting emerging capacity constraints.
- Paediatric GA performance shows overall improvement in longest waits, despite ongoing operational challenges.

Key pressures include:

- GA capacity remains the primary constraint, affecting both adult and paediatric pathways.
- Dorset waiting lists remain high, reflecting earlier-stage improvement and local operational pressures.
- Workforce pressures, including sickness absence, continue to moderate the pace of recovery.

Areas of focus include:

- Increasing GA capacity through system-wide actions.
- Accelerating the recovery trajectory in Dorset.
- Sustaining progress in Somerset while managing capacity constraints.

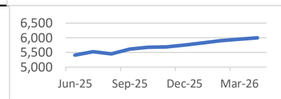
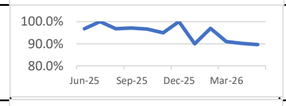
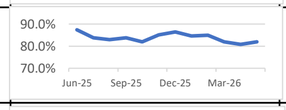
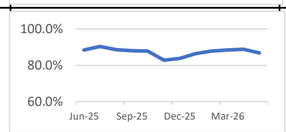
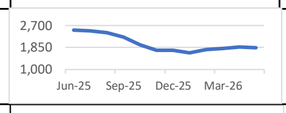
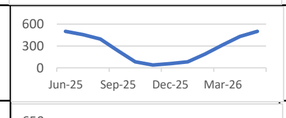
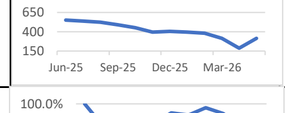
Acute Paediatrics

- ED four-hour performance remains challenged, with delays in clinical review and referral contributing to a slight decrease in performance to 86.7%, slightly below the Operational Plan trajectory of 87.0%. Work has commenced to develop more streamlined clinical pathways in the absence of a Paediatric Assessment Unit (PAU) on the YDH site, pending a longer term move to the Women's Hospital where a PAU footprint can be provided. The ED four-hour performance trajectory for CYP is currently at risk due to the lack of PAU on the YDH site. Development work continues within PAU on the MPH site, further optimising the service to ensure only CYP who require the PAU are seen there.

- PEWS escalation and documentation compliance remains variable between sites, with improvement to 80% at YDH and significant and concerning decline to 0% at MPH. The service group recognises this as a serious concern and is taking robust and immediate action to drive urgent improvement, introducing enhanced oversight to monitor performance and support improvement.

SOMERSET NHS FOUNDATION TRUST

CHILDREN AND YOUNG PEOPLE'S SERVICES

No.	Description		Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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%	80.0%	85.7%	85.7%	83.3%	87.5%	83.3%	>=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	98.2%	97.0%	98.2%	89.8%	90.9%	90.8%	90.8%	91.8%	91.0%	97.1%	96.9%	98.3%	>=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	5,408	5,524	5,451	5,610	5,676	5,691	5,751	5,822	5,896	5,945	5,998	6,013	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	96.8%	100.0%	96.7%	97.1%	96.6%	94.9%	100.0%	90.0%	97.0%	90.9%	90.1%	89.6%	>=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	87.4%	83.7%	82.9%	83.7%	81.9%	85.1%	86.4%	84.6%	85.0%	82.0%	80.8%	82.0%	From April 2025 >=80% = Green <80% = Red		
CYP6	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours from March 2026, rising to 95% by September 2026: Trust-wide performance - Under 16 years old		PAF	2	88.4%	90.4%	88.6%	88.0%	87.8%	82.8%	83.7%	86.3%	87.8%	88.4%	88.8%	86.7%	From April 2026 >=trajectory = Green <trajectory = Red		
CYP7	Community dental services - General, Domiciliary or Minor Oral surgery waiting 18 weeks or more		SFT	1,2,3	2,523	2,495	2,420	2,252	1,956	1,747	1,747	1,645	1,766	1,815	1,866	1,840	From April 2024 <1,979 = Green >=1,979 = Red		
CYP8	Community dental services - General, Domiciliary or Minor Oral surgery waiting 52 weeks or more				501	456	393	234	84	39	55	81	189	316	431	501	From April 2024 <574 = Green >=574 = Red		
CYP9	Community dental services - Child GA waiters waiting 18 weeks or more		SFT	1,2,3	551	537	522	491	454	395	405	397	380	316	187	315	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	62.5%	100.0%	57.1%	66.7%	73.3%	58.3%	81.0%	76.9%	91.7%	80.0%	50.0%	0.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
CYP11		YDH	SFT	1,2,4	100.0%	100.0%	71.4%	88.9%	66.7%	100.0%	93.3%	100.0%	100.0%	50.0%	66.7%	80.0%			

NARRATIVE REPORT

PEOPLE

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

Areas of Success / Celebration

- Retention – while rates remain stable, there are variances across service groups and services. This is being reviewed as part of the service group Performance Oversight Meetings and People Plans.
- Mandatory training – compliance increased to 93.5% in May 2026. Seven service groups have seen an increase in compliance and eight have seen an increase in the number of colleagues in date with all their mandatory training.

Areas of Concern

- Job planning - Overall compliance has reduced following year end, reflecting the expected expiry of a significant number of job plans aligned to the financial year. Work is under way to complete renewals ahead of the next planning cycle, with a continued emphasis on prospective job planning to improve in-year compliance and reduce reliance on year-end completion.

  There are positive developments to note. The work undertaken in Urology in relation to service-level job planning is gaining regional and national attention, with this model demonstrating a more integrated approach to aligning workforce capacity and service delivery. The principles from this work have now been developed into a training programme for medical and service managers to support wider rollout across the Trust.

  Additional support capacity has also been introduced through a new leadership role focused on job planning, aimed at providing targeted support to departments experiencing challenges with volume, complexity, or sign-off. This is expected to help improve pace and consistency as the new cycle progresses.

- Sickness absence – colleagues with a disability are less likely to take periods of sick leave, however when they do they tend to be off for longer periods, this is particularly significant for stress-related sickness. This is reflected in the staff survey results where

colleagues with a disability were significantly less positive about their wellbeing, including feeling unwell due to workplace stress and coming to work when not feeling well. A focus on understanding the key drivers underpinning these is under way.

Focus Areas

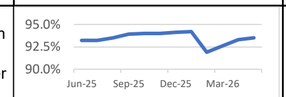
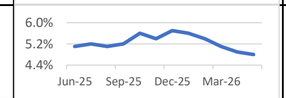
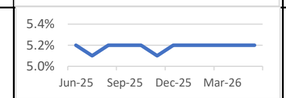
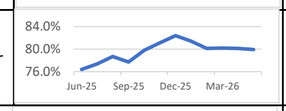
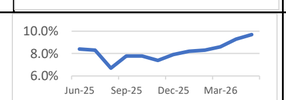
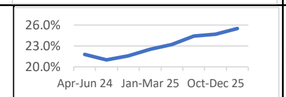
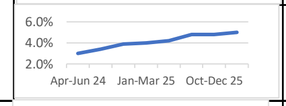
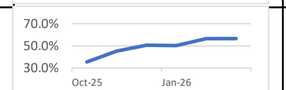
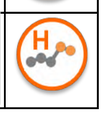
- Vacancy levels – The upward trend and widening gap between funded establishment and in-post workforce continues. The gap is creating pressures in specialist and hard-to-recruit roles, including Estates craft skills, where there is strong local market competition. Recruitment activity remains high, with significant growth in pipeline volumes (over 50% since October 2025). Actions are under way to improve recruitment throughput and stabilise vacancies, including prioritising critical roles, streamlining approvals, targeted campaigns via Talent Acquisition, and strengthening workforce pipelines and retention approaches.

- Appraisal – overall the Trust remains significantly under compliance. The Mental Health & Learning Disabilities (MHLD) service group has the highest compliance level at 87.4%, although this was a drop of 1.2% from the previous month. Clinical Support and Cancer Services had the greatest in-month improvement of 1.6%, taking their compliance to 79.3%. The Surgical Service Group has the lowest compliance rate of the clinical service groups, at 73.2%. The appraisal deliverable focuses on the quality of an appraisal and is working with MHLD and Neighbourhoods to test and learn how to make the appraisal more meaningful. Focus groups have commenced and the data gathering exercise will continue until the end of July 2026.

- Formal HR cases – case volumes are beginning to decline, with 42 cases closed in the past month and a reduction in suspensions to eight active cases (down from 12), although duration remains a key area of focus. Changes to police investigation approaches and greater flexibility in progressing internal cases, alongside ongoing upskilling of investigating officers, are expected to support further improvement. Recent enhancements to the advisory team, including the appointment of a new HR Manager, and the recruitment of an HR Advisor and Specialist focused on medical colleagues, will strengthen policies and processes, reduce reliance on formal routes, improve colleague experience, and mitigate risks to service delivery linked to sickness, exclusion, and reintegration.

SOMERSET NHS FOUNDATION TRUST

PEOPLE

No.	Description		Source	Links to strategic aims	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
P1	Mandatory training: percentage completed	Combined	SFT	5	93.2%	93.2%	93.5%	93.9%	94.0%	94.0%	94.1%	94.2%	91.9%	92.6%	93.3%	93.5%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber		
P2	Monthly percentage of days lost due to sickness absence		NOF	5	5.1%	5.2%	5.1%	5.2%	5.6%	5.4%	5.7%	5.6%	5.4%	5.1%	4.9%	4.8%	SPC (Upper Control Limit 5.4%)		
P3	Sickness absence levels - rolling 12 month average (Trust-wide)		NOF	5	5.2%	5.1%	5.2%	5.2%	5.2%	5.1%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	SPC (Upper Control Limit 5.2%)		
P4	Career conversations (12 months)		SFT	5	76.4%	77.4%	78.7%	77.7%	79.8%	81.1%	82.4%	81.4%	80.1%	80.2%	80.1%	79.9%	>=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%	6.7%	7.8%	7.8%	7.4%	7.9%	8.2%	8.3%	8.6%	9.3%	9.7%	<=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	89.5%	89.6%	89.4%	89.7%	89.8%	89.8%	89.9%	90.0%	89.9%	90.0%	90.1%	90.0%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red		
P7	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	SFT	1,5	23.2%	24.4%			24.7%			25.3%			Reported quarterly		>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red		
P8		Who are female	SFT	1,5	57.9%	58.7%			59.0%			59.1%							
P9		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	12.8%	20.2%	31.6%	60.4%	76.4%	80.6%	83.7%	84.1%	84.1%	91.0%	37.3%	39.1%	>=95%= Green >=85% to <95% =Amber <85% =Red		
P11	Percentage of patient-facing staff receiving a 'flu vaccination		PAF	1,5	Reporting to run from October 2025 to January 2026.				35.4%	45.3%	50.7%	50.2%	56.5%	56.4%	Programme finished		By February 2025 >=33.1% = Green <33.1% = Red		
P12	Number of formal HR case works (disciplinary, grievance and capability).		SFT	5	55	68	86	88	128	105	95	124	111	123	190	148	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

The number of Care Opinion stories received in May 2026 has continued at around the average monthly level. The majority of stories received by the Trust were responded to within the month.

