NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust

Annual Report 2025/26

Somerset NHS Foundation Trust

Annual Report and Annual Accounts 2025/26

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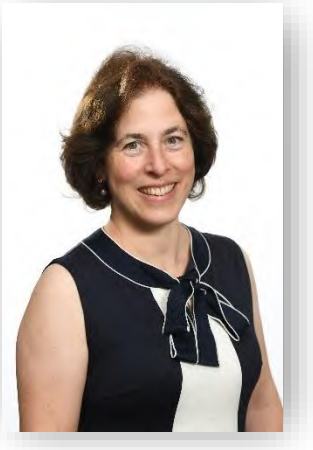
1. INTRODUCTION FROM THE CHAIR



It is my pleasure to provide the foreword for Somerset NHS Foundation Trust's annual report for 2025/6. During a year of significant national reorganisation in the NHS, the focus was on bringing down waiting lists, living within our means and improving productivity levels. The Government also published the 10 Year Health Plan that sets a blueprint for the future and focuses on three shifts in the delivery of care: from treatment to prevention, from hospital to community, and from analogue to digital.

I want to begin by thanking every patient, carer, family, and member of the public who supported us. We benefit from the hard work and dedication of people throughout Somerset, whether they support our charities, volunteer for us, or give up their time to work as governors. We are also indebted to the Third Sector in Somerset who support our work by helping people to stay well, providing connection and social interaction, or practical support. Thank you.

This year we welcomed new non-executive colleagues to the Trust Board. Dr Rosie Benneyworth, Darshan Chandarana, and Professor Olena Doran joined as non-executive directors, and Tom Frederick joined as an associate non-executive director. All four are leaders in their fields, with experience at regional and national level. I'd like to thank Martyn Scrivens who stepped down after many years' service as a non-executive director.

We are privileged to work with over 15,000 colleagues who work in clinical and corporate services in Somerset and Dorset. Together our mission is to improve the health and wellbeing of everyone in Somerset and to deliver outstanding integrated care by supporting our colleagues and nurturing an inclusive culture of kindness, respect and teamwork. Our colleagues are at the heart of the services we provide. We work to understand their experience of work, support them, and provide development opportunities. We aim to create a just and restorative culture guided by our values of Kindness, Respect and Teamwork.

At the end of 2025/6, we achieved a strong relative performance, and against national standards, in our community and mental health services. Our performance in our acute service is more mixed. Our performance compared to others is relatively good, but we have not delivered some national standards such as the percentage of patients waiting no longer than 18 weeks for treatment and a first appointment, the number of patients waiting 52 weeks or more for treatment, and the national 4-hour A&E standard. We remain focused on achieving these targets in the coming year.

We delivered our financial plan that included making very significant savings of £50 million. We achieved this due to colleagues' exceptional hard work that resulted in some transformational changes and an enormous reduction in the amount we spent on agency staff.

Our relative good performance was recognised in the National Oversight Framework (NOF) interactive dashboard and league tables. The most recent league tables

published in June for quarter 4, ranks Somerset NHS Foundation Trust 29th out of 134 trusts. We were compared with acute trusts in England and placed in segment 2.

As we turn our attention to 2026/7, it is essential that we build on the momentum of 2025/6 to continue to improve our performance and productivity, and make savings, as the country faces economic uncertainty.

That will include continuing to implement the three shifts in the Government's 10 Year Health Plan and building on the work that we did in 2025/6. We began making changes to our community hospitals to enable us to move more services out of the acute hospitals and closer to home. We developed, designed and are running two pilots to test the impact of these changes on local people's experiences of healthcare.

The first pilot is in Frome, West Mendip and Bridgwater. We have made temporary adjustments to our provision for patients who receive intermediate care or reablement services in their own homes following an acute hospital stay, or in a community hospital following an acute hospital stay, or for those who need to move to a permanent care placement as their needs change. The temporary changes include expanding services to care for more people in their own homes and reducing the number of community hospital beds at Frome, West Mendip and Bridgwater community hospitals. We think we can improve patients' access to intermediate care or reablement services, improve outcomes for patients and at the same time improve flow through our acute hospitals, and we are tracking a range of metrics to test whether this is the case.

Our evaluation of the metrics at 12 weeks showed improvements in some areas, with further work to do in others. So far, the data shows:

- Shorter harmful delays for patients leaving an acute hospital and accessing reablement in their own homes or in a community hospital.
- Shorter harmful delays for patients whose needs have changed and who require a long-term care home placement, with fewer subsequent moves for them.
- Encouraging reductions in length of stay for patients receiving reablement in a community hospital, and a reduction in the number whose discharge from a community hospital is delayed.

We have extended this pilot until the end of September 2026, so that it runs over 12 months to embed improvements, test the changes under varying conditions across a full calendar year, and gather more feedback.

We are running the second pilot in Burnham-on-Sea and Crewkerne where we are providing a greater mix of services from our community hospitals to test whether we can improve local people's access to services. We have engaged with local people to understand the barriers to accessing services and looked closely at population health data in both areas. Based on what we heard and our understanding of the needs of the local populations, we are temporarily reducing the number of beds in both hospitals from 16 to 8 from 1 April 2026 and providing a range of additional services in line with the needs of those communities.

Our engagement with people across Somerset, and in the areas where we are running both pilots, has given us a greater understanding of what people value, what frustrates them and the barriers that prevent them from accessing NHS services. Building on that, we have developed Neighbourhood Reference Groups in each of the five areas where we are running the pilots to bring together a diverse range of voices to help shape community health and care services, ensuring decisions are informed by real experiences and local priorities.

There are other examples of our trust providing more services in local communities, and at the same time improving population health by providing self-referral pathways that enable quick and early cancer diagnoses. Patients with symptoms that could indicate bowel, lung, breast, and womb cancer can self-refer themselves without needing to see their GPs. These pathways enable patients to either get the all-clear and peace of mind or an earlier cancer diagnosis which optimises their likelihood of successful treatment.

In 2025/6 we significantly expanded diagnostic capacity by developing and opening community diagnostic centres. The Yeovil Diagnostic Centre, run by our trust in partnership with InHealth, will provide over 70,000 diagnostic tests and outpatient appointments every year for people in Yeovil, North Dorset and the surrounding area. We also received approval from NHS England to construct a brand-new diagnostic centre next to Bridgwater Community Hospital. The new £17.8 million state-of-the-art centre will provide a range of specialist diagnostic and outpatient services to the population of Bridgwater and the surrounding areas when it opens in August 2026.

During the year, our Trust and three NHS trusts in Dorset signed a contract with Epic to provide an electronic health record for the two counties that will give health and care professionals a clearer, more complete picture of each person’s health and replace a patchwork of existing IT systems. It will reduce delays, improve safety, and ensure the 1.4 million people living in the area don’t have to repeat their story every time they move between services or across county boundaries. The team is now working with Epic to design and build the new system, with implementation planned for April 2028.

Thanks to the hard work and ingenuity of colleagues, we won a number of national awards during the year. These included:

- Winner in the 'Improving Medicines Management and Pharmacy through Digital' category at the HSJ Digital Awards 2025, for our successful integration of the Better Meds ePMA and Electronic Prescribing Service (EPS) into the Somerset Integrated Digital e-Record (SIDeR) system.
- Finalist in the ‘Acute Sector Innovation of the Year’ category of the HSJ Awards for our post-menopausal bleeding service.
- Winner of the ‘Mental Health Innovation of the Year’ category of the HSJ Awards for the Open Mental Health alliance, of which we are part alongside voluntary, community, faith, and social enterprise partners.
- Our project Reusable theatre caps in theatre with name and role, was Highly Commended in the ‘Patient Safety Collaboration of the Year’ category at the 2026 HSJ Partnership Awards.

2025/6 also brought some very significant challenges and in May 2025 we took the very difficult step of temporarily closing our inpatient maternity service and Special Care Baby Unit (SCBU) at YDH due to concerns about the safety, quality and fragility of the paediatric service at the hospital. The Care Quality Commission (CQC) inspected paediatric services in January 2025 and subsequently issued a Section 29a warning notice with respect to paediatric services at YDH. It published its reports in June, which rated the paediatric service at YDH inadequate overall.

This was a very difficult step for the Trust to take but we must ensure that the services we provide are safe, and we took decisive action to address failings. Our teams have done a huge amount of work to address them and have created a Somerset-wide paediatric service and recruited five new paediatric consultants.

On 21 April we reopened the Special Care Baby Unit and inpatient maternity service. We thank everyone who has worked very hard to reopen our services; Dorset County Hospital and Musgrove Park Hospital who have cared for mothers, babies and families while services in Yeovil have been temporarily closed; and local families whose care was transferred while services at YDH were temporarily closed. Thank you for your patience and understanding.

Our trust's maternity services are one of 12 that are part of the National Investigation into Maternity and Neonatal Services. We welcome being part of the investigation. We will continue listening to the voices of service users and use the feedback and learning from the national investigation to continue improving.

I'd like to end by paying tribute to the everyone who make up our NHS community in Somerset. Together, drawing on our strengths and experience, we can make changes where needed and continue to do our best for the patients of today and the future. Perhaps this tenacity is best summed up by 90-year-old Mary Nicholson who has walked the entire 97-mile length of Hadrian's Wall to raise money for the Beacon Centre at Musgrove Park Hospital. Thank you.

With best wishes

Dr Rima Makarem
Chair

2. PERFORMANCE REPORT

The purpose of this performance report and overview is to give the reader a short summary about Somerset NHS Foundation Trust (the Trust), that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

History of Somerset NHS Foundation Trust and its statutory background

Somerset NHS Foundation Trust was created through a series of strategic mergers designed to strengthen the sustainability and integration of health and care services across the county. In April 2020, Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust came together to form the legacy Somerset NHS Foundation Trust, making it the first trust in mainland England to bring together community, mental health and acute hospital services within a single organisation. This was followed on 1 April 2023 by the merger of the legacy Somerset NHS Foundation Trust with Yeovil District Hospital NHS Foundation Trust, creating the current Trust.

The decision to merge was underpinned by a shared recognition that the scale and complexity of the challenges facing health and care services in Somerset could not be effectively addressed by individual organisations working alone. The merger brought together complementary skills, expertise and resources across acute, community, mental health and learning disability services, and strengthened collaboration with partners in social care, education, housing and the voluntary and community sector. Together, these changes were intended to support more coordinated approaches to tackling health inequalities and improving outcomes for local communities.

As a result of the merger, Somerset NHS Foundation Trust now delivers all NHS acute, community, mental health and learning disability services provided within Somerset, alongside responsibility for around a fifth of local primary care services. The development of the merged organisation was undertaken in close partnership with system partners across Somerset. This integrated model places the Trust in a strong position to deliver joined-up mental and physical healthcare across whole pathways, supporting people to receive the right care, in the right setting, at the right time.

Purpose and activities of the Trust

Somerset NHS Foundation Trust delivers a broad range of health services for people across Somerset, as well as parts of North and West Dorset. We work in close partnership with health and social care organisations across Somerset to deliver high-quality services that respond to the needs of our local population. The Trust's core services are commissioned by Integrated Care Boards, while a small number of specialist services are commissioned at a national level.

The Trust provides acute hospital services from two main sites: Musgrove Park Hospital in Taunton, with approximately 700 inpatient beds, and Yeovil District Hospital in Yeovil, with around 330 beds. In addition, the Trust operates 13 community hospitals delivering inpatient, outpatient and diagnostic services. Urgent and unscheduled care is

supported through six Urgent Treatment Centres and one Minor Injuries Unit. Primary care services are also provided through Symphony Healthcare Services, a wholly owned subsidiary of the Trust, which operates across 21 locations in Somerset.

The Community Dental Service delivers care to more than 5,700 patients across Somerset and Dorset. The service also supports children with high dental needs who require a single course of treatment, often involving inhalation sedation or general anaesthetic. Good progress has been made in reducing waiting times in Dorset, and across both counties for adults and children requiring general anaesthetic for dental treatment.

Community services provided by the Trust cover a wide range of specialties, including district nursing, stroke services, podiatry, physiotherapy, acute home treatment for frailty and respiratory care, and diabetic eye screening. These services are delivered across a variety of settings, including GP practices, community clinics, local facilities and in patients' own homes.

The Trust provides inpatient mental health services and specialist healthcare for adults with learning disabilities across ten mental health wards located on four sites. Community mental health services include Talking Therapies, Early Intervention in Psychosis, a community eating disorder service, and specialist provision for people with autism and personality disorder. The Trust is also an early implementer of Open Mental Health, the national model for transforming community mental health services.

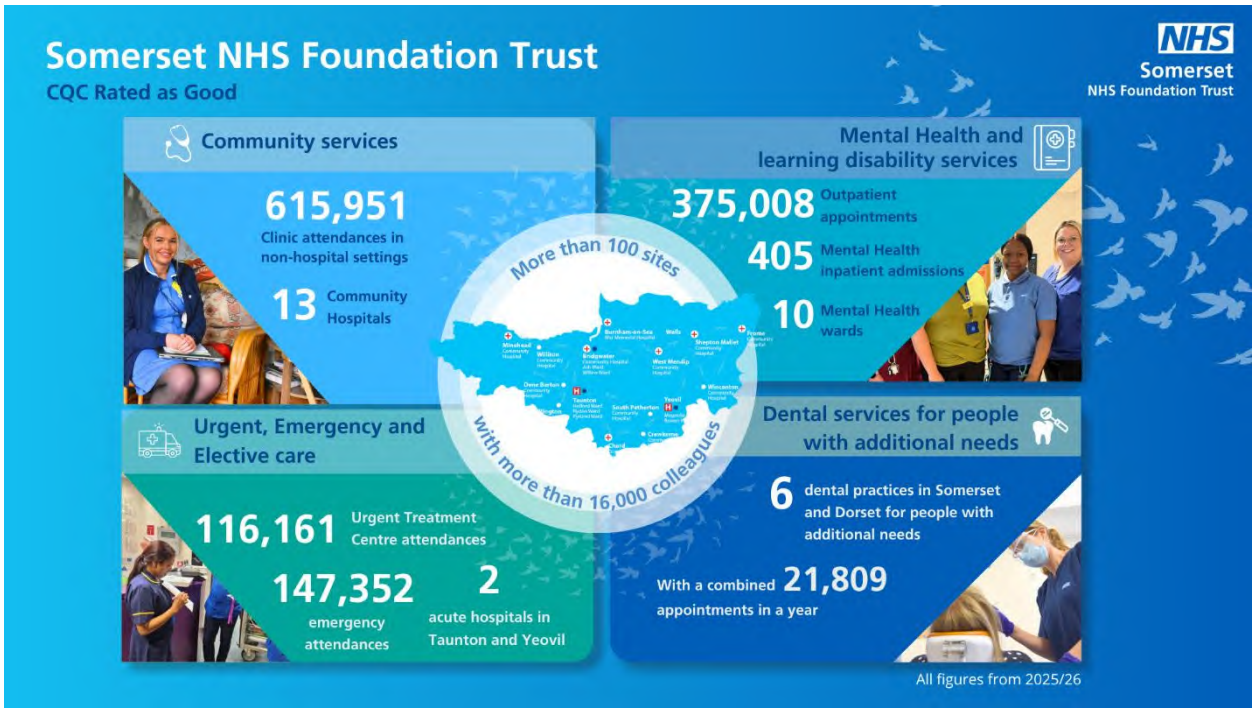
In addition to serving the population of Somerset, the Trust provides care for patients from neighbouring areas, including North Somerset, North and West Dorset, Devon, Bristol, Bath and North East Somerset, Wiltshire, Swindon and South Gloucestershire.

The Trust is supported by over 15,000 substantive and bank colleagues who deliver and enable patient care. From clinical and therapeutic staff to researchers, scientists, estates and facilities teams, corporate services and front-of-house colleagues, every role plays an important part in supporting patients and their families.

Alongside the delivery of patient services, Somerset NHS Foundation Trust plays an active role in educating and training the future health and care workforce, including nurses, doctors and therapists, and undertakes research to support the continued development of clinical practice and treatments.

Map of key Somerset healthcare sites

Some key facts about the Trust and our services



Statement from the Chief Executive on performance over the period

During 2025/26, Somerset NHS Foundation Trust continued to deliver services in the context of sustained system pressure, with high levels of demand across acute, community and mental health services. As with NHS providers nationally, this required

careful balancing of urgent and emergency care, recovery of planned services, and support for people with increasingly complex needs, while maintaining a clear focus on quality, safety and experience.

Over the course of the year, the Trust has concentrated on strengthening operational grip and embedding improvements in patient pathways, alongside further investment in estates and digital infrastructure. This work has been critical in supporting resilience across services, improving flow and access, and positioning the organisation to meet both immediate operational challenges and longer-term transformation priorities.

There have been areas of real progress during the year, as well as moments of challenge that have required difficult decisions. In particular, following earlier concerns about safety and staffing in paediatric and neonatal services, in May 2025, the Trust took the difficult decision to temporarily close the Special Care Baby Unit (SCBU) at Yeovil District Hospital which meant we were also unable to safely provide care during labour and birth at the Yeovil Maternity Unit.

During 2025/26, significant work has taken place to strengthen staffing, address the issues raised, and prepare for the safe reopening of maternity services at Yeovil. This work has been undertaken in close collaboration with colleagues, partners and regulators, with safety remaining the overriding priority.

The Trust has continued to engage openly with the Care Quality Commission during the year. In February 2026, the CQC undertook a re-inspection of maternity services at Musgrove Park Hospital and in community settings. At the time of writing, the final report is awaited. Initial feedback from the inspection acknowledged the progress made by teams and highlighted positive examples of compassionate care and committed leadership, while also identifying areas where further improvement is required, including ongoing challenges associated with the maternity estate. We are committed to continuing this improvement and to learning from the CQC's findings once the report is published.

From a financial perspective, the Trust delivered its planned breakeven position for 2025/26. Capital investment during the year has supported improvements in clinical environments, equipment and digital capability, contributing to the delivery of safe and effective care. However, the financial environment remains challenging, with rising demand and ongoing national changes to the structure and operating model of the NHS. Maintaining financial sustainability while continuing to improve quality and access will remain a central focus as we move into 2026/27.

The Somerset healthcare system

Somerset benefits from mature and well-established partnerships across health, social care and the voluntary and community sector. These relationships are characterised by openness, shared responsibility and constructive challenge, supporting collective responses to immediate operational pressures while maintaining a focus on longer-term system improvement and transformation.

Integrated Care Systems (ICSs) were established as statutory entities on 1 July 2022 under the Health and Care Act 2022, building on earlier Sustainability and Transformation Partnerships. Each ICS comprises an Integrated Care Partnership (ICP), which brings together NHS, local authority and voluntary sector partners, and an NHS Integrated Care Board (ICB), which is responsible for planning and funding NHS services.

During 2025/26, the system has also been adapting to wider national changes to NHS commissioning arrangements. As part of this, NHS Somerset ICB has begun working more closely with Dorset and Bath and North East Somerset, Swindon and Wiltshire (BSW) ICBs through the development of a formal cluster arrangement. Over time, these arrangements are expected to evolve further, with a future formal merger of ICBs anticipated.

Somerset NHS Foundation Trust plays a central role within this evolving system landscape. As a large, integrated provider delivering acute, community and mental health services, the Trust is well placed to support place-based partnerships, provider collaboration and system-wide improvement. The Trust works closely with commissioners and partner organisations to ensure that changes at system level continue to support safe, effective and locally responsive services for patients and service users.

The Trust remains committed to shared planning and collective leadership across Somerset and the wider region. Its organisational objectives align closely with system priorities, supporting a coherent approach to quality, access, financial sustainability and workforce development.

Planning and delivery are closely aligned with system-wide priorities, including the ICB's annual operating and capital plans. The Trust works with partners to prioritise investment in services, estates and digital capability, ensuring that resources are used effectively and within the financial framework set nationally. The ongoing development of shared digital and data infrastructure remains a key enabler, supporting real-time planning, performance management and population health approaches as system arrangements continue to evolve.

During 2025/26, the Trust and partner organisations across Dorset took a significant step forward in digital transformation, signing a contract with Epic to implement a shared electronic health record across Somerset and Dorset. This major joint investment will replace multiple legacy systems with a single, integrated platform, enabling health and care professionals to access more complete, consistent and timely patient information.

The programme will support safer, more efficient care by reducing duplication, minimising delays and enabling more coordinated decision-making across organisational and geographical boundaries. Covering a population of around 1.4 million people, it represents a step change in how information is shared across the system and will support the delivery of more joined-up, person-centred care pathways.

The programme is an example of large-scale partnership working, bringing together multiple NHS organisations with a shared ambition to modernise digital infrastructure and improve outcomes for patients and communities. Implementation is planned for

2028 and forms part of the Trust's long-term approach to digital transformation.

Strategic context

Somerset remains a predominantly rural county with a population of approximately 593,000[1]. The county continues to experience steady population growth alongside a significant shift towards an ageing demographic. Nationally, the proportion of people aged over 75 living with long-term conditions continues to increase, with care needs becoming more complex and resource-intensive. This pattern is mirrored locally, placing sustained pressure on health and care services across Somerset. Over the next four decades, the number of people aged 65 to 79 is projected to increase by almost a third, while those aged 80 and over, the fastest-growing age group, are expected to more than double.

While smoking prevalence in Somerset continues to decline, the incidence of long-term conditions such as diabetes, obesity, dementia and mental health conditions is rising. These trends underline the need for more preventative, coordinated and person-centred approaches to care, with greater emphasis on early intervention, community-based support and integrated pathways that address both physical and mental health needs.

Somerset's geography, characterised by rural and coastal communities and relative distance from major urban centres, presents ongoing challenges for the equitable delivery of services. National evidence consistently demonstrates that rural and coastal populations can face additional barriers in accessing timely care, workforce supply and transport infrastructure. These factors remain particularly relevant in Somerset and require continued focus on innovative service models and partnership working to ensure fairness of access and outcomes.

As across much of the NHS, workforce pressures continue to present a significant challenge. In Somerset, this is further intensified by a comparatively smaller working-age population and competition for staff across health, social care and other sectors. While colleagues continue to demonstrate exceptional commitment and professionalism, workforce shortages and high demand mean that current models of delivery are not always sustainable in the longer term. Supporting staff wellbeing, stability and retention remains a strategic priority for the Trust and the wider system.

The NHS continues to operate within a period of profound and ongoing change. During 2025/26, national priorities have remained focused on improving access and recovery, particularly for urgent, elective and diagnostic services, while continuing the shift from hospital-based care to community settings, from analogue to digital systems, and from treatment to prevention. These priorities sit alongside sustained financial constraints and increasing expectations around productivity, efficiency and accountability.

NHS providers continue to operate within a tightly constrained financial environment. During 2025/26, trusts have been required to deliver services within fixed financial envelopes while responding to sustained growth in demand and increasing complexity of need. Alongside this, there is a continued national expectation to improve productivity, make best use of available resources and reduce unwarranted variation,

[1] Somerset Trends – Population Overview - https://www.somersettrends.org.uk/topics/population/population-2/

both within organisations and across systems. These pressures reinforce the importance of ongoing service transformation, collaboration with partners and careful prioritisation, to ensure that services remain safe, sustainable and responsive to the needs of the population.

Summary of the principal risks faced and how these have affected the delivery of objectives

During 2025/26, Somerset NHS Foundation Trust continued to operate in an environment of heightened and inter-related risk. Sustained demand for services, workforce pressures, financial constraint and the condition of elements of the Trust's estate have continued to impact the delivery of both strategic and operational objectives. These risks are closely inter-connected and, if realised concurrently, have the potential to amplify one another and place additional pressure on service quality, safety and sustainability.

The most significant risks faced by the Trust during the year included:

- **Demand, capacity and access pressures**
  The Trust has experienced sustained high levels of demand across emergency, planned, diagnostic, community and mental health services. Capacity constraints, challenges with patient flow and ongoing pressures in primary and social care have continued to contribute to long waiting times, bottlenecks within acute settings and difficulties in meeting national access standards. These pressures have had a direct impact on the delivery of timely care and remain a key focus for the Trust and system partners.

- **Workforce sustainability and staffing pressures**
  Workforce risks remain one of the most significant challenges facing the Trust. While progress has been made in some areas of recruitment, persistent shortages in key professional groups, alongside sickness absence and reliance on temporary staffing, have affected service resilience. These pressures have, at times, required temporary service changes or escalation arrangements and have increased risks associated with staff wellbeing, burnout and retention.

- **Discharge and system flow challenges**
  Ongoing difficulties in discharging patients, particularly where care packages, community capacity or social care placements are required, have continued to impact flow through acute and community services. Despite close collaboration with local authority and system partners and the development of enhanced discharge pathways, rising demand across partner organisations has limited the pace of improvement and contributed to pressure on bed capacity and escalation arrangements.

- **Estate, infrastructure and capital investment risks**
  The age and condition of parts of the Trust's acute and community estate, particularly at Musgrove Park Hospital, continue to present operational, safety and financial risks. While significant progress has been made on major capital programmes, including the new Surgical Centre at Musgrove Park Hospital and developments at the Yeovil District Hospital site, the scale of backlog

maintenance and reliance on ageing infrastructure remain material risks. Constraints associated with national capital availability and delivery timescales also continue to affect the pace of improvement.

- **Maternity, neonatal and paediatric service pressures**
  Risks relating to workforce capacity, estate limitations and service configuration within maternity, neonatal and paediatric services have remained a significant area of focus during the year. These risks have required intensive operational and clinical oversight and have directly influenced service delivery decisions, including temporary changes to service provision, while improvement programmes continue.

- **Digital transformation and information governance**
  The Trust continues to manage risks associated with reliance on multiple legacy digital systems, data quality, information governance and the delivery of its digital and electronic health record ambitions. Delays or uncertainty in national approvals and funding have the potential to impact the pace of digital transformation, with associated implications for safety, efficiency and regulatory compliance.

- **Financial sustainability**
  The Trust has continued to deliver services within a challenging financial context, balancing fixed funding with growing demand and cost pressures. While the Trust achieved its planned financial outcome for the year, the margin for flexibility remains limited. Financial risks are closely linked with workforce, estate and capacity challenges, reinforcing the need for careful prioritisation, transformation and partnership working.

These risks are monitored through the Board Assurance Framework and the Corporate Risk Register, which enable the Board to maintain oversight of the principal risks to delivery of the Trust's strategic aims and associated objectives. The Board recognises that many of these risks are influenced by factors beyond the Trust's direct control and therefore require coordinated action with system partners.

The Trust continues to strengthen its risk management arrangements, focusing on the identification and management of compound risks, where the interaction of multiple pressures could lead to the greatest potential impact on patient safety, service continuity, workforce wellbeing and organisational sustainability. Further detail on individual risks and mitigating actions is provided elsewhere in this report.

Going concern

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

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

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

After making enquiries of internal information sources and receiving assurance from reviews of the requirements set out in the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), the board of directors has a reasonable expectation that the Trust will have access to adequate resources to continue to deliver the full range of mandatory services for the 12 months from the date of approval of the financial statements and fulfil any liabilities as they fall due.

The directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the 12 months from the date of approval of the financial statements.

On this basis, the Trust has adopted the going concern basis for preparing the accounts that has been supported by the Trust's external auditor.

Our vision, strategy, values and behaviours

The Trust has a clear vision, strategy and set of values that reflect our role as an integrated provider and our commitment to improving the health and wellbeing of the population we serve. These continue to guide decision-making, priorities and behaviours across the organisation and underpin the delivery of safe, high-quality and compassionate care.

Our values were developed through widespread consultation with colleagues and provide a shared understanding of how we work together and how we deliver care. They support a culture that is inclusive, respectful and focused on collaboration, learning and continuous improvement.

Mission

To improve the health and wellbeing of everyone in Somerset and to deliver outstanding integrated care by supporting our colleagues and nurturing an inclusive culture of kindness, respect and teamwork

Vision

Thriving Colleagues, Integrated Care, Healthier People

During 2025/26, the Trust reviewed its strategic framework and refined the way in which its priorities are articulated. As part of this review, two former objectives were combined, resulting in seven strategic aims, supported by a clear set of objectives beneath each aim.

The Trust's seven strategic aims are:

1. Improve the health and wellbeing of the population and reduce 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.

These aims bring together clinical, people and financial priorities into a single, coherent framework. They recognise that improving population health and outcomes requires integrated clinical care, sustainable use of resources and a supported, skilled and motivated workforce.

The Trust's clinical strategy, people strategy and finance strategy remained the three core strategies that support delivery of the strategic aims. Together, they describe what the Trust will deliver, how it will support its people, and how it will ensure long-term sustainability. In addition, work has continued with the Board during 2025/26 to refresh the Trust's strategy, recognising the evolving operating environment. This programme of work will continue into 2026/27.

We recognise that the clinical health and care aims cannot be delivered by the Trust in isolation. Effective partnership working across the Somerset system and beyond, including with primary care, local authorities and the voluntary and community sector, will be critical to achieving our ambitions.

A number of enabling strategies support delivery of the Trust's strategic aims, including:

- **Green Plan** – setting out how the Trust will achieve its ambition to become a net zero carbon organisation by 2040
- **Digital strategy** – describing how digital services and technology support safer care, better communication, improved access to information and increased efficiency
- **Estates strategy** – explaining how the Trust will maximise the use of its estate to support safe, effective and high-quality care
- **Quality strategy** – setting out how patient safety, learning, improvement and effective clinical governance are embedded across the organisation
- **Communications and engagement strategy** – outlining how the Trust engages with patients, communities, colleagues and wider stakeholders.

Our values

The Trust's values and behaviours set out the expectations for how we work with one another and how we care for patients and service users. They provide a shared foundation for an inclusive, respectful and compassionate culture and support the delivery of the Trust's vision.