Key themes highlight that staff were kind, caring and reassuring, professional and respectful and supportive during stressful situations. This was particularly strong in Maternity and Paediatrics, Surgery and the Emergency Departments.

During May 2026, the Trust did not receive any requests for second letters, a decrease compared with the previous month. This suggests that first responses are more effectively addressing the issues raised, providing clear explanations and reducing the need for further correspondence. It may also indicate that the continued focus on response quality and early resolution is having a positive impact. In May 2026, second letters accounted for 12.2% of open formal complaints, which remains above the Trust target of less than 10%.

What is going less well

Around a quarter of stories raised concerns about the long waits in the Emergency Departments and Outpatient pathways, with delays mentioned between appointments and tests. A couple of people were waiting several hours post discharge for medication. Communication remains a theme, with people reporting a lack of clarity about what appointments would involve, with confusing or inconsistent information.

Formal complaints continue to show an upward trend, with 145 complaints currently open across the Trust. The thematic review of complaints continues to highlight concerns relating to dismissive communication, and patients and those who matter to them not feeling listened to, heard, or understood. Further recurring themes include a lack of personalised care and concerns regarding essential elements of nursing care, particularly nutrition and hydration, end-of-life care, and pressure area care.

The increasing use of artificial intelligence by those raising concerns to draft correspondence continues to have an impact on the complexity of complaints received.

In May 2026, the response rate for formal complaints responded to within agreed time frame increased slightly, to 54.2%. Delays were attributable to the following factors:

- A focus on complaints led within individual service groups has, in some cases, delayed responses to complaints led in other service groups, where cross-service input is required.
- 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.

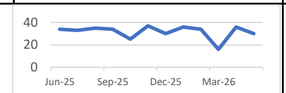
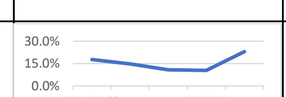
Focus of improvement work

- Liaise with service leads and feedback responders to ensure they feel confident and supported when responding to patient and carer feedback.
- Review and enhance the supporting information available on the intranet for Care Opinion responders.
- Continue to refine team job planning to ensure all Care Opinion stories are responded to promptly and meaningfully.
- Update internal information boards and promotional materials to raise awareness of Care Opinion among patients, carers and relatives, and emphasise the importance of their feedback.
- Trust-wide complaints training has commenced, with delivery dates scheduled across multiple sites, including West Mendip Community Hospital. Uptake has been high, and additional training dates have been added 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	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Thresholds	Trend	Variation / Assurance
PE1	Care Opinion: Number of stories per month	SFT	2	34	33	35	34	25	37	30	36	34	16	36	30	Increase from 2024/25 baseline		
PE2	Care Opinion: Percentage of stories with responses	SFT	2	100.0%	100.0%	100.0%	91.2%	92.0%	81.0%	100.0%	97.2%	100.0%	100.0%	91.7%	93.3%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE3	Percentage of complaints responded to within the timescale agreed with the complainant	SFT	2	73.3%	73.3%	56.8%	62.0%	52.8%	73.0%	50.0%	55.8%	51.5%	49.0%	54.1%	54.2%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE4	Percentage of open complaints that are second letters	SFT	2	New reporting										11.4%	12.2%	<=10%= Green >10% - <=15% =Amber >15% =Red		
PE5	Percentage of formal complaints fully upheld	SFT	2	17.6%	14.8%			10.7%			10.4%			23.0%		Compare to national average		
PE6	Percentage of formal complaints partially upheld	SFT	2	63.7%	62.3%			72.8%			73.6%			68.9%		Compare to national average		

Appendix 1 – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in May 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	958	38	2,807	65.9%
Urology	1,460	132	3,102	52.9%
Trauma & Orthopaedics	3,029	323	8,800	65.6%
Ear, Nose & Throat (ENT)	2,015	220	5,094	60.4%
Ophthalmology	607	20	3,055	80.1%
Oral Surgery	1,817	151	3,662	50.4%
Plastic Surgery	12	1	112	89.3%
Cardiothoracic Surgery	1		13	92.3%
General Medicine	17		55	69.1%
Gastroenterology	551	10	2,090	73.6%
Cardiology	1,062	13	3,156	66.3%
Dermatology	681	33	3,013	77.4%
Thoracic Medicine	206		1,507	86.3%
Neurology	427	9	1,124	62.0%
Rheumatology	335	1	823	59.3%
Geriatric Medicine	145	3	712	79.6%
Gynaecology	1,666	72	3,847	56.7%
Other – Medical Services	911	17	3,834	76.2%
Other - Paediatric Services	324	12	1,175	72.4%
Other - Surgical Services	2,355	249	5,809	59.5%
Other – Other Services			221	100.0%
Total	**18,579**	**1,304**	**54,011**	**65.6%**

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

Tumour site	No of breaches	Trust performance
Brain	0.0	100.0%
Breast	3.0	91.9%
Colorectal	18.0	45.5%
Gynaecology	2.0	83.3%
Haematology	1.0	92.9%
Head & Neck	6.0	50.0%
Lung	12.0	48.9%
Other	0.0	100.0%
Skin	10.5	84.4%
Upper GI	5.5	75.0%
Urology	28.5	63.9%
Total	**86.5**	**71.8%**

Eighteen patients were treated in April 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 pathways were delayed due to a range of factors, including elements outside of our control.
- Three 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.
- Two patients' pathways were delayed due to the need to treat another medical condition first.
- One pathway had administrative / pathway management delays.

Appendix 2 – Infection Control and Prevention – May 2026

MRSA bloodstream infections	Commentary on MRSA /MSSA BSIs
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Total to date = 0**	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. **MSSA** – A Quality Improvement project is in place for the MPH Site in Cardiology focusing on right site, right device, removal when no longer needed. This will be monitored through the Infection Control Operational Group.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 4 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0 **Internal Threshold = 64** **Total to date = 14**	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 5 Yeovil District Hospital = 4 Community Hospitals / Mental Health = 0 **Threshold = 100 (2025/26)** **Total to date = 12**	The annual thresholds for 2026/27 have not been published, therefore the same figures as last year will be used until agreed. As a Trust we are under trajectory for all the Gram-negative organisms.
Klebsiella bloodstream infections	
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Threshold = 36 (2025/26)** **Total to date = 6**	
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Threshold = 12 (2025/26)** **Total to date = 1**	

C. difficile	Commentary on C. difficile
Musgrove Park Hospital = 5 Yeovil District Hospital = 0 GP = 0 **Threshold = 90 (2025/26)** **Total to date = 10**	The annual thresholds for 2026/27 have not been published, therefore the same figures as last year will be used until agreed. As a Trust we remain under trajectory to date
Respiratory Viral Infections - inpatients	**Commentary on Respiratory Viral Infections**
COVID (Trust Cases) = 3 Musgrove Park Hospital = 1 Yeovil District Hospital = 2 Community / Mental Health = 0 **Influenza = 1 (Inpatients)** Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Respiratory Syncytial Virus (RSV) = 0 (Inpatients)**	**Respiratory Viruses** All respiratory virus case numbers remain low.
Outbreaks	**Commentary on outbreaks**
COVID = 1 (YDH) **Influenza = 0** **Norovirus = 5** Musgrove Park Hospital = 1 Yeovil District Hospital **= 4** **Carbapenemase Producing Organism (CPO)** Yeovil District Hospital	There were significant pressures in April 2026 due to norovirus outbreaks, particularly affecting the Yeovil site. **Carbapenemase Producing Organism (CPO)** On the Yeovil district hospital site work continues to manage the CPO 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. Since February 2926 nice 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.
Surgical Site Infections	**Commentary on Surgical Site Infections**
Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions. **Musgrove Park Hospital Site** Continuous surveillance for Total Hip Replacement (THR), Total Knee Replacement (TKR) and Spinal Surgery has been in place on the MPH site since 2009. **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 Innovation, West of England launched PreCiSSIon: 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. **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.	**There is a delay in finalising the data for the latest period, May 2025 to April 2026, with the clinical teams. This will be published as soon as it is complete. Therefore, the data presented is currently unchanged from the April report.** **Musgrove Park Hospital Site** • **Hip Replacement** Within the last year (April 2025 to March 2026) a total of 342 operations were undertaken with no infections identified. • **Knee Replacement** Within the last year (April 2025 to March 2026) a total of 199 operations were undertaken and one infection identified giving an infection rate of 0.5%. This is in line with the national benchmark of 0.4% • **Spinal Surgery** Within the last year (April 2025 to March 2026) a total of 347 operations were undertaken and 5 infections identified giving an infection rate of 1.44%. The infection rate is above the national benchmark of 1.1%. • **Caesarean Section** Between December 2025 to February 2026 a total of 376 C-sections were undertaken and 19 infections identified (3 readmissions and 16 patient-reported) giving an infection rate of 5.05% which is below the adopted benchmark of 13.3%. **Yeovil District Hospital Site** • **Hip Replacement** Within the last year (April 2025 to March 2026) a total of 334 operations were undertaken with no infections identified.

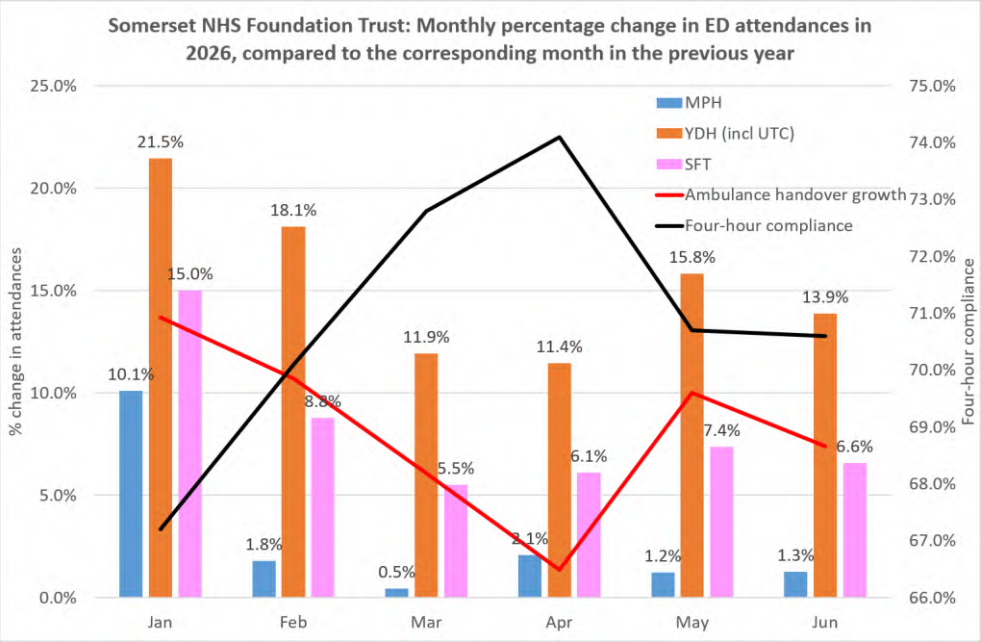
	• **Knee Replacement** Within the last year (April 2025 to March 2026) a total of 449 operations were undertaken with no infections identified. The national rate is calculated over the period April 2019 to March 2024 and therefore not directly comparable to trust infection rates. However, as a trust the national benchmark is always used as a guide.

Appendix 3 – Operational Plan recovery trajectories

Recovery trajectories for the measures currently not meeting the Operational Plan trajectories are set out below.

ED four-hour standard

Performance against the ED four-hour standard was 70.7% in May 2026, against an Operational Plan standard for May 2026 of 76.5%. Both Musgrove Park Hospital and Yeovil District Hospital (including the Urgent Treatment Centre) have seen significant levels of growth in attendances in 2026, compared to 2025. Attendances at MPH during the period 1 January to 30 June 2026 were 2.7% higher than during the corresponding period in 2025, and attendances at YDH during the period 1 January to 30 June 2026 were 15.3% higher than during the corresponding period in 2025, giving an overall Trust-wide increase of 8.1%. The Operational Plan assumption was growth of 1%, in line with the Office of National Statistics population growth forecast. The monthly percentage changes in attendances are shown as bars in the chart below, measured against the left-hand vertical axis. Monthly compliance with the four-hour standard is shown as the black line, measured against the right-hand vertical axis. The monthly Trust-wide level of growth in ambulance handover levels is shown as the red line, measured against the left-hand vertical axis:



Key actions relating to ED four-hour performance include:

- Review of the overnight time to seen at MPH ED.
- YDH UTC and SDEC clinical service leads to be reviewed.
- MPH SDEC - proposal for a new model being progressed under the 2026/27 transformation priorities programme.
- One-week trial of an additional SHO overnight.
- Review of Rapid Assessment and Treatment (RAAT) data capture at YDH – RAAT to be documented as time to see, where consultant led.
- Explore the feasibility of earlier starts at MPH to reduce four-hour breaches / time to seen in early morning.

ED four-hour standard trajectory

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	74.1%	70.7%										
Planned trajectory	76.0%	76.5%	77.0%	77.5%	78.1%	78.5%	79.0%	79.5%	80.0%	80.5%	81.0%	82.0%
Recovery trajectory			70.5%	71.5%	72.4%	73.4%	74.3%	75.3%	76.3%	78.2%	80.1%	82.0%

ED four-hour standard: patients aged under 16 years

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	88.8%	86.7%										
Planned trajectory	85%	87%	89%	91%	93%	95%	95%	95%	95%	95%	95%	95%
Recovery trajectory			86.7%	89%	92%	95%	95%	95%	95%	95%	95%	95%

Ambulance handovers

The table below sets out the growth in ambulance conveyances to MPH and YDH in 2026, compared to 2025, as sourced from the SWAST report 'Somerset ICB Activity, Outcomes and THP Impact Review, May 2026'.

Site	24 February 2025 to 18 May 2025	23 February 2026 to 17 May 2026	Increase	Percentage increase
MPH	6,134	6,447	313	5.1%
YDH	2,850	3,232	382	13.4%
Total	**8,984**	**9,679**	**695**	**7.7%**

This shows a growth in conveyances to MPH of 5.1%, and a growth in conveyances to YDH of 13.4%, with an overall Trust-wide growth level of 7.7%. The Operational Plan assumption was that any projected growth would be negated by work being undertaken with SWAST to reduce conveyance levels to SFT to a level no higher than the regional average.

Work being undertaken to eliminate corridor care will reduce the availability of space for handovers and potentially provide a further challenge to handover performance. Actions include:

- The ED reconfiguration programme at MPH includes increased dedicated RAAT cubicles.
- Capture evidence on clustered arrivals for a review of patterns for a potential service Quality Improvement project.
- SWAST plans are currently still awaited, outlining the actions to be taken to normalise the rate of ambulance conveyances in Somerset, down to the regional average.

Percentage of ambulance handovers over 15 minutes

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	67.8%	68.1%										
Planned trajectory	66.0%	63.1%	60.4%	57.7%	55.0%	52.3%	49.7%	47.0%	44.2%	41.2%	38.5%	35.7%
Recovery trajectory			72.5%	68.4%	64.3%	60.2%	56.1%	52.1%	48.0%	43.9%	39.8%	35.7%

Percentage of ambulance handovers over 45 minutes

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	4.0%	5.2%										
Planned trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Recovery trajectory			7.5%	6.7%	5.8%	5.0%	4.2%	3.3%	2.5%	1.7%	0.8%	0.0%

RTT Total Waiting list size

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	53891	54011										
Planned trajectory	51346	50653	49981	49170	48544	47845	47489	47147	46738	46425	46124	45835
Recovery trajectory			54071	52298	51412	49048	47489	47147	46738	46425	46124	45835

RTT 52-week waiters

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	1135	1304										
Planned trajectory	770	709	600	541	485	383	261	141	93	65	23	0
Recovery trajectory			1357	1332	1282	1157	972	787	662	437	212	65

Cancer 28-day Faster Diagnosis Standard (FDS)

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	78.6%											
Planned trajectory	80.2%	80.5%	80.7%	82.3%	78.0%	78.6%	80.1%	80.3%	80.0%	77.1%	81.8%	81.4%
Recovery trajectory		79.0%	80.7%	78.3%	78.0%	78.6%	80.1%	80.3%	80.0%	77.1%	81.8%	81.4%

Cancer 62-day Referral to Treatment

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	71.8%											
Planned trajectory	74.7%	68.4%	75.8%	75.1%	72.5%	70.7%	74.8%	78.1%	79.7%	77.5%	78.6%	82.0%
Recovery trajectory		65.0%	68.5%	72.1%	72.5%	70.7%	74.8%	78.1%	79.7%	77.5%	78.6%	82.0%

Cancer 31-day decision to treat to treatment

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	91.9%											
Planned trajectory	93.7%	94.4%	94.7%	94.4%	92.4%	92.9%	93.7%	93.5%	94.1%	94.1%	95.3%	94.6%
Recovery trajectory		90.0%	89.5%	91.0%	92.4%	92.9%	93.7%	93.5%	94.1%	94.1%	95.3%	94.6%

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 29 April 2026
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Inga Kennedy, Chair of the Quality and Governance Assurance Committee
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	The Committee met on 29 April 2026 and reviewed the Board Assurance Framework, Corporate Risk Register, patient safety and quality oversight, emerging executive concerns, governance assurance arrangements and the assurance report from Simply Serve Limited. Assurance was received regarding the reopening of maternity services at Yeovil District Hospital, strengthening governance arrangements, continued development of patient safety processes and positive progress in community response services. Key risks remain around patient flow and delayed discharge, corridor care, deteriorating patient performance, patient safety investigation capacity and estates and infrastructure risks.
Recommendation	That the Board **notes** the assurance provided and the key risks highlighted, particularly those relating to patient flow and corridor care, deteriorating patient care, patient safety investigation capacity and estates and infrastructure risks.

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

- ☐ Aim 1 Contribute to improving the physical health and wellbeing of the population and reducing health inequalities
- ☒ Aim 2 Provide the best care and support to people
- ☐ Aim 3 Strengthen care and support in local communities
- ☒ Aim 4 Respond well to complex needs
- ☒ Aim 5 Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture

☐ Aim 6	Live within our means and use our resources wisely
☐ Aim 7	Deliver the vision of the Trust by transforming our services through, innovation, research and digital transformation

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
Staff involvement takes place through the regular service group and topic updates.

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MEETING OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE HELD ON 29 APRIL 2026

1. PURPOSE

1.1. This report provides a summary of the key items discussed at the Quality and Governance Assurance Committee (Q&GAC) meeting held on 29 April 2026, including assurance received, areas of concern and risks or issues to be escalated to the Board.

2. ASSURANCE RECEIVED

2.1. The Committee received updates on the Board Assurance Framework (BAF) and the Corporate Risk Register, noting that significant operational pressures continue to impact a number of strategic objectives. Assurance was received regarding progress in community services, elective and diagnostic pathways, implementation of eSTEP and the reopening of maternity services at Yeovil District Hospital.

2.2. The Committee received assurance that risk management arrangements continue to mature, supported by the recently approved Risk Management Strategy and ongoing work to strengthen risk identification, escalation and oversight. Positive assurance was also noted regarding improvements in estates governance and review of fire safety risks.

2.3. The Committee received assurance regarding governance and quality oversight through the Governance Support Summary, Data Review Group and Patient Safety Board. Members noted strengthening service group governance arrangements, improved analysis of incidents and complaints and continued development of patient safety governance processes.