Respect		
Honesty	**I will…** make it safe and easy for people to speak up about issues, give kind and fair feedback, and be open to receiving it too	**I won't…** criticise people for mistakes, stay silent when needing to speak up, be closed to feedback about myself
Integrity	**I will…** set and deliver high standards, adhere to follow agreed, evidence-based practice, professional, ambitious, try to do the right thing, put patients first	**I won't…** accept low standards, 'walk past' issues when I see them, come across as 'too busy' or often be late, unprofessional, fail to adhere to agreed, evidence-based practice
Equity	**I will…** embrace others' strengths, value different backgrounds, cultures and stories, include others, advocate for equity and diversity in the organisation	**I won't…** dismiss others' views, experiences or backgrounds, ignore if you see someone being treated differently because of their background
Civility	**I will…** be polite approachable and welcoming to everyone, challenge each other respectfully, be considerate of others	**I won't…** belittle or dismiss others, be rude, uncivil, or use an abrupt tone of voice, undermine or bully others, be reactive to others or ignore others
Kindness		
Compassion	**I will…** treat people as valued individuals, protect their dignity and privacy with compassion, be patient, understanding, self aware, patient	**I won't…** be indifferent to others struggles, or dismissive of their feelings, stories or journeys, make mean comments or be unkind
Positivity	**I will…** be optimistic, bring a positive, 'can-do' attitude, bring a smile, welcome change, be hopeful about what is possible, act with courage	**I won't…** focus on problems rather than solutions, moan, be negative or complain without acting to solve or improve the situation, avoid challenges and growth opportunities
Understanding	**I will…** put myself in other people's shoes, act with empathy; take the time to understand others' concerns, be self aware; be authentic, calm	**I won't…** refuse to see things from other people's perspectives, or consider what might be going on for other people

Appreciation	**I will…** notice the little things other people do to make a difference and give ABC appreciation so that they feel valued, celebrate success	**I won't…** ignore it when people do great things or 'take the credit' for others' achievements, only give negative feedback without appreciating what is going well
Teamwork		
Support	**I will…** be attentive to other people's needs and feelings, reliable, offer help, do what I say I will, encourage others and help them take responsibility	**I won't…** avoid helping when I see someone in need, make people feel 'a burden', have a 'not my patient / job' attitude
Collaboration	**I will…** work together, seek opportunities to share, ask for ideas and input, seek cross team and service input, involve and encourage others, communicate clearly	**I won't…** work in 'silos', not seek out opportunities to work with or share learning with other teams, services or divisions, isolate or exclude others
Listening	**I will…** listen with curiosity and empathy, giving people time to speak, welcome different views, seek out information	**I won't…** dismiss others' views or ideas without giving them a chance to explain, talk over people as if they aren't there, ignore concerns, dictate, interrupt, lecture or argue
Trust	**I will…**be open and transparent when communicating, building trusting relationships with colleagues, reassuring	**I won't…** be 'economical with the truth', make no effort to share information, withhold information others need, or leave them 'in the dark'

Achievements, celebrations and anniversaries within 2025/26

Opening of Yeovil Community Diagnostic Centre transforms access to tests

In January 2026, the Trust marked a major milestone with the opening of the Yeovil Community Diagnostic Centre (CDC), significantly increasing access to diagnostic tests including MRI, CT, endoscopy and cardiology investigations.

The new facility is already improving patient experience by enabling more care to be delivered closer to home, reducing waiting times and supporting earlier diagnosis. The CDC represents a key step in the Trust's commitment to modernising services and supporting the national ambition to shift care from hospital to community settings. This achievement reflects continued investment in infrastructure and innovation to improve access, capacity and outcomes for patients across Somerset.

Cancer self-referral milestone improving access and saving lives

In April 2026, the Trust reached a significant milestone, with more than 3,000 people using its cancer self-referral pathways. These innovative pathways enable patients to access diagnostic tests and specialist care more quickly, removing delays associated with traditional referral routes.

The programme has already led to the early detection of at least 74 cancers, enabling earlier treatment and improved outcomes. It has also saved the equivalent of 65 days of GP time, supporting wider system efficiency.

This achievement demonstrates the Trust's commitment to improving access, reducing inequalities and empowering patients to take control of their own care.

National recognition for digital innovation in medicines management

The Trust's digital medicines team received national recognition at the HSJ Digital Awards 2025, winning the award for Improving Medicines Management and Pharmacy through Digital.

The award recognised the successful integration of electronic prescribing systems into the Somerset Integrated Digital e-Record, enabling safer prescribing, improved access to medications and more efficient workflows for clinicians.

This achievement highlights the Trust's position as a leader in digital innovation and its commitment to improving safety and outcomes through technology.

New diagnostic centre in Bridgwater to transform community care

In October 2025, construction began on a new £17.8 million Community Diagnostic Centre in Bridgwater, marking a major investment in local healthcare infrastructure. The centre, expected to open in 2026, will provide advanced imaging and outpatient services closer to home, including CT, MRI and cardiac diagnostics. This will improve patient experience, reduce travel and release capacity within acute hospitals.

This development reflects the Trust's commitment to expanding community-based care and improving access to diagnostic services.

National recognition for patient safety and sustainability initiative

The Trust received national recognition at the 2026 HSJ Partnership Awards, where its work to introduce reusable theatre caps was named Highly Commended in the Patient Safety Collaboration category.

The initiative improves communication and teamwork in operating theatres by making staff roles clearly visible, while also reducing single-use waste. Feedback showed improved communication and a positive impact on patient experience.

National award recognises innovative mental health partnership

The Trust, as part of the Open Mental Health alliance, was awarded the Health Service Journal Award for Mental Health Innovation of the Year in November 2025.
The programme brings together NHS, local authority and voluntary sector partners to provide more accessible, personalised mental health support across Somerset. Since its introduction, the model has delivered measurable improvements, including a 35% reduction in acute mental health bed days and reduced admissions and A&E attendances.

Group entities

Somerset NHS Foundation Trust has a number of joint ventures and subsidiary companies. Joint ventures are separate entities over which the Trust has joint control with one or more other parties. The meaning of control is where the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits.

During 2025/26, Somerset NHS Foundation Trust owned or had shares in the following subsidiary companies:

- Simply Serve Limited (100%)
- Symphony Healthcare Services Limited (100%)
- Southwest Pathology Services LLP (66.7%)
- SPS Facilities LLP (66.7%)

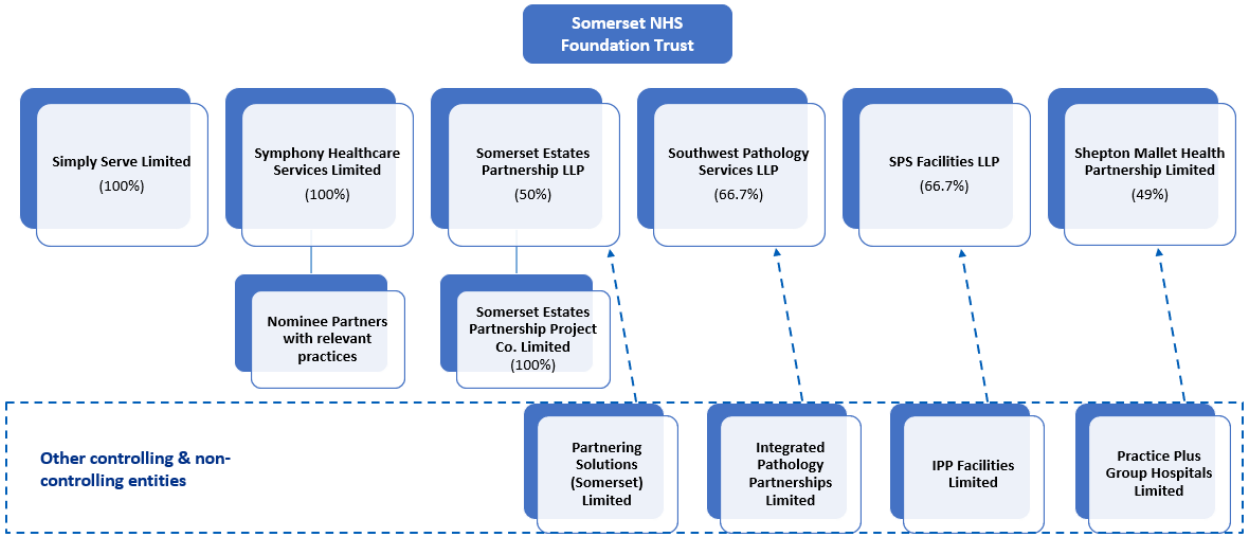
Somerset NHS Foundation Trust owns a proportion of the following joint ventures and associates:

- Somerset Estates Partnership LLP (50%)
- Shepton Mallet Health Partnership Limited (49%)

In addition, the Trust works in close partnership with its associated NHS charities, which are independent organisations that support the Trust's work through fundraising and volunteering. The Trust's principal charities are:

- Love Musgrove
- Yeovil Hospital Charity
- Somerset NHS Charity

The group structure (as of 31 March 2026) can be seen below:



Simply Serve Limited: Simply Serve Limited, the Trust's wholly owned estates and facilities management company, commenced operations in February 2018. The company was established to support the delivery of high-quality, cost-effective services while enhancing the ability to recruit and retain key staff groups at Yeovil District Hospital. It plays an important role in protecting existing jobs, creating local employment opportunities and ensuring the continued delivery of essential hospital services.

Simply Serve Limited operates as an integral part of the Somerset NHS Foundation Trust group. Its values, culture and objectives are closely aligned with those of the Trust, and its workforce is embedded within the wider organisation. The company provides a comprehensive range of estates, facilities and operational support services to Yeovil District Hospital, while also delivering services to a growing number of external clients.

During 2025/26, Simply Serve Limited has continued to provide effective operational support to the Trust, particularly in responding to increasing levels of demand and supporting service delivery at Yeovil District Hospital. Core services, including estates, facilities, sterile services, medical engineering and catering, have maintained performance across key quality and safety measures, despite sustained pressures.

Activity has continued to grow across a number of service areas, reflecting increased clinical demand and the company's ability to respond flexibly. For example, sterile services and medical device management have supported rising levels of activity while maintaining strong performance against key indicators and reducing incidents.

The company has also supported the delivery of the Trust's capital and infrastructure priorities during the year. This includes contributions to major estate developments and the opening of the Yeovil Diagnostic Centre in January 2026, alongside wider investment in infrastructure and utilities to support safe, effective care.

Simply Serve Limited has continued to strengthen its workforce and organisational development. Initiatives to improve engagement, leadership visibility and staff development have supported workforce stability and performance across services,

alongside targeted recruitment and succession planning in key areas.

The company has also contributed to the Trust's sustainability objectives, supporting energy efficiency improvements, waste reduction initiatives and progress towards net zero in line with the Trust's Green Plan.

During the year, Simply Serve Limited successfully retained its Royal College of Physicians Joint Advisory Group (JAG) accreditation for endoscopy decontamination services and continued to maintain relevant ISO certifications for quality and medical device processing. These accreditations provide assurance that services meet required quality and safety standards across both NHS and external customers.

All required accreditations have been maintained, reflecting the company's ongoing commitment to delivering safe, effective and high-quality services.

Symphony Healthcare Services Limited: Symphony Healthcare Services provides primary care services via General Medical Service (GMS) and Personal Medical Service (PMS) contracts to approximately 132,000 patients.

During 2025/26, Symphony Healthcare Services has focused on maximising the benefits of at scale provision by merging Oaklands Surgery and Ryalls Park Medical Centre, two surgeries within Yeovil, in June and then Burnham & Berrow Medical Centre and Highbridge Medical Centre (renamed Symphony North Healthcare) in November 2025. The organisation continues to follow this direction and is actively progressing the merger of Crewkerne Health Centre, Buttercross Health Centre, Hamdon Medical Centre and Martock & South Petherton Surgery.

The Symphony practices have demonstrated impressive quality despite significant financial and workforce challenges, including reducing funding, sub-inflationary contract uplifts and sustained high and complex patient demand. All practices are rated CQC 'Good' or above with two recent inspections during the last year for Lister House Surgery and Warwick House Medical Practice. The organisation has also achieved 94% for the national Quality Outcomes Framework (QOF) programme. In addition, patient satisfaction has remained high with approximately 41,500 patients responding to the Friends and Family feedback questionnaire with 92% positive about the services provided, demonstrating consistent quality for patients compared to the year before.

Practice	Integration	Merged	List Size (31 March 2026)
Buttercross Health Centre	07/04/16	1 July 18	7,868
The Ilchester Surgery	07/04/16		
Yeovil Health Centre	07/04/16	1 Sept 17	16,624
Oaklands Surgery	01/08/17		
Ryalls Park Medical Centre	01/04/21	30 Jun 25	
Crewkerne Medical Centre	01/07/17	1 July 18	12,369
West One Surgery	01/07/18		

Wincanton Health Centre	01/10/17		8,686
Hamdon Medical Centre	01/05/18		6,017
The Meadows Surgery	01/11/18		4,055
Martock Surgery	01/12/18	Pre-integration	10,208
South Petherton Medical Centre	01/12/18		
Bruton Surgery	01/02/19		5,040
Exmoor Medical Centre	01/04/20		3,892
Creech Medical Centre	01/10/21		5,350
Lister House Surgery	01/10/21		6,906
North Petherton Surgery	01/10/21		7,322
Warwick House Medical Centre	01/10/21		7,782
Highbridge Medical Centre	01/04/17	12 Nov 25	28,324
Burnham Medical Centre	01/04/23		
Berrow Medical Centre	01/04/23		
TOTAL			130,443

Symphony Healthcare Services has continued to manage and support its practices by embedding the organisation's vision, mission and values. It has spent a considerable time nurturing engagement across the organisation, encouraged by the organisations Employee Forum, Patient Participation Chairs Group and a range of clinical and non-clinical working groups, which come together to discuss and support solutions to key challenges, as well as ideas and new ways of working.

The organisation participated within the NHS General Practice Staff Survey which was introduced during 2024/25 and eagerly await the outcomes to support future initiatives and improvements.

During 2025/26, the Symphony Healthcare Services practices continued to participate within nine Primary Care Networks (PCN) across Somerset, making the most of the additional roles to deliver the PCN contracts and support the practice multidisciplinary teams. With one PCN consisting solely of Symphony practices, the organisation has been working with its shareholder, Somerset NHS Foundation Trust, to pilot new ways of working across neighbourhood and community services for the intended benefit of patients across all PCNs and neighbourhood areas. This PCN is also one of the first to develop a contact hub to manage telephony as well as a triage hub to support urgent and acute needs, enabling the practices to focus on continuity for patients. The contact hub is well embedded following its establishment in December 2024 and the triage hub is starting to gain traction following its establishment during 2025.

Although Symphony Healthcare Services remains dependent on funding from the Somerset Integrated Care Board, the level of funding is reducing significantly year-on-year. This is being achieved through cost saving and efficiency gains coupled with a reduction in clinical vacancies and less reliance on agency support. However, the

compound effect of sub-inflationary contract uplifts and sustained high and complex demand is putting an increasing strain on finances across the sector.

Somerset Estates Partnership LLP: Somerset Estates Partnership LLP (SEP) is a strategic estates partnership with Interserve Prime to provide an estate, infrastructure and service transformation solution to generate value and savings, in line with clinical strategy. The 15-year partnership (originally established with Yeovil District Hospital NHS Foundation Trust on 29 October 2014) enables the Trust to fully explore all its options and ensures that these are realistic and fundable, as well as identifying opportunities for the Trust to earn income, which can be reinvested into frontline services.

Southwest Pathology Services LLP, SPS Facilities LLP: Established in 2011/12, Southwest Pathology Services took responsibility for delivering the full range of laboratory services to Musgrove Park Hospital and Yeovil District Hospital on 1 June 2012, serving a population of over 500,000 and over 100 GP practices. The SPS hub laboratory provides services for the NHS and other organisations in the southwest, undertaking the high quality, efficient processing of routine and non-urgent testing, reporting results according to clinically agreed turnaround times. The Trust now has majority shareholdings following the merger between legacy Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust.

Somerset NHS Foundation Trust Charities: In addition to its subsidiary companies and joint ventures, the Trust benefits from the support of its associated NHS charities, which play an important role in enhancing patient experience, supporting staff and funding improvements beyond core NHS provision.

The Trust's principal charities include Love Musgrove, Yeovil Hospital Charity and Somerset NHS Charity. These charities work closely with the Trust to raise funds for projects, equipment and facilities that make a meaningful difference to patients, their families and the environments in which care is delivered. This includes investment in clinical equipment, improvements to buildings and ward environments, and support for innovation and wellbeing initiatives.

The charities are supported by the generosity of local communities, volunteers and fundraisers, and form an important part of the wider partnership between the Trust and the populations it serves. Alongside these organisations, a number of independent charitable groups, including hospital Leagues of Friends, also provide valuable ongoing support to services across Somerset.

Details of overseas operations

The Trust has no overseas operations other than recruitment campaigns.

Peter Lewis, Chief Executive, 22 June 2026

3. PERFORMANCE ANALYSIS

Oversight Framework targets

The NHS Oversight Framework sets out the key national standards which are applicable to Somerset NHS Foundation Trust as a service provider. The table below sets out our performance levels across the year:

Target	Threshold	Performance				
		Q1	Q2	Q3	Q4	Full year total
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway (1)	67.3% (year-end)	65.8%	62.5%	62.4%	65.4%	-
Difference between actual and planned 18-week performance	Zero or higher	4.3%	0.0%	(2.3%)	(1.9%)	-
Percentage of patients waiting over 52 weeks	1.5% (year-end)	2.8%	3.0%	2.4%	2.0%	-
Percentage of patients waiting over 52-weeks for community services	0.0% (year-end)	0.01%	0.0%	0.0%	0.0%	-
Percentage of urgent cancer referrals to receive a definitive diagnosis within 28 days	80% (year-end)	70.2%	73.0%	78.4%	78.3%	75.1%
Percentage of patients treated for cancer within 62 days of referral	85% (year-end)	69.1%	69.6%	73.7%	75.0%	71.9%
A&E maximum waiting time of four hours from arrival to admission/transfer/discharge (2)	78% (year-end)	73.4%	74.3%	70.4%	70.1%	72.1%
Percentage of emergency department attendances spending under 12 hours in the department	97.3%	97.1%	97.4%	97.1%	96.7%	-
Annual change in number of children and young people accessing NHS-funded MH services	5,400	5,408	5,610	5,751	5,945	-
Average number of days from discharge ready date to actual discharge date (including zero days)	-	1.6	2.8	2.5	2.2	2.3
Percentage of mental health inpatients with >60 day length of stay	-	30.2%	36.2%	25.0%	27.3%	30.2%

Target	Threshold	Performance				
		Q1	Q2	Q3	Q4	Full year total
Percentage of Urgent Community Response referrals reached within two hours	70%	92.5%	92.7%	92.3%	92.7%	92.6%
Number of Healthcare Associated Infections (MRSA)	0	3	1	1	2	7
Rates of Healthcare Associated Infection (Clostridium difficile)	91	20	35	14	14	83
Rates of Healthcare Associated Infection (E-Coli)	100	33	33	28	31	125
Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours	-	78.4%	75.0%	73.2%	71.8%	74.6%
Sickness absence rate	5.4% or less	5.1%	5.2%	5.7%	5.1%	-

1) RTT incomplete pathways – the indicator is expressed as the percentage of patients on an incomplete pathway (i.e. those still awaiting first consultant led treatment) who have waited less than 18 weeks from referral.
2) A&E maximum waiting times - the indicator is expressed as a percentage of all A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge. The national standard is 95%, but in December 2022, England implemented an intermediate minimum standard, where at least 76% of A&E attendances should be seen within four hours, rising to 78% in March 2026.

More detailed analysis and explanation of performance during the year

Performance during 2025/26 has been delivered within a challenging financial and operational environment, with the Trust required to respond to sustained demand while maintaining financial sustainability. While the Trust achieved its planned breakeven position, this required delivery of a significant cost improvement programme alongside a continued focus on productivity, workforce efficiency and reduction in agency usage.

These considerations have shaped operational decision-making throughout the year, including prioritisation of capacity, service delivery models and investment in key areas such as diagnostics and digital infrastructure.

Alongside this, the Trust has continued to prioritise the delivery of safe, high-quality care and improvements in access and outcomes, with a clear focus on addressing areas of highest patient need.

The following sections set out how these factors have influenced performance across key operational areas during the year.

For 2025/26 there was a shift in emphasis on making progress towards the national ambition of more than 92% of patients waiting under 18 weeks from Referral to Treatment (RTT) by March 2029. Aligned with this, the three core areas of focus as set out in the national operating framework were to:

- Improve the percentage of patients waiting under 18 weeks RTT for treatment by 5% by March 2026, relative to the November 2024 reported performance.
- Improve the percentage of patients on an RTT pathway waiting under 18 weeks for a first outpatient appointment, relative to the November 2024 reported performance.
- Reduce the percentage of patients waiting over 52 weeks for treatment to less than 1% of the total waiting list size.

Over the past year there have been a number of actions we have been taking to reduce waiting times for patients waiting for routine treatment. These have included the following:

- Implementing Advice & Refer as out ‘front door’ to outpatient services, using the Cinapsis advice and guidance platform. Advice & Refer enables GP teams to seek secondary care opinion, including both requesting advice & guidance or an outpatient appointment, via a single route. Having rolled out eOpinion to fifteen services including gynaecology, dermatology, rheumatology, neurology, ENT, urology, cardiology, vascular, gastroenterology, endocrinology and diabetes, we are now the national leaders in the use of this pre-referral advice and guidance. In implementing Advice & Refer we have delivered the elective care Single Point of Access requirements, set out in the operating plan framework for 2026/27. This is increasing the numbers of patients who are being treated in primary care but

also reducing the number of patients needing to be added to our waiting lists and have an outpatient appointment in secondary care. During 2026/27 we will start to see the impact of this on waiting times, especially for first outpatient appointment waiting times. But during the latter half of 2025/26 it reduced the number of patients waiting under 18 weeks, as well as total numbers of patients on the RTT waiting list, hence negatively impacting on our reported performance.

- Increasing our first outpatient capacity through the use of in-house waiting list initiatives and insourcing providers. This included additional capacity being provided within gynaecology, ear, nose and throat (ENT), and orthopaedics, especially during the last quarter of the year. During quarter 4 this offset the otherwise negative initial impact on 18-week RTT performance of introducing Advice & Refer.
- Improving utilisation of our clinical and physical resources with:
    - improvement in our British Association of Day Surgery (BADS) daycase rates for surgery, which reduces the risk of bed related cancellations.
    - maintaining our improved rates of theatre session utilisation, and our national upper quartile performance for DNA (Did Not Attend) and Patient Initiated Follow-ups rates.
- Outsourcing to local Independent Sector providers to expand our surgery capacity, including for orthopaedic surgery and general surgery, to enable our longest waiting patients to be treater sooner than they would otherwise have been.

The Trust ended the year reporting performance of 65.4% of patients waiting less than 18 weeks RTT, against the baseline of 62.2% and a target of 67.2%. The total waiting list size was 1,124 pathways lower than the plan of 53,426, which explains 0.7% of the variance from target.

The implementation of Advice & Refer introduced a significant change in referral pathways, particularly following the go-live across four high-volume specialties in the final four months of the year. This reduced the number of patients being added to RTT pathways, as more patients were managed appropriately without the need for a secondary care outpatient appointment.

This change had a short-term impact on reported RTT performance, as fewer patients were entering the pathway and being counted within the under 18-week cohort. A similar effect was seen in first outpatient performance, which was 73.9% in March 2026 compared to a target of 79.7%.

However, this reflects a positive shift in clinical practice and patient flow. Over time, Advice & Refer is expected to reduce waiting times for first outpatient appointments and decrease the number of patients waiting over 18 weeks, by ensuring that patients are directed to the most appropriate care setting from the outset.

In line with the national NHS priorities for 2025/26, there was also continued focus within the Trust on treating the longest-waiting patients. The national maximum wait in 2025/26 reduced from 78 weeks to 65 weeks RTT. Because many trusts continued to report over 65-week waiters at the end of March 25 the target was

extended, with a requirement being introduced mid-year for all these remaining very longest-waiting patients to be treated by the end of September 25. Although the Trust did not achieve the zero target in September, the number of patients waiting over 65 weeks reduced from 86 at the start of the year to 17 at the end of March 26, having peaked at 157 in October. From the end of December, the patients waiting over 65 weeks at each month-end had exceptional causes for the breach of the 65-week standard. This included patients with unexpected other medical problems which prevented surgery being undertaken sooner, patients unfortunately cancelled due to last-minute trauma cases needing to be accommodated, or patients needing specific types of surgical implants or complex treatments involving other providers.

The national elective recovery plan, published in February 2022, also set out the priority to achieve a maximum waiting time for a diagnostic test of six weeks, for at least 95% of patients, by March 2025. Unfortunately, this target continued to not be achieved during 2025/26, with performance against the six-week wait standard being maintained between 75% and 81% across the year. At the end of March 2026 performance was 80.7%, having improved across quarter 4. Demand for diagnostic tests has remained very high over the last year, reflecting the high level of complexity of patients on our waiting lists and the growth in referrals by GPs for urgent conditions including cancer and musculoskeletal problems. In addition to high demand there have been staffing challenges, with unexpected departures and long-term sickness in some diagnostic departments. The diagnostic modalities with the highest number of six-week waiters during the latter part of the year were endoscopy and echo, which together made-up just under 70% of the over 6-week diagnostic waiters.

The endoscopy service had significant numbers of nursing vacancies in the Musgrove and Bridgwater teams throughout much of the year, which limited to an extent the number of endoscopy sessions which could be run. This followed a period of scope washing facilities being periodically out of commission, along with the loss of a locum endoscopist, at the start of the year. The vacant nursing posts have been recruited to, which has supported an increase in service capacity during quarter 4. The Yeovil Community Diagnostic Centre (see below) opened in January which has also increased the endoscopy service capacity in the east of the county. We have therefore been redirecting more of the GP referred patients from the boundary area between Musgrove and Yeovil hospitals, across to Yeovil. These actions have led to a reduction in endoscopy waiting times during quarter 4.

There is a national shortage of echo physiologists, which pose ongoing challenges when members of our team leave or there are gaps due to maternity leave or long-term sickness. We have continued to work with an insourcing provider to fill the capacity gaps we have had. But this year our providers has also struggled to provide consistent levels of capacity. This has now been addressed but it had a significant impact on echo waiting times during the latter half of the year. With this additional capacity in place, and other changes made to optimise our use of capacity including reviewing the balance of demand between inpatient and outpatient work and concluding the training of physiologists now able to work independently, we are expecting further reductions in the number of over 6-week waiters to be delivered in the first half of 2026/27.

The Yeovil Community Diagnostic Centre (CDC) opened in January 2026 following a delay to the opening due to unforeseen circumstances outside of the control of the Trust. This is providing additional diagnostic capacity for MRI, CT, echo, endoscopy and audiology, along with additional space for several other services. The national emphasis in 2026/27 continues to be to ensure the right level of diagnostic capacity is available to support the achievement of RTT and Cancer waiting times standards set for the year, but also to support the 'left shift' of services into the community. The additional capacity provided by the Yeovil CDC will put the Trust in a better position to meet the rising demand for diagnostic tests and meet the national elective care waiting times standard.

Later in 2026 we will be opening a Diagnostic Centre in Bridgwater, which will importantly increase our complex CT and MRI scanning capacity including cardiac scans and scans to support the diagnosis or ruling out of cancer. Providing complex scanning capacity off the acute hospital sites provides more options for seeing patients closer to home, but it also frees-up scanning capacity for those inpatients and emergencies that need their imaging undertaken at Musgrove Park Hospital or Yeovil District Hospital due to its specialist nature and the co-location of other services. As part of our move from acute to community, we are also exploring options for creating surgical investigations units. These units are likely to offer a shared space for several different clinical teams, but in the first instance urology, providing co-located outpatients and diagnostic facilities as a one-stop service to patients.

Performance against the national cancer waiting times standards at an aggregate level varied across the year and was largely driven by sustained high levels of suspected cancer referrals and capacity challenges in specific diagnostic services. Performance against the 62-day combined referral to treatment cancer standard varied between 68% and 76%, with the performance from the end of October being consistently above the national standard of 70% for 25/26. The 28-day existing Faster Diagnosis Standard (FDS) target of 77% was met from the end of September, with the exception of January, which was impacted by high levels of patient choice to defer tests and appointments. Lastly, performance against the 31-day combined decision to treat to treatment standard also varied across the year, with the 96% national standard not being met during the year. Across the three cancer standards, the tumour sites that had the greatest number of breaches of waiting times standards were colorectal, urology and gynaecology.

The capacity challenges faced within the endoscopy service were a significant contributing factor in the lower than national standard performance in colorectal, for both the 28-day FDS and 62-day cancer waiting times standards. This was in combination with lengthened waits for CT colonograms, for which we now have additional capacity following the opening of the Yeovil CDC. There have also been periods during the year when there have been peaks in demand for surgical treatment, when referrals have increased a couple of months earlier. During 2026/27 we will be increasing our theatre capacity, with the opening of the Musgrove Surgical Centre, which will provide greater flexibility in terms of meeting surges in demand.

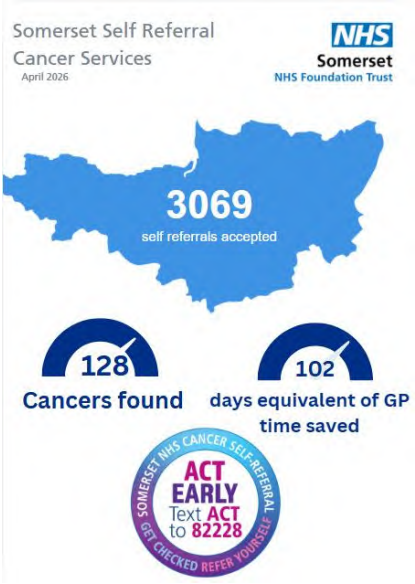
We often experience periods of heightened growth in suspected bowel cancer referrals, especially when there are high profile celebrities with a bowel cancer diagnosis. This suggests people may have symptoms but may not seeking help or may for a range of reasons have difficulties going to their GP to get their symptoms checked out. We have over the last few years seen increasing numbers of younger patients diagnosed with bowel cancer, and these patients currently fall below the age threshold for participating in the national bowel cancer screening. These are some of the reasons why we rolled-out the Somerset Bowel Service during 2025/26, which enables patients aged 40-49 to self-refer for appropriate tests, if they have symptoms of bowel cancer. This should support earlier diagnosis of any cancers or pre-cancerous conditions but also reduce future peaks in referrals which are challenging to respond to in as timely a way as we would like.

Urology and gynaecology experienced consultant shortages during 25/26, which impacted on the services' ability to meet national waiting times standards. Urology took part in the national 100 Days Matter challenge, which through increases in service capacity and pathway redesign, led to a greater than 40% improvement in Faster Diagnosis Standard performance during the second half of the year. In March 25, Gynaecology commenced a pilot of WID-Easy vaginal swab, for detecting endometrial cancers. This has the potential to reduce time to diagnosis from several weeks to 72 hours. This will also eliminate the need for patients to have certain tests, which will free-up service capacity to see other patients more quickly.

Suspected skin cancer referrals increased significantly during the last quarter of 2025/26, possibly due to the prolonged period of sunny weather we experienced in the South West during the first half of the year. With the sustained increase in skin cancer referrals year on year, we are continuing to review options for how we increase our service capacity to meet rising demand. This includes the potential use of emerging technologies to support earlier diagnosis. But alongside this we plan to increase access options for patients by offering self-referral for suspected skin cancers.

Over the last two years we have implemented a range of self and direct referral options for patients with symptoms of a potential cancer, and this work accelerated in 2025/26. The programme commenced with self referral with bleeding in menopause, where patients are offered an appointment in a community clinic, to have an ultrasound and see a specialist. This has reduced the time taken to diagnose a cancer to just 18 days, when prior to the service being introduced patients were waiting up to 64 days to see a specialist. A similar approach has been taken to self-referral for suspected bowel and lung cancers, with patients referring themselves for

tests to rule-out cancer. We have also been piloting direct referral for patients phoning NHS 111 service with breast symptoms, as recently highlighting in The National Cancer Plan for England: delivering world class cancer care (February 2026) case study. In total, over 3,000 referrals have been received through these self and direct referrals services, since the original go live of the bleeding in menopause service in September 24, with 128 cancers found to date and the equivalent of 102 days of GP time saved. We are now increasing awareness of the self-referral options through banners on buses and billboards.