2.4. Some assurance was also received from Simply Serve Limited regarding governance, quality, financial performance and alignment with Trust assurance processes. That said, it was recommended that reports should contain more evidenced based assurance as opposed to process narrative.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee noted ongoing concerns regarding deteriorating patient care, particularly NEWS2 escalation performance and the need for stronger assurance regarding recognition and response to patient deterioration.

3.2. Concerns were raised regarding patient flow, delayed discharge, Criteria to Reside performance and the increasing national focus on corridor care. Members emphasised the importance of clear governance, reporting arrangements and improvement plans.

3.3. The Committee discussed significant delays in the completion of Patient Safety Incident Investigations (PSIIs), noting the impact on organisational learning, staff and families.

3.4. Workforce and capacity pressures continue to affect a number of areas, including patient safety investigation capacity, data quality, governance

infrastructure and delivery of improvement programmes, which also impacts on the ability to demonstrate organisational learning.

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

4.1. The Committee agreed that patient flow pressures, delayed discharge and corridor care continue to present significant risks to patient safety, quality and performance and remain above the Trust's risk appetite.

4.2. The Committee noted that deteriorating patient care remains a key risk, particularly in relation to escalation, response times and assurance regarding compliance with established processes.

4.3. The Committee highlighted the risk arising from delays in Patient Safety Incident Investigations and the potential impact on learning, improvement and organisational culture.

4.4. The Committee also noted ongoing risks relating to maternity and paediatric services following the reopening of maternity services, alongside continuing estates and fire safety risks, particularly within the Yeovil estate.

Inga Kennedy
CHAIR OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 27 May 2026
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Inga Kennedy, Chair of the Quality and Governance Assurance Committee
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	The Committee met on 27 May 2026 and reviewed strategic quality priorities, including Mental Health Services transformation, progress against Strategic Aim 4, learning from deaths, maternity and neonatal quality and safety, assurance from Symphony Healthcare Services and progress against the Children and Young People's Services CQC action plan. Assurance was received regarding the development of Mental Health Services transformation plans, improvements in paediatric diabetes services and electronic end-of-life care planning, strengthening governance arrangements within primary care services, and continued progress within maternity, neonatal and children's services improvement programmes. Key risks remain around workforce sustainability, patient flow and corridor care, organisational culture and escalation processes, maternity and neonatal workforce capacity, and the delivery and sustainability of improvements within Children and Young People's Services.
Recommendation	That the Board **notes** the assurance provided and the key risks highlighted, particularly those relating to workforce sustainability, patient flow and corridor care, organisational culture and escalation practices, maternity and neonatal workforce capacity, and the ongoing delivery of improvement programmes within Children and Young People's Services.

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

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

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

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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)				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MEETING OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE HELD ON 27 MAY 2026

1. PURPOSE

1.1. This report provides a summary of the key items discussed at the Quality and Governance Assurance Committee (Q&GAC) Focus Meeting held on 27 May 2026, including assurance received, areas of concern and risks or issues to be escalated to the Board.

2. ASSURANCE RECEIVED

2.1. The Committee received updates on strategic quality priorities, including development of the Mental Health Services transformation programme, progress against Strategic Aim 4 and assurance relating to corridor care governance and reporting arrangements.

2.2. The Committee received assurance regarding improvements in paediatric diabetes services, progress in electronic end-of-life care planning and ongoing work to strengthen transitions between children's and adult services.

2.3. Assurance was received through the Learning from Deaths Report, highlighting continued oversight of learning themes, mortality indicators and actions arising from deaths reviews, inquests and Prevention of Future Deaths reports. The Committee also noted work underway to strengthen organisational learning arrangements and implementation of learning from incidents and deaths.

2.4. The Committee received positive assurance from Symphony Healthcare Services regarding governance arrangements, patient safety processes, quality improvement activity and learning from complaints and incidents. It was acknowledged that reporting needs to be more focussed on assurance as opposed to process narrative.

2.5. The Committee also received assurance regarding maternity and neonatal services, including strengthened governance arrangements, progress following the reopening of maternity services at Yeovil District Hospital, positive quality indicators and ongoing support from national improvement programmes.

2.6. The Committee reviewed progress against the Children and Young People's Services CQC action plan and received assurance regarding improvements in safeguarding, workforce arrangements, governance processes, training compliance and delivery of the improvement programme.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee noted continuing concerns regarding patient flow pressures, use of escalation spaces and corridor care, particularly during periods of sustained operational demand.

3.2. Concerns were raised regarding workforce sustainability across a number of services, particularly within neonatal, mental health and primary care services.

3.3. The Committee discussed challenges relating to organisational culture, professional behaviours and escalation processes, highlighting the importance of ensuring staff feel confident to raise concerns and escalate issues appropriately.

3.4. The Committee also noted ongoing concerns regarding capacity for Patient Safety Incident Investigations and the need to strengthen assurance regarding implementation and sustainability of learning from incidents and deaths.

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

4.1. The Committee agreed that workforce pressures within maternity, neonatal, mental health and primary care services remain a significant risk requiring continued oversight.

4.2. The Committee noted that patient flow pressures, escalation spaces and corridor care continue to pose risks to patient safety, quality of care and operational performance.

4.3. The Committee highlighted risks associated with organisational culture and escalation practices, particularly where these may impact patient safety and learning.

4.4. The Committee also noted continuing risks relating to the sustainability of maternity and neonatal services, including workforce capacity, culture and service resilience, although assurance was received regarding ongoing improvement activity and governance oversight.

Inga Kennedy
CHAIR OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 24 June 2026
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Inga Kennedy, Chair of the Quality and Governance Assurance Committee
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	The Committee met on 24 June 2026 and reviewed the Board Assurance Framework, Corporate Risk Register, patient safety and quality oversight, emerging executive concerns, governance assurance arrangements, patient experience, the Quality Account and the Healthset digital programme. Assurance was received regarding progress in strengthening strategic risk management arrangements, governance and patient safety processes, patient engagement and organisational learning. Assurance was also received regarding the Trust's Quality Account priorities and the mobilisation of the Healthset programme. Key risks remain around patient flow and discharge delays, mental health service pressures, organisational learning and the implementation of learning from incidents and complaints, consent to care arrangements and information governance performance.
Recommendation	That the Board **notes** the assurance provided and the key risks highlighted, particularly those relating to patient flow and delayed discharge, mental health service pressures, organisational learning, consent to care arrangements, information governance performance and delivery of the Healthset programme.

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MEETING OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE HELD ON 24 JUNE 2026

1. PURPOSE

1.1. This report provides a summary of the key items discussed at the Quality and Governance Assurance Committee (Q&GAC) meeting held on 24 June 2026, including assurance received, areas of concern and risks or issues to be escalated to the Board.

2. ASSURANCE RECEIVED

2.1. The Committee received updates on the development of the Board Assurance Framework (BAF) and Corporate Risk Register, noting progress in strengthening strategic risk management and assurance arrangements.

2.2. The Committee received assurance regarding actions being taken to address quality, safety and operational pressures, including improvements to patient flow, discharge processes, clinical operational standards and governance arrangements.

2.3. Assurance was received through the Governance Support Summary, Patient Safety Board and Patient Experience Report, highlighting continued development of governance processes, organisational learning, patient safety oversight and patient engagement arrangements.

2.4. The Committee received assurance regarding the Trust's Quality Account priorities for 2026/27, noting alignment with strategic objectives and key quality improvement programmes.

2.5. The Committee also received assurance regarding mobilisation of the Healthset programme, including the establishment of governance arrangements, recruitment to key roles and development of clinical and technical leadership structures.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee noted ongoing concerns regarding patient flow, discharge delays and operational pressures, particularly at Yeovil District Hospital.

3.2. Concerns were raised regarding out-of-area mental health placements and the need to ensure sufficient focus on mental health services within future assurance arrangements.

3.3. The Committee highlighted recurring themes relating to deteriorating patient care, organisational learning and the implementation of learning from incidents, complaints and inquests.

3.4. Members also discussed concerns regarding complaint response times, consent to care arrangements and information governance performance.

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

4.1. The Committee agreed that patient flow pressures and delayed discharge continue to present significant risks to patient safety, quality and operational performance.

4.2. The Committee noted ongoing risks relating to mental health services, including out-of-area placements and maintaining appropriate strategic oversight.

4.3. The Committee highlighted risks associated with the organisation's ability to consistently embed learning from incidents, deteriorating patient reviews, complaints and inquests.

4.4. The Committee also noted continuing risks relating to consent to care arrangements, information governance performance and delivery of the Healthset programme.

Inga Kennedy
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 16 June 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:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	The Committee met on 16 June 2026 and reviewed Mental Health Act and Mental Capacity Act governance arrangements, Approved Mental Health Professional Services, mental health commissioning developments, out-of-area placements, complaints, CQC inspections and current risks relating to mental health services. Assurance was received regarding Mental Health Act compliance, Mental Capacity Act arrangements, management of out-of-area placements, workforce development and governance processes. The Committee also received positive assurance following the recent CQC inspection of Rowan Ward 1. Key risks remain around CAMHS Tier 4 provision and provider collaborative arrangements, mental health bed flow and delayed discharge, workforce pressures, ward environment risks and the actions arising from the Pyrland Ward 2 CQC inspection.
Recommendation	That the Board **notes** the assurance provided and the key risks highlighted, particularly those relating to CAMHS Tier 4 provision and provider collaborative arrangements, mental health bed flow and delayed discharge, workforce pressures, ward environment risks and the actions arising from the Pyrland Ward 2 CQC inspection.

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

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

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

Equality The Trust wants its services to be as accessible as possible, to as many people as possible. Please indicate whether the report has an impact on the protected characteristics
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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)
Staff involvement takes place through the regular service group and topic updates.

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 16 JUNE 2026

1. PURPOSE

1.1. This report provides a summary of the key items discussed at the Mental Health Legislation Committee meeting held on 16 June 2026, including assurance received, areas of concern and risks or issues to be escalated to the Board.

2. ASSURANCE RECEIVED

2.1. The Committee received assurance regarding Mental Health Act governance arrangements, noting continued compliance with training, advocacy provision, Section 132 audits and Mental Health Act processes. Assurance was also received regarding the resilience of the Mental Health Act team during a prolonged vacancy in the Mental Health Act Lead role.

2.2. The Committee received assurance regarding Mental Capacity Act and Deprivation of Liberty Safeguards arrangements, including strong training compliance within mental health services, continued delivery of targeted training and a lawful organisational approach following recent legal developments relating to deprivation of liberty.

2.3. The Committee received updates on Approved Mental Health Professional Services, Integrated Care Board commissioning arrangements, forensic services and out-of-area placements. Members noted that Somerset continues to maintain low levels of inappropriate out-of-area placements and effective management of patients requiring secure services.

2.4. The Committee also received positive assurance following the recent CQC Mental Health Act Monitoring Visit of Rowan Ward 1, which highlighted strong compliance with the Mental Health Act, patient-centred care and the use of least restrictive practices.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. The Committee noted ongoing challenges regarding Approved Mental Health Professional referral processes and delays in emergency departments, recognising the need for a consistent and effective referral pathway.

3.2. Concerns were raised regarding CAMHS Tier 4 provision and the absence of a formal, sustainable pathway for managing young people requiring escalation to specialist inpatient services.

3.3. The Committee discussed findings from the recent CQC Mental Health Act Monitoring Visit to Pyrland Ward 2, including concerns relating to patient flow, the ward environment, access to advocacy, mixed-sex accommodation and

access to physical healthcare services. Actions had been identified and would be monitored by the Service Group.

3.4. Workforce pressures, delayed discharges and patient flow through mental health services remain areas of concern, particularly where these impact the ability to provide care in the least restrictive environment.

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

4.1. The Committee agreed that CAMHS Tier 4 provision and wider provider collaborative arrangements remain a significant risk. Members highlighted the lack of a sustainable local pathway, reliance on informal arrangements and potential delays associated with future commissioning decisions following the closure of Wessex House.

4.2. The Committee noted ongoing risks associated with mental health bed flow and delayed discharge, including challenges in securing appropriate placements and maintaining patients in the least restrictive setting.

4.3. The Committee highlighted workforce pressures, particularly reduced availability of agency staffing, and the potential impact on patient experience and service resilience.

4.4. The Committee also noted continuing risks relating to the Pyrland Ward 2 CQC findings, including environmental risks, mixed-sex accommodation and discharge delays.

Alex Priest
CHAIR OF THE MENTAL HEALTH LEGISLATION COMMITTEE

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Maternity & Neonatal Quarter 4 (2025/26) Quality & Safety Report
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse & Midwife
REPORT BY:	Sally Bryant, Director of Midwifery and Deputy to the Chief Midwife
PRESENTED BY:	Sally Bryant, Director of Midwifery and Deputy to the Chief Midwife
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	For assurance of the safety & quality of maternity & neonatal services
Recommendation	The Board is asked to: • Review the Q4 Q&S report • Note the actions being taken to address the strategic risks.

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

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

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

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

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
MNVP provide service user feedback and work with SFT colleagues as quorate members of all quality & safety meetings within the governance workstream.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – e.g. in Part B]
Report has been reviewed and discussed at Safety Champions Board; LMNS Programme Board and Perinatal Governance.

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

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

SOMERSET NHS FOUNDATION TRUST

MATERNITY & NEONATAL QUARTER 4 (2025/26)
QUALITY & SAFETY REPORT

1 BACKGROUND AND PURPOSE

To provide the Board with assurance on the current position of perinatal quality, safety and leadership, including key risks, mitigations, and required Board actions, with a specific focus on YDH reopening, workforce sustainability, and safety culture.

1.1 The report outlines key achievements in the quarter:

- Strengthened governance and external assurance
- Clear progress in national improvement programmes
- Successful mobilisation toward YDH reopening
- Focused quality improvement in key safety areas

However, these achievements sit alongside ongoing high-risk pressures, particularly in workforce, culture, and flow, requiring sustained Board oversight.

Key Achievements – Q4 2025/26:

1.1.1. Strengthened Governance and Oversight

- Establishment of a Perinatal Quality & Safety Framework, aligning maternity and neonatal services with the wider Trust governance model.

- Introduction of Board-level assurance through MNIP Programme and NED oversight, improving scrutiny and accountability

- Development of a maternity and neonatal oversight model to support safety, transparency and reliability

1.1.2. Progress in National Improvement and Compliance

- Active engagement with MNIST intensive support programme, with the majority of actions on track (20/26)

- Successful alignment with Maternity Incentive Scheme (MIS) requirements, including preparation for Year 8

- Continued compliance with Saving Babies' Lives Care Bundle (SBLCBv3) elements, with strong performance in key areas

1.1.3. Safe Reopening of Yeovil District Hospital (YDH)

- Delivery of a planned, criteria-led reopening of maternity and neonatal services at YDH (April 2026)

- Establishment of formal programme oversight, stakeholder engagement, and communication plans.

- Implementation of enhanced senior leadership presence and safety oversight mechanisms to support safe transition.

1.1.4. Targeted Quality Improvement Initiatives

Launch of Gold QI programmes focusing on high-risk areas:

- Maternity triage (flow, responsiveness, safety)
- Obstetric Anal Sphincter Injury (OASI) reduction

Initiation of audits and investigations into:

- Induction of labour delays
- Neonatal readmissions
- Escalation processes and clinical decision-making
- Informed consent

1.1.5. Strengthening Clinical Safety and Practice

- Improved on-call staffing and escalation arrangements, enhancing responsiveness to risk.

- Standardisation of equipment and clinical processes across services.

- Enhanced neonatal resuscitation competence and training compliance

- Positive progress in APGAR outcomes and clinical quality indicators.

1.1.6. Workforce and Training Improvements

- Continued delivery of mandatory training, PROMPT and NLS programmes
- Recruitment activity underway across midwifery, obstetrics and neonatal services.
- Strengthened focus on staff competence, skills maintenance and leadership development.

1.1.7. Improved Learning from Incidents and Patient Experience

Enhanced PSIRF approach to incident review and learning (with ongoing development required).

Increased focus on triangulating data from incidents, complaints and patient feedback.

Identification of clear themes driving targeted action (e.g. triage, escalation, communication).

1.1.8. Positive Patient Care Indicators

- Sustained high rates of breastfeeding at first feed, above national average.

- Continued delivery of kind, compassionate care, reflected in positive patient feedback.

- Strong examples of individualised care and staff commitment within services.

2.1 The planned focus for Q4:

- Stabilising the system following YDH reopening
- Embedding cultural and leadership improvements
- Delivering critical quality improvement programmes (triage, OASI)
- Strengthening workforce sustainability and governance

This represents a shift from mobilisation and recovery to stabilisation and embedding sustainable improvement.

2.2 Areas of concern:

Across the service, the main concerns converge into five critical risk areas:

- Workforce fragility
- Flow and clinical safety delays
- Culture and escalation behaviours
- YDH reopening and system stability
- Neonatal safety and staffing

These are interdependent risks—progress in one area (e.g. reopening YDH) may increase pressure elsewhere (e.g. workforce and flow) if not carefully managed

2.3 Mitigations in place:

- Stabilising workforce through recruitment and redeployment
- Ensuring safe YDH reopening with structured oversight
- Targeting key clinical risks through QI programmes
- Strengthening governance, data and assurance systems
- Driving cultural improvement and leadership visibility

2.4 Workforce Mitigations

- Active recruitment across midwifery, neonatal and medical workforce
- Temporary redeployment of staff across sites to maintain safe staffing levels
- Job planning and workforce modelling support from MNIST
- Expansion of training and competency programmes (e.g. neonatal resuscitation, PROMPT)

Intent: Maintain minimum safe staffing and improve workforce resilience during transition

3. YDH Reopening Controls

- Phased, criteria-led reopening plan for maternity and neonatal services
- Ongoing stakeholder engagement and communication plan
- Dedicated programme governance and assurance structure
- Increased senior leadership visibility and on-site presence post-reopening

4. Clinical Safety and Flow Improvements

Gold Quality Improvement (QI) programmes:

- Triage (critical safety priority)
- OASI (harm reduction)

Audits and reviews of:

- Induction of labour (IOL) delays
- Neonatal readmissions

Enhanced escalation processes and updated on-call arrangements

Intent: Reduce delays, standardise care, and improve clinical decision-making

5. Governance and Oversight

- Implementation of Perinatal Quality & Safety Framework.
- Establishment of Board Assurance via MNIP Programme and NED oversight.
- Regular governance monitoring of incidents, risks and performance.
- Revised processes to ensure RADAR incidents are allocated and reviewed appropriately.

6. Culture and Leadership

- Development of a comprehensive cultural improvement plan
- Integration with:

  SCORE survey
  EDI diagnostic findings
  Staff Survey results

- Implementation of safety oversight framework, including structured escalation processes
- Leadership visibility plans during critical periods (e.g. reopening)

7. Data and Insight Improvements

- Dedicated informatics support to develop fit-for-purpose dashboards
- Local audit programmes to support real-time service insight
- Work to improve data quality and reporting capability

8. Incident Management and Learning (PSIRF)

- Implementation of PSIRF approach to safety incidents

  Use of:
  After Action Reviews
  Walkthroughs
  Thematic reviews

9. Neonatal Safety Mitigations

- Targeted training and competency assessments (airway skills, NLS)
- Development of cross-site clinical leadership model for neonatal care
- Ongoing support from Neonatal Improvement Advisors

10. Estates and Infrastructure Controls

- Escalation of estate risks to programme and Board level
- Ongoing monitoring of estate progress and timelines
- Interim operational adjustments to maintain service delivery (e.g. theatre/workflow adaptations)

11. Communication and Engagement

- Comprehensive communications plan for staff and service users (particularly YDH reopening)

  Engagement with:

  - Clinical teams
  - Regional partners
  - Service users (MNVP)

12. MIS Safety Action Briefing Reports:

Maternity Incentive Scheme Year 8:

The Maternity Incentive Scheme (MIS) Year 8 introduces a significant shift towards an outcomes-focused, assurance-led approach, with greater emphasis on Board accountability and reduced reliance on process compliance. The scheme now centres on six core safety actions, requiring organisations to demonstrate measurable impact, effective oversight, and sustained improvement across workforce, training, culture and governance domains.

Somerset Foundation Trust has undertaken an initial readiness review, which confirms that foundations are in place, particularly through the Maternity and Neonatal Improvement Programme (MNIP) and existing governance arrangements. However, there are key areas requiring further focus, including workforce capacity (particularly neonatal staffing against BAPM standards), delivery of training compliance and simulation requirements, and ensuring robust Board oversight of culture improvement and performance.