Although the performance of our Emergency Departments (EDs) in relation to the four-hour target was consistently above the regional average level, it was below the intermediate minimum standard for the year, and was also generally below the national average. Performance during the year was significantly affected by pressures relating to bed availability and patient flow, and increases in the numbers of ED attendances, particularly at Yeovil District Hospital. Somerset NHS Foundation Trust remained one of the highest-performing Trusts in the southwest region, in relation ambulance handover times, consistently delivering monthly average handover times at both acute sites which were better than the South Western Ambulance Service NHS Foundation Trust (SWAST) average, and reducing the Trust-wide average handover time from 37.4 minutes in April 2025 to 21.7 minutes in March 2026.

2025/26 continued to be challenging, particularly as a result of pressures associated with patient flow and bed availability, on both of our acute sites with patients not meeting the criteria to reside typically accounting for between 17% and 27% of available beds. There is strong system-wide working to improve patient flow to support appropriate and timely discharge from the hospital setting, and continued emphasis on the development of alternate pathways of care in reducing pressures on urgent and emergency care. Actions being taken to improve patient flow, to care for people at home where appropriate, and to facilitate timely and appropriate discharge from hospital include the further expansion of Criteria-Led Discharge, to enable the timely discharge a patient when they meet pre-agreed clinical criteria for discharge, as identified by the lead clinician. This reduces delays in the discharge

process and ensures that patients can be discharged in an appropriate and timely way. Further work has also been undertaken to expand the capacity and occupancy levels of our virtual wards for Frailty and Respiratory, enabling patients to receive care in their own homes where appropriate, although caseload levels were adversely affected in the later months of 2025/26, due to a significant shortfall in capacity in the Frailty team. A workforce plan has been developed to address this issue.

As part of our arrangements to ensure that our services were accessible, our community-based physical and mental health services have continued to offer patients, where appropriate, appointments via telephone and a virtual video clinic 'Attend Anywhere'. The expansion of services also continued, including our Community Mental Health Service Transformation work, Open Mental Health. Appointment outcomes remained favourable, with the standard for the percentage of people completing a course of talking therapies treatment moving to recovery being met and exceeded in the majority of months during the year.

Activity levels and referrals to our mental health services and community physical health services remained high throughout 2025/26. Direct referrals to our community mental health services between 1 April 2025 and 31 March 2026 were 5.9% higher than the same months of 2024/25 and 12.4% higher than the same months of 2023/24. Attendances for the same reporting period were 5.3% higher than the same months of 2024/25 and 8.1% higher than the same months of 2023/24. Services which have seen significant increases in recorded activity include Primary Care Mental Health Services (Open Mental Health), Home Treatment, and Older People's Community Mental Health services. Community mental health service caseloads as at 31 March 2026 3.1% lower than as at 31 March 2025 but were 8.7% higher than as at 31 March 2024. It should be noted that investment has facilitated the expansion of some community mental health services.

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

Waiting times for our community physical health services and mental health services were largely maintained at a low level throughout the year. Over 90% of people waiting to be seen for the first time by our community mental health services for adults, older people, children & young people, and adults with learning disabilities had waited less than six weeks at the month-end in every month throughout the year. The latest available data from the NHS Benchmarking Network shows that our waiting times for first and subsequent appointments for adults with learning disabilities and mental health services for adults, older adults and children & young people all compare favourably with peer providers nationally.

We continued to perform well in relation to the length of time patients waited to be seen by our community physical health services. As at 31 March 2026, the percentage of people who had waited over 18 weeks from referral to be seen by our community physical health services (excluding community dentistry) was 89.1%, above the national standard of 78% to be achieved from April 2026. No patients had waited 52 weeks or more. The majority of the long-waiting patients were waiting to be seen by our MSK Physiotherapy service (67% of the total), which has experienced considerable challenges due to vacancies, sickness absence and insufficient cover for colleagues on maternity leave, along with an increase in referral levels and increasing complexity, which has resulted in the numbers of patients waiting over 18 weeks increasing in 2025/26. The service has implemented actions, including holding community appointment days, and proactively contacting patients by letter and telephone to provide advice and guidance and to confirm that they still wish to be treated. Mitigations of the position continue through robust triage into the Orthopaedic Assessment Service in Somerset (OASIS), pathway standardisation, reducing unwarranted variation, and appropriate use of third sector and digital interventions.

The number of people who had waited over 18 weeks from referral to be seen by our Somerset and Dorset community dentistry service reduced by 29%, from 2,544 as at 31 March 2025, to 1,815 as at 31 March 2026, and the numbers waiting 52 weeks or more fell by 41%, from 538 as at 31 March 2025 to 316 as at 31 March 2026. During the same period, the number of young people who had waited over 18 weeks from referral for an appointment for a dental procedure involving a general anaesthetic (GA) reduced by 44% from 567 to 316. Good progress was made by the service during the year in respect of recruitment, and the service is now operating close to full establishment.

Our urgent community response service, which provides urgent care to people in their own homes, and which helps to avoid hospital admissions and enable people to live independently for longer, continued to perform well throughout 2025/26. Against a national standard to see at least 70% of people within two hours, our service achieved performance of over 90% in every month throughout the year.

The number of women accessing our specialist community perinatal mental health exceeded the 12-month-rolling target level of 640 in every month throughout the year. Good performance was maintained throughout the year, in respect of adult mental health inpatients receiving a follow up within 72 hours of discharge from psychiatric inpatient care, with compliance of 97% being achieved against a required standard of at least 80%.

Performance in respect of the six-week national waiting time standards for Talking Therapies was below the national standard for the majority of the year. Because compliance is reported at point of discharge, this performance reflected the challenges faced by the service around a year previously, when there was a significant shortage of assessment workers, leading to an increase in the number of people waiting 18 weeks or more to enter treatment. Compliance is expected to return back above the 75% level in the early months of 2026/27. Across the year, 99.3% of people were seen within 18 weeks of referral against a national standard of 95% or more. Performance against the recovery rate was maintained above the 50%

national standard in all but two months during 2025/26 (in both of which it exceeded 49%), and for reliable recovery in all but four months (with an average performance across the year of 49.5% against the national standard of 48%). The national compliance standard was also met and exceeded in every month for reliable improvement (with an average performance of 72.6% against the national standard of 67%).

For Early Intervention in Psychosis (EIP), the requirement that at least 60% of people should begin treatment with a NICE-recommended care package within two weeks of referral was maintained throughout the year, with performance averaging 93.7% across the year, and reaching 100% in each of the last eight months of the year.

Our numbers of inappropriate out-of-area placements for adult mental health services remained amongst the lowest nationally. The majority of out of area placements are due to patients requiring admission into our Psychiatric Intensive Care Unit (PICU). With only ten beds available there are occasions when, due to clinical acuity or gender, it would be unsafe to admit a patient. When a patient is so placed, a key worker is immediately assigned to maintain regular contact with the patient until the patient is either transferred back to our wards, discharged, or moved to secure services. The placements sought are always as close to Somerset as possible. At times, episodes relate to patients awaiting transfer to secure services. We continue to work closely with other NHS providers, to facilitate such transfers and closely monitor processes to minimise risk. The service has reviewed processes to ensure that barriers to repatriation and/or discharge of patients are minimised and escalated with system partners where appropriate.

We again had no admissions to adult facilities of patients under 16 years old in 2025/26.

The Trust had seven cases of MRSA bloodstream infection in 2025/26. A total of 83 Clostridium difficile cases were recorded during the year, which was lower than the threshold for the year of 91. All Trust associated cases are thoroughly investigated to assess whether there was any lapse in care that may have contributed. These assessments are subsequently peer reviewed and validated with the Trust's commissioners.

Equality of service delivery

As a public sector organisation, the Trust is required to ensure that equality, diversity and human rights are embedded across all functions and activities, in line with the Equality Act 2010, the Human Rights Act 1998 and the NHS Constitution. In all aspects of our work, we have due regard to the need to meet the general duties set out in the Equality Act:

- Eliminate unlawful discrimination, harassment and victimisation, and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share protected characteristics and those who do not.

To support these duties, the Trust continues to:

- Remove or minimise disadvantage experienced by people due to their protected characteristics.
- Meet the specific needs of individuals from protected groups.
- Encourage participation where representation is disproportionately low.

Aligned with our strategic aim to improve population health and reduce inequalities, we are committed to ensuring equitable access, experience and outcomes for all those who use our services. This includes ensuring that services are accessible, inclusive and responsive to the diverse needs of the communities we serve.

The Trust works closely with Somerset Integrated Care Board and system partners to support a coordinated and consistent approach to equality, diversity and inclusion across the health and care system. This includes aligning organisational priorities with system-wide strategies to improve access, experience and outcomes for all population groups.

As the county's integrated provider of acute, community, mental health and learning disability services, we recognise the importance of designing and delivering care that is inclusive, person-centred and equitable. We are committed to ensuring that no individual receives a lower standard of care as a result of unfair or unlawful discrimination based on age, disability, gender, race, religion or belief, sexual orientation or any other characteristic.

During 2025/26, we have continued to work with system partners, public health teams and local communities to support improved outcomes for groups who experience poorer health outcomes, including people with serious mental illness, learning disabilities and autistic people. This includes improving access to services, supporting personalised care and removing barriers that may prevent individuals from accessing the care they need.

Further detail on how the Trust identifies and addresses health inequalities through data, analysis and system working is provided in the following section.

Tackling healthcare inequalities

NHS England defines health inequalities as "unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them."

The NHS Act 2006 (as amended, by the Health and Care Act 2022) places a range of health inequalities duties on the NHS and provides extended legal duties on reducing and tackling health inequalities. NHS England's statement, published on 19 November 2025, set out their views on how integrated care boards (ICBs), Trusts and Foundation Trusts should collect, analyse publish and use information on health inequalities. Relevant NHS bodies have a legal duty to include in their annual reports a review of the extent to which they have exercised their functions consistently with this statement. The duty to report information on health inequalities

will encourage better quality data, completeness and increased transparency and enable the use of the data to shape and monitor improvement activities. The statement will help drive improvement in the provision of good quality services and in reducing healthcare inequalities, helping to ensure equitable access, experience and outcomes for all.

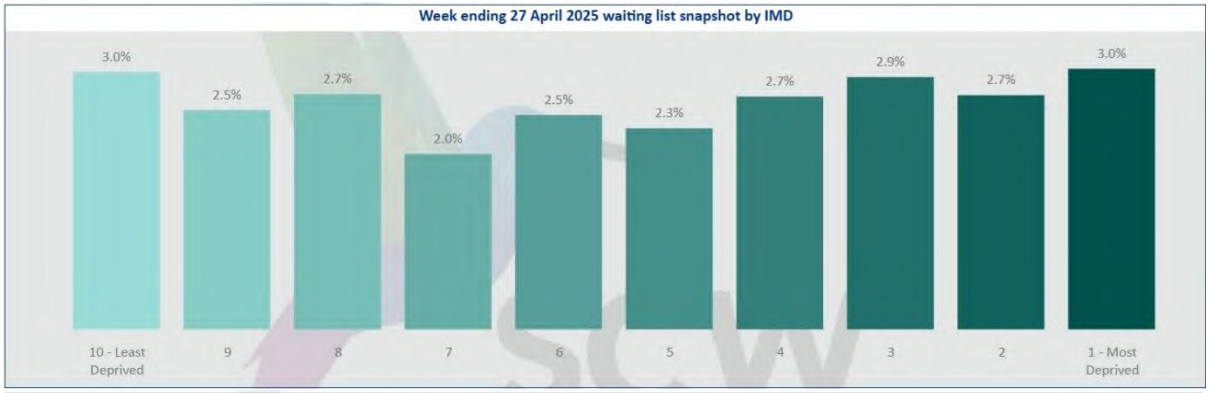
To ensure a consistent approach across Somerset Integrated Care System, we have worked collaboratively with partner organisations, using the same data sources, including a locally-developed health inequalities dashboard; we have utilised a combination of nationally published and locally compiled reports to enable more up to date reporting (and also to allow drill through to understand if variation exists). This has ensured that we have a commonality of approach and understanding of the issues on both a Trust and Somerset ICB basis.

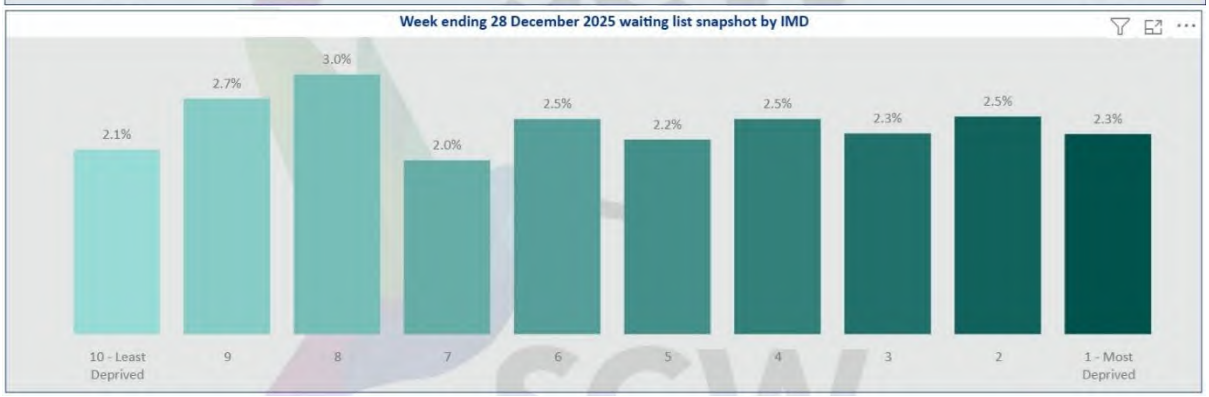
Elective inequalities

During 2025/26, the Trust continued to implement and refine its targeted elective prioritisation model to expedite elective care for patients at highest risk of deterioration whilst waiting for treatment. The points-based model, which identifies patients with learning disabilities, active mental health needs or high levels of social deprivation, remained embedded across elective pathways, enabling earlier review and targeted support for a small but highly vulnerable group of patients. Patients waiting for their first routine outpatient appointment have had their average wait reduce from six months to 2 months and received support from Learning Disability liaison teams where relevant. Significant change has also taken place in surgical specialties such as Gynaecology, Orthopaedics and Urology, with prioritised patients receiving surgery 6-8 weeks sooner than others.

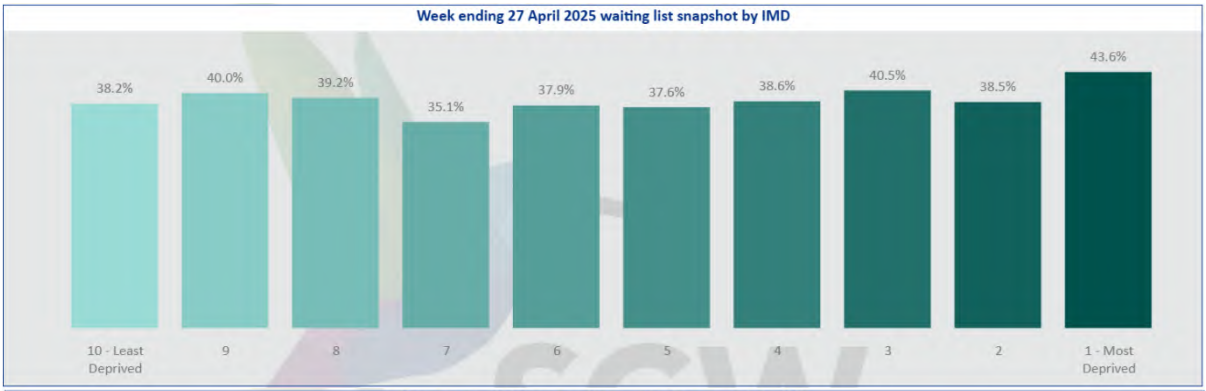
In the last year, the elective prioritisation model was also fully rolled out to the YDH waiting list. Recent work has particularly focused on extending the approach for children and young people, initially including Children Looked After within the model, and now aligning local processes with emerging national tools designed to assess health inequalities in children more broadly. Further expansion for children and young people remains dependent on specialty capacity, particularly within ENT, and therefore temporarily paused, but the programme continues to provide a robust, evidence-based framework for improving access and reducing healthcare inequalities with clear potential for further expansion.

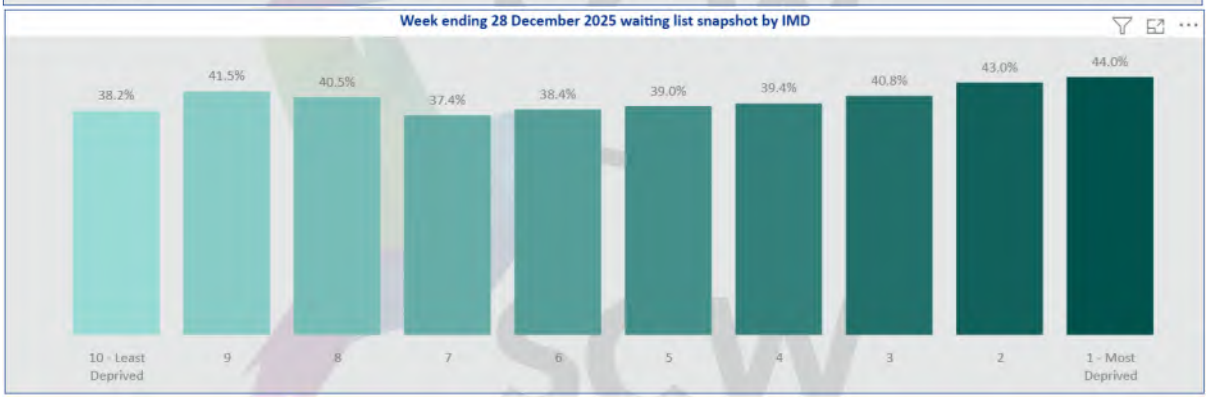
The charts below show the numbers of people in each of the Index of Multiple Deprivation (IMD) deciles waiting over 52 weeks, as a percentage of the total number of people waiting in each decile. The charts show that, between April 2025 and December 2025 – the latest data currently available – the percentages waiting over 52 weeks in all of the more deprived deciles reduced.





The charts below show the numbers of people in each of the IMD deprivation deciles waiting over 18 weeks, as a percentage of the total number of people waiting in each decile. The charts show that, between April 2025 and December 2025 – the latest data currently available – the percentages waiting over 18 weeks in all of the more deprived deciles increased.



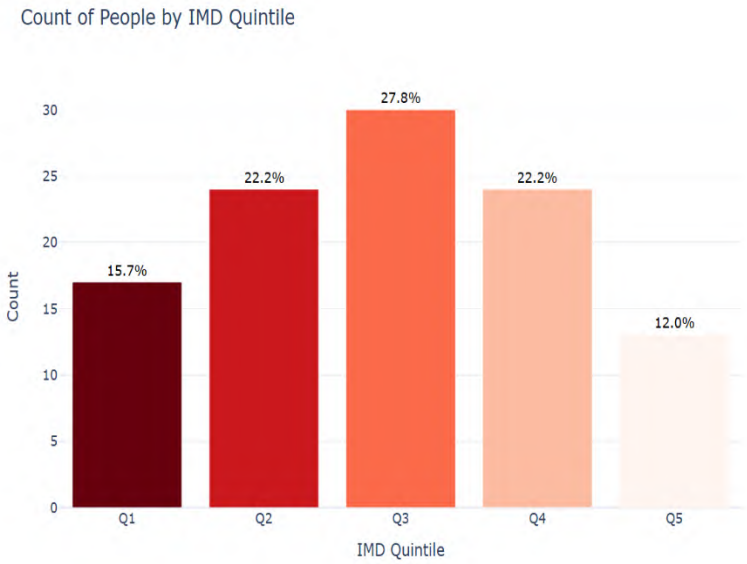


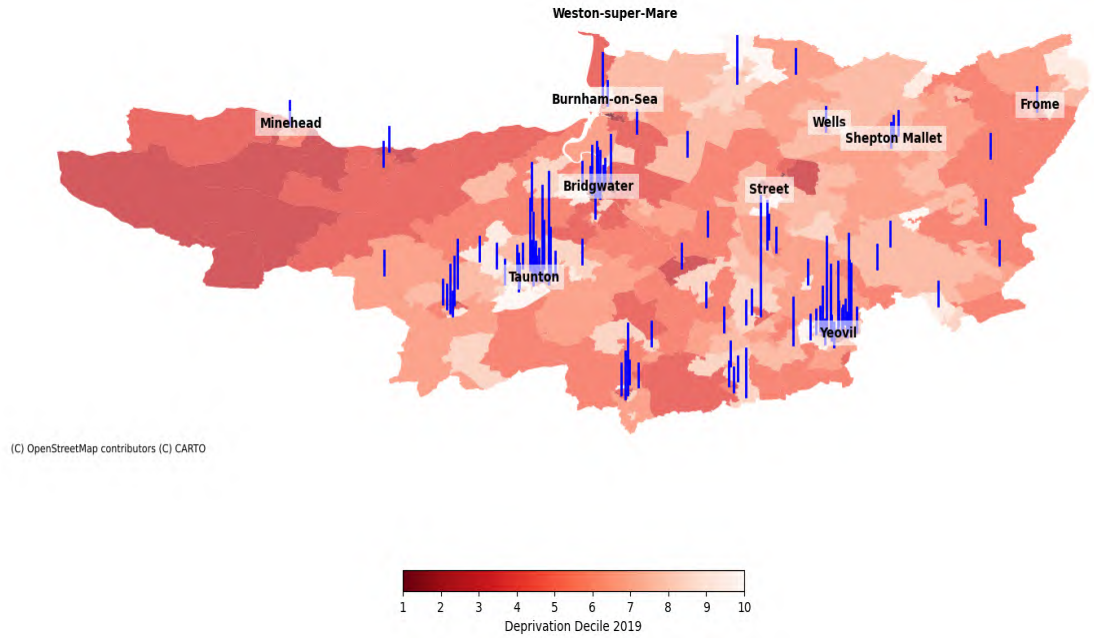
High Intensity Users

Throughout 2025/26, the Trust's Under-18s High Intensity Use Group (HIUG) continued to operate across both emergency departments, identifying and supporting children and young people with frequent attendances. This was originally established in 2023, following successful implementation of the Adult HIUGs, and included children and young people with 10 or more ED attendances within 3 months. Using routinely monitored data, the programme has brought together a multidisciplinary partnership including health, social care, police, public health, safeguarding and voluntary sector services to better understand unmet need and coordinate earlier, more appropriate support in the community.

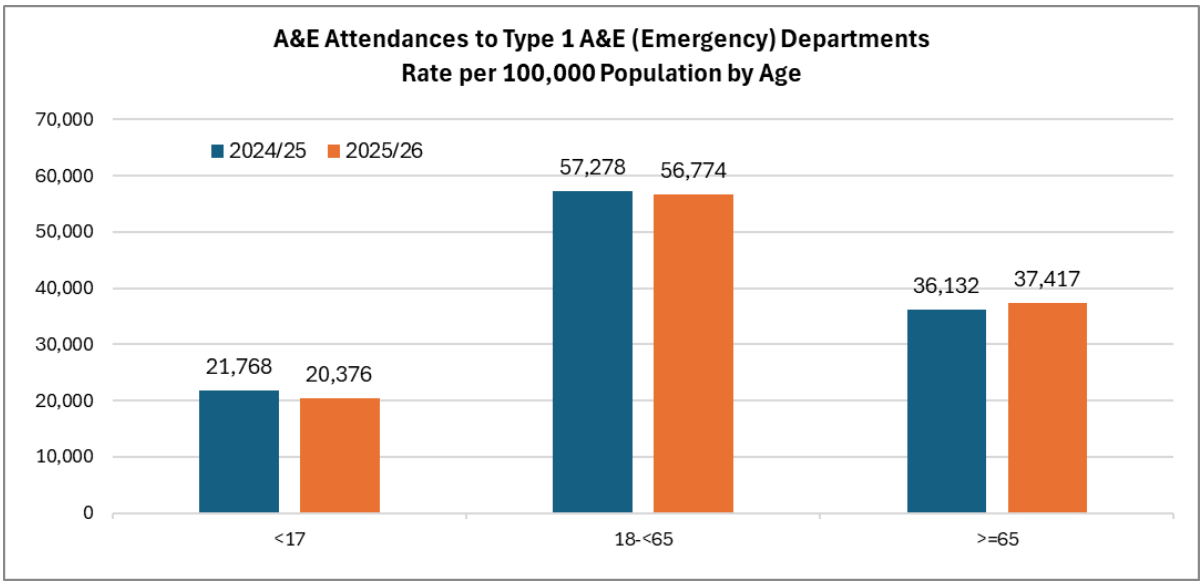
During the year, the programme delivered sustained and increasing reductions in emergency department attendances for children discussed through the HIUG, significantly exceeding national expectations for attendance reduction. In 2025 the HIUG worked with 56 individuals, with an overall reduction in attendances of 77% following support. The figures below demonstrate more detailed information about the cohort being supported. As the programme has matured, thresholds have been refined and practice has shifted towards earlier intervention and improved clinical understanding of age-related attendance patterns.

A summary of patients, by Deprivation decile and by Lower Layer Super Output Area (LSOA) is set out below. The blue bars on the map of Somerset represent the numbers of high intensity users.

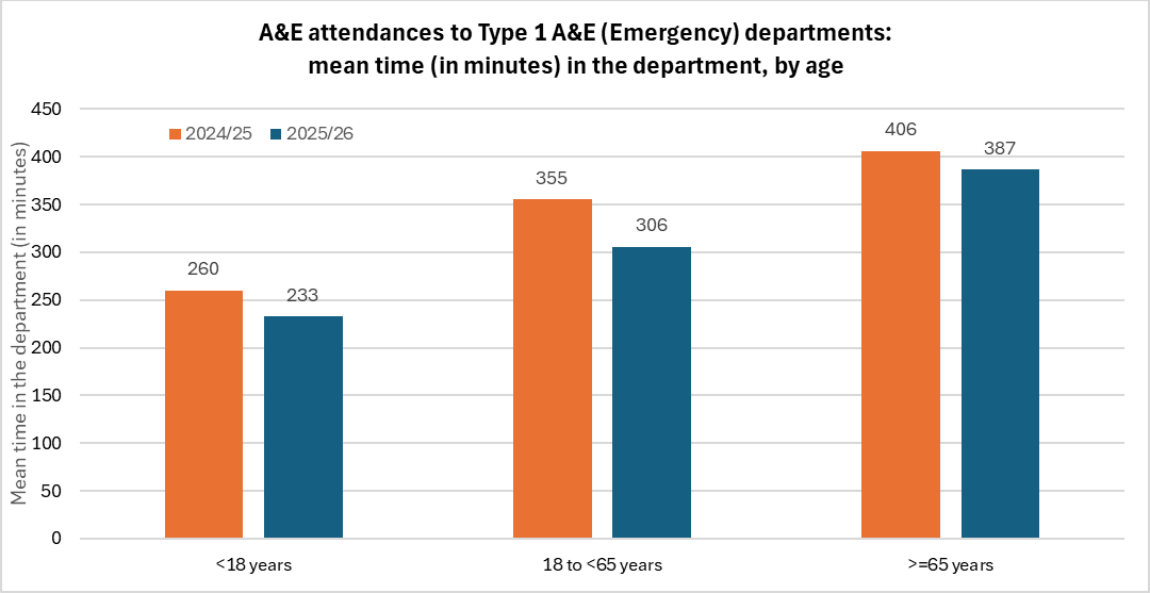




The chart below shows the rate of attendances to Somerset NHS Foundation Trust emergency departments, per 100,000 population by age group, in 2024/25 and 2025/26. The rate of attendances by people aged under 18 years fell by 6.4%, compared to 0.9% for those aged 18 to under 65 and a rise of 3.6% for those aged 65 years and over.



The chart below shows the mean average time, in minutes, spent in Somerset NHS Foundation Trust emergency departments, by age group, in 2024/25 and 2025/26. It can be seen that the mean time in the department fell in all age groups in 2025/26, compared to 2024/25, and that the average time spent by people aged under 18 years was the lowest of all age groups in both years.



Maternity

In 2025/26, the Trust strengthened its focus on addressing inequalities in maternity services through improved use of data, targeted care pathways and enhanced access to care. A new national Inequalities Dashboard is enabling more detailed review and analysis of local data in order to highlight gaps in service provision or areas where data recording requires improvement, and to inform service development. Ethnicity and deprivation are routinely considered within adverse outcome and incident reviews to ensure potential disparities are recognised and acted upon.

Enhanced pathways continue to support women and birthing people with complex social or mental health needs, including through maternal and perinatal mental health services and the Women Requiring Extra Nurturing (WREN) pathway. Those identified as being at higher risk of poor outcomes are placed on the same level of surveillance and support as someone having their first baby, regardless of parity. Access improvements included increased use of translation services and more flexible triage arrangements for those with English not as a first language. The Somerset Maternity and Neonatal Voices Partnership remains central to co-production of services. Recent appointment of an Engagement Officer is further strengthening meaningful involvement of service users.

The charts below show the percentages of term and pre-term births, by ethnic group, and by IMD deprivation decile.

Stolen Years

During 2025/26, the Stolen Years workstream focused on improving the quality and consistency of physical health monitoring for people with severe mental illness, with a particular emphasis on data collection and reliability. A detailed review of existing dashboards and reporting identified discrepancies between clinical activity and reported compliance, alongside variation in referral and recording practices across localities.

In response, activity during the year centred on practical, short-term improvements, including targeted staff training, simplification of monitoring forms and work to standardise referral pathways. While larger system changes are limited by the planned transition to a new electronic health record, progress in 2025/26 has helped lay the groundwork for more equitable and reliable physical health monitoring across mental health services. The table below shows the numbers and percentages of physical health checks for adults with Severe Mental Illness (SMI), by recorded ethnicity, during the period from 1 April 2025 to 31 March 2026.

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

Y. Client not asked	1		100.0%
Z. Not stated	1		100.0%
Total	135	9	93.3%

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

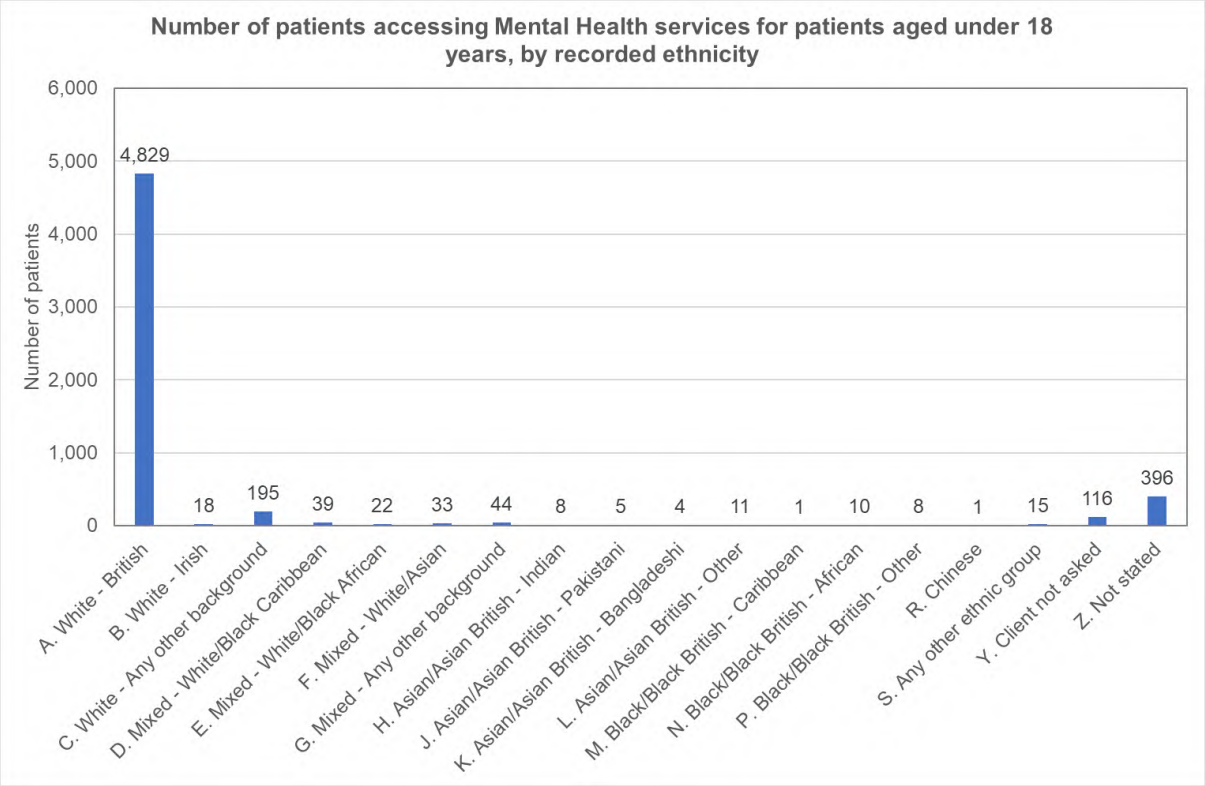
It should be noted that, due to a coding issue which is being addressed, the numbers of patients identified with SMI is likely to be understated.

Patient and Carer Race Equality Framework (PCREF)

During 2025/26, the Trust continued implementation of the Patient and Carer Race Equality Framework (PCREF) to improve access, experience and outcomes in mental health services for people from racialised and ethnically and culturally diverse communities. A dedicated working group, involving voluntary sector partners and experts by experience, met throughout the year to shape priorities and guide action, developing a local response to this nationally mandated initiative.

Key progress in 2025/26 included improvements to outcome and experience data to improve visibility of the communities of focus within Trust activity, and incorporation of specific questions into existing patient engagement work carried out by the trust. Focus has also been on workforce development for cultural safety and competence, with internal courses on offer in addition to sessions for medical colleagues commissioned from Stand Against Racism and Inequality (SARI). Membership of the Somerset Equality Partnership Group is supporting learning and ensuring accountability to partners. The Trust recognised ongoing challenges, particularly around identifying and engaging with some local diverse and transient communities for example Gypsy, Roma and Travellers and transient workers at Hinkley Point. This will remain a focus for future work.

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

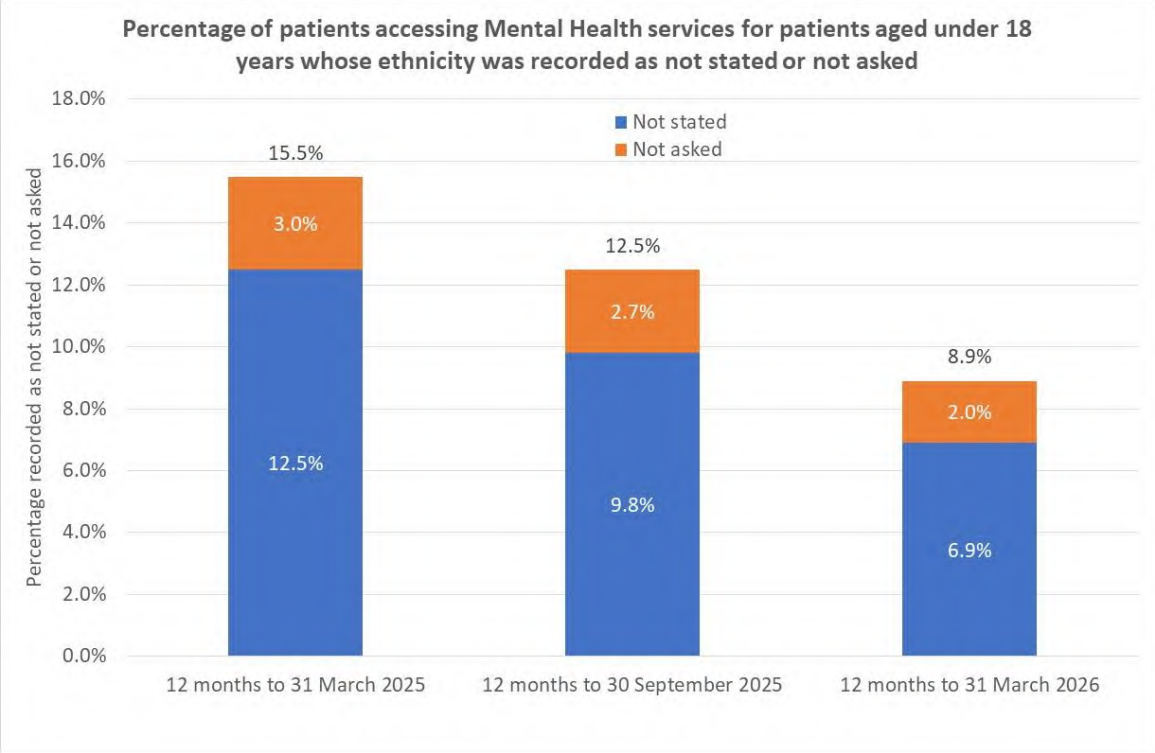


The data shows that, of the total of 5,755 patients accessing mental health services during the period, 5,042 (87.6%) were patients from a White ethnic group, and 512 (8.9%) were patients whose ethnicity was either not stated (6.9%) or was not asked (2.0%).

Patients of mixed ethnicity comprised 2.4% of the total, compared to 1.2% for the wider population of Somerset (all ages), and patients recorded as Black / Black British made up 0.3% of patients, compared to 0.4% for the wider population of Somerset (all ages).

It is notable that patients whose ethnicity was Asian or Asian British comprised only 0.5% of the total – up from 0.4% on the previous PCREF report - compared to 1.5% for the wider population of Somerset (all ages).

The chart below shows how the percentages of patients whose ethnicity was recorded either as not stated or not asked have changed over time.



Treating Tobacco Dependency

In 2025/26, the Trust's Tobacco Reduction Service delivered continued progress across maternity, mental health and acute services, despite operating with a small workforce. In maternity services, a new in-house delivery model has been fully embedded, strengthening pathways for pregnant women and their partners as they progress on their quit journeys, and contributing to local smoking at time of delivery rates below the national average. Challenges persist in resolving inaccuracies in national datasets.

Across mental health, the service supported smokefree sites, with a noticeable cultural shift seen during the first year of this being in place allowing patients and staff to benefit from the health benefits of smokefree environments. There have been many quit and harm-reduction successes, supported by behavioural interventions and nicotine replacement therapy (NRT). Continued use of vaping as a harm-reductio tool remains central to this approach. Motivational initiatives, including certificates for achieving 4-week, 12-week, and 12-month quits, have been warmly received by mental health inpatients, many of whom may not previously have experienced such positive recognition.

Within acute settings, increased identification of smoking status is evident and supports a greater number of inpatients to receive intervention from one of the service's practitioners prior to referral to the community service. Between April and December 2025, 309 acute inpatients were referred to the SmokeFree Somerset community team following expert inpatient support, with 59 achieving a successful quit.

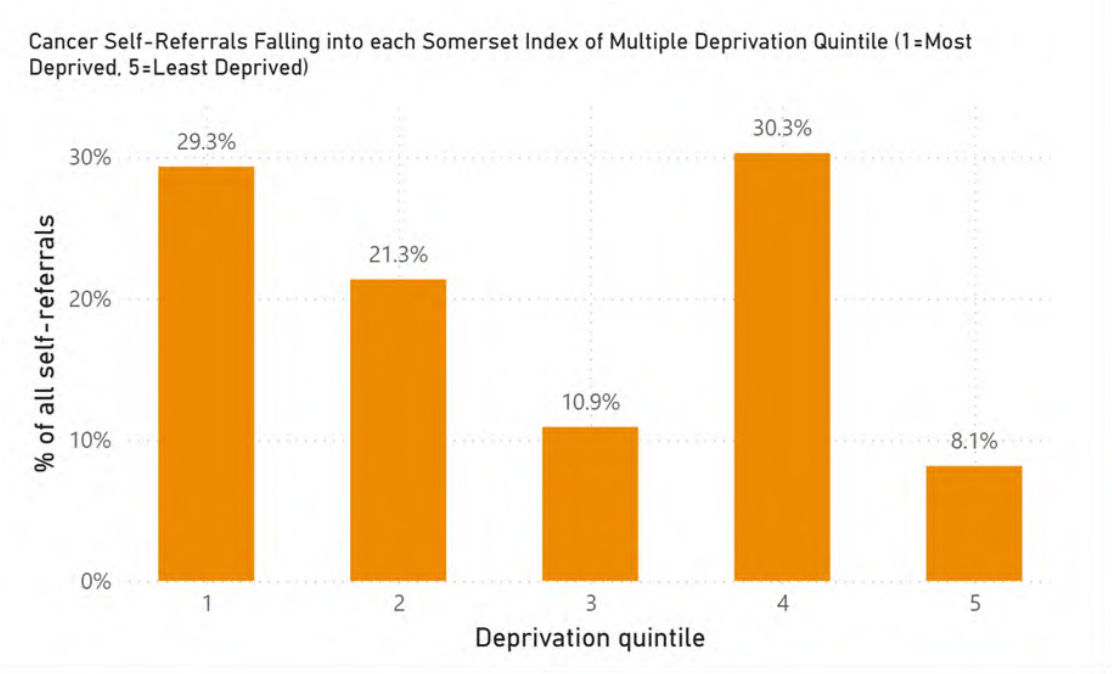
Staff and patient engagement initiatives during high profile campaigns (e.g. Stoptober) and at local meetings and events have strengthened engagement,

enhancing our smokefree message. Additionally, increased support for colleagues has been introduced in the form of free access to the SmokeFree App, including tailored support and NRT. Finally, improvements in local data in the form of a new referral database have enabled better understanding of variation and inequalities, supporting more targeted delivery.

Cancer self-referral

During 2025/26, cancer services have continued to develop the Post Menopausal Bleeding self-referral pathway in addition to rolling out new self-referral pathways for breast, colorectal and lung cancer. The pathways aim to improve access for people experiencing potential cancer symptoms, particularly those facing barriers to traditional referral routes. Targeted communications and outreach activity were delivered across selected Primary Care Networks (PCNs) to raise awareness and encourage appropriate self-referral. A number of outreach events have also been held within local communities to promote the pathways and better understand any barriers to access.

Data reviewed during the year suggests a higher proportion of self-referrals are coming from more deprived communities, indicating progress in addressing access inequalities. As roll-out has been phased, analysis undertaken this year will continue to inform future expansion, including plans to develop referral routes via community pharmacies.



Breast screening outreach

In 2025/26, targeted outreach activity within the Somerset Breast Screening Programme focused on improving equity, awareness and uptake among groups with historically lower participation. Work during the year aligned promotion and community engagement with the mobile unit screening schedules and strengthened partnerships with primary care, cancer care coordinators and Village Agents. An extensive programme of outreach events took place across the county, providing

multilingual information and practical support to address common barriers to attendance.

Specific initiatives delivered in the last year supported people with learning disabilities, those experiencing homelessness and newly arrived asylum seekers. Focused work with the local homeless health service and the Nelson Trust has worked to address barriers linked to trauma, instability, and lack of GP registration. Translated breast awareness and screening information has been embedded into health assessments for newly arrived asylum seekers, supporting early engagement with preventive care. The dedicated Learning Disability Pathway, launched in May 2025, continues to enhance inclusive care and is supported by an accessible picture book for individuals with learning disabilities. Additional initiatives include continued distribution of HRT pharmacy campaign slips, ongoing social media engagement, and a new personalised DNA call/text project. Early indications during the year suggest improved awareness and re-engagement among some persistent non-attenders.

Finally, funding has been secured for a breast screening bus wrap, with plans for free bus travel and a potential linked radio campaign. This multi-platform approach aims to normalise screening and reduce transport-related inequalities.

Ethnicity recording improvement

During 2025/26, the Trust continued to work towards improvements in ethnicity data recording as a key enabler for understanding and therefore addressing health inequalities. A group has come together to review and begin implementation of the NHSE Ethnicity Recording Improvement Plan, with initial work involving development of a dashboard which enables a comprehensive understanding of ethnicity recording across the organisation as a whole and within services, departments and wards. Further work will focus on developing staff understanding of why accurate data matters for patient care and service improvement, and ensuring this is communicated effectively to patients so they also understand the reason they are being asked for the information.

There has been a continued improvement in the completeness of ethnicity recording across key service areas during the year. In particular, admitted patient care and emergency departments have seen steady progress, reflecting a sustained organisational focus on improving data quality at the point of care. This indicates that actions to strengthen staff awareness and recording practices are having a positive impact, supporting more reliable data to inform service planning and the identification of health inequalities.

High levels of compliance have been maintained in mental health wards and community hospitals, where recording has remained consistently strong. This sustained performance suggests that robust processes are well embedded in these services. Taken together, the improvements in acute settings and the continued high standards in other areas provide increased assurance that the organisation’s data is both more complete and more representative of the population it serves.

Monitoring performance, improvements in Quality and meeting national targets

Somerset NHS Foundation Trust has a comprehensive quality monitoring and performance management framework in place, to ensure that high standards of care are delivered to patients and that all applicable performance targets are delivered.

Our monitoring and reporting arrangements involve a hierarchy of performance management and assurance arrangements, ranging from the Trust Board to individuals and line managers. The key performance management arrangements relating to each of the four levels
are set out below.

Level 1: Corporate Level Reporting Arrangements

Integrated Performance Report

Performance is reported to the Trust Board through the Integrated Performance Report. The Integrated Performance Report is continually reviewed, to ensure that it reflects the most current and relevant metrics and analysis. The report includes a scorecard of key performance and quality measures, and a narrative report outlining notable areas of good and adverse performance for each of the following areas:

- National priorities, drawn from NHS England's 'Priorities and operational planning guidance'.
- Neighbourhoods and Community services
- Symphony Healthcare Services
- Mental Health and Learning Disabilities services
- Urgent and Emergency Care
- Elective Care
- Cancer services
- Maternity
- Children and Young People's services
- People
- Patient Experience and Involvement

The monthly Integrated Performance Report assists the Board in assessing the achievement of the Trust's corporate aims, objectives and key targets. The aim of the report is to provide the Board with a high-level overview of key performance and quality indicators, spanning the breadth of the Trust's responsibilities.

The reports allow the Board to evaluate whether the Trust is meeting national and local standards and targets for the quality of services delivered to patients, and operating efficiently and effectively. The Integrated Performance Report identifies good and adverse performance and sets out the actions which are being taken to address any areas of adverse performance.

Quality and Governance Assurance Committee
The Trust's Quality and Governance Assurance Committee, a sub-committee of the Trust Board, provides detailed challenge and assurance, in relation to key performance and patient safety metrics.

This detailed analysis and challenge, in relation to the quality and performance position of the Trust, supplements high-level Board discussions on performance. This enables a balance to be struck between effective Non-Executive Director scrutiny of the operational detail, whilst enabling the Board to remain focused on the key strategic issues.

The Quality and Governance Assurance Committee receives the Integrated Performance Report and corporate scorecard, as well as a range of more detailed tabulated performance information, at the level of individual service group, service and ward.

Level 2: Service Group / Corporate Directorate Level Arrangements

The Trust also maintains Service Group level performance scorecards for each of its Service Groups.

Each Service Group scorecard sets out the performance of the Service Group, in relation to its contribution towards the Trust's national and local performance requirements, as well as quality and safety measures.

This allows the Trust's key measures to be managed at a more granular level, and to identify any areas of concern which contribute to overall underperformance against a measure at the corporate level, or which relate to a measure for which the corporate-level performance meets the required standard.

As with the Board-level scorecards, each service group scorecard is 'RAG' rated for each indicator which has a specified compliance level, using a trigger against each measure, and given an overall rating of Green (at or above the required standard), Amber (below the required standard) or Red (significantly below the required standard).

The key forums, via which performance management arrangements for Service Groups are managed are:

- Finance and Performance Group meeting for each of the Trust's six Service Groups, held every other month, with the performance section of the meeting chaired by the Trust's Associate Director of Planning and Performance. The Finance and Performance Group focuses on the principal performance issues for each Service Group, and considers the exceptions arising from the Service Group scorecards. Monthly Finance and Performance Group meetings are also held for each of the Trust's corporate directorates, focusing on Finance, and performance issues relating principally to People.
- Quality, Outcomes, Finance and Performance Group, held in the intervening months for Service Groups, has a similar remit to the Finance and

Performance Group, but is extended to include a more in-depth focus on patient safety and quality issues and a more detailed review of performance issues relating to People.

The main purposes of these meetings are to:

- review actual performance against plan;
- provide support and challenge to teams, in relation to their performance position and to gain assurance that performance issues are being addressed effectively;
- assess risks to future delivery and agree mitigation plans;
- identify and agree future performance management arrangements;
- identify the contributory issues behind any decline in performance and to have a clear escalation and de-escalation process;
- focus on early performance management intervention, where Service Groups and corporate directorates might be at risk of failing to meet required standards.

Level 3: Service-Level Performance Management

Review meetings are held within each Service Group, with representation from individual services managed within the Service Group, enabling a discussion of operational issues for each service.

All Service Group management teams are expected to have regular reviews for all areas within their sphere of responsibility, linking to individual-level objective setting. Service Group management teams are expected to meet regularly with specialty level teams, to provide both the opportunity for performance management and also for escalation of any issues.

It is the responsibility of the Service Group Directors to identify, reward and share good practice, and to support and challenge teams regarding any performance issues within the Service Group.

The Service Group finance leads and People partners also link with the Service Group management teams, supporting the wider performance management agenda across the Trust.

In addition to the corporate level and Service Group level scorecards, the Trust also maintains a range of performance tools at individual service level, including ward-level performance scorecards, and performance reports and trend analyses for some individual services.

Level 4: Service Group, Directorate and Departmental Performance Responsibilities for Individuals

Line Management Responsibility: Service Group and directorate management teams hold the primary responsibility for delivery within each Service Group or directorate.

In Service Groups, the triumvirate (i.e. the Service Group Director, the Associate Medical Director, and the Associate Director of Patient Care), supported by the Deputy Service Group Director and team managers, are responsible for performance. In corporate directorates, the Executive Director, supported by their senior managers, are responsible for performance.

In Service Groups and corporate directorates, the senior teams work to resolve most performance management issues within the Service Group, through individual accountability and appraisal and through the Service Group-level review.

Care Quality Commission (CQC)

Maternity Services Inspection

In November 2023, Somerset NHS Foundation Trust's maternity services were inspected by the CQC as part of its national maternity inspection programme. The inspection covered services at Yeovil District Hospital, Musgrove Park Hospital, and the Mary Stanley Midwife-Led Unit at Bridgwater Community Hospital. The findings, published in May 2024, identified several areas requiring significant improvement, and the Trust was issued with a Section 29a Warning Notice in January 2024.

In February 2026, CQC re-inspected the maternity services at Musgrove Park Hospital. The maternity and neo-natal services at Yeovil District Hospital were temporarily closed at the time of the inspection. At the time of writing this report, the final report of the inspection is still awaited but in feedback the CQC inspection team noted the ongoing improvement work that had taken place and observed some "lovely examples of caring" and enthusiastic staff and leaders who were passionate about the service. The inspection team did note areas for improvement remained in some aspects of care and practice and commented on the continuing challenges of the Musgrove Park Hospital maternity estate.

Paediatric Services Inspection

Following the CQC inspection in January 2025 of the Trust's acute services for children and young people at our Yeovil District Hospital site and subsequent staffing challenges, the Trust took the difficult decision to temporarily close the Special Care Baby Unit (SCBU) at Yeovil District Hospital which meant we were also unable to safely provide care during labour and birth at the Yeovil Maternity Unit for an initial period of six months.

The temporary closure has been used as an opportunity to review the staffing and service delivery model for paediatrics, including neonatal care. It also supported our successful efforts to recruit additional staff to strengthen rota resilience and address the safety and cultural concerns highlighted in the CQC warning notice.

We were pleased to confirm the re-opening of the services on 21 April 2026 and we anticipate a further CQC inspection of the services at Yeovil Hospital in due course.

Mental Health Inpatient Services

Our mental health inpatient wards have again been subject to Mental Health Act compliance inspections by CQC over the course of the year. During 2025/26, the CQC inspection team visited:

- Ash ward, Low Secure Unit, in Bridgwater
- Rowan ward 2, inpatient ward for adults of working age, in Yeovil
- Rydon ward 2, inpatient ward for adults of working age, in Taunton

The feedback from these inspections has been overwhelmingly positive, including comments from patients, carers, families and the Independent Mental Health Advocates who attend the wards.

On Rydon ward 2, the inspector noted a patient had told them:

“I just can’t fault it. Staff are so caring, and I really believe staff want to make a difference. Its not just a job for them. They listen to you even when you don’t really know what to say or how to start the conversation. They just listen. It has a made a big difference and has made a difficult time considerably more bearable for me”.

On Rowan ward 2:

“Staff here are wonderful, really caring and kind. If I need anything they make sure I get it, though sometimes when they are busy, I might have to wait. I do not mind that because they have a job to do. Overall, the team here are very efficient and they are really trying to help me.”

On Ash ward, they quoted a family carer as saying:

“We have no concerns as a family. We are very happy with everything and find the staff to all be warm and approachable. I seriously cannot fault any of them, the whole team have been wonderful. They have restored my faith in mental health services.”

The CQC inspector did share some concerns about medication processes on both Rydon and Ash wards and about estates at Rowan ward which we have quickly addressed but overall, these were very positive sources of assurance for us on the standards of care being offered in our mental health wards.

Environmental Sustainability including task force on climate-related disclosures (TFCD)

Progress towards delivery of the strategic aims set out in our Green Plan is reported to Board twice a year. The Trust Board Assurance Framework (BAF) includes a climate-related risk entry, which is regularly reviewed by the Board. The Associate Director of Resilience has a severe weather plan and is involved in the development of a climate adaptation plan, led by the ICB.

In 2025 the Green Plan was updated in line with NHS Green Plan guidance, to provide a new focussed plan for the next 3 years. The new aims are:

- Workforce and leadership: To foster a culture of sustainability throughout the organisation, empowering our workforce and leadership to drive green initiatives including net zero clinical transformation.
- Estates and facilities: To achieve net zero carbon for all energy use in our buildings, ensuring a sustainable and resilient estate. Also to consider how our operations including waste, and food and nutrition, can be more sustainable.
- Travel and transport: To significantly reduce emissions from all travel and transport associated with our services, promoting sustainable options for our colleagues and service users.
- Supply chain and procurement: To work collaboratively with our supply chain, including medicines, to reduce our environmental footprint. We will reduce single use and seek to introduce circular economy principles.
- Digital Transformation: To embed net zero principles across all clinical services through digital transformation, leveraging technology for environmental benefit.
- Climate Change Adaptation: Develop our sites to be resilient to the effects of climate change.

Our six core aims have specific objectives to achieve for the three-year duration of this Green Plan, with actions aligned to achieving these objectives. The focus of the Green Plan for the next three years will be on the areas of significant carbon emissions where we believe interventions and actions can make a marked reduction in our carbon footprint.

Achievements

The following describes the Trust's successes in reducing the impact on the environment:

- LED lighting installations have been completed at Minehead and South Petherton hospitals.
- Work is ongoing on three solar panel projects to the Jubilee building at Musgrove Park Hospital, South Petherton and Frome community hospitals.
- The Trust, ICB and Somerset Council have jointly developed a Climate Change Adaptation Plan for Somerset Integrated Care System 2025. The objectives of this project are:
    - To build an understanding of the risks to public health and NHS service delivery in the Somerset ICS and existing adaptation activities in the region.
    - To provide an adaptation action plan for addressing these risks.
    - To build momentum and give strategic direction to climate adaptation in the ICS.

Governance, Monitoring and Performance

Our interim targets are to achieve a 47% reduction in the NHS carbon footprint, by 2032 at the latest and a reduction of 73% in the NHS carbon footprint plus by 2038 at the latest, based on 2019/20 baselines.

The latest figures show that after an increase in our carbon footprint between the baseline year 19/20 and 20/21, our carbon footprint reduced in 21/22. The reductions continued in 22/23 and 23/24, but the 24/25 year resulted in a slight increase of 2.9%, though still showing an 11% reduction since 19/20.

Of the 20,000tonnesCO_2e in the Trust carbon footprint, energy makes up by far the largest proportion of our carbon footprint accounting for 84.3% of the Trust carbon footprint. Business travel and fleet mileage makes up 6.3% and nitrous and entonox medical gases another 6.1%.

Our carbon footprint plus remains relatively erratic without a clear trend of increasing or decreasing emissions. The products and equipment from our medical and other supply chain have the greatest impact on this. These account for approximately 57% of our carbon footprint plus. Patient travel, visitor travel and staff commute account for 15% and our carbon footprint (energy, waste, water, business travel etc) makes up 14% of the carbon footprint plus. Our carbon footprint plus for 24/25 is approximately 144,000tonnesCO_2e.

Our carbon footprint and carbon footprint plus data is provided by NHS England through the pilot Green Plan Support Tool. We must achieve net zero by 2040 for the NHS carbon footprint and 2045 for the NHS carbon footprint plus.

Task Force on Climate-Related Disclosures (TFCD)

NHS England's NHS foundation trust annual reporting manual adopted a phased approach to incorporate the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

Governance Pillar

The Trusts Green Plan forms the primary strategy related to climate risks and opportunities. Updates on the Trusts Green Plan and progress towards the Green Plan objectives as set out in the Environmental Sustainability section of this report are presented to the board every 6 months.

The Strategic Sustainability Group (SSG) undertakes governance of the Environmental Sustainability topic within the Trust. The SSG is chaired by the Director of Strategy and Digital Development. The SSG reports directly to Executive Board. Membership of the group consists of senior leadership from various service groups and includes the Trust Associate Director of Resilience with responsibility for the Emergency Preparedness, Resilience and Response (EPRR). The SSG provides strategic decision making on the environmental sustainability topic including climate related risks and opportunities.

A Greener Care Action Group (GCAG) provides clinicians and non-clinicians with an avenue to engage with the Environmental Sustainability topic including climate related issues. The GCAG is chaired by the Deputy Chief Nurse and reports to the SSG.

Strategy pillar

As well as update to the Trust Green Plan in 2025/26, NHS Somerset, the ICB, led the development of a Somerset ICS Climate Adaptation Plan for the ICS, as reported in the Environmental Sustainability section of this report. The plan is available from ICB website Somerset ICS Adaptation Plan 2025 Final. This plan will inform our Trust strategy to adapting to climate related impacts alongside our Green Plan that sets our strategy for actions to reduce the Trust impact on the environment.

Risk management Pillar

The Somerset ICS Climate Adaptation Plan provides a risk assessment of climate related effects on the Trusts sites and operations as well as recommendations for the Trust to mitigate these risks and adapt to future climate events.

The Plan has been presented at the SSG to discuss climate-related risks that have been identified. The group represents the Trust process for assessing the risks identified by the climate adaptation risk assessment and any future climate-related risks. Members of the Trust are also taking part in the Somerset Adaptation Community of Practice. This includes representatives from estates, clinicians and governance. The group includes stakeholders from across Somerset to discuss climate risks and mitigation.

Climate risk is not yet fully embedded as a core consideration in all business plans, decision making, or service group operations and development plans. The potential impact on operational capabilities by extreme weather events are addressed in the EPRR for the Trust and therefore addressing the required actions to safeguard people and services in these instances. Looking ahead, we will build on this work by developing longer-term plans and adaptations to help ensure the increasing frequency of extreme weather events does not significantly affect operations in the future.

Metrics and Targets pillar

NHS bodies are not required to disclose or develop processes to disclose scope 1, scope 2 and scope 3 emissions as part of the metrics and target pillar. Emissions estimates for the NHS in England will be provided by NHS England.

The Trusts Green Plan provides a breakdown of the overall NHS targets related to carbon emissions, and also describes the Trusts objectives, targets and actions within each of the environmental sustainability subjects. The below represents a summary of the metrics and targets set out in the Green Plan 2025-2028:

- To increase from baseline (April 2025), colleague engagement in sustainability initiatives by 25% by 2028, as measured by number of members in the Greener Care Action Group, proportion of colleagues completing sustainability-focused training modules and number of submissions to internal and external awards focussed on environmental achievements.

- develop an estate decarbonisation plan identifying and prioritising work to achieve an 80% reduction in Scope 1 and 2 carbon emissions from the estate by 2032
- To achieve an 80% reduction in Scope 1 and 2 transport-related carbon emissions by 2032 for our fleet, through the transition to a fully zero-emission fleet for all new owned and leased vehicles from 2027
- To reduce Scope 3 carbon emissions from the Trust's supply chain by 30% by 2032, achieved by actively engaging with our top 50 suppliers to evaluate progress against their carbon reduction plans

The metrics that will be used to measure climate adaptation are yet to be determined but will be identified and presented at SSG for consideration during the 26/27 year.

Our interim targets are to achieve a 47% reduction in the NHS carbon footprint, by 2032 at the latest and a reduction of 73% in the NHS carbon footprint plus by 2038 at the latest, based on 2019/20 baselines. The final targets are to achieve net zero carbon for our carbon footprint by 2040 and for our carbon footprint plus by 2045.

Human Rights

We recognise our responsibilities under the European Convention on Human Rights, as incorporated into UK law by the Human Rights Act 1998. These rights are fundamental to the delivery of health and care services and include:

- The right to life
- The right not to be subjected to inhuman or degrading treatment
- The right to liberty and security
- The right to respect for private and family life.

The Trust is committed to embedding respect for human rights in all aspects of its work. This includes ensuring that care is delivered in a way that protects dignity, promotes autonomy, and supports individuals to make informed choices about their care and treatment.

Human rights considerations are integral to the Trust's approach to quality, safety, safeguarding and inclusion. This includes the protection of vulnerable individuals, the use of least restrictive practice, and ensuring that patients, service users and their families are treated with compassion, fairness and respect.

Through its policies, training and governance arrangements, the Trust continues to promote awareness of human rights and to ensure that these principles are considered in decision-making at all levels of the organisation. This supports the Trust in meeting its legal duties and in delivering care that is person-centred, equitable and aligned with the NHS Constitution.