Plans are underway to deliver full compliance by March 2027, including establishing clear leadership, stakeholder engagement and strengthened oversight mechanisms. While progress is evident, successful delivery will require continued investment, focused leadership and sustained Board attention to ensure consistent assurance across all safety actions.

13. MBRRACE Mortality Report 2024:

The MBRRACE-UK perinatal mortality report (2024 births) shows that Somerset Foundation Trust performs broadly in line with comparator organisations for stillbirths and extended perinatal deaths (Amber rating) but has a higher-than-expected rate of neonatal deaths (Red rating when all deaths are included). When congenital anomalies are excluded, outcomes improve to within expected ranges across all measures, indicating that case mix is an important contributing factor.

Overall, stillbirth rates are close to the national average, while neonatal mortality remains an area requiring focused attention. It is recognised that mortality data is subject to variation and influenced by population characteristics and does not in isolation represent quality of care; however, it provides an important signal for further review and improvement activity.

Mitigations are in place through robust use of the Perinatal Mortality Review Tool (PMRT), strengthened governance arrangements, and implementation of real-time monitoring tools, including MBRRACE surveillance and the Maternity Outcomes Signal System (MOSS). These actions aim to enhance oversight, enable early identification of trends, and ensure learning is consistently translated into improvements in care.

14. Home Birth services benchmarking

The SFT Home Birth Services benchmarking and self-assessment was undertaken in response to national learning from a high-profile coroner's inquest, highlighting significant gaps in national guidance, governance and risk management for home birth services. Locally, Somerset has established a structured home birth service with 24/7 coverage, standardised equipment, defined risk assessment processes and access to MDT support, providing a solid operational foundation.

The review identified that while many core elements are in place, there are key areas requiring further strengthening, including consistency in communication processes, embedding of guidelines into practice, alignment of on-call arrangements, and enhanced training across the wider community workforce. There is also a need to strengthen governance, audit and assurance mechanisms, particularly in relation to risk assessment, data collection and oversight.

A clear programme of improvement is underway, focusing on enhancing governance reporting, expanding training (including NLS and emergency skills), and standardising staffing and on-call arrangements. These actions aim to ensure a more consistent, safe and evidence-based approach to home birth care, aligned with emerging national expectations and strengthened local oversight.

Sally Bryant
Director of Midwifery and Deputy to the Chief Nurse and Midwife

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Safe Staffing Establishment Report
SPONSORING EXEC:	Professor Deirdre Fowler, Chief Nurse & Midwife
REPORT BY:	Jo Poole, Deputy Chief Nurse, SFT (Development of report informed by Associate Directors of Patient Care in Service Groups - Individual SG reports can be found in the appendices including maternity and neonates)
PRESENTED BY:	Deirdre Fowler, Chief Nurse & Midwife
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	This report provides a nine-monthly update, July 25 to March 26, In accordance with National Quality Board (NQB) safe staffing guidance and workforce standards for all Somerset NHS Foundation Trust (SFT) inpatient wards, critical care, emergency departments and theatres, AHPs, maternity and neonates. The paper provides an overview on associated safer staffing risks for the nursing. midwifery and AHP workforce and the controls and mitigations in place for these risks. This report offers a description of staffing across the organisation and highlights how safe staffing is reviewed holistically considering a variety of metrics, data, and professional opinion given the absence of the acuity tools SNCT, CNSST and MHOST. Implementation of these tools will be a priority for the Chief Nursing Team once the Safer Staffing Lead is in post. Birthrate Plus is already well embedded within maternity services and is therefore addressed within the maternity staffing section. Key headlines include: • High pressures on urgent and emergency care leading to ongoing use of unfunded escalation beds and corridor beds and an increased reliance on agency

	and bank usage as well as increased sickness and staff burnout/ fatigue. • Overall staffing fill rates to current templates have improved or remained stable however in the acutes we have seen an increase in pressure injuries and evidence of poor patient feedback around the fundamentals of care, therefore implementation of the acuity tools is a key priority to provide an evidence based picture. • Registered nurse vacancies reducing in key areas with agency usage continuing to decline however increased bank usage to support unfunded escalation/ corridor beds. • HCA vacancy remains static with a strong pipeline in place • Targeted roster reviews, enhanced workforce pipelines, and proactive sickness and recruitment management have delivered measurable improvements, particularly within Surgical Services across theatres and critical care. • There is currently no national acuity tool in place for the AHP workforce. • Bank & agency fill rate decreasing month on month – Risk in draft to articulate the following - Nursing agency market contraction causing safer staffing risk 3673 score 20 (without mitigation • Risk relating to urgent treatment centres currently scoring 16 and relates to lack of triage. Workforce plans in place to mitigate the risk. There is an 8.7 WTE vacancy within the ENP line across the community UTCs which can lead to early closure and pausing of the service. • Risk relating to community hospital bed reduction leading to less resilience in registered nurse staffing particularly at night - currently scoring 15 • Triple lock business case for substantive funding of additional posts in ED, SDEC and CYP at YDH – awaiting approval. • Material workforce risk across maternity and neonatal services driven by persistent vacancies, with the most significant gaps at senior clinical levels (B6 -7) therefore limiting service resilience and leadership capacity. Ongoing reliance on agency to fill gaps and maintain safer staffing levels as well as a skills mix risk emerging due to over recruitment to junior B5 roles which has created a relatively inexperienced workforce and places an additional supervisory burden on senior staff.

	Further work is required to offer robust assurance to the Board regarding fitness for purpose of the current staffing templates and compliance with NQB safe staffing and workforce standards.
Recommendation	The Board is asked to **consider** the report and note the above points and **approve** this report for publication on the public website as per requirements.

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
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☒ Aim 4 Respond well to complex needs
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☒ Aim 6 Live within our means and use our resources wisely
☒ Aim 7 Deliver the vision of the Trust by transforming our services through, innovation, research and digital transformation

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

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

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – e.g. in Part B]
The six-monthly review was last presented to the Board in Nov 25 covering the period of Jan 25 to June 2025.

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

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

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Finance Report (M2)
SPONSORING EXEC:	Chief Finance Officer
REPORT BY:	Deputy Chief Finance Officer
PRESENTED BY:	Deputy Chief Finance Officer
DATE:	14 July 2026

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

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

Links to 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
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Implications/Requirements (Please select any which are relevant to this paper)					
☒ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☐ Patient Safety/ Quality
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)				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

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

SOMERSET NHS FOUNDATION TRUST

FINANCE REPORT

1. SUMMARY

1.1 In May, the Trust recorded a deficit of £3.347m, this was breakeven to plan for the month.

1.2 The May headlines were:-

- May agency expenditure was £1.477m, £0.187m higher than April but £0.185m lower than for the same period in 2025/26. This was primarily driven by medical agency which was £0.198m higher than in April due to vacancy cover.
- CIP of £2.680m was delivered in May, £0.404m above plan and of this, savings of £5.081m have been delivered cumulatively, this is £0.528m favourable to the year-to-date plan. In total, recurrent savings are £1.384m (27% of total)
- A further £0.14m of claims relating to the April resident doctor industrial action were processed in May, bringing the cumulative cost to £0.84m. No central funding is available to offset these pressures. A £0.899m provision has been included this month to reflect the estimated impact on activity delivery, based on a comparison of April delivery with previous periods. This will be updated once the data is fully captured.

2. INCOME AND EXPENDITURE

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

Table 1: Income and Expenditure Summary May

Statement of Comprehensive Income	Annual Budget	Current Month 2			Year to date		
	£000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	1,088,814	91,866	89,656	(2,210)	180,898	176,659	(4,239)
Other Operating Income	91,578	6,032	7,455	1,423	12,078	15,013	2,935
Total operating income	1,180,392	97,898	97,111	(787)	192,976	191,672	(1,304)
Operating expenses							
Employee Operating Expenses	(789,588)	(67,631)	(68,308)	(677)	(134,931)	(136,815)	(1,883)
Drugs Cost: Consumed/Purchased	(87,922)	(8,163)	(6,459)	1,704	(16,205)	(13,553)	2,652
Clinical Supp & Serv Exc-Drugs	(69,915)	(7,138)	(7,342)	(204)	(14,189)	(14,552)	(363)
Supplies & Services - General	(37,257)	(3,084)	(3,217)	(133)	(6,095)	(6,394)	(299)
Other Operating Expenses	(184,631)	(14,513)	(14,728)	(215)	(28,889)	(28,040)	849
Total operating expenses	(1,169,312)	(100,528)	(100,053)	475	(200,309)	(199,354)	955
Operating Surplus/Deficit	11,079	(2,631)	(2,942)	(312)	(7,333)	(7,682)	(349)
Finance Expense	(15,032)	(1,110)	(913)	197	(2,485)	(2,105)	380
Finance Income	2,510	209	326	117	418	642	224
Other	1	0	(2)	(2)	1	(2)	(3)
Overall Surplus/(Deficit)	(1,442)	(3,531)	(3,531)	0	(9,400)	(9,147)	252
Depr On Donated Assets	2,106	175	95	(81)	351	178	(173)
Donated Assets Income	(810)	0	0	0	0	0	0
Amortisation	0	0	3	3	0	6	6
PFI UK GAAP Adjustments	146	9	88	79	22	(62)	(84)
Impairments	0	0	(1)	(1)	0	(1)	(1)
Adjustments to control total	1,442	184	184	0	373	121	(252)
Adjusted Financial Performance	0	(3,347)	(3,347)	0	(9,026)	(9,026)	(0)

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

2.3 In May, total staffing was 12,837 WTE, 265 WTE under the planned establishment for the month of 13,103 WTE with the following variances: -

- Substantive staffing was 422 WTE under the establishment plan.
- Bank 119 WTE over plan.
- Agency 36 WTE over &
- Locums 1 WTE over the plan

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

Table 2: Pay expenditure information

2026/27 Monthly Pay Expenditure analysis	Jan-26 £000	Feb-26 £000	Mar-26 £000	Apr-26 £000	May-26 £000	2026/27 In Month Budget	F/(A) Variance £000	2026/27 Total £000	2026/27 YTD Budget	F/(A) Variance £000
Temporary staff										
Bank Staff	2,126	2,183	2,881	2,141	2,377	1,591	(786)	4,518	3,454	(1,063)
Medical Agency	1,013	1,135	506	924	1,122	534	(588)	2,045	1,184	(861)
Medical Locums	658	370	1,047	1,995	1,213	527	(687)	3,208	1,240	(1,968)
Nursing Agency	349	306	409	268	273	182	(90)	541	388	(153)
Other Agency	24	103	62	99	83	34	(49)	182	72	(109)
Total Temporary Staff	**4,171**	**4,098**	**4,905**	**5,426**	**5,067**	**2,868**	**(2,199)**	**10,493**	**6,338**	**(4,155)**
Nursing	16,871	16,784	16,826	17,332	17,351	17,311	(40)	34,683	34,585	(97)
Support to Nursing	5,947	5,888	6,486	6,156	6,228	6,195	(32)	12,384	12,166	(218)
Medical	14,166	18,057	14,184	14,773	14,506	15,237	731	29,279	30,207	928
AHP's	9,758	10,128	9,798	10,005	10,001	10,109	108	20,006	20,161	155
Infrastructure Support	10,037	10,587	10,645	10,738	10,764	11,373	609	21,501	22,582	1,080
Other	3,718	3,560	50,499	4,077	4,392	4,538	146	8,468	8,891	422
Substantive Staff	**60,497**	**65,004**	**108,438**	**63,081**	**63,240**	**64,762**	**1,522**	**126,322**	**128,592**	**2,270**
Total All Staff	**64,668**	**69,102**	**113,343**	**68,507**	**68,308**	**67,630**	**(677)**	**136,815**	**134,930**	**(1,885)**
% Temporary	6.45%	5.93%	4.33%	7.92%	7.42%	4.24%		7.67%	4.70%	

Table 3: WTE information

2026/27 Monthly Workforce analysis	Jan-26 WTE	Feb-26 WTE	Mar-26 WTE	Apr-26 WTE	May-26 WTE	In Month WTE	In Month Budget WTE	F/(A) Variance WTE
Temporary staff								
Bank Staff	491.54	500.37	556.53	501.04	509.73	509.73	390.43	(119.30)
Medical Agency	45.28	44.80	47.50	44.23	46.00	46.00	23.84	(22.16)
Medical Locums	58.59	46.96	66.85	87.24	61.40	61.40	60.22	(1.18)
Nursing Agency	45.84	46.67	48.40	37.33	35.87	35.87	21.97	(13.90)
Other Agency	6.27	10.31	8.90	9.98	13.37	13.37	13.27	(0.10)
Total Temporary Staff	**647.52**	**649.11**	**728.18**	**679.82**	**666.37**	**666.37**	**509.73**	**(156.64)**
Nursing	3,516.68	3,517.16	3,499.91	3,498.85	3,491.45	3,491.45	3,529.52	38.07
Support to Nursing	1,854.45	1,846.69	1,869.95	1,871.31	1,866.84	1,866.84	1,789.36	(77.48)
Medical	1,264.41	1,275.83	1,267.59	1,286.66	1,290.47	1,290.47	1,336.64	46.17
AHP's	1,653.52	1,649.63	1,645.29	1,640.72	1,636.99	1,636.99	1,724.11	87.12
Infrastructure Support	2,737.58	2,742.18	2,724.42	2,707.30	2,708.42	2,708.42	2,909.40	200.97
Other	1,204.79	1,205.72	1,207.22	1,183.95	1,176.90	1,176.90	1,304.09	127.19
Substantive Staff	**12,231.42**	**12,237.19**	**12,214.38**	**12,188.79**	**12,171.08**	**12,171.08**	**12,593.12**	**422.04**
Total All Staff	**12,878.94**	**12,886.30**	**12,942.56**	**12,868.61**	**12,837.45**	**12,837.45**	**13,102.85**	**265.40**
% Temporary	5.03%	5.04%	5.63%	5.28%	5.19%	5.19%	3.89%	

2.5 Total agency and locum costs were £2.690m in May, £0.595m lower than in April. Agency costs increased by £0.187m to £1.477m, driven by a £0.198m increase in medical agency and a £0.005m increase in nursing agency. Locum costs reduced by £0.782m, primarily because April included £0.7m of backfill costs relating to industrial action.

2.6 Continued focus is being maintained on temporary staffing expenditure. This includes ensuring that rostering arrangements are operating effectively and progressing targeted recruitment initiatives to address hard-to-fill medical vacancies, which accounted for 76% of agency expenditure in May.

3. COST IMPROVEMENT PROGRAMME

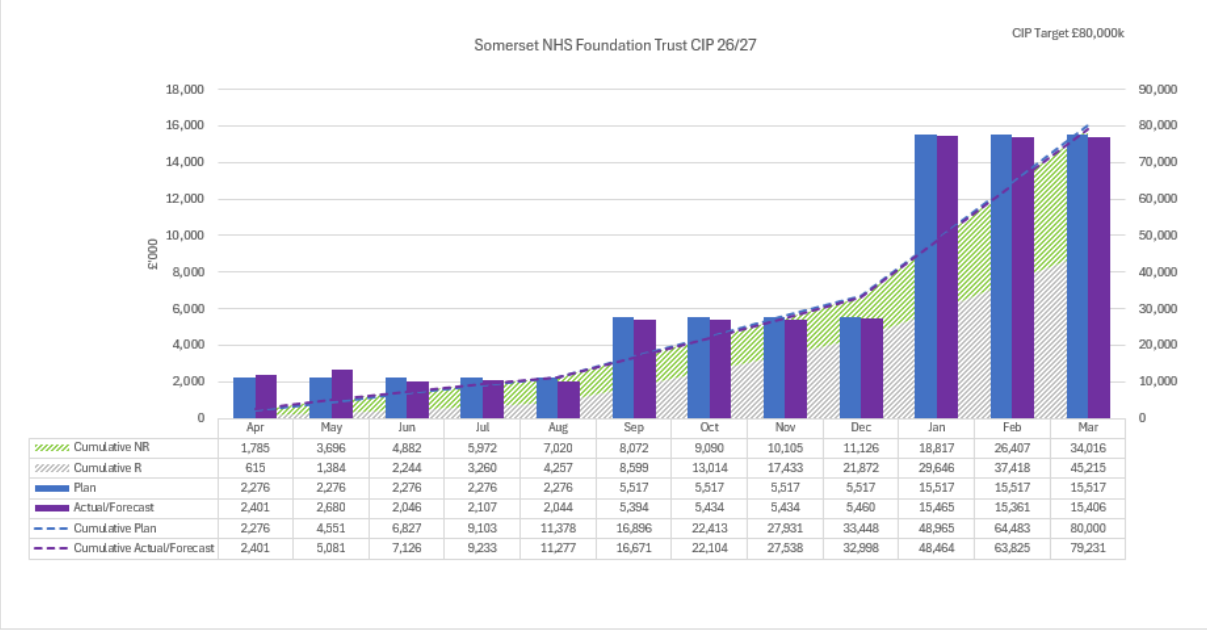
3.1 The Trust has set a CIP plan of £80m for the year, this represents c6.6% of operating expenses. The target is split; £27.3m is BAU CIP allocated fully to clinical and non-clinical services. This effectively offsets the inflationary (pay and non-pay) uplifts to budgets which is aligned to the net cost uplift we have received from Commissioners. In addition, there is transformation CIP of £52.7m, this includes Estates transformation.

3.2 In May, savings of £2.680m were delivered, £0.404m favourable to plan. Of this, recurrent savings were £0.769m (27% of total).

3.3 Forecast delivery has improved by £1.3m to £79.2m, leaving a remaining shortfall of £0.8m against plan. Overall progress is encouraging, with significant work undertaken to identify service-level schemes at an earlier stage. This represents a marked improvement compared with last year; however, further work is required to increase the value and proportion of recurrent schemes.

3.4 Transformation programmes are progressing and are beginning to identify their key areas for improvement. However, these plans are not yet fully developed and the associated benefits have not yet been quantified. This presents a delivery risk, and work is underway to consider how any shortfall in this area could be mitigated.

Chart 1: CIP Plan 2026/27



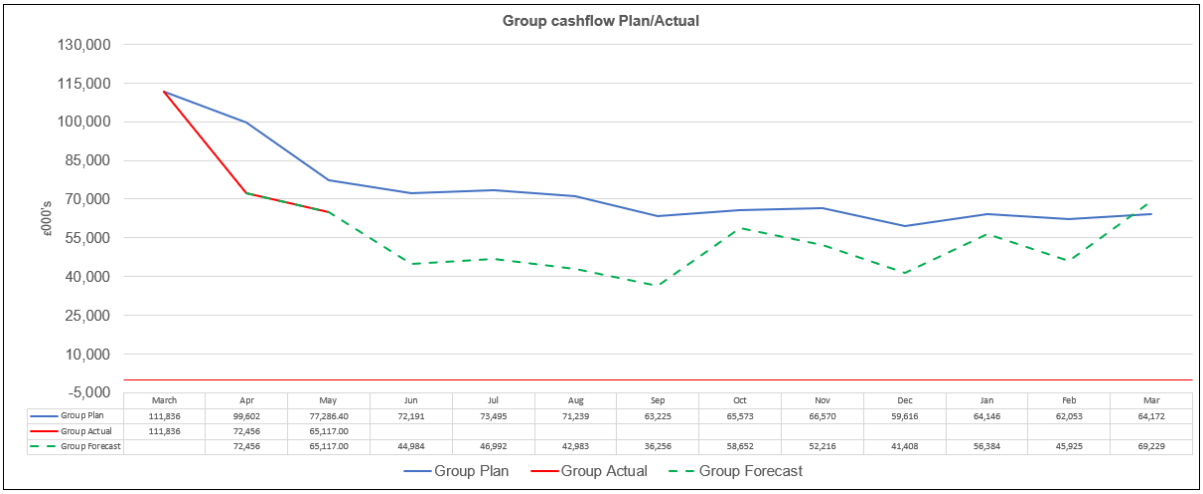
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative NR	1,785	3,696	4,882	5,972	7,020	8,072	9,090	10,105	11,126	18,817	26,407	34,016
Cumulative R	615	1,384	2,244	3,260	4,257	8,599	13,014	17,433	21,872	29,646	37,418	45,215
Plan	2,276	2,276	2,276	2,276	2,276	5,517	5,517	5,517	5,517	15,517	15,517	15,517
Actual/Forecast	2,401	2,680	2,046	2,107	2,044	5,394	5,434	5,434	5,460	15,465	15,361	15,406
Cumulative Plan	2,276	4,551	6,827	9,103	11,378	16,896	22,413	27,931	33,448	48,965	64,483	80,000
Cumulative Actual/Forecast	2,401	5,081	7,126	9,233	11,277	16,671	22,104	27,538	32,998	48,464	63,825	79,231

4. CASH

4.1 Cash balances at 31 May were £65.1m; £12.2m lower than plan, largely due to capital expenditure invoices received and settled slightly ahead of plan.