Events after the reporting period

Since 31 March 2026, the Trust has continued to progress a number of operational and service developments, including the reopening of services at Yeovil District

Hospital and ongoing implementation of service transformation programmes. These developments have been consistent with the priorities described within this report and do not materially change the financial position reported for 2025/26.

Peter Lewis, Chief Executive, 22 June 2026

4. ACCOUNTABILITY REPORT

Financial overview and review

Overview

2025/26 was another challenging year for our organisation. Our colleagues and services were under sustained pressure as demand for our services remained exceptionally high and periods of industrial action disrupted service delivery throughout the year.

The Trust financial performance is assessed by NHS England on an adjusted financial performance basis. The Trust achieved a small surplus position of £18k under this measure. However, when revaluation of land and buildings is applied this results in a deficit of £26.5 million, see page 26; note 2 of the Annual Accounts attached to this report.

NHS England decided to redistribute any Deficit Support Funding (DSF) foregone by systems that did not deliver their plans this year to those providers that did so, as long as those providers are part of a system that delivered plan and also submitted a balanced plan for 2026/27, for SFT this value was £4.915m.

Operational and financial performance continued to be strong. We delivered a small financial surplus against our planned breakeven position, based upon the regime under which NHS England assesses the financial performance of organisations.

Capital investment in infrastructure and equipment totalled £117.4million in year and will help to ensure the Group has the buildings, equipment, and IT to continue to deliver high quality safe services for its patients.

The delivery of the financial plan becomes increasingly more challenging as demand continues to increase on us and our public sector partners. There is a clear expectation that organisations will live within their means and set plans that are affordable while continuing to make progress against a key set of NHS priorities:

- Maintain our focus on quality and safety, particularly in maternity and neonatal services.
- Improve waiting times in our A&E departments
- Continuing to reduce our elective long waits and improve performance against the core cancer and diagnostic standards.
- Make it easier for people to access community and primary care services, particularly general practice and dentistry.
- Improve patient flow through mental health crisis and acute services and improve access to children and young people's mental health services

Agency expenditure reduced by £11.2m compared to 2024/25 and represents a 39% reduction. This represents a significant achievement in managing the Trust agency bill.

The Trust CIP plan was achieved; of which 30% was recurrent. While this was forecast, it was significantly below that planned at the start of the year. Work is underway to develop robust plans that will achieve both a much higher level of overall efficiency and recurrent savings in 2026/27.

Cash Balances at 31 March 2026 were £111.8m, significantly higher than plan due to capital expenditure incurred and not yet settled (capital creditors £42.3m) and £28.1m cash balance held on behalf of partner Trusts for EHR supplier payments under the Trust's role as lead provider. It is essential the Trust keep a continued focus on surplus cash reserves to serve the needs of the Trust in 2026/27.

We will work closely with our system partners to continue to improve our efficiency and productivity and tackle waste. We want to ensure our services are delivered as efficiently as possible and will continue to transform how our services are provided to ensure resources are used to best meet the health needs of the population of Somerset. This will require us to deliver a challenging efficiency programme and take difficult decisions as we balance operational priorities with the funding available.

NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS England publishes league tables and supporting information that provides a view of how NHS trusts are performing in key services including community services, mental health & learning disabilities services, urgent & emergency care, and elective services.

Based on their performance in these services along with other considerations, such as overall level of financial deficit, each trust is placed into one of four core segments. Segment 1 represents the organisations with the narrowest range of challenges while segment 4 contains those with the broadest. Trusts in the lower performing segments are likely to receive additional support to help them improve but support can be provided to any organisation, where it is needed. For providers facing the most significant performance or governance challenges intensive, tailored support may be provided through the Recovery Support Programme accessed via segment 5.

Somerset NHS Foundation Trust is in Segment 2. This segmentation information is the Trust's position as of March 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website.

Financial instruments

It is Trust policy to avoid the use of financial instruments, when possible, thus minimising financial risk to the Trust. This means that the Trust's exposure to risks created by financial instruments is much lower than commercial organisations of the same size. The accounts state the Trust's accounting policies and the nature and value of the risk that the Trust faces.

Income disclosure statement

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2022) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust confirms that income from health services is greater than income from any other source.

Statement on compliance with cost allocation and charging guidance issued by HM Treasury

Somerset NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

Political donations

Somerset NHS Foundation Trust has not made any political or charitable donations in 2025/26.

Better payment practice code

The Better Payments Practice Code requires the Trust to aim to pay all undisputed invoices by the due date, or within 30 days of receipt of goods or receipt of invoice, or from the invoice date, whichever is the later. The results against this target for the financial year 2025/26 are shown below.

	Number	£
Total non-NHS trade invoices paid in period	159,468	582,480,488
Total non-NHS trade invoices paid within target	152,151	556,822,069
Percentage of non-NHS trade invoice paid within target	95.4%	95.6%
Total NHS trade invoices paid in period	2,633	83,211,265
Total NHS trade invoices paid within target	2,434	81,260,744
Percentage of NHS trade invoices paid within target	92.4%	97.7%

There were no amounts paid or payable under The Late Payment of Commercial Debts (Interest) Act 1998.

Financial statements and accounting policies

The complete set of financial accounts is provided in full within this report. They have been prepared in accordance with International Financial Reporting Standards (IFRS), completed in accordance with directions given by NHS England, and are designed to show a true and fair view of the Trust's financial activities. The accounting policies used comply with the NHS Foundation Trust Annual Reporting Manual and form the basis on which the financial statements have been compiled.

Cost improvement programme (CIP)

In year, savings of £49,998k (2024/25: £64,337k) were delivered which were on plan. 30% (2024/25: 53%) of cost improvement plans achieved were recurrent £15,149k (£34,245k). This saving reflects 1.3% (2024/25: 5.5%) of turnover.

Peter Lewis, Chief Executive, 22 June 2026

Directors' report

Code of Governance for NHS Provider Trusts Disclosures

The directors are required to prepare an annual report and accounts for each financial year. The directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess Somerset NHS Foundation Trust's performance, business model and strategy.

The Code of Governance for NHS Provider Trusts was published in October 2022 and has been appliable since 1 April 2023. It replaces the previous NHS Foundation Trust Code of Governance issued by Monitor.

The Code of Governance for NHS Provider Trusts sets out a common overarching framework for the corporate governance of NHS providers (being NHS trusts and NHS foundation trusts), reflecting developments in UK corporate governance and the development of integrated care systems. Providers must comply with each of the provisions of the code or, where appropriate, explain in each case why the provider has departed from the code.

Somerset NHS Foundation Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a comply or explain basis. The Board considers the Trust to be fully compliant with the principles of the Code of Governance for NHS Provider Trusts as well as the provisions of the code.

In accordance with the Code of Governance for NHS Provider Trusts, the Board has considered the independence of its Non-Executive Directors, including those who have served for more than six years when taking account of service prior to the merger. The Board is satisfied that these individuals continue to demonstrate independence in character and judgement, and that their experience, knowledge of the organisation and ability to provide constructive challenge remain strong. The Board therefore considers that they continue to be independent.

The Board

The membership, skills and expertise of the Board of Somerset NHS Foundation Trust during 2025/26, together with attendance at meetings, the commitments of the Board members are outlined below.

Non-Executive Directors

Dr Rima Makarem	**Chair** **Joint Chair of Nomination and Remuneration Committee**

Dr Rima Makarem joined the Trust on 1 January 2025. Rima has extensive experience of working at Board level in the NHS and has worked at both regional and national level. She had previously been the chair of the Bedfordshire, Luton and Milton Keynes Integrated Care Board since 2020. She is also chair of the Sue Ryder charity, chair of Queen Square Enterprises Ltd (an independent healthcare provider based in London), and a lay council member for the General Pharmaceutical Council. Rima trained as a scientist and has held senior roles within the global pharmaceutical industry. Other senior roles she has held include senior independent director and audit chair of the National Institute for Health and Care Excellence (NICE) and audit chair and external commissioner at the House of Commons Commission, working closely with the Speaker and the Leader of the House.

Appointed: 1 January 2025 **Term Expires:** 31 December 2027	Public Board Attendance: 6/6 Board Remuneration Committee Attendance: 3/3 Audit Committee: 1/1

Martyn Scrivens	**Non-Executive Director** **Deputy Chairman**

Martyn is a Fellow of the Institute of Chartered Accountants and chairs the Institute's Internal Audit Advisory Panel. He has 40 years of experience in audit and risk management, operating at board level with both the public and private sector. Over the last 15 years he has led the internal audit functions first at a major UK bank and then at a global investment and wealth management bank. From 2010 to 2012, he was a board member of the East Kent Hospitals NHS Trust. Martyn chaired the Trust's Financial Committee. Martyn was previously a non-executive director and chairman at Yeovil District Hospital NHS Foundation Trust before the trusts merged in April 2023.

Appointed: 1 October 2021 as Associate Non-Executive Director and 1 November 2021 as Non-Executive Director	Public Board Attendance: 5/5 Board Remuneration Committee Attendance: 3/3 Audit Committee: 4/5 Finance Committee: 12/13

Re-appointed: 1 April 2024
Resigned: with effect from 28 February 2026

People Committee: 2/3

Graham Hughes — Non-Executive Director

Graham has over 40 years of experience in the financial and legal sectors and was previously an executive director of Bank and Clients PLC. Prior to this, in his capacity as managing partner and latterly chairman, he developed a legal practice to a multi office large employer. He has a deep understanding of commercial and risk management within the financial sector together with a thorough knowledge of the core strategic principles of heavily regulated and competitive sectors. He has also been involved in change management, developing policies for large and complex organisations including whistle blowing, IT security and data protection and people policies. Graham joined the Trust Board of Yeovil District Hospital NHS Foundation Trust in April 2018 and subsequently joined the Trust Board of the merged trust in April 2023.

Appointed: 1 April 2023
Re-appointed: 1 April 2026
Term Expires: 31 March 2029

Public Board Attendance: 6/6
Board Remuneration Committee Attendance: 3/3
People Committee: 4/4
Quality and Governance Assurance Committee: 9/10
Charity Committee: 4/4

Jan Hull — Non-Executive Director

Jan spent the early part of her career with Unilever, in an international perfumery business covering sales, marketing and general management roles, including two years in the USA. She has over 20 years' experience of the NHS in Somerset, initially in public health and later as deputy chief executive for NHS Somerset, until she became managing director of the South, Central and West Commissioning Support Unit. Jan retired from this post in 2016. Jan has worked at senior level with all of the major health and social organisations in the county, including primary care, local authorities and the voluntary sector. She also has significant experience of structural change, having led the merger of three commissioning support units in 2015. Jan was previously also a non-executive director at Yeovil District Hospital NHS Foundation Trust prior to the merger of the trusts in April 2023.

Appointed: 1 August 2017
Re-appointed: 1 August 2020, 1 August 2023, 1 August 2024 and 1 February 2025

Public Board Attendance: 1/1
Board Remuneration Committee Attendance: 1/1
Audit Committee: 1/1
People Committee: 0/0

Term Expired: 31 May 2025

Quality and Governance Assurance Committee: 2/2

Paul Mapson — Non-Executive Director

a career spanning 41 years in the NHS, including 17 years as Director of Finance and Information at University Hospitals Bristol NHS Foundation Trust, Paul retired in June 2019. He became a non-executive director of Yeovil Hospital NHS Foundation Trust in March 2020 and joined the Trust Board of the merged trust in April 2023.

Appointed: 1 April 2023
Re-appointed: 1 April 2026
Term Expires: 31 March 2029

Public Board Attendance: 6/6
Board Remuneration Committee Attendance: 3/3
Audit Committee: 5/5
Finance Committee: 13/13
Mental Health Legislation Committee: 4/4
Charity Committee: 2/2

Alexander Priest — Non-Executive Director

Following a degree and PhD in chemistry at Oxford University (where he used A.I. to design anti-cancer drugs), Alex started his career promoting apprentice partnerships as chief executive of an educational charity in London. In January 2016, he jumped from a successful career in intellectual property law to become chief executive of Mind (the mental health charity) in his home county of Somerset, where he now farms with his young family. Alex also holds various trusteeships and directorships in the property, education and third sectors. Alex was previously also a non-executive director at Yeovil District Hospital NHS Foundation Trust prior to the merger of the trusts in April 2023.

Appointed: 1 April 2020
Re-appointed: 1 April 2023, 1 April 2026
Term Expires: 31 March 2027

Public Board Attendance: 5/6
Board Remuneration Committee Attendance: 3/3
Audit Committee: 3/5
Finance Committee: 11/13
Charity Committee: 2/4
Mental Health Legislation Committee: 4/4

Inga Kennedy CBE Non-Executive Director

Inga has spent a large part of her career working in the NHS in a range of nursing, midwifery and education roles, but also has extensive experience working in senior roles in the Royal Navy. Inga was appointed Inspector General of the Defence Medical Services where she designed and implemented a new healthcare governance framework. Subsequently she took on the role of Head of the Medical Service and Medical Director General for the Royal Navy. Inga is a trustee of the White Ensign Association, which provides independent advice to all serving and former members of the Royal Navy, Royal Marines, Royal Fleet Auxiliary, and their families. Inga was previously a non-executive director for the Isle of Wight NHS Trust and the Portsmouth Hospital University NHS Trust and is a director of a private healthcare consultancy providing healthcare advice and reasonable challenge to executive teams with the aim of delivering enhanced governance and assurance.

Appointed: 1 October 2023 as Associate Non-Executive Director and 1 February 2024 as Non-Executive Director
Term Expires: 30 September 2027

Public Board Attendance: 5/6
Board Remuneration Committee Attendance: 3/3
Audit Committee: 4/5
Quality and Governance Assurance Committee: 7/10

Rosie Benneyworth Non-Executive Director

Rosie has worked in the NHS for over 30 years and is passionate about improving the quality and safety of care that patients receive. She lives in Somerset and was a GP in Taunton for several years, as well as a clinical commissioner in Somerset with the previous primary care trust and clinical commissioning group. . She is currently the Interim CEO of the Health Services Safety Investigations Body, and has also held national roles as the Chief Inspector of Primary Medical Services and Integrated Care at the Care Quality Commission, and Deputy Chair of the National Institute of Health and Care Excellence (NICE). She was previously the managing director of the South West Academic Health Science Network, and has also held roles as a Non-Executive Director of University Bristol and Weston NHS Foundation Trust, and trustee of the Nuffield Trust and National Children's Orchestras of Great Britain.

Appointed: 1 July 2025
Term Expires: 30 June 2028

Public Board attendance: 4/5
Board Remuneration Committee Attendance: 2/2
Quality and Governance Assurance Committee: 5/10
Mental Health Legislation Committee: 1/3

Darshan Chandarana Non-Executive Director

Darshan Chandarana joined as a NED on 1st July 2025, bringing over three decades of experience across the IT and advisory landscape. With a career that spans global banking technology, leadership roles in some of the world's largest technology firms and senior consulting positions at Deloitte and McKinsey, Darshan has shaped and delivered large-scale digital transformation initiatives across multiple sectors. Most recently, as a Partner at PwC, Darshan was instrumental in guiding major clients through complex technology strategy, digital innovation and mass scale adoption of AI across government departments and in the private sector. His varied background allows him to bring an "outside-in" perspective to the leadership team, blending the rigour of large consultancies with a deep understanding of real-world business needs. Darshan's career is distinguished by his ability to bridge the gap between business and technology. He has served as a trusted adviser to executive boards, driven technology-enabled growth and mentored the next generation of leaders. His extensive network and broad experience underpin his commitment to delivering lasting impact for both clients and communities.

Appointed: 1 July 2025
Term Expires: 30 June 2028

Public Board attendance: 3/5
Board Remuneration Committee Attendance: 2/2
Finance Committee: 7/13

Olena Doran Non-Executive Director

Professor Olena Doran is internationally recognised in the field of Biomedical Research, with over 30 years of strategic leadership experience across higher education, translational research, international innovation and public sector partnerships. Throughout her career, Olena has held governance and advisory positions across numerous public and third-sector organisations including the UK Research Council Committees and the Biosciences Skills and Careers Strategy Advisory Panel. Her senior leadership roles also include serving on the Boad of Governors of the Bristol Zoological Society and advising the European Commission on food quality and safety through international initiatives such as COST Actions, Marie Curie Actions and other. In her senior leadership positions, Professor Doran has played a key role in translating research discoveries into practical applications and in shaping regional, national and international policies and agenda to benefit public and improve healthcare.

Appointed: 1 July 2025
Term Expires: 30 June 2028

Public Board attendance: 4/5
Board Remuneration Committee Attendance: 2/2
People Committee: 2/3

Tom Frederick — Associate Non-Executive Director

Tom is a digital and technology leader with over 20 years' experience delivering transformation across health and financial services. He has worked across the full continuum of care—social care, community, mental health, acute, and primary—as well as with major private health insurers. His work spans digital health strategy, data and AI, and electronic patient records, always focused on improving outcomes for patients and professionals. He brings deep expertise in governance, delivery, and innovation. A former national team athlete and club captain, Tom is also a committed advocate for inclusive leadership and health equity. He supports Somerset FT in embedding digital as a strategic enabler of care.

Appointed: 1 July 2025
Term Expires: 30 June 2028

Public Board attendance: 3/4
Audit Committee: 1/3

Executive Directors

Peter Lewis — Chief Executive

Peter was the chief executive of both Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust before the trusts merged in April 2023. Peter joined one of our predecessor trusts, Taunton and Somerset NHS Foundation Trust which ran Musgrove Park Hospital, in 2005 as director of finance and performance. He then became deputy chief executive in 2008 and took on the responsibility of chief operating officer in 2010. Before Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust merged in April 2020, Peter became chief executive of both organisations in November 2017. Prior to joining Taunton and Somerset NHS Foundation Trust, Peter was director of performance at Dorset and Somerset Strategic Health Authority, and also worked in both commissioning and provider organisations in Somerset prior to that. Peter is also a fellow of the Chartered Institute of Management Accountants.

Public Board Attendance: 6/6
Audit Committee: 1/1

Andy Heron — Chief Operating Officer and Deputy Chief Executive

Andy was one of two chief operating officers for Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust before the trusts merged in April 2023 and is now the single chief operating officer and deputy chief executive. Andy joined the NHS in Somerset in 2014 when he joined Somerset Partnership NHS Foundation Trust as chief operating officer. Having originally qualified as an occupational therapist, he worked in a number of clinical roles within mental health across the south west before moving into leadership roles during the 1990s. Andy played a role in the establishment of a new specialist NHS mental health trust serving the Avon and Wiltshire areas and became the general manager of mental health services. Following this, Andy gained a broad range of experience in London and the south west in senior commissioning and provider roles in the NHS, and also in social care, with most of his work being focused on service modernisation. Andy maintains a strong interest in care pathway redesign and service transformation and in recent years has taken on a number of system leadership roles within Somerset, centred on improving patient flow and working with partners in the development of successful community alternatives to hospital admission.

Public Board Attendance: 6/6
Finance Committee: 10/13
People Committee: 1/4
Quality and Governance Assurance Committee: 9/10

Dr Melanie Iles — Chief Medical Officer

Dr Melanie Iles was previously national chief clinical information officer (CCIO) at NHS England on an interim basis, on secondment from her substantive role as NHS England's medical director and CCIO for the East of England region. Dr Melanie joined Somerset NHS Foundation Trust on Monday 1 April 2024. Dr Melanie Iles is an experienced leader, having worked as a medical director in different settings for over 8 years, in an acute trust, for NHS Improvement and for NHS England at regional level. Prior to this, she held a variety of regional and national roles as a senior clinical leader focussed on children and young people. She is a paediatrician with over 31 years' service in the NHS.

Public Board Attendance: 6/6
Quality and Governance Assurance Committee: 9/10
People Committee: 2/4

Hayley Peters — Chief Nurse (until 29 June 2025)

Hayley was previously the chief nurse for both Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust before the trusts merged in April 2023. Prior to becoming an executive director, Hayley worked in senior clinical leadership roles in the southwest, London and the southeast. Hayley's early professional career centred in critical care, first as an intensive care nurse and later, following a period of training at Birmingham Medical School, as one of the very first physician's assistants to practise in the UK. As part of Hayley's role at Somerset NHS Foundation Trust, she has executive responsibility for safeguarding, patient safety and quality (jointly with the chief medical officer). Hayley is Trust Board safety champion for our armed forces, children, maternity, and neonates.

Public Board Attendance: 0/1
People Committee: 0/1
Quality and Governance Assurance Committee: 0/2

David Thomas — Interim Chief Nurse (from 1 May 2025 to 29 September 2025)

David was previously Director of Nursing Strategy & Transformation and the Chief Nursing Information Officer across Somerset NHS Foundation Trust, prior to becoming the Interim Chief Nurse from 1 May 2025 to 29 September 2025. He previously held an Executive Nursing post in Devon. A career nurse of over 35 years, Dave has significant nursing experience in military and trauma leadership. Dave is also a Senior Officer in the Royal Army Medical Services in the rank of Lieutenant Colonel. He is Professor and Director of International affairs with the Datta Meghe Institute of Medical Sciences.

Public Board Attendance: 2/3
People Committee: 1/2
Quality and Governance Assurance Committee: 4/4

Professor Deirdre Fowler Chief Nurse and Midwife (from 29 September 2025)

Deirdre is a registered nurse with over 40 years of experience, including 30 years as a Midwife. She has had a varied career nationally in many senior professional leadership roles, and she has served as an Executive Chief Nurse for more than 13 years. In addition to her clinical leadership, Deirdre spent eight years in academia which further deepened her commitment to education and clinical excellence and is also a firm advocate for continuous quality improvement. Most recently, she held the position of Chief Nurse and Midwife at University Hospitals Bristol and Weston NHS Foundation Trust, a role she fulfilled until August 2025. Since relocating to the South West in 2021, Deirdre has continued to serve the region in her current role at Somerset NHS Foundation Trust. She is passionate about inclusive clinical workforce development and is dedicated to strengthening clinical leadership at all levels. Deirdre is also a strong advocate for personalised, holistic care that truly meets the needs of individuals and communities. In addition to her NHS leadership roles, she is a visiting professor at the University of the West of England (UWE), where she continues to contribute to the advancement of Nursing and Midwifery education.

Public Board Attendance: 3/3
People Committee: 1/2
Quality and Governance Assurance Committee: 4/5
Mental Health Legislation Committee: 0/2

Pippa Moger Chief Finance Officer

Pippa was previously the chief finance officer for both Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust before the trusts merged in April 2023. Pippa has over 20 years of experience in NHS finance and over thirteen years at deputy and director level. She has worked across regulator, commissioning and provider sectors and has a broad perspective on NHS finances. Pippa joined Somerset Partnership NHS Foundation Trust in June 2013 as director of finance and business development. She was then appointed as director of finance for Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust in October 2017 before the two trusts merged in 2020. Pippa believes NHS resources must be used in the most efficient and effective way while ensuring patient safety is not compromised. Pippa is a fellow of the Association of Chartered Certified Accountants (ACCA).

Public Board Attendance: 6/6
Audit Committee: 5/5
Finance Committee: 13/13
Charity Committee: 3/4

Isobel Clements — Chief of People and Organisational Development

Isobel was previously the chief of people and organisational development at both Somerset NHS Foundation Trust and Yeovil District Hospital, NHS Foundation Trust before the trusts merged in April 2023. Isobel started her career at Musgrove Park Hospital in 1988 and held several senior human resources and organisational development management roles, including at associate and deputy level, until she was appointed director of people and organisational development in 2018 for both Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust before the two trusts merged. Isobel has played a key role in developing the trust's system of distributed leadership, ensuring that the organisation's values are brought to life in everyday behaviour. Isobel is a fellow member of the Chartered Institute of Personnel and Development (CIPD).

Public Board Attendance: 4/6
People Committee: 4/4
Quality and Governance Assurance Committee: 3/13

David Shannon — Director of Strategy and Digital Development

David was previously the director of strategy and digital development for both Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust before the trusts merged in April 2023. David first joined Musgrove Park Hospital in 2016 as director of finance and went on to become the director of strategic development and improvement for both Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust before the two trusts merged in 2020. David was previously director of operational finance at North Bristol NHS Trust from June 2014. Before that he spent six years at Nottingham University Hospitals NHS Trust, most of them as assistant director of finance. He originally joined the NHS in 1998 on its graduate financial management training scheme.

Public Board Attendance: 6/6
Finance Committee: 11/13
People Committee: 4/4
Charity Committee: 4/4

Non-voting Directors

Jade Renville — Director of Corporate Services

Jade is our Director of Corporate Services, a role she does jointly with the Somerset Integrated Care Board with the aim of fostering collaborative working across the health system in Somerset. She has extensive experience within the NHS and the field of corporate governance, beginning her career in commissioning, then moving into senior company secretarial and governance roles within the NHS provider trust sector, working at both Yeovil District Hospital and Musgrove Park Hospital prior to merger of these organisations. For Somerset NHS Foundation Trust she has responsibility for corporate governance and the Board secretariat, legal services, emergency preparedness, resilience, and response (EPRR), business continuity, and security. She is also the Accountable Emergency Officer (AEO). In her free time, she is Chair of the Board of Trustees of a Multi-Academy Trust within the education sector.

Public Board Attendance: 6/6
Audit Committee: 4/5

Further information on all Directors' declarations of interests is published within the Board of Directors meeting papers that are available on the Trust's website.

Statement of disclosure to the auditors

So far as the directors are aware, there is no relevant audit information of which the Trust's auditor is unaware. The directors have taken all steps that ought to have been taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

Modern Slavery and Human Trafficking Act 2015 Policy Statement

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps taken to ensure slavery and human trafficking is not taking place in any of its supply chains and in any part of its business. The Trust's statement is available on the public website.

Audit function and Audit Committee role

The Audit Committee has responsibility for providing assurance to the Board concerning the system of internal control, risk management, financial statements and compliance and governance. The Audit Committee oversees the effective operation of the internal and external audit programme and counter fraud activities.

BDO is the Trust's appointed internal auditor, and they undertake reviews for the level of assurance on the adequacy of internal control arrangements, including risk management and governance. The Trust's external auditor is KPMG which provides

the Trust's statutory audit services.

During 2025/26, KPMG reviewed whether their general procedures support their independence and objectivity, including any matters related to the provision of non-audit services, and positive affirmation has been presented to the Audit Committee. This is in line with guidance from the National Audit Office, which states that the total fees for advisory services should not exceed 70% of the total fee for all audit work carried out a public body.

When considering the effectiveness of the external auditors, the Audit Committee:

- reviewed in detail the presentations, reports and communications from KPMG
- expected attendance from KPMG at every scheduled Audit Committee and
- received the external audit plan and kept it under review to ensure the quality of the external audit and to assess any risks of delivery against plan.

In addition, the non-executive director members of the Audit Committee, including the Chair of the Audit Committee, have the opportunity to meet with KPMG and BDO after each Audit Committee meeting to seek views about the executive directors, particularly the Chief Finance Officer, as to their effectiveness. KPMG and BDO also met regularly with members of the executive team to broaden their knowledge of the trust and to provide information on sector developments and examples of best practice. KPMG has built a strong and effective working relationship with the internal auditors to maximise assurance to the Audit Committee, avoid duplication and provide joint value for money.

During the year, the Audit Committee considered the following significant audit risks identified by external audit:

- Fraud risk from expenditure recognition – completeness
- Management Override of Controls.

The Audit Committee also considered the financial statements risks identified by external audit through their risk assessment processes. KPMG issued an unqualified opinion on the Trust's financial statements audit for 2025/26. In addition, no significant weaknesses were identified with regard to the Trust's arrangements for ensuring value for money.

How the Board of Directors and the Council of Governors operate (including the handling of any disputes)

The Trust's constitutional documents, relevant legislation and the regulatory framework set out how the Board and the Council of Governors exercise their functions. The Trust retained a register of interests for the Council of Governors and the Board, and these are reviewed at least annually. The register for all Board members is presented to the Board of Directors meeting at each meeting and available within published Board papers. The registers are also available, on request, from the Board Secretary and Corporate Services Manager.

The general duty of the Board and of each director individually is to act with a view to promoting the success of the Trust to maximise the benefits for its members and for

the public. The Board of Directors' objectives are to govern the organisation effectively and to ensure that the Trust is providing safe, high quality, patient-centred care. The Board has the same role as that of any other unitary Board – to set strategic direction and to oversee the work of the executive to ensure that corporate objectives and performance targets are achieved. No individual on the Board has unfettered powers of decision. All powers which have not been retained by the Board or delegated to a committee of the Board are exercised on its behalf by the Chief Executive. If the Chief Executive is absent, powers delegated to him may be exercised by the Deputy Chief Executive. The Board remains accountable for all its functions, including those that have been delegated.

The Board may appoint committees consisting wholly or partly of directors, or wholly or partly of persons who are not directors. The committees of the Board are: Audit Committee, Quality and Governance Assurance Committee, Mental Health Legislation Committee, Finance Committee, People Committee and a Nomination and Remuneration Committee (which approves the appointment of executive directors and reviews their performance annually along with their levels of remuneration).

The National Health Service Act 2006 gave the Council of Governors various statutory roles and responsibilities, and these were expanded, clarified and added to through both the 2012 and 2022 Health and Social Care Acts.

The Council of Governors is responsible for appointing and, if appropriate, removing the Chairman and non-executive directors (on the recommendation of the Remuneration and Nominations Group), for appointing the external auditors and for approving (or not) the appointment of the Chief Executive. It is responsible for deciding the remuneration and other terms and conditions of the Chairman and non-executive directors (on the recommendation of the Remuneration and Nominations Group), for receiving the annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council of Governors.

The Council of Governors is also responsible for holding the non-executive directors, individually and collectively, to account for the performance of the Board, representing the interests of members, approving significant transactions or any application by the Trust to enter into a merger, acquisition or dissolution, deciding whether its non-NHS work would significantly interfere with its NHS work, and reviewing amendments to the organisation's Constitution.

The Council of Governors comprises elected and appointed governors and is chaired by the Trust Chair. The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint committees or working groups consisting of governors, directors, and other persons to assist it in carrying out its functions. The committees and working groups of the Council of Governors in operation during 2025/26 were: Nomination and Remuneration Group, Strategy and Planning Group, Membership, Involvement and Communications Group, Quality and Patient Experience Group and the People Group. Members of the Board, including the non-executive directors, regularly attend the Council of Governors and working groups meetings and also attend part of the Governor Development Days. The Chairman and Chief Executive regularly meet with the governors who are also

encouraged to attend and observe meetings of the Board and its assurance committees as part of their role.

During 2025/26, the Council of Governors discharged its statutory duties. The governors reviewed key aspects of finance, performance and quality through its various activities, and received the Annual Accounts and the Annual Report at the Annual General Meeting. To comply with its role to hold the Non-Executive Directors to account, the Council of Governors regularly met with the Non-Executive Directors, requested updates and attended meetings of the Board and, where relevant, its assurance committees.

Where any disagreements between the Council of Governors and the Trust Board occur, the Trust policy "Policy and Procedure for Council of Governors: Raising Concerns" details the process by which these disagreements are resolved. A copy of the policy can be requested from the Board Secretary and Corporate Services Manager by contacting CompanySecretary@somersetft.nhs.uk. There were no disputes between the Council of Governors and the Board during 2025/26.

The Senior Independent Director is available to governors and members should they have concerns which they have not been able to resolve through the normal channels of communication via the Chairman and Chief Executive or for which such contact is inappropriate. To contact the Senior Independent Director, all correspondence, marked private and confidential, should be sent to the Board Secretary and Corporate Services Manager at the Management Office, Yeovil District Hospital, Higher Kingston, Yeovil, BA21 4AT.

Governors and membership information

The Council of Governors meet on a quarterly basis and during 2025/26 comprised of up to 42 Governors including 21 elected public governors, 12 elected staff governors, two local authority governors and one Somerset ICB governor. The partnership organisations eligible to nominate governors are:

- The Voluntary, Community, Faith and Social Enterprise (VCFSE) sector – two governors
- The Somerset Primary Care Board – one governor
- Universities – one governor
- Subsidiary companies – two governors in total

As of 31 March 2026, there were five vacancies across the public and appointed sectors. Jack Torr was the Lead Governor for 2025/26.

Members of the public who reside within the Trust's various constituencies can be elected as a public governor. Elected governors (public and staff) are usually appointed for three-year terms.

Anyone aged 14 and over who lives in England may become a member of Somerset NHS Foundation Trust, subject to a small number of exclusions. The public constituency is divided into six areas, five of which cover core wards and districts served by the trust across Dorset and Somerset. The five areas are Mendip,

Sedgemoor, South Somerset, Somerset West and Taunton, and Dorset. The sixth constituency (Outside Somerset and Dorset) acknowledges the interest of members from the wider catchment area.

During the year, the Council of Governors and the Board of Directors jointly reviewed the size and composition of the Council to ensure it remains effective, representative, and aligned with the Trust's governance needs. Following this review, a decision was approved to resize the Council of Governors. The Trust's Constitution has been amended accordingly, with the revised structure scheduled to take effect from 1 May 2026, following the completion of the next round of governor elections. At this point, the Council of Governors will comprise of up to 25 governors.

As at 31 March 2026, membership of the public constituency was at 12,109. Public membership equates to approximately 4% of the Trust's catchment area. As at 31 March 2026 membership of the staff constituency was 13,688.

Continuous internal quality assurance assessments of membership data are undertaken to promote accuracy, remove duplicate records and resolve any other inconsistencies.

Steps taken by members of the Board in understanding the views of the Council of Governors and membership

All Board members are encouraged to attend Council of Governors' meetings and routinely do so, with the Chief Executive leading on standing agenda items and other Directors presenting agenda items and responding to questions as required.

As the majority of Board members attend the Council of Governors' meetings, feedback from the meetings can be taken into account immediately. In addition, representatives from the Council of Governors also attend the public Board meetings and governors are invited to attend the joint Board/Council of Governors away day held in December each year to discuss strategic issues. With exception of the Audit Committee, membership of the Board Committees includes dedicated Governor observer(s).

The Chairman meets with the Lead and Deputy Lead Governor on a regular basis to discuss issues arising from Board meetings and governors' concerns. The Chairman and/or Chief Executive meet with the Staff Governors on a regular basis. Governors also meet with Non-Executive Directors on a quarterly basis.

During the year, three Governor Development sessions were held. Development days were changed following the July development day, where attendance had significantly decreased. Development sessions are now part of a full Council day including development sessions, Non-Executive Director Q&A sessions and the formal Council of Governors to encourage attendance. These development sessions covered: Inclusivity, Kindness and Civility training, Allyship training and a workshop to discuss the future of an engaged and effective Council.

Board members are invited to join the Development sessions and Q&A sessions with a small number of Non-Executive Directors. Board members are not members of the Council but have a standing invitation to attend Council meetings.

Alongside this, the Governors have discussed and been part of ongoing discussions on improving engagement with members and patient engagement, such as through reviewing the schedule of governor surgeries to allow for governors and corporate services teams to focus some time on engagement activities such as Medicine for Members and tours/visits to community sites and various departments within the trust.

Board member attendance at Council of Governors meetings

		Meetings	
		Possible	Actual
Dr Rima Makarem	Chair	4	3
Alexander Priest	Non-Executive Director	4	3
Martyn Scrivens	Non-Executive Director	4	2
Paul Mapson	Non-Executive Director	4	3
Graham Hughes	Non-Executive Director	4	3
Inga Kennedy	Non-Executive Director	4	2
Peter Lewis	Chief Executive	4	3
Pippa Moger	Chief Finance Officer	4	2
Andy Heron	Chief Operating Officer	4	2
Isobel Clements	Chief of People and Organisational Development	4	2
David Shannon	Director of Strategy and Digital Development	4	2
Melanie Iles	Chief Medical Officer	4	3
Jade Renville	Director of Corporate Services	4	3
Dave Thomas	Interim Chief Nurse	2	1
Deirdre Fowler	Chief Nurse and Midwife	2	1
Olena Doran	Non-Executive Director	3	1
Rosie Benneyworth	Non-Executive Director	3	2
Darshan Chandarana	Non-Executive Director	3	1
Tom Frederick	Non-Executive Director	3	1

Nominations and Remuneration Group (Council of Governors)

The Council of Governors is required to approve the remuneration and terms of service of the Chairman and Non-Executive Directors and has established a Nominations and Remuneration Group to do so, in accordance with the Trust's Constitution.

The role of the Group is:

- to consider the Non-Executive Director or Chairman vacancies due in the next 12 months and make recommendations to the Council of Governors (Annex 4, para 4.2 of the Standing Orders); and
- to advise the Council of Governors as to the remuneration and allowances and

of the Terms and Conditions of the office of the Chairman and other Non-Executive Directors (para 33.2 of the Constitution).

The Senior Independent Director, the Chairman and other Directors may be invited to attend meetings of this Committee.

The Group met three times (once via electronic approvals) during the year, to discuss:

- Non-Executive Director appointments
- Non-Executive Director and Chair Appraisal
- Summary Report from the Chair's Appraisal
- Summary Report from the Non-Executive Directors' Appraisals
- Re-appointment of Non-Executive Directors
- Recruitment process for new Non-Executive Director

The Group's attendance is set out below:

Nomination and Remuneration Group – Attendance at meetings		
	Possible	**Actual**
Jack Torr (Chair) replaced Kate Butler as Lead Governor	2	2
Kate Butler (stepped down as Lead Governor during 25/26)	1	1
Jeanette Keech	2	2
Judith Goodchild	2	2
Stuart Goble	1	1
Robert Williams	2	2
Neil Thomas	1	1

The Group received feedback from the Non-Executive Directors' performance reviews and concluded that all Non-Executive Directors had had a successful year, and all Non-Executive Directors had performed well above the standards required.

As the Chair only joined the Trust in January 2025 and this was the first appraisal round, it was agreed that the Chair would instead provide a set of objectives for the year, as undertaking a full performance appraisal would not be practicable.

The Group recommended an extension of Paul Mapson's and Graham Hughes' term for another three years and an extension to Alex Priest's term for an additional year.

Elected Governors – public constituency

Name	Constituency	Date Elected	Attendance at Council of Governor Meetings 25/26
Virginia Membrey	Mendip	1 May 2023	4/4
Alison James	Mendip	26 July 2024 (appointed midterm)	3/4
Utpal Barua*	Mendip	14 November 2024 (appointed midterm	1/2
Jude Glide**	Mendip	1 May 2025	2/3
Judith Goodchild	Sedgemoor	1 May 2019 1 May 2022	3/4
Jack Torr	Sedgemoor	1 September 2021 1 April 2023	4/4
Eddie Nicolas	Sedgemoor	1 May 2022 1 May 2023	3/4
Martin Davidson***	Sedgemoor	1 May 2023	0/0
Jeanette Keech****	West Somerset and Taunton	1 May 20219 1 May 2022	3/3
Kate Butler	West Somerset and Taunton	1 May 2019 1 May 2022	4/4
Erica Adams	West Somerset and Taunton	1 April 2020 1 April 2023	3/4
Stuart Goble	West Somerset and Taunton	1 May 2025	3/4
Howard Millington*****	West Somerset and Taunton	1 May 2025	2/3
Ian Hawkins	South Somerset	1 May 2020 1 May 2023	4/4
Sue Steele	South Somerset	1 May 2020 1 May 2023	3/4
Mick Beales	South Somerset	1 May 2022	4/4
Sarah Duncan	South Somerset	26 July 2024	4/4
Ray Tostevin	South Somerset	1 May 2025	4/4
Jessica Cross	South Somerset	1 May 2025	4/4
Alan Peak	Outside Somerset	1 May 2019 1 May 2022	4/4
Peter Shorland	Dorset	1 May 2023	3/4

There were five vacancies across Mendip, Sedgemoor and West Somerset and Taunton constituencies.

*Stepped down during their first term and during the election period, the position was not filled.
**Stepped down during their first term.
***Stepped down during their first term in March 2025.
****A mid-term vacancy arose during the year.
*****Stepped down during their first term.

Elected Governors - staff constituency

Name	Constituency	Date Elected	Attendance at Council of Governor Meetings 25/26
Joe Silsby	Staff	1 May 2022	4/4
Phil Hodgson-Purves	Staff	1 May 2023	1/4
Adekunle Akinola	Staff	1 May 2023	1/4
Halley Kimber- Keirle	Staff	1 May 2023	0/4
Heather Sparks	Staff	1 April 2023	4/4
Jonathan Moore	Staff	1 April 2023	2/4
Sun Sander-Jackson	Staff	1 April 2023	1/4
Julie Reeve	Staff	1 April 2023	4/4
Lydia Karamura	Staff	1 April 2023	1/4
Neil Thomas*	Staff	1 May 2025	0/3
Emmanuel Audu	Staff	1 May 2025	1/4
Robert Williams	Staff	1 May 2025	0/4

One staff Governor stepped midterm.

Appointed Governors

Name	Stakeholder Organisation	Attendance at Council of Governor Meetings 25/26
Dirk Williamson	Simply Serve Limited	3 / 4
Heather Shearer	Somerset Council	2 / 4
Val Keitch*	Somerset Council	0 / 2
Sarah Wakefield*	Somerset Council	1/2
Caroline Gamblin	ICB	2 / 4
Jos Latour	Universities	3 / 4
Val Bishop	Voluntary, Community, Faith and Social Enterprise (VCFSE)	2 / 4
Jane Knowles	Voluntary, Community, Faith and Social Enterprise (VCFSE)	2 / 4

There are two vacancies within the Somerset GP Board and subsidiary companies partnership organisations.
*A new appointed Governor from Somerset Council was appointed in January 2026.

Public membership

Constituency	Mendip	Sedgemoor	West Somerset and Taunton	South Somerset	Outside Somerset	Dorset	Total
31 March 2026	1294	1862	3716	2482	2360	395	12109

Staff membership

Staff Membership	2025/26
31 March 2026	13688

Engagement with members

We recognise the importance of having a strong and engaged membership. With over 25,000 members (public and staff combined), the Trust has access to the local population, interaction with which helps to improve services.

The membership strategy for 2023/26 came into effect from 1 April 2023. The focus of the Trust's membership strategy was on improving meaningful engagement with its members and a key form of engagement is through the annual members' meeting held in September each year. Membership and membership engagement is monitored via the Membership, Involvement and Communications working group. Engagement with members during 2025/26 continued to develop. Governors have maintained a number of Governor Surgeries, and governor attendance at other events out in the communities, such as school and college events and establishing the return of Medicine for Members events.

The Trust's membership is broadly representative of the population it serves. According to 2011 census data, the majority of Somerset residents are 'white British'. Somerset also has an increasingly older population, and the Trust's membership largely reflects this trend but there is an under representation of members in the 12-21 age group. There is also a slight under representation of male members.

The Membership, Involvement and Communications group have been discussing how to improve engagement through the use of the Member Newsletter. The Youth Strategy subgroup has met once this year, and has been put on hold until after the election period.

Elected governors listen to and represent the opinion of the Trust members on a whole range of issues including the objectives, priorities, and strategy. The governors are given the opportunity to communicate those opinions expressed by members directly or via the Council's working groups. Appointed governors are able to present the views of their appointing bodies on the objectives, priorities and strategy directly to the Council of Governors.

Contact information for members

The Corporate Services Officer acts as the key point of contact for governors. Any member wishing to raise an issue with a director or governor can do so by writing, emailing or telephoning the individual at Yeovil District Hospital or by speaking to the governor in their constituency. Contact details for Directors, Governors and the Corporate Services Officer are available on the website.

Performance evaluation of the Board/governance arrangements (including details of external facilitation and the NHS England Well-Led Framework)

The Board is satisfied that the Trust applies the principles, systems and standards of good corporate governance that would reasonably be regarded as appropriate for a provider of NHS healthcare services. The Trust has structured governance arrangements in place, with clear lines of accountability and reporting across operational, quality, safety, patient experience and financial domains, supported by the Board's committees and assurance framework.

As an NHS foundation trust, the organisation is subject to the NHS Foundation Trust Code of Governance for NHS provider trusts and the NHS England Well-Led Framework, which encourage Boards to undertake regular and robust evaluations of their effectiveness, including the performance of committees and individual directors. The Trust has established arrangements and these are described within this section and in further detail in the Annual Governance Statement from page 110 onwards. This includes an overview of the Trust's system of internal control and assurance, together with actions taken to strengthen the governance of quality.

On the basis of the expertise and experience described in the overview of Board members, the Trust is confident that the necessary range of knowledge and skills exists within the Board of Directors and that its balance, completeness and appropriateness to the requirements of the NHS Foundation Trust constitute a high performing and effective Board. Going into 2026/27, further recruitment has been underway with the appointment of a new Non-Executive Director to fill the vacancy following Martyn Scrivens' departure, and to supplement the skills and knowledge of the Board.

No Board member has declared any company directorships or other material interests where the company or related parties are likely to do business, or are seeking to do business, with the Trust. The Chair holds no other significant commitments that would conflict with their responsibilities to the Trust. A register of interests is maintained and is available from the Board Secretary and Corporate Services Manager, published within Board papers on the Trust's website, and accessible through the publicly available Conflict of Interest system.

Non-Executive Directors are subject to regular feedback and an annual appraisal process led by the Chair, with the removal of Non-Executive Directors being a matter reserved to the Council of Governors. Appraisal arrangements for the Chair and Non-Executive Directors operate during 2025/26, with feedback informing the work of the Nomination and Remuneration Committee and summary themes shared with the Council of Governors. The appraisal process is reviewed and agreed with the Council of Governors on an annual basis.

Executive Directors are subject to regular supervision and an annual appraisal process led by the Chief Executive. The Chief Executive's performance is reviewed by the Chair, with outcomes reported to the Nomination and Remuneration Committee.

The Board considers that during the year all the Non-Executive Directors are independent in character and judgement and there are no known circumstances or relationships which are likely to affect, or could appear to affect, the directors' judgement. The Board also considers that all Board members meet the Fit and Proper Persons test.

In assessing the Trust's performance during 2025/26, the Board has regard to delivery against the NHS Oversight Framework and the national priorities set out for the year. This includes consideration of performance across quality and access, people and workforce, productivity and use of resources, financial sustainability, and leadership and organisational capability, alongside wider contextual measures such as health inequalities and outcomes.

Our performance against these is set out in the Performance and Accountability Reports of this document. No material inconsistencies between the annual governance statement, corporate governance statement, annual report and reports from the Care Quality Commission have been identified.

Peter Lewis, Chief Executive, 22 June 2026

Remuneration report

This report is made by the Board of Somerset NHS Foundation Trust in compliance with:

- Sections 420 to 422 of the Companies Act 2006 (that apply to NHS foundation trusts);
- Parts 2 and 4 of schedule 8 of the Regulations as adopted by NHS England;
- Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008; and
- Elements of the Code of Governance for NHS Provider Trusts.

The term “senior manager” covers those who influence the decisions of the Trust as a whole, rather than the decisions of individual directorates or departments and the Board has decided that disclosures will be made in respect of Executive Directors and Non-Executive Directors.

Statement of policy on the remuneration of senior managers for current and future years

For the purposes of this report, the Trust considers its Executive Directors to constitute its Very Senior Managers (VSMs), in line with the NHS VSM Pay Framework definition.

The pay policy for Executive Director remuneration aims to deliver the main principles for director remuneration under Section E of the Code of Governance for NHS Provider Trusts.

Levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the NHS Foundation Trust successfully, but an NHS Foundation Trust should avoid paying more than is necessary for this purpose.

The Trust will set executive remuneration taking account of data on pay available elsewhere for each particular role within the benchmark data. The principal benchmark will be the national public sector and foundation trusts with an annual turnover of a comparative level will be used as a secondary benchmark. Additional factors, as defined by the Nomination and Remuneration Committee, will also be taken into account.

Board Remuneration Committee

The Board Remuneration Committee of the Board comprises the non-executive directors and determines the level of remuneration, terms of service for the Chief Executive and other executive directors. It supports the work of the Chair in assessing the size, structure and skill requirements of the Board. The remuneration element of the Committee is chaired by the Senior Independent Director, Graham Hughes. The nomination element of the Committee is chaired by the Trust’s Chair.

The Committee met three times in the year and attendance is set out in the accountability report. The Chief Executive or his nominated representative attended

the meetings to present the Interim Chief Nursing Officer arrangements, Chief Nurse Appointment and a review of Executive Director salaries. There was no requirement for the Chief People Officer to attend to provide further advice.

Remuneration packages for Non-Executive Directors

The remuneration packages for Non-Executive Directors as at 31 March 2026 were:

Salary	£16,500 per annum for all non-executive directors
Salary	£60,000 per annum for the non-executive chair
Salary	£3,000 per annum for the additional roles of Senior Independent Director, Deputy Chair and Chair of the Audit Committee.

Remuneration packages and any changes made to it for Executive Directors

Element	**Rationale**
Salary	The Board approved the Trust Strategy, Aims and Objectives. These are delivered by the Directors. This success measure is one of the ways in which the Directors performance is monitored. All executive director remuneration is subject to satisfactory performance of duties in line with their employment and monitored through regular 1:1 with the Chief Executive and annual appraisal. The Chief Executive performance review is led by the Trust Chair. There is no performance related pay, and Directors receive 100% of their salary subject to the relevant deductions. Salary is benchmarked and there are no automatic rises for executive directors.
Taxable Benefits	Any taxable benefit is agreed by the Nomination and Remuneration Committee. This forms part of the recruitment and retention of executive directors by ensuring that the Trust remains competitive. There is no maximum amount payable.
Bonus	No bonus scheme operates at the Trust therefore the maximum that could be paid is £0.
Pension	Standard pension arrangements were in place for 2025/26.

During 2025/26, the Nomination and Remuneration Committee considered executive pay in line with national guidance, including recommendations from the Senior Salaries Review Body (SSRB) and guidance issued by NHS England on Very Senior Manager (VSM) pay ranges. Following this review, a pay uplift was applied to Executive Director salaries with effect from 1 April 2025, in line with national policy. In addition, targeted adjustments were made where required to ensure that salaries aligned with the relevant VSM pay framework.

In some cases, an additional responsibility payment may be paid where individual senior managers are required to take on significant responsibilities outside of their core role for an extended period. The allowance should be linked to the proportion of time spent on the additional responsibilities and would not normally exceed 10%

of basic salary. Executive members of the Board are employed on contracts with no fixed or specified term. Notice periods for executive members of the Board are set at six months. No provision is made for additional termination payments.

Expenditure on consultancy

A total of £51,000 was spent on consultancy in 2025/26 (2024/25: £66,000).

Off payroll arrangements

There were no off-payroll engagements of board members and/or senior officials with significant financial responsibility.

The Trust policy is not to use off-payroll engagements unless in exceptional circumstances, and then for the minimum time demanded by such circumstances.

Payments for loss of office (subject to audit)

The Nomination and Remuneration Committee is the body charged with determining payments for loss of office. There is no policy for such payments. Instead, the Committee makes individual decisions on the rare occasions where such payments may be warranted. These decisions relate to both the award of a loss of office payment and on the value of any such payment. The Committee is free to exercise its discretion and bases its decisions on the circumstances of the loss of office, the performance of the office-holder, and any other factors deemed relevant.

This section includes information on any individuals who were a senior manager in the current or in a previous financial year that has received a payment for loss of office during the financial year. All payments made for loss of office were contractual payments as per the national NHS terms and conditions.

There were no payments to any individual who were a senior manager in the current or in a previous financial year for loss of office.

Payments to past senior managers (subject to audit)

There were no payments of money or other assets to any individual who was not a senior manager during the financial year but had previously been a senior manager at any time.

Statement on remuneration levels higher than the British Prime Minister

In accordance with guidance issued by the Secretary of State, the Trust is required to disclose the steps it has taken to satisfy itself that remuneration is appropriate in cases where senior managers are paid more than £150,000 per annum.

During 2025/26, there were six senior managers within the Trust Group whose remuneration exceeded £150,000 per annum. These roles are the Chief Executive, the Deputy Chief Executive/Chief Operating Officer, the Chief Medical Officer, the

Chief Finance Officer, the Director of Strategy and Digital Development and the Chief of People and Organisational Development.

The Nomination and Remuneration Committee has considered the remuneration for these roles in line with its agreed governance processes. Salaries have been reviewed against relevant national guidance, including NHS England Very Senior Manager pay frameworks, and benchmarked against comparable roles within organisations of similar size, scale and complexity.

The Committee is satisfied that the level of remuneration for these roles is appropriate and reflects the scope of responsibility, level of accountability and the complexity of the services provided by the Trust. These roles carry significant organisational, clinical and financial responsibility, and remuneration is set at a level necessary to recruit and retain individuals with the experience and capability required to lead the organisation effectively.

Executive Directors allowed to work elsewhere as a Non-Executive

In the case of executive directors serving as a non-executive, earnings will not be retained by the relevant director. The Board does not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.

Employment conditions of other employees

The Trust applies national pay rates, terms and conditions for other staff, both medical and non-medical and has not implemented any local conditions reflecting market forces or other factors.

All other employees' remuneration is based on the national terms and conditions appropriate to their contract of employment. While the Trust does not consult with staff on remuneration for directors, it is always mindful of the remuneration of staff when making decisions. When reviewing salary, the Board Remuneration Committee considers what is happening to staff pay across the sector, the comparison to the median ratio of the workforce and ensuring that the Committee continues to be financially prudent. NHS Providers produce an annual remuneration survey for benchmarking.

The future focus of activity for people services will relate to the People Strategy (continuing to deliver a range of resilience, stress management and health promotion initiatives placing the emphasis on prevention) alongside the creation of a new people services strategy, supporting the merger and working towards the delivery of the NHS People Promise.

Fair/median Pay (subject to audit)

The Trust is required to disclose the relationship between the remuneration of the highest-paid director and the lower quartile, median and upper quartile remuneration of the workforce.

The banded remuneration of the highest paid director in the financial year 2025/26 was £255-260k (2024/25, £245-250k), which is a 4% change between years (2024/25, 5%). This was in line with the recommendation for the 2025/26 annual pay increase for Very Senior Managers (VSM) from NHS England.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, pay award, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2025/26 was £250 to £447,992 (2024/25, £50 to £442,990). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is a 7.3% increase (2024/25, 0.1% increase). 49 employees received remuneration in excess of the highest-paid director in 2025/26 (2024/25, 96 employees). The average remuneration for the workforce was £51,040 (2024/25: £47,588).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

	25th percentile	Median	75th Percentile
Salary component of pay	£26,598 2024/25: £25,674	£37,796 2024/25: £36,483	£47,810 2024/25; £46,148
Total pay and benefits excluding pension benefits	£30,501 2024/25: £28,547	£41,271 2024/25: £38,372	£54,598 2024/25: £50,746
Pay and benefits excluding pension; pay ratio for highest paid director	8.4:1 2024/25: 8.6:1	6.2:1 2024/25: 6.4:1	4.7:1 2024/25: 4.8:1

Expenses of the Governors

During 2025/26, the expenses paid to the members of the Council of Governors totalled £2,449 compared to £2689 for 2024/25.

Salary and pension entitlements of senior managers 2025/26 (subject to audit)

Total remuneration 2025/26	Note	Salary	Taxable benefits *	Pension related benefits **	Total Remuneration	Recharges Salary	Recharges taxable benefits	Recharges pension related benefits	Remuneration Net of recharges
Name and Title		(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)
		£000		£000	£000	£000		£000	£000
Peter Lewis Chief Executive		245 - 250	300	0	250 - 255	n/a	n/a	n/a	250 - 255
Melanie Iles Chief Medical Officer		215 - 220	300	52.5 - 55	270 - 275	n/a	n/a	n/a	270 - 275
Andy Heron Deputy Chief Executive & Chief Operating Officer	15	180 - 185	0	0	180 - 185	n/a	n/a	n/a	180 - 185
Pippa Moger Chief Finance Officer	1	165 - 170	500	57.5 - 60	220 - 225	n/a	n/a	n/a	220 - 225
David Shannon Director of Strategy and Digital Development	2	155 - 160	400	72.5 - 75	230 - 235	n/a	n/a	n/a	230 - 235
Isobel Clements Chief of People and Organisational Development		150 - 155	400	27.5 - 30	175 - 180	n/a	n/a	n/a	175 - 180
Hayley Peters Chief Nurse	3	35 - 40	100	12.5 - 15	50 - 55	n/a	n/a	n/a	50 - 55
David Thomas Acting Chief Nurse	4	65 - 70	0	25 - 27.5	90 - 95	n/a	n/a	n/a	90 - 95
Deirdre Fowler Chief Nurse and Midwife	5	95 - 100	100	0	95 - 100	n/a	n/a	n/a	95 - 100
David Shire Director of Estates		125 - 130	0	17.5 - 20	140 - 145	n/a	n/a	n/a	140 - 145
Katie Mattravers SSL Managing Director		85 - 90	0	30 - 32.5	115 - 120	n/a	n/a	n/a	115 - 120
Jade Renville Director of Corporate Services	8	n/a	n/a	n/a	n/a	60 - 65	0	32.5 - 35	95 - 100
Berge Balian SHS, Medical Director	6	65 - 70	0	0	65 - 70	n/a	n/a	n/a	65 - 70

Kelsy Boddington SHS, Medical Director	7	90 - 95	0	0	90 - 95	n/a	n/a	n/a	90 - 95
Kerry White SHS, Managing Director		115 - 120	0	0	115 - 120	n/a	n/a	n/a	115 - 120
Rima Makarem Chair		60 - 65	800	n/a	60 - 65	n/a	n/a	n/a	60 - 65
Rosie Benneyworth Non-Executive Director	9	10 - 15	0	n/a	10 - 15	n/a	n/a	n/a	10 - 15
Tom Frederick Associate Non-Executive Director	10	10 - 15	300	n/a	10 - 15	n/a	n/a	n/a	10 - 15
Jan Hull Non-Executive Director	11	0 - 5	100	n/a	0 - 5	n/a	n/a	n/a	0 - 5
Alexander Priest Non-Executive Director		5 - 10	100	n/a	5 - 10	n/a	n/a	n/a	5 - 10
Martyn Scrivens Non-Executive Director	12	20 - 25	0	n/a	20 - 25	n/a	n/a	n/a	20 - 25
Paul Mapson Non-Executive Director		20 - 25	300	n/a	20 - 25	n/a	n/a	n/a	20 - 25
Graham Hughes Non-Executive Director		20 - 25	200	n/a	20 - 25	n/a	n/a	n/a	20 - 25
Inga Kennedy Non-Executive Director		15 - 20	0	n/a	15 - 20	n/a	n/a	n/a	15 - 20
Olena Doran Non-Executive Director	13	10 - 15	0	n/a	10 - 15	n/a	n/a	n/a	10 - 15
Darshan Chandarana Non-Executive Director	14	10 - 15	0	n/a	10 - 15	n/a	n/a	n/a	10 - 15

Notes
1 Also Shareholder Director of SSL
2 Also Shareholder Director of SSL
3 Until 29 June 2025
4 Between 1 May 2026 – 29 September 2025
5 From 29 September 2025
6 Until 31 August 2025
7 From 1 September 2025 - Reported figure is total renumeration however Medical Director role is £70-£75k per annum
8 Employed by ICB so only 50% attributed to SFT
9 From 1 July 2025
10 From 1 1 July 2025
11 Until 31 May 2025
12 Until 28 February 2026
13 From 1 July 2025
14 From 1 July 2025
15 The disclosed pension entitlement has reduced following partial drawdown of benefits from the 1995 NHS Pension Scheme during the year.

*Taxable benefits are costs associated with travel expenses allowances that are subject to income tax.
**The value of pension related benefits is determined in accordance with the HMRC method, which incorporates pensions payable for a 20-year period.

Salary and pension entitlements of senior managers 2024/25 (subject to audit)

Total remuneration 2024/25	Note	Salary	Taxable benefits *	Pension related benefits **	Total Remuneration	Recharges Salary	Recharges taxable benefits	Recharges pension related benefits	Remuneration Net of recharges
Name and Title		(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)
		£000		£000	£000	£000		£000	£000
Peter Lewis Chief Executive		245 – 250	300	n/a	245 – 250	n/a	n/a	n/a	245 – 250
Melanie Iles Chief Medical Officer		215 – 220	200	330 – 332.5	545 – 550	n/a	n/a	n/a	545 – 550
Andy Heron Deputy Chief Executive & Chief Operating Officer		175 – 180	0	50 – 52.5	225 – 230	n/a	n/a	n/a	225 – 230
Pippa Moger Chief Finance Officer		160 – 165	500	22.5 - 25	185 – 190	n/a	n/a	n/a	185 – 190
David Shannon Director of Strategy and Digital Development		145 – 150	500	20 – 22.5	170 – 175	n/a	n/a	n/a	170 – 175
Isobel Clements Chief of People and Organisational Development		145 – 150	400	15 – 17.5	165 – 170	n/a	n/a	n/a	165 – 170
Hayley Peters Chief Nurse		145 – 150	400	20 – 22.5	165 – 170	n/a	n/a	n/a	165 – 170
Phil Brice Director of Corporate Services	1	35 – 40	0	0	35 – 40	n/a	n/a	n/a	35 – 40
David Shire Director of Estates	2	80 – 85	0	87.5 – 90	170 – 175	n/a	n/a	n/a	170 – 175
Katie Mattravers SSL Managing Director		80 – 85	0	35 – 37.5	115 – 120	n/a	n/a	n/a	115 – 120
Jade Renville Director of Corporate Services	3	n/a	n/a	n/a	n/a	40 – 45	0	55 – 57.5	100 – 105
Berge Balian SHS, Medical Director		165 – 170	0	n/a	165 – 170	n/a	n/a	n/a	165 – 170
Kerry White SHS, Managing Director		115 – 120	0	n/a	115 – 120	n/a	n/a	n/a	115 – 120

Colin Drummond Chairman	4	40 – 45	0	n/a	40 – 45	n/a	n/a	n/a	40 – 45
Rima Makarem Chairman	5	10 – 15	0	n/a	10 – 15	n/a	n/a	n/a	10 – 15
Martyn Scrivens Non-Executive Director		20 – 25	0	n/a	20 – 25	n/a	n/a	n/a	20 – 25
Kate Fallon Non-Executive Director	6	10 – 15	0	n/a	10 – 15	n/a	n/a	n/a	10 – 15
Jan Hull Non-Executive Director		15 – 20	0	n/a	15 – 20	n/a	n/a	n/a	15 – 20
Alexander Priest Non-Executive Director		5 – 10	0	n/a	5 – 10	n/a	n/a	n/a	5 – 10
Paul Mapson Non-Executive Director		20 – 25	0	n/a	20 – 25	n/a	n/a	n/a	20 – 25
Graham Hughes Non-Executive Director		15 – 20	0	n/a	15 – 20	n/a	n/a	n/a	15 – 20
Inga Kennedy Non-Executive Director		15 – 20	0	n/a	15 – 20	n/a	n/a	n/a	15 – 20
Tina Oakley Non-Executive Director	7	10 – 15	0	n/a	10 – 15	n/a	n/a	n/a	10 – 15

Notes

1. To 15 July 2024
2. From 1 June 2024
3. From 8 July 2024 - Employed by Somerset ICB and 50% recharged to SFT. Full pension related benefits attributed to the employee have been disclosed in the table above rather than the amount chargeable to the Trust
4. To 31 December 2024
5. From 1 January 2025
6. To 30 November 2024
7. To 31 December 2024

*Taxable benefits are costs associated with travel expenses allowances that are subject to income tax.