4.2 The group cashflow position including the updated forecast is shown below.

Chart 2: Cash flow Actual/Plan



	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Group Plan	111,836	99,602	77,286.40	72,191	73,495	71,239	63,225	65,573	66,570	59,616	64,146	62,053	64,172
Group Actual	111,836	72,456	65,117.00										
Group Forecast		72,456	65,117.00	44,984	46,992	42,983	36,256	58,652	52,216	41,408	56,384	45,925	69,229

4.3 The Trust continues to monitor its level of cash closely to ensure it retains a level of cash sufficient to support day to day operational expenditure and the requirements of the capital programme.

5. STATEMENT OF FINANCIAL POSITION

Apr-26	May-26	Movement		Mar-26	May-26	Movement in Year
£000	£000	£'000		£000	£000	£000
70,889	76,562	5,673	Intangible Assets	70,958	76,562	5,604
420,025	419,807	(218)	Property, plant and equipment, other	420,594	419,807	(787)
26,437	26,248	(189)	On SoFP PFI assets	26,626	26,248	(378)
86,841	87,406	566	Right of use assets	87,482	87,406	(76)
14	14	(0)	Investments	14	14	0
14	14	0	Other investments/financial assets	14	14	0
3,304	3,349	44	Trade & other receivables >1yr	3,340	3,349	8
607,524	**613,400**	**5,876**	**Non-current assets**	**609,028**	**613,400**	**4,372**
13,352	13,256	(96)	Inventories	13,022	13,256	234
12,983	9,349	(3,634)	Trade and other receivables: NHS receivables	10,586	9,349	(1,236)
39,186	32,955	(6,231)	Trade and other receivables: non-NHS receivables	22,684	32,955	10,271
0	0	0	Non current assets held for sale	0	0	0
72,456	65,117	(7,339)	Cash	111,836	65,117	(46,719)
137,978	**120,678**	**(17,299)**	**Total current assets**	**158,129**	**120,678**	**(37,451)**
(132,920)	(130,464)	2,456	Trade and other payables: non-capital	(134,715)	(130,464)	4,251
(13,784)	(12,810)	974	Trade and other payables: capital	(42,354)	(12,810)	29,545
(25,954)	(20,959)	4,995	Other liabilities	(12,074)	(20,959)	(8,886)
(12,701)	(12,769)	(68)	Borrowings	(12,695)	(12,769)	(74)
(8,905)	(8,900)	5	Provisions <1yr	(8,908)	(8,900)	8
(194,263)	**(185,901)**	**8,363**	**Current liabilities**	**(210,745)**	**(185,901)**	**24,845**
(56,286)	**(65,223)**	**(8,937)**	**Net current assets**	**(52,617)**	**(65,223)**	**(12,606)**
(112,316)	(112,628)	(312)	Borrowings >1yr	(112,107)	(112,628)	(521)
(2,684)	(2,687)	(3)	Provisions >1yr	(2,725)	(2,687)	38
(1,143)	(1,121)	22	Other liabilities > 1Yr	(1,164)	(1,121)	43
(116,143)	**(116,436)**	**(293)**	**Total long-term liabilities**	**(115,996)**	**(116,436)**	**(440)**
435,095	**431,741**	**(3,355)**	**Net assets employed**	**440,415**	**431,741**	**(8,674)**
			Financed by:			
466,225	466,225	0	Public dividend capital	466,224	466,225	0
60,819	60,819	0	Revaluation reserve	60,819	60,819	0
(3,702)	(3,702)	0	Other reserves	(3,702)	(3,702)	(0)
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(85,818)	(89,347)	(3,529)	I&E reserve	(81,325)	(89,347)	(8,022)
			Other's equity			
44	218	175	Non-controlling Interest	871	218	(652)
435,095	**431,741**	**(3,355)**	**Total financed**	**440,415**	**431,741**	**(8,674)**

6. CAPITAL

6.1 Schemes are being progressed in accordance with the agreed programme for the year. Year to date, capital expenditure is £10.899m compared with the plan of £4.196m, resulting in an overspend of £6.703m. A significant element of this has resulted from the scheduled annual implementation payment to Epic being recognised in May whereas the budget phased the payment in June. Spend and budget will more closely align in June.

6.2 A summary of the programme is shown in Table 4 below.

Table 4: Capital Programme Summary

Capital Programme 2026-2027	Plan £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000
Backlog Maintenance	6,169	342	253	(89)
Essential Facilities Improvement Works	1,367	165	214	49
Service Redesign Enabling Works	5,142	932	857	(75)
Service Redesign Enabling Works - Major	3,176	292	135	(157)
Infrastructure	0	0	0	0
Rolling IT & Digital Development	18,165	2,135	7,381	5,246
Equipment Replacement	5,285	131	81	(49)
Subsidiary Companies	260	0	35	35
Leases	4,258	0	1,446	1,446
Total Internal Capital Envelope	43,822	3,997	10,401	6,404
Externally Funded Capital Schemes	**Plan £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total Additional Schemes	22,808	199	498	299
TOTAL TRUST PROGRAMME	66,630	4,196	10,899	6,703

7. CONCLUSION & RECOMMENDATION

7.1 The Trust delivered its in-month plan and remains on plan after two months. This includes managing the year-to-date impact of resident doctor industrial action through the release of non-recurrent resources. NHSE has confirmed that no central funding will be available to offset these costs.

7.2 Services have made good progress in identifying service-level efficiency schemes, which now represent approximately one-third of the Trust's overall efficiency requirement. Further work is ongoing to increase the recurrent element of these schemes. The forecast outturn position has improved by c£1.3m compared with April.

7.3 The transformation element of the programme is also progressing. Programme Boards are now established and are developing detailed plans to identify opportunities across their respective areas. The financial impact of these programmes is currently being quantified.

CHIEF FINANCE OFFICER

NHS Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charity Committee meeting held on 21 April 2026
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	Katie Fry, Executive Assistant to Director of Strategy & Digital Development
PRESENTED BY:	Graham Hughes, Chair of the Charity Committee
DATE:	14 July 2026

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

Executive Summary and Reason for presentation to Committee/Board	The Charity Committee met on 21 April 2026 and reviewed the financial position, fundraising performance, and governance arrangements. The charity remains financially strong, but income is lower than the previous year. The Committee noted progress on major commitments. This report provides assurance and highlights key risks for Board oversight.
Recommendation	The Board is asked to **note** the assurance provided and the key risks identified, including income volatility, project delivery delays, and the need to review the investment strategy.

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

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

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

Kindness, Respect, Teamwork
Everyone, Every day

Details: N/A
Equality and Inclusion **The Trust aims to make its services as accessible as possible, to as many people as possible. We also aim to support all colleagues to thrive within our organisation to be able to provide the best care we can.** **How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?**
All major service changes, business cases and service redesigns must have a Quality and Equality Impact Assessment (QEIA) completed at each stage. Please attach the QEIA to the report and identify actions to address any negative impacts, where appropriate.
Public/Staff Involvement History How have you considered the views of service users and / or the public in relation to the issues covered in this report? Please can you describe how you have engaged and involved people when compiling this report.

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

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

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

This report was produced with the assistance of AI

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 21 APRIL 2026

1. PURPOSE

1.1. The Charity Committee met on 21 April 2026 to review fundraising activity, financial performance, risk management, governance arrangements, and investment oversight. The Committee provides assurance to the Board that charitable funds are being managed appropriately and in line with regulatory, ethical, and governance expectations

2. ASSURANCE RECEIVED

2.1. Fundraising Performance

The Committee received a positive fundraising report noting strong momentum supported by high-profile partnerships, including a testimonial year partnership with Somerset County Cricket Club, community events, and a range of legacy-focused initiatives. Legacy income remains a significant, though variable, source of funding. Members recognised the reputational and engagement benefits of these activities alongside financial returns.

2.2. Future Fundraising Opportunities

The Committee received a positive fundraising report noting strong momentum supported by high-profile partnerships, including a testimonial year partnership with Somerset County Cricket Club, community events, and a range of legacy-focused initiatives. Legacy income remains a significant, though variable, source of funding. Members recognised the reputational and engagement benefits of these activities alongside financial returns.

2.3. Risk Management

The updated Charity Risk Register was reviewed. Members received assurance that risks associated with income volatility, fundraising events, reputational exposure, and compliance are being actively managed. The highest residual risk score remains within the Committee's risk appetite, and no new risks were identified.

2.4. Finance and Governance

The Committee received assurance on financial controls, reporting arrangements, and overall financial health. Total charitable funds exceed £7m, with appropriate balance between restricted, designated, and unrestricted funds. There were no concerns regarding overspend, misuse of funds, or compliance with donor intent.

2.5. **Investments**

The Committee reviewed investment performance with CCLA Investment Management. While short-term performance has been weaker than desired due to challenging market conditions, the Committee received assurance regarding the robustness of the long-term investment strategy and ethical framework. It was agreed that CCLA should be retained as investment managers, with enhanced reporting to support ongoing scrutiny.

3. AREAS OF CONCERN OR FOLLOW UP

3.1. Continued short-term underperformance of investment returns due to market volatility, requiring close monitoring and enhanced reporting.

3.2. Ongoing exposure to income volatility, particularly reliance on events and legacy income.

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

4.1. The Committee noted although the charity remains financially strong, there are ongoing risks for awareness. These include investment market volatility affecting income generation, the inherently unpredictable nature of legacy and event-based fundraising, and the need to maintain clear, targeted communication of charitable impact to sustain public and staff engagement.

Graham Hughes
CHAIR OF THE CHARITABLE FUNDS COMMITTEE