**The value of pension related benefits is determined in accordance with the HMRC method, which incorporates pensions payable for a 20-year period.

Pension benefits of senior managers 2025/26 (subject to audit)

Pension Benefits	Note	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2026	Lump sum at pension 60 related to accrued pension at 31 March 2026	Cash equivalent transfer value at 31 March 2026	Cash equivalent transfer value at 1 April 2025	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
Name and Title		(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)				
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Andy Heron Deputy Chief Executive & Chief Operating Officer	1	0.0	0	40 - 45	0.0	693	592	69	0
Pippa Moger Chief Finance Officer	2	2.5 - 5	0 - 2.5	60 - 65	150 - 155	1,381	1,276	63	0
Melanie Iles Chief Medical Officer		2.5 - 5	0	85 - 90	225 - 230	2,117	1,987	69	0
Hayley Peters Chief Nurse	3	0 - 2.5	0 - 2.5	60 - 65	150 - 155	1,375	1,276	14	0
Isobel Clements Chief of People and Organisational Development		0 - 2.5	0	70 - 75	175 - 180	1,632	1,546	41	0
David Shannon Director of Strategy and Digital development	4	2.5 - 5	2.5 - 5	55 - 60	135 - 140	1,192	1,080	75	0
David Thomas Acting Chief Nurse	5	0 - 2.5	2.5 - 5	55 - 60	140 - 145	1,242	1,127	32	0
Katie Mattravers SSL Managing Director		0 - 2.5	0	10 - 15	0	176	147	15	0
David Shire Director of Estates		0 - 2.5	0	30 - 35	0	558	515	19	0
Jade Renville Director of Corporate Services	6	2.5 - 5	0	35 - 40	0	480	415	51	0

Notes

1 The disclosed pension entitlement has reduced following partial drawdown of benefits from the 1995 NHS Pension Scheme during the year.

2 Also a Shareholder Director of SSL

3 Left Trust 29 June 2025

4 Also a Shareholder Director of SSL

5 Between 1 June 2025 and 29 September 2025

6 Employed by ICB so split is 50/50

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accumulated in their former scheme.

The pension figures shown relate to the benefits that the individual has accumulated as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accumulated to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. Real increase / (decrease) in CETV -This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accumulated pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. No other directors are part of the NHS Pension Scheme hence non-inclusion in the above table.

Exit packages

	2025/26 Compulsory redundancies	2025/26 Other departures	2025/26 Total Number	2024/25 Total number
< £10,000	0	27	27	1
£10,001 - £25,000	0	28	28	0
£25,001 - £50,000	2	5	7	1
£50,001 - £100,000	0	2	2	5
£100,001 - £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	1
Total Number	2	62	64	8
Total resource cost	£91,923	£855,022	£946,946	£561,838

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally agreed arrangements or local arrangements for which Treasury approval was required.

Other/non-compulsory departures

	Agreements Number	Total Value of Agreements £000's
Voluntary redundancies including early retirement contractual costs	1	36
Mutually agreed resignation (MARS) contractual costs	57	726
Contractual payments in lieu of notice	5	58
Exit payments following employment tribunals or court orders	1	35
Total	64	855

Gender Pay Gap

Information on the Trust's gender pay gap can be found at: https://gender-pay gap.service.gov.uk/

Peter Lewis, Chief Executive, 22 June 2026

People report

Headcount and full-time equivalent colleagues

The Group employs the following people (as at 31 March 2026):

Headcount (Excluding Bank Employees)			
	Female	Male	Grand Total
Directors & Chief Executive	5	3	8
Non-Executives & Chair	4	4	8
Other Senior Managers	66	54	120
All other employees	10,943	2,982	13,925
Grand Total	11,018	3,043	14,061

Headcount (Including Bank Employees)			
	Female	Male	Grand Total
Directors & Chief Executive	5	3	8
Non-Executives & Chair	4	4	8
Other Senior Managers	66	54	120
All other employees	12,312	3,626	15,938
Grand Total	12,387	3,687	16,074

Full-Time Equivalent (Excluding Bank Employees)			
	Female	Male	Grand Total
Directors & Chief Executive	4.71	3.00	7.71
Non-Executives & Chair	2.81	4.00	6.81
Other Senior Managers	58.22	52.39	110.61
All other employees	9,427.17	2,800.63	12,227.80
Grand Total	9,492.91	2,860.02	12,352.93

The average number of employees employed by the Group:

Average Number of Employees (Full-Time Equivalent)	2025/26			2024/25
	Permanent	Other	Total	Total
Medical and dental	1,358	100	1,458	**1,315**
Ambulance staff	31	0	31	**15**
Administration and estates	2,937	62	2,999	**2,741**
Healthcare assistants and other support staff	3,124	86	3,210	**3,495**
Nursing, midwifery and health visiting staff	3,422	154	3,576	**3,594**
Scientific, therapeutic and technical staff	2,024	32	2,056	**1,884**
Healthcare science staff	122	2	124	**125**
Other	19	0	19	22
Total Average Numbers	**13,037**	**436**	**13,473**	**13,190**

Staff costs

Group	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	585,194	533,018
Social security costs	80,210	59,578
Apprenticeship levy	2,713	2,827
Employer's contributions to NHS pensions	121,489	112,354
Pension Cost – other	91	2,610
Termination benefits	951	562
Temporary staff	54,680	67,010
Total staff costs	**845,328**	**797,959**

Absence data

Sickness absence rates have experienced fluctuation across the year, with an average rolling sickness absence rate of 5.2% for 2025/26.

Further information on the Trust's sickness absence data is published as part of the national NHS Digital publications and is available here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff turnover

The average turnover rate across the year was 10.6%. Reducing staff turnover remains a key priority for the People Team, who continue to analyse trends and implement targeted interventions to address the underlying causes of colleagues leaving the organisation. As part of our commitment to the NHS People Promise and national retention programme, several initiatives are underway. These include participation in a flexible working leadership development programme, delivered in partnership with NHS England and Timewise, as part of a national pilot. These efforts aim to enhance work-life balance, support career development, and improve overall staff experience.

Retirements due to ill-health

During 2025/26 there were 16 early retirements from the Trust agreed on the grounds of ill-health (2024/25: 14 early retirements). The estimated pension liabilities of this ill-health retirement was £637,373 (2024/25: £1,017,315).

The additional pension costs for individuals who retired early on ill-health grounds will be borne by the NHS Business Services Authority- Pensions Division.

Supporting disabled colleagues

The Trust is committed to supporting colleagues with disabilities or long term health conditions as part of creating a workplace where people feel valued, supported and able

to perform at their best. The Trust participates annually in the Workforce Disability Equality Standard (WDES), which provides insight into the representation, experience, progression and retention of disabled colleagues. WDES data forms part of the Trust's annual inclusion report, which is presented to and discussed by the Board and informs the Workforce Inclusion Plan 2023–2028. In 2025/26, the Trust focused on improving the response to reasonable adjustments, weaving this through all the work we do.

Information on diversity and inclusion, initiatives and longer-term ambitions

Somerset NHS Foundation Trust is committed to fostering an inclusive environment where all colleagues and communities are supported to thrive. The Board has agreed the following statement, which defines what inclusion means at SFT:

"At SFT, we believe inclusion is essential - for the people we care for, for our colleagues and for better care. We listen to every voice and work to remove barriers across our communities."

The Board is focused on agreeing the measures used to support this inclusion statement, ensuring they bring together workforce inclusion and health inequalities to strengthen impact and accountability.

The Trust is committed to creating a fair, inclusive and supportive working environment where all colleagues feel valued and able to thrive. As part of this commitment, the Trust supports seven colleague networks, all of which are open to colleagues across the organisation.

These networks are brought together through the Colleague Inclusion Community, which provides opportunities for connection, learning and engagement, supporting colleagues' wellbeing, sense of belonging and professional development.

The colleague networks offer safe and trusted spaces where colleagues can share experiences, access peer support and engage in meaningful conversation. Colleagues may choose to participate in network specific sessions, wider inclusion events, or both, depending on their interests and needs.

Through the Inclusion Community, colleagues have access to a programme of events, speakers and learning opportunities focused on inclusion, wellbeing and personal growth. Participation is encouraged across the organisation to promote understanding, awareness and shared learning.

Inclusion is a strategic priority for the Trust. The Chief Executive and Board actively support this agenda, recognising the important role colleague networks play in shaping an inclusive culture where everyone can contribute and succeed.

People policies and actions applied during the financial year

The Trust now has a well-established programme in place to oversee the review and updating of all People policies. This programme brings together operational management and Staff Side colleagues to ensure a collaborative approach. The Trust has also prioritised the reintroduction of systematic policy monitoring throughout

2025/2026. This monitoring process ensures that newly introduced and revised policies meet organisational needs and are subject to regular review to assess their impact on colleagues.

Actions on areas of concern and involvement of staff in the improvement of performance

The Trust continues to foster a culture of openness and transparency, where colleagues feel safe and supported to speak up about concerns relating to patient safety and experience, as well as colleague wellbeing and experience at work. The Freedom to Speak Up (FTSU) service remains a vital mechanism for raising concerns, providing a simple, accessible, and confidential route for all colleagues, including learners.

During 2025/26, the number of concerns raised through the FTSU service decreased by 14.20%. This reduction reflects increased confidence and capability in the use of routine speaking up routes across the organisation, while recognising that the FTSU service continues to play an essential role in supporting colleagues where alternative routes are not appropriate or have been exhausted.

Concerns raised are categorised in line with the National Guardian's Office thematic framework. Worker safety and wellbeing accounted for 66% of all concerns, representing a 13% increase compared to the same period last year. In addition, 38% of concerns included elements of inappropriate attitudes and behaviours, a 10% increase on the previous year. Concerns containing an element of patient safety or quality constituted 17% of all cases, reflecting a 14% reduction compared to last year.

In addition to the FTSU service, the Trust has strengthened alternative routes for speaking up, particularly in relation to sexual misconduct. The establishment of the Sexual Safety Working Group has enabled a more targeted focus on identifying themes and hotspot areas, informing preventative action and tailored support. Intelligence from FTSU, the Sexual Safety Working Group, and other data sources is triangulated through the Colleague Experience Monthly meetings to identify key risk areas and inform delivery of the Trust's People Strategy annual priorities.

Health and safety

There continues to be a positive health and safety culture within the organisation. An independent health & safety internal audit had been conducted by BDO during Quarter 4 2024/25 with recommendations carried out during 2025/26. Moderate assurance of the Trust health & safety policy has been awarded.

The Trust's Health and Safety Committee and the Safety Environment and Advisors Group (SEAG) are effective meetings that ensure structures and processes are in place to manage health and safety successfully. Safety topic leads are supported through Health & Safety Team and/or SEAG or directly via specialist safety meetings such as the Fire Safety Committee.

The Health and Safety Committee is in place to ensure appropriate consultation with colleagues on all issues affecting their health and safety. Terms of reference are in line with relevant health and safety legislation.

The Head of Health & Safety and Risk is responsible for ensuring that a structure is in place to manage the health and safety functions for the 24 topic leads.. This includes policy consultation, development and approval, monitoring of policy implementation plans, policy monitoring and action plan updates. This work schedule aligns with the Quality Assurance Group (QAG).

Incidents reported to the Health and Safety Executive (HSE) under RIDDOR

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulation 2013 (RIDDOR) requires the Trust to report deaths, certain types of injury, specified occupational diseases and dangerous occurrences that 'arise out of or in connection with their work'. An annual RIDDOR report is prepared and shared widely for consideration / action. All RIDDORs are fully investigated and reviewed. An overview of all RIDDORs is a standing agenda item at the quarterly Health & Safety Committee.

During 2025/26 the Trust reported 59 incidents to the Health and Safety Executive (HSE) as RIDDOR reportable events. This is an increase of 22 on the previous year 2024/25. It is thought this increase is due to the implementation of a robust process within the Health and Safety Team of proactive reviewing and monitoring of all possible RIDDOR events reported and changes to how reporters are reporting events. The increase is seen as a positive effect of the new report eventing system, Learning from Patient Safety Events (LfPSE), implemented into the Trust on the 1 May 2024.

Occupational health

The Trust entered its second year of partnership with its outsourced Occupational Health service provider in 2026. Collaboration has continued positively, with constructive working relationships further strengthening over the year. The provider continues to deliver comprehensive management information, which is routinely reviewed through monthly contract meetings. This enables the Trust to identify key trends, priority areas, and opportunities for targeted intervention.

The Trust remains committed to addressing the primary causes of colleague absence, with musculoskeletal (MSK) conditions and stress and mental health continuing to be leading contributors. In response, a range of support mechanisms remain in place to help colleagues manage these challenges effectively and sustainably.

A rapid access MSK service is available to colleagues, ensuring timely assessment and intervention to support health, wellbeing and safe, return to work where appropriate. In addition, the Colleague Support Service continues to play a central role in providing a comprehensive offer of support, ranging from early advice and guidance to specialist interventions for individuals and teams. This includes Staff Support following incidents and Compassion Circles, which offer timely reflective, and compassionate support following challenging or critical events.

The Trust's Wellbeing Team further supports colleagues across a broad range of areas, including financial wellbeing, stress management, and the promotion of overall health and resilience. Together, these services contribute to a holistic approach to colleague wellbeing, supporting attendance, engagement, and a healthy, resilient workforce.

Counter Fraud and Corruption

The Trust values our reputation for top quality patient care and financial probity, and we conduct our business in a fair and ethical manner. As part of this, the Trust supports the NHS Counter Fraud Authority strategy that aims to reduce fraud, bribery and corruption within the NHS. We are committed to the prevention, detection and investigation of any such allegations and will seek to apply criminal, disciplinary, regulatory and civil sanctions where allegations are upheld. This includes the recovery of identified financial losses to ensure that NHS resources are used for their intended purpose - the delivery of patient care.

We expect all organisations and contractors instructed by our organisation to demonstrate a comparable commitment in order to do business with us. This enables us to reassure our patients, members and stakeholders that public funds are protected and safeguarded.

The Trust employs Counter Fraud Managers who conduct both proactive and reactive work in line with the requirements of the Government Functional Standard 013: Counter Fraud ('functional standards').

To limit our exposure to the risks of fraud, bribery, and corruption we also have a number of key policies and procedures which includes, but is not limited to anti-fraud, bribery and corruption policy/procedure, Raising Concerns policy and a Code of Conduct and Conflict of Interest policy. These policies apply to all colleagues and individuals who act on behalf of our organisation.

The success of our approach is dependent on colleagues, stakeholders, service users, visitors or anyone associated with the Trust to report suspicions of Fraud, Bribery and Corruption. We actively encourage reporting to the nominated Counter Fraud Managers, Chief Finance Officer or to the NHS Counter Fraud Authority.

During 2025/26 colleagues had the confidence to report concerns of suspected fraudulent activities. This enabled the Trust's Counter Fraud Managers to conduct comprehensive investigations, which led to a number of criminal sanctions and the recovery of monies lost to fraud.

In November 2025, the Trust hosted representatives of the NHS Counter Fraud Authority (NHSCFA), as the Trust being one of the 25 health bodies nationally with budgets exceeding £1 billion, from which six had been selected for engagement visits. NHSCFA colleagues met with key stakeholders to assess how effectively the Trust has embedded and delivers its counter fraud responsibilities. Meetings were held with the Counter Fraud Managers, Audit Committee Chair, Chief Finance Officer and Freedom to Speak-up Guardian.

The NHSCFA commended the Trust on its approach to countering fraud stating:

'During our visit to the trust, what was incredibly encouraging to witness first hand, was the well-established, coherent and committed approach to countering fraud in the NHS. The trust takes its responsibility to protect public funds extremely seriously and not only provides its LCFS an appropriate platform they need to carry out their role but also empowers them to embed a robust anti-fraud culture throughout the organisation. This culture is built on accountability, integrity and diligence. The trust, and specifically the CFO should be commended for giving LCFSs meaningful access to senior staff to promote fraud awareness. Strong integration between LCFSs and key stakeholders in teams such as HR and finance has contributed to positive outcomes and ensuring staff understand what constitutes fraud and where to report it.'

Engaging our people

We are committed to ensuring our colleagues feel informed, engaged, and connected - to their teams, services, sites, and to the Trust as a whole. We also strive to ensure that their dedication and hard work are consistently recognised and valued.

Our shared values, Kindness, Respect, and Teamwork, shape how we work with one another and how we care for patients, families, and carers. They are prominently featured in our internal communications and visual materials, reinforcing their importance in our daily practice.

We maintain a strong internal communications infrastructure to keep all colleagues informed and connected. Core channels include a weekly online newsletter, three-weekly live briefings with the Chief Executive, and Trust-wide email updates that support major organisational announcements and initiatives.

The Trust has introduced an Annual Listening Report, which brings together colleague feedback gathered throughout the year from a wide range of sources. The report provides a comprehensive overview of key themes, alongside updates on the actions and initiatives undertaken to improve colleague experience.

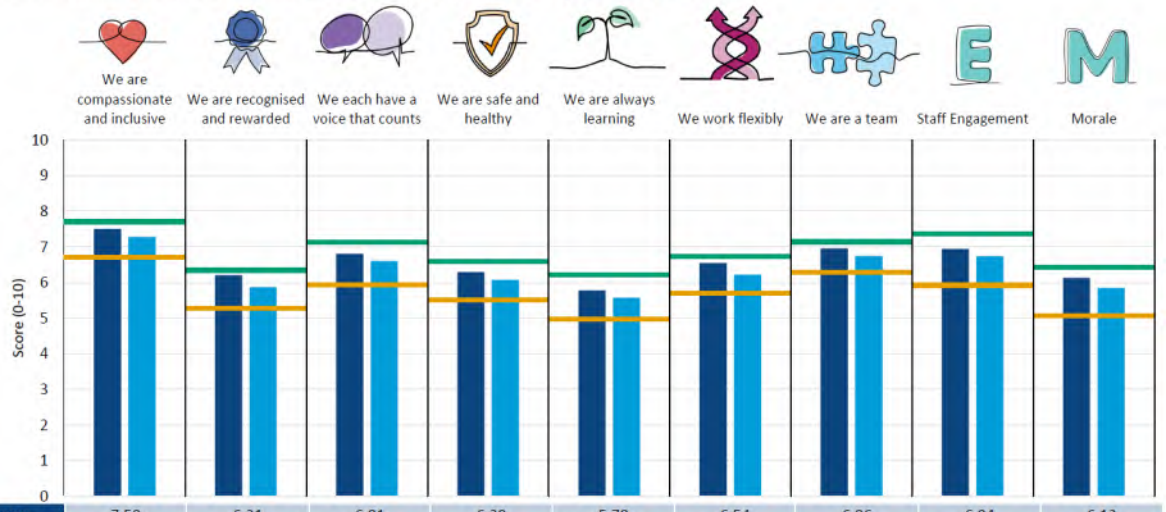
Our Senior Leadership Forum, now expanded to include a broader group of leaders, meets quarterly. These forums provide a space for senior leaders and the executive team to align on strategic priorities across quality, performance, operations, finance, and other key areas. Additionally, the Operational Leadership Team meets monthly, further reinforcing collaborative leadership across the Trust.

Across the organisation, regular meetings are held within each service group and through professional networks, including senior nursing and medical leadership teams. These forums support ongoing engagement at all levels, ensuring colleagues are connected, collaborative, clear on their contribution to the Trust's objectives, and well supported in their roles.

Staff survey

The 2025 NHS Staff Survey was completed during October and November 2025 with a 45.63% response rate. This year was the fifth year that the staff survey was aligned to the themes of the NHS people promise and our third year as a merged Trust. The response rate has fallen each consecutive year. Our results can be seen in the table below. The table below highlights the feedback from our people and in every theme the Trust scored higher than the comparator group average. However, it should be noted that while our scores have generally fallen across the last 3 years, we still rank highly amongst trusts within our comparator group.

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.50	6.21	6.81	6.29	5.78	6.54	6.96	6.94	6.13
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	6045	6043	5996	5998	5732	6024	6039	6050	6046

The highest scoring themes for the Trust in 2025 remain the People Promises of:

- We are compassionate and inclusive
- Staff engagement

The element of ‘we are always learning’, which is made up of topics including appraisals and development, remains as one of our most challenged areas. Although we had seen gradual improvements over the last 2 years, this has dipped once more in the 2025 results (5.81 in 2024 to 5.78 in 2025)

The people promise score of ‘we are a team’ is an area the Trust has improved in the 2025 results, moving up from 6.97 to 6.98.

Although the results have dipped for the organisation in 2025, we are still in a positive position in comparison to our peers, with all areas seeing higher results. Two of our highest performing areas are ‘we work flexibly’ which sits at 0.39 above our peers and ‘we are recognised and rewarded’ which is 0.34 above.

Trust Staff Survey scores 2022 - 2025				
People Promise Theme	2025	2024	2023	2022
We are compassionate and inclusive	7.50	7.48	7.78	7.54
We are recognised and rewarded	6.21	6.25	6.52	6.22
We each have a voice that counts	6.81	6.90	7.22	7.03
We are safe and healthy	6.29	6.33	6.55	6.17
We are always learning	5.78	5.81	5.93	5.60
We work flexibly	6.54	6.60	6.81	6.51
We are a team	6.96	6.97	7.25	7.00
Staff engagement	6.94	7.06	7.42	7.15
Morale	6.13	6.20	6.45	6.10

2025 scores against comparator group			
People Promise / Theme	Trust	Comparator group average	Difference
We are compassionate and inclusive	7.52	7.25	0.27
We are recognised and rewarded	6.22	5.88	0.34
We each have a voice that counts	6.82	6.58	0.24
We are safe and healthy	6.30	6.07	0.23
We are always learning	5.78	5.56	0.22
We work flexibly	6.59	6.20	0.39
We are a team	6.98	6.71	0.27
Staff engagement (theme)	6.95	6.71	0.24
Morale (theme)	6.14	5.83	0.31

Score: 0 = low 10 = high

Future priorities and targets

The People Strategy 2023-2028 supports the corporate aim to *support our colleagues to deliver the best care though a compassionate, inclusive and learning culture.* Structured around five commitments with supporting high level ambitions. Each year a selection of ambitions is identified for focus while previous years ambitions are consolidated. The priorities identified for the year ahead are:

Data and Digital
Strengthening digital capability, through more connected systems, standardised processes, and improved analytics, will be essential for developing reliable workforce plans, supporting financial recovery, and informing evidence-based decision-making.

This deliverable will include:

- Remove equality and diversity data gaps
- Improve use of staff survey and pulse data – leading to action
- Support use and interpretation of data dashboard and application of insights to inform decision making

Cultural and Engagement
Improving engagement scores through focus on bullying, harassment, discrimination, leadership capability, and the embedding of a just and fair.

This deliverable will include:

- Roll out and consolidation of Compassionate and Inclusive Leadership
- Embed principles into systems such as recruitment, appraisals and processes.

Colleague health and wellbeing
Reducing sickness absence through consistent approaches, reducing burnout risk, and improving access to flexible working all contribute to improved operational performance and patient experience.

This deliverable will include:

- Promoting and supporting application of flexible working policy
- Review of Reasonable Adjustments Process and recording system
- Systemic Approach to Wellbeing (Compassionate Leadership)
- Scope potential for introduction of absence management system

Collectively, the three priority areas address the structural, cultural, and wellbeing issues most critical to the organisation's long-term resilience. Strengthening these foundations will not only improve workforce sustainability and colleague experience but also positively influence the quality and continuity of patient care and will be measured through retention levels and the National Quarterly Pulse Survey metrics on engagement, motivation, advocacy and involvement.

Board members and/or senior officials with significant financial responsibility

	2025/26
	Number of Engagements
Number of off-payroll engagement of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility".	25

Statement of the Chief Executive's responsibilities as the Accounting Officer of Somerset NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS foundation trust accounting officer memorandum issued by NHS England.

NHS England has given accounts directions which require Somerset NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Somerset NHS Foundation Trust and of its income and

expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the Department of Health and Social Care Group accounting manual and in particular to:

- observe the accounts direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS foundation trust annual reporting manual (and the Department of Health and Social Care Group accounting manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS foundation trust accounting officer memorandum.

Peter Lewis, Chief Executive, 22 June 2026

5. ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS foundation trust accounting officer memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Somerset NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Somerset NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, the Chief Executive is ultimately responsible for the leadership of risk management and for ensuring the organisation has adequate capacity in place to handle risk. The Board oversees that appropriate structures and robust systems of internal control are in place, supported by the Audit Committee and Governance and Quality Assurance Committee.

The Chief Medical Officer is the designated executive director with Board level accountability for clinical quality, safety and risk management. The Chief Nurse and Midwife and Chief Executive support this role. Somerset NHS Foundation Trust has a designated Head of Health & Safety and Risk and two Trust Risk Managers within the Governance Support Team together with governance leads within the Service Groups within the organisation. In addition, the Boards of the group's subsidiary companies are responsible for reviewing the risks associated with that entity, although Somerset NHS Foundation Trust is ultimately responsible for risk management.

The non-executive director who chairs the Audit Committee, supported by the Quality and Governance Assurance Committee, independently reports to the Board with assurance on the appropriateness and effectiveness of risk management and internal control processes. A Quality Assurance Group chaired by the Chief Nurse, reviews compliance against the Care Quality Commission and Health and Safety Executive standards across the Trust's regulated activities. This process allows for a systematic

review of compliance, providing assurance and highlighting areas of risk and focus for improvement.

To ensure that a risk management culture is embedded across the Trust, there are actions in place to guarantee that colleagues are clear as to their responsibilities with regard to risk management with communication of the risk management strategy amongst staff. Guidance and training are provided by the Head of Health & Safety and Risk and the Trust's Risk Managers to all colleagues available. Additional on-going training is also provided through supported team one-to-one or group department-led training sessions. The Head of Health & Safety and Risk and the Trust's Risk Managers meet regularly with risk owners and service leads to ensure all risks on the risk register, and identified risks managed locally within departments, are scored, actioned and reviewed appropriately.

The Trust has continued to develop and embed its risk management framework over recent years. In a previous internal audit review of risk management arrangements, a number of areas of strength were identified, including the Trust's comprehensive Risk Management Strategy, clear articulation of risk appetite and tolerance, robust Corporate Risk Register arrangements, and well-established risk management processes within Service Groups. The audit concluded that the Trust's risk management structures were clearly defined, with the organisation demonstrating a 'managed' level of maturity, with elements of 'defined' across the domains of governance, risk assessment, risk management and reporting.

During 2025/26, this work has continued, with further focus on strengthening the Board Assurance Framework (BAF), which underpins the identification and management of strategic risks. An internal audit review of the BAF during the year provided moderate assurance over both its design and effectiveness, identifying opportunities to strengthen the strategic focus of the framework, improve the clarity of controls and assurance, and enhance the identification of gaps and mitigating actions.

The Trust has commenced a programme of work to address these areas, including the refresh of the Trust strategy, review and redesign of the BAF, and improvements to risk management processes and guidance. This work will continue into 2026/27 to further strengthen the Board's ability to receive robust assurance over the delivery of its strategic objectives.

Training

Risk management training is completed through various in-house channels at Somerset NHS Foundation Trust; this training is designed to equip staff with the necessary skills to enable them to manage risk effectively. For colleagues who are likely to be risk owners or services lead, training is provided by the Head of Health & Safety and Risk or the Trust's Risk Managers. In addition, and to act as a reminder, all members of staff are required to complete mandatory training, including Level 1 Risk Management Training. This training reflects the essential training needs and includes risk management processes such as fire, health and safety, manual handling, resuscitation, infection control, safeguarding and information governance. Skills and competencies are also assessed for medical device equipment and for blood transfusion to ensure

safety in care. E-learning and workbooks support this programme and are provided as the preferred model of training.

The Trust has a number of trained investigators to undertake Patient Safety Incident Investigations (PSIIs). Additional training for managing safety alerts is provided on a needs basis. Learning from national and internal reports and from external and internal investigations is presented at the Board, the assurance committees and/or their sub-groups.

Somerset NHS Foundation Trust also understands the importance of audits and uses these to ensure that processes in place throughout the Trust are robust and of required standards. Where recommendations have been presented, the Trust reviews these through the relevant department and Board assurance committees to make further improvements in methods of working.

The risk and control framework

The Board of Directors has developed a risk management vision and risk management objectives for the organisation. The Risk Management Strategy was developed outlining how the organisation will meet its risk management vision and objectives and how these will ensure the Trust will achieve its strategic aims and associated objectives. The Strategy includes the building blocks to achievement and a comprehensive implementation plan.

The Trust's Risk Management Policy, which provides additional information on the risk management processes, was approved and disseminated throughout the organisation in May 2024.

The Risk Management Strategy and Risk Management Policy applied to Somerset NHS Foundation Trust, with the Trust's subsidiary companies Simply Serve Limited and Symphony Healthcare Services adopting the Trust strategy, and Simply Serve Limited adopting the Somerset NHS Foundation Trust policy.

The Risk Management Strategy demonstrates the organisational risk management structure, which details that all committees have a shared responsibility for managing risk across the organisation. The Trust recognises that there is an acceptable level of risk within the Trust; this may be defined as potential hazards that are either small enough to have an immaterial effect on the achievement of organisational objectives, or are significant risks that have been mitigated by the establishment of effective controls. The Trust's risk appetite identifies what level of risk is acceptable at departmental level and at which point this risk is required to be escalated. Systematic identification of risks starts with a structured risk assessment with identified risks documented on departmental risk registers. These risks are analysed in order to determine their relative likelihood and consequence using risk matrix scoring.

During 2025/26, the Board undertook a review of the Trust's strategic framework to ensure it remained focused, coherent and supportive of effective risk oversight. As part of this review, the Trust refined its previously agreed eight high-level strategic objectives into seven overarching Strategic Aims. Each Strategic Aim is supported by a small

number of clear objectives, which together provide greater clarity on how the Trust will deliver its strategy and manage its principal risks. These objectives are monitored through the Board Assurance Framework, enabling the Board to maintain clear sight of the key risks to delivery, the effectiveness of controls and assurance, and progress against agreed mitigating actions.

A risk appetite and risk tolerance statement were considered and approved by the Board in May 2025. The risk appetite and risk tolerance statement sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds. This is reviewed on an annual basis by the Trust Board. The risk appetite and risk tolerance statement does not negate the opportunity to potentially take decisions that result in risk-taking that is outside of the risk appetite.

The risk appetite approach as approved for use within the Trust and based on the Good Governance Institute Risk Appetite for NHS Organisations Matrix, is:

Risk Appetite	Definition
None (0)	Avoidance of risk and uncertainty is a key organisational objective
Minimal (1)	Minimal (as little as reasonably possible). Preference for very safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious (2)	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open (3)	Willing to consider all potential delivery options while also providing an acceptable level of reward (and value for money)
Seek (4)	Eager to be innovative and choose options offering potentially higher business rewards (despite greater inherent risk)
Significant (5)	Confident in setting high levels of risk appetite because of controls, forward scanning and responsiveness systems are robust

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

Continuing risks affecting the organisation

The last few years have been extremely challenging for the NHS with continuing unprecedented levels of demand that have been reflected at Somerset NHS Foundation Trust, alongside industrial action taken by colleagues across different staff groups. These challenges are reflected within the wider region including North and West Dorset for which Somerset NHS Foundation Trust also provides services. The pressure of this is felt across the local health and social care economy, with ever-increasing demand, coupled with difficulties in having sufficient staff to deal with demand and complexity of patient conditions.

Notwithstanding the risks outlined above, the Trust still faces a number of risks continuing into 2026/27, including:

- RSK-000012 Waiting Times (20)
- RSK-003775 Risk of degradation of the safety of patient and service user care due to a care environment where safer staffing standards cannot maintained in one or more areas across the trust (20)
- RSK-001789 Unsafe Premises and environment (20)
- RSK-001611 Failure to secure the necessary infrastructure to meet the current and future demands of the population and the clinical strategy (20)
- RSK-002192 Risk of: SHS not becoming self-sustaining (20)
- RSK-001517 Non-compliance with subject access requests (20)

There are a number of mitigating actions and processes in place to reduce these risks. The Trust's Corporate Risk Register is reviewed at least once a quarter by the Board and all of its sub-Committees. In addition, the Trust's risks against its aims and objectives are captured and monitored within the Board Assurance Framework, which is published within the Trust's Board of Directors papers on a quarterly basis.

Principles of corporate governance

The Board is satisfied that in 2025/26 Somerset NHS Foundation Trust applied those principles, systems and standards of good corporate governance, which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS. The Trust had structured governance arrangements in place with clear lines of reporting across operational, quality, safety, patient experience and finance, through assurance committees, to the Board.

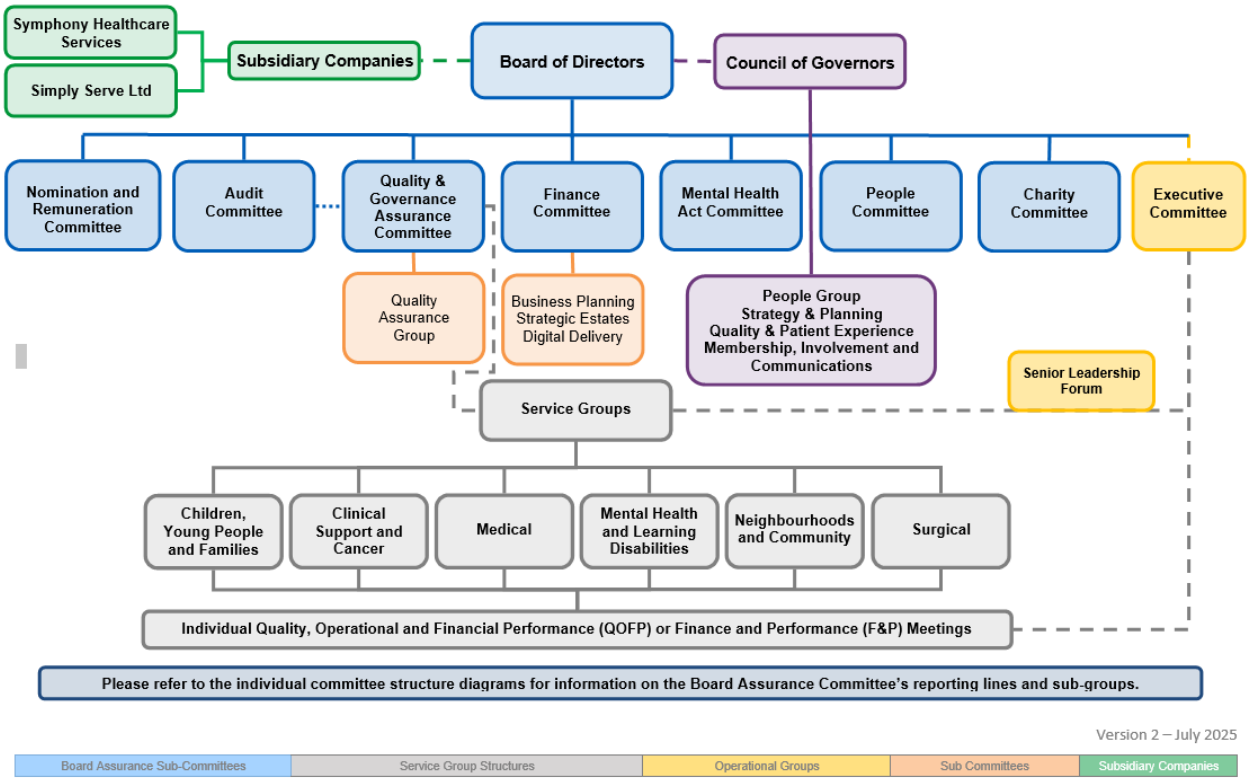
To ensure compliance with Condition 4 (Condition FT4) of the Trust's license with NHS Improvement which relates to governance, NHS foundation trusts are subject to the recommendations of the Code of Governance for NHS Provider Trusts (modelled on best practice UK governance principles) and the Well-Led and Use of Resources Frameworks.

The Trust had a standardised rolling agenda programme for the Board and its assurance committees. A clear Board Governance Structure was in place that outlined the reporting lines (see diagram below). This structure includes a number of Board assurance committees.

There are a range of mechanisms available to these committees to gain assurance that our systems are robust and effective. These include using internal and external audit, peer review, external inspection and review, management reporting and clinical audit.

The Board of Directors receives regular reports from its sub committees on business covered, risks identified and actions taken, based on the principle of exception reporting.

The Board Governance Structure in place during 2025/26 is shown below:



The **Audit Committee** plays a critical role in providing independent and objective assurance to the Board and senior management on the adequacy and effectiveness of the Trust's risk management, control, and governance processes. The Committee supports the Board in fulfilling its statutory responsibilities by overseeing the Trust's internal control framework and ensuring robust systems are in place to manage risk. It reviews and monitors the Trust's Board Assurance Framework, considers the findings and recommendations from internal and external audit reports, and oversees the work of the counter fraud service. Membership of the Audit Committee comprises four Non-Executive Directors, ensuring independent oversight and challenge. Through its work, the Committee contributes to the continuous improvement of the Trust's governance and assurance arrangements.

The **Quality and Governance Assurance Committee (QGAC)** is a sub-committee of the Board responsible for providing oversight and assurance on matters relating to quality, safety and governance. The Committee supports the Board in fulfilling its responsibilities across the three domains of quality: patient safety, clinical effectiveness and patient experience.

QGAC operates within the Trust's governance framework, which places clear executive leadership responsibility for each of the three quality domains and strengthens alignment between operational delivery and Board assurance. Meetings alternate between "focus" and "business" formats, enabling both in-depth strategic discussion and formal assurance reporting.

The Committee receives reports across three core areas:

- Risk, performance and quality assurance – including the Corporate Risk Register, Board Assurance Framework, and quality and performance dashboards.
- External reports and reviews – including those from the Care Quality Commission (CQC), Parliamentary and Health Service Ombudsman (PHSO), and other national and regional bodies.
- Thematic quality reports – including patient safety, clinical effectiveness, health and safety, and patient and carer experience.

Each operational Service Group within the Trust has devolved responsibility for quality governance, supported by local governance structures aligned to the Trust's Quality and Safety Framework. These arrangements ensure clear accountability at service level, with reporting and escalation pathways providing a robust line of sight to QGAC and the Board.

The Committee receives exception reporting on key quality performance indicators and triangulates this with clinical governance, workforce and patient experience data to provide a comprehensive view of service quality and risk.

Regular reports to QGAC include:

- Board Assurance Framework and Corporate Risk Register updates
- Quality and performance reporting, including exception reports and outlier analysis
- Patient safety reporting, including serious incident oversight, learning from deaths, and the Patient Safety Board report
- Patient experience and involvement reporting, including feedback, complaints, and engagement insights
- Workforce and safer staffing information to support triangulation of quality and safety risks
- Safeguarding (adults and children), infection prevention and control, health and safety, and Emergency Preparedness, Resilience and Response (EPRR)
- External reporting, including CQC inspection outcomes and action plans, national audits, surveys and regulatory findings
- Governance and compliance reporting, including information governance, policy assurance and litigation and claims oversight
- Subsidiary assurance reports, including Simply Serve Limited and Symphony Healthcare Services.

QGAC is supported by the Quality Assurance Group and wider governance support functions, including teams responsible for risk, compliance, audit and patient safety,

which provide detailed oversight and escalation into the Committee.

Where appropriate, issues and risks are escalated to the Audit Committee for further independent assurance. The Committee also considers findings from external regulators and oversight bodies, including the Information Commissioner, HM Coroner and the Health and Safety Executive.

The Committee maintains close working relationships with other Board sub-committees, including the People Committee, Mental Health Act Committee and Finance Committee, ensuring a coordinated and system-wide approach to governance and assurance.

Membership of QGAC includes three Non-Executive Directors (one of whom also sits on the Audit Committee), together with Executive Directors including the Chief Nurse, Chief Medical Officer and Chief Operating Officer.

The **Finance Committee** comprises four Non-Executive Directors, the Chief Finance Officer, the Deputy Chief Finance Officer, the Chief Operating Officer, and the Director of Strategy and Digital Development. The Committee focuses on the delivery by the Trust of its key financial targets, its management of capital and investment, including the IM&T and Estates strategies.

The **Mental Health Legislation Committee** focuses on compliance and monitoring of the Trust's approach to Mental Health legislation, including the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. The Committee comprises three Non-Executive Directors, the Chief Operating Officer, the Chief Medical Officer, and the Director of Governance together with senior leaders from relevant areas. Representatives from Somerset Council and from the Somerset Integrated Care Board also invited to attend meetings.

The **People Committee** oversees the development and delivery of the People Strategy. The Committee monitors development and performance against the core objectives of the policy relating to colleague engagement; leadership; learning and development and workforce planning. The Committee comprises three non-executive directors: the Chief of People and Organisational Development, Deputy Chief People Officer, Chief Operating Officer, Director of Strategy and Digital Development, and the Chief Medical Officer or Chief Nurse. Freedom to Speak Up Guardians, staff governors and staff side representatives also attend the meeting.

Representatives from the Council of Governors and their working committees are invited to attend and observe board sub-committees and report on their activities to the public meetings of the Council of Governors.

Individual Board meetings also take place within **Simply Serve Limited** and **Symphony Healthcare Services**. These Board meetings review the strategic and commercial direction of the respective organisations together with various key performance indicators across various categories, including performance, activity levels and workforce. Assurance Reports from the entities are reported to the QGAC and data on the entities is reported to the Finance Committee on their financial and commercial performance.

There are constructive working relationships in place with key public stakeholders, including governors, NHS England, and the Somerset and Dorset Integrated Care Systems. Where specific issues arise, these are addressed through proactive and candid dialogue or via scheduled monitoring meetings.

Quality governance is a key element of the overall governance framework of the Trust. At the heart of the Trust's commitment to quality is a clearly defined system of quality performance management and a robust risk management process.

An Integrated Performance Report (IPR) is presented to the Board at each meeting, highlighting key issues, risks and trends in relation to the delivery of safe, effective and high-quality care and patient experience.

The Chief Executive retains overall accountability for clinical governance within the Trust. During the year, this responsibility has been delegated to the Chief Medical Officer, working in close partnership with the Chief Nurse and Midwife and supported by the Director of Governance.

Executive Directors bring extensive experience of NHS leadership, while Non-Executive Directors provide independent oversight and constructive challenge, drawing on a wide range of senior-level experience from the public and private sectors. Non-Executive Directors are subject to regular appraisal led by the Chair, and the Chief Executive is appraised by the Chair.

The Trust has an integrated framework for monitoring quality and safety, supported by a committee structure with both Executive and Non-Executive representation. The Board oversees quality through a range of mechanisms, including:

- The monthly Integrated Performance Report
- Reporting of serious incidents and organisational learning
- Oversight from the Quality and Governance Assurance Committee
- The Quality Assurance Group, which monitors compliance with statutory, regulatory and quality standards and escalates exceptions

Together, these arrangements provide a clear line of sight from operational services through to Board-level assurance.

The Trust maintains a comprehensive clinical audit programme, incorporating both national and local priorities, to support continuous improvement in clinical effectiveness and patient outcomes.

A robust framework is in place for the management and accountability of data quality. The Trust remains compliant with the registration requirements of the Care Quality Commission.

The Trust operates a Code of Conduct and Conflicts of Interest Policy in line with NHS England's guidance on managing conflicts of interest. Declarations are obtained from all staff identified as decision-makers, and the interests of Board members are published within Board papers and on the Trust's public website. Additional controls are

in place to ensure that conflicts of interest are appropriately managed throughout procurement and tendering processes.

As an employer participating in the NHS Pension Scheme, the Trust has controls in place to ensure compliance with scheme regulations. This includes ensuring that employee and employer contributions are correctly calculated and remitted, and that pension records are maintained accurately in accordance with required timescales. Control measures are also in place to ensure compliance with equality, diversity and human rights legislation.

The Trust undertakes risk assessments in relation to environmental sustainability and maintains a Green Plan which reflects national policy and climate change obligations. This includes consideration of UK Climate Projections and supports compliance with the Climate Change Act and associated adaptation requirements.

Public engagement with risk management

The Trust involves its key public stakeholders with managing the risks that affect them through the following mechanisms:

- Engagement with HealthWatch Somerset.
- The Council of Governors and Trust members are consulted on key issues and risks.
- Annual members' meeting.
- Engagement with patient and carer representative groups, including the voluntary sector and Leagues of Friends.
- Involvement with local patient representative groups.

Developing workforce safeguards

In October 2018, NHS Improvement published 'Developing workforce safeguards – supporting providers to deliver high-quality care through effective staffing'. The guidance set out expectations and good practice to support organisations in making evidence-based decisions about safe staffing levels across all clinical areas and staff groups.

The Trust has embedded these principles within its workforce planning and governance arrangements. Central to this is the approach set out in the Trust's People Strategy, which supports the delivery of safe, effective and sustainable services through appropriate staffing capacity, capability and skill mix.

The Trust operates a systematic approach to monitoring safe staffing, particularly within inpatient ward areas. This includes regular review of workforce data which enables a comprehensive understanding of staffing risks and supports timely mitigation where required.

A formal safer staffing report is presented to the Board on a six-monthly basis, providing assurance on workforce capacity, risks and actions taken to maintain safe care. In addition, staffing risks are routinely escalated through governance structures, including

Service Group governance arrangements and the Quality and Governance Assurance Committee.

Service changes, skill mix reviews and the introduction of new roles are subject to a Quality Impact Assessment process, ensuring that any proposed changes are fully assessed for their potential impact on quality and safety. These assessments are aligned with system-wide approaches across Somerset.

Clear escalation processes are in place at both local and system level to manage periods of increased pressure, ensuring that risks associated with staffing capacity and patient demand are recognised early and managed effectively.

Emergency Preparedness, Resilience and Response

During 2025/26, the Trust maintained a strong focus on organisational resilience and emergency preparedness, achieving full compliance with all NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards. Compliance was confirmed through the annual self-assessment, independent review, and submission of evidence in line with national assurance requirements.

Throughout the year, the Resilience Team provided essential strategic and tactical support to the Trust in response to a range of pressures impacting service delivery. This included coordinated resilience planning and real-time response during:

- Resident doctors' industrial action, ensuring continuity of safe patient care through robust service prioritisation and escalation processes.
- Episodes of severe weather, including flooding events and storm-related disruption, which required activation of adverse weather plans and enhanced communication with system partners.
- Periods of significant operational pressure, where the Trust experienced sustained demand surges leading to the declaration of both Critical Incidents and Business Continuity (BC) incidents. The EPPR function supported decision-making, incident coordination, and recovery planning to safeguard essential services.

In 2025, the Trust also responded to and treated casualties from the Wheddon Cross coach crash, a major incident that tested local and regional emergency arrangements. A Post-Incident Review has since identified a number of learning points. These findings are now being used to strengthen the Trust's major incident and contingency planning, improve interoperability with emergency services, and refine surge and trauma pathways.

The Trust continued to enhance its collaborative response arrangements with local, regional, and national partners. Notable activity included participation in:

- A regional mass-casualty exercise, designed to test whole-system coordination, surge capacity, and command-and-control arrangements.
- A national pandemic preparedness exercise, contributing to UK-wide readiness aligned with the updated government pandemic framework.

Alongside incident response, the Trust continues to develop and implement further improvements to its resilience and contingency arrangements.

Overall, EPPR activity in 2025/26 ensured the Trust remained fully compliant, well-prepared, and operationally resilient, with enhanced capability to respond effectively to both anticipated and emerging threats.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has in place a range of systems and processes to ensure that resources are used economically, efficiently and effectively in delivering its objectives. These arrangements are embedded within the Trust's governance framework and are subject to regular monitoring and review.
Key elements of this framework include:

- A Scheme of Delegation and Reservation of Powers approved by the Board.
- Standing Financial Instructions which set out the financial responsibilities and controls across the organisation.
- Robust financial management arrangements, including budget setting, in-year monitoring and variance analysis. Monthly financial reports are produced for each operational area, with an overall organisational position reported to the Board and reviewed in detail by the Finance Committee.
- Competitive procurement processes for non-staff expenditure, ensuring value for money and compliance with relevant regulations.
- Cost improvement programmes, subject to robust governance and Quality Impact Assessment, with clinical ownership and accountability for delivery.
- Vacancy management and recruitment controls to support workforce affordability and sustainability.
- Contract monitoring arrangements with commissioners to ensure that services are delivered in line with agreed requirements and funding.

All staff across the Trust have a responsibility for the effective use of resources and for identifying and managing risk. Budget holders are accountable for managing their financial resources and internal control systems, ensuring that appropriate controls are in place to mitigate risks while maintaining efficiency and value for money. These arrangements are subject to ongoing internal review and independent scrutiny through the Trust's internal and external audit programmes.

The Trust maintains arrangements to prevent, detect and respond to fraud and corruption in line with NHS Counter Fraud Authority requirements. Dedicated counter fraud resources are in place to support this work and to provide assurance to the organisation.

The Finance Committee provides assurance to the Board in relation to financial performance, budgetary control and resource management. The Audit Committee provides independent oversight of financial reporting, internal controls and risk management, including the review of internal and external audit findings, losses and special payments, and counter fraud activity.

A programme of internal and external audits provides further assurance on the Trust's use of resources, including reviews of financial controls, budgetary management and cost improvement programmes. Where areas for improvement are identified, action plans are agreed and monitored through established governance arrangements.

As outlined elsewhere in this report, the Trust has been subject to Care Quality Commission inspections during recent years, which identified areas requiring improvement. These findings have been reflected within the Trust's governance and risk management arrangements and have informed the continued strengthening of oversight, assurance and control processes, including those relating to the effective use of resources.

Information governance

The Trust recognises data security and information governance as a high priority and continues to ensure that high standards are met throughout the organisation.

The NHS Digital Data Security & Protection Toolkit (DSPT) is an annual self-assessment tool that requires the Trust to provide evidence of compliance with the standards laid down by the National Data Guardian's (NDG) review published in 2016. The Trust's Data Security and Protection Toolkit submission for 2025/26 will be completed in June 2026. It is expected that all mandatory evidence items will be reached, with an assessment status of 'standards met.'

In line with the DSPT reporting tool, 3 incidents were reported to the ICO in 2025/26. The ICO has acknowledged the reported incidents, and no further action has been taken. All incidents are fully investigated; action plans created where appropriate and additional targeted IG training sessions made available. Data security and information governance breaches are reported and monitored through the Data Security and Protection Group, which, in turn, reports to the Quality Assurance Committee.

The Senior Information Risk Owner position is held by the Director of Strategy and Digital Development.

Data quality and governance

The Trust has established a comprehensive framework for data quality and information governance, ensuring that data used to support decision-making, performance monitoring and regulatory reporting is accurate, timely and reliable.

Throughout the year, the following arrangements have been in place to provide assurance to the Board that appropriate controls exist to maintain data quality:

- Information is subject to robust validation, review and challenge through operational and corporate governance structures, including Quality, Outcomes, Finance and Performance (QOFP) meetings and Service Group governance forums. This is further reviewed and triangulated through the Quality and Governance Assurance Committee and the Board.

- Key aspects of data quality and information governance are included within the annual internal audit programme, providing independent assurance on the effectiveness of controls.
- Data quality and information governance are monitored through regular reporting to the Data Security and Protection Group, alongside oversight of compliance with the Data Security and Protection Toolkit.

The Trust's governance model integrates corporate, clinical and information governance, providing a cohesive approach to performance oversight and regulatory compliance. This is supported by structured reporting through the Quality Assurance Group and its associated governance arrangements, with defined escalation routes into the Quality and Governance Assurance Committee and the Board.

Service Groups hold devolved responsibility for data quality within their areas, supported by corporate governance teams. This ensures that accountability for data accuracy is embedded at all levels of the organisation, with clear lines of sight from operational services to Board-level assurance.

To support data quality, the Trust provides appropriate training and guidance to staff responsible for data collection and reporting. This includes ensuring that colleagues have the skills, systems and support required to maintain accurate and consistent data, underpinning effective performance management and decision-making.

Quality and performance metrics are reported regularly to the Quality and Governance Assurance Committee and the Board, and, where appropriate, to the Council of Governors. These metrics include locally and nationally defined indicators and are used to provide assurance on service quality, safety and patient experience.

Any data quality issues identified are managed through established information governance processes, with actions tracked through governance structures to ensure that issues are addressed in a timely and effective manner.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within Somerset NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Governance and Quality Assurance Committee and Quality Assurance Group; a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides an annual opinion on the adequacy and effectiveness of the Trust's risk management, control and governance arrangements. For 2025/26, the opinion concludes that the Trust has a generally satisfactory system of internal control, designed to meet its objectives, with improvements required in some

areas. This reflects that, while appropriate controls are in place across the majority of areas reviewed, some weaknesses and instances of non-compliance were identified which may, if not addressed, impact the achievement of objectives.

In forming this opinion, BDO completed a programme of risk-based internal audit work between April 2025 and March 2026. A total of 13 assurance audits were completed during the year, with a mix of substantial, moderate and limited assurance opinions.

There has been an improvement compared to the previous year, including a reduction in the number of limited assurance opinions in operational effectiveness. This programme included a review of the Trust's Board Assurance Framework, which provided moderate assurance over its design and effectiveness and has informed ongoing improvements to the Trust's risk management arrangements.

In assessing the level of assurance to be given, BDO also took into account:

- Their assessment of the design and operation of the underpinning risk management framework and supporting processes, including whether risk appetite has been established and embedded within the activities, limits and reporting of the organisation.
- The range of individual opinions arising from risk-based audit assignments reported throughout the year, including the relative materiality of these areas.
- Any significant recommendations not accepted by management and the consequent risks.
- Management's progress in addressing control weaknesses and implementing recommendations.
- Any limitations placed on the scope of internal audit.
- Reliance placed upon other assurance providers.
- The effects of any significant changes in organisational objectives or systems.
- The proportion of the Trust's audit need covered to date.

The Trust has continued to progress a focused programme of improvement in response to matters raised through previous CQC inspection activity, particularly in relation to maternity and children and young people's services.

There has been a clear trajectory of improvement during 2025/26, with a number of actions now completed and others progressing through assurance processes. Governance arrangements have been strengthened, including clearer routes for oversight, escalation and assurance through established Board and committee structures.

The focus has increasingly shifted from delivery of actions to evidencing and sustaining improvement. Work is underway to ensure that assurance is robustly collated and reported against each improvement area, supported by enhanced oversight arrangements and continued monitoring of key risks, and regular repotting to the Board and its committees. These arrangements have strengthened the Trust's governance framework and support ongoing compliance with the requirements of its CQC registration.

The Trust's Risk Management Strategy outlines the process for maintaining the effectiveness of the system of internal control. Assurance as to the effectiveness of the system is primarily overseen by the Audit Committee, which reports to the Board, supported by the Quality and Governance Assurance Committee. Where weaknesses are identified, recommendations are made and action plans monitored through this assurance process to ensure continuous improvement. The Quality and Governance Assurance Committee also reviews the Quality Assurance Group work plan and governance framework in respect of assigned risk areas, reporting directly to the Board.

The opinion is based on information provided between April 2025 and March 2026.

Conclusion

I am satisfied that there are systems of internal control are in place and that the culture of risk management is embedded at Somerset NHS Foundation Trust.

Peter Lewis, Chief Executive, 22 June 2026

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Somerset NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

Somerset NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Somerset NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed .....

Name **Peter Lewis**
Job title **Chief Executive**
Date **19 June 2026**

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOMERSET NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Somerset NHS Foundation Trust ("the Trust") for the year ended 31 March 2026 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers' Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2026 and of the Group's and the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Group and the Trust's services or dissolve the Group and the Trust without the transfer of their services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Group and the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to the Group's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.

- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Group management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the nature of the funding provided to the Group and the Trust during the year. We therefore assessed that there was limited opportunity for the Group and the Trust to manipulate the income that was reported.

We also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries with unusual characteristics compared to the total journal population.
- For a selection of cash payments and expenditure transactions in the period post 31 March 2026, verifying that the expenditure had been recognised in the correct accounting period to which the expenditure related.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and from inspection of the Group's and the Trust's regulatory and legal correspondence and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Group is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We did not identify any laws and regulations that are likely to have a material impact on the financial statements recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with laws and regulations to enquiry of the Accounting Officer and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial

statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 112, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Group and the Trust or dissolve the Group and the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 125, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial

sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

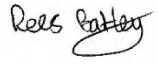
THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Somerset NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.



Rees Batley

for and on behalf of KPMG LLP

Chartered Accountants

66 Queen Square

Bristol

BS1 4BE

24 June 2026

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	1,132,662	1,081,516	1,097,458	1,043,622
Other operating income	4	79,227	82,030	84,620	86,444
Operating expenses	7,9	(1,217,024)	(1,180,960)	(1,192,129)	(1,151,238)
Operating deficit from continuing operations		**(5,135)**	**(17,414)**	**(10,051)**	**(21,172)**
Finance income	11	2,149	3,801	2,655	3,950
Finance expenses	12	(3,215)	(5,190)	(4,206)	(6,058)
PDC dividends payable		(8,722)	(8,005)	(8,722)	(8,005)
Net finance costs		**(9,788)**	**(9,394)**	**(10,273)**	**(10,113)**
Other gains / (losses)	13	(13)	(1,039)	(13)	(1,041)
Corporation tax expense		(902)	(758)	-	-
(Deficit) for the year		**(15,838)**	**(28,605)**	**(20,337)**	**(32,326)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8	(14,362)	(12,779)	(14,335)	(12,779)
Revaluations	19	3,721	8,463	3,721	8,614
Other recognised gains and losses		-	-	(2,121)	-
Other reserve movements		(37)	146	-	1,546
Total other comprehensive income for the period		**(10,678)**	**(4,170)**	**(12,735)**	**(2,619)**
Total comprehensive (expense) for the period		**(26,516)**	**(32,775)**	**(33,072)**	**(34,945)**
Surplus/ (deficit) for the period attributable to:					
Non-controlling interest, and		187	136	-	-
Somerset NHS Foundation Trust		(16,025)	(28,741)	(20,337)	(34,945)
Total		**(15,838)**	**(28,605)**	**(20,337)**	**(34,945)**
Total comprehensive (expense for the period attributable to:					
Non-controlling interest, and		187	136	-	-
Somerset NHS Foundation Trust		(26,703)	(32,911)	(33,072)	(34,945)
Total		**(26,516)**	**(32,775)**	**(33,072)**	**(34,945)**

The notes on pages 8 to 66 form part of these accounts.

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	14	46,195	30,692	46,192	30,652
Property, plant and equipment	16	469,522	442,230	450,069	419,462
Right of use assets	20	89,945	90,467	90,062	94,079
Investments in subsidiary undertakings	23.1	-	-	13,948	13,948
Investments in associates and joint ventures	22	14	14	14	14
Other investments / financial assets	23	14	14	-	-
Receivables	25	3,341	3,063	12,874	16,153
Total non-current assets		**609,031**	**566,479**	**613,159**	**574,308**
Current assets					
Inventories	24	13,022	11,281	10,741	9,198
Receivables	25	33,254	24,133	34,327	25,015
Non-current assets held for sale	26	-	496	-	496
Cash and cash equivalents	27	111,836	79,215	98,245	66,636
Total current assets		**158,112**	**115,126**	**143,313**	**101,345**
Current liabilities					
Trade and other payables	28	(177,053)	(120,259)	(169,460)	(114,227)
Borrowings	30	(7,215)	(11,637)	(12,930)	(10,835)
Provisions	31	(8,908)	(9,521)	(7,824)	(8,827)
Other liabilities	29	(12,074)	(18,455)	(11,059)	(17,740)
Total current liabilities		**(205,250)**	**(159,872)**	**(201,273)**	**(151,629)**
Total assets less current liabilities		**561,894**	**521,733**	**555,199**	**524,024**
Non-current liabilities					
Borrowings	30	(117,588)	(117,400)	(124,533)	(131,262)
Provisions	31	(2,725)	(2,790)	(3,095)	(2,670)
Other liabilities	29	(1,164)	(1,423)	(1,164)	(1,423)
Total non-current liabilities		**(121,477)**	**(121,613)**	**(128,792)**	**(135,355)**
Total assets employed		**440,416**	**400,120**	**426,407**	**388,669**
Financed by					
Public dividend capital		466,225	399,414	466,225	399,414
Revaluation reserve		60,819	73,581	60,673	73,408
Financial assets reserve		(2,472)	(2,472)	(2,471)	(2,471)
Other reserves		(3,702)	(354)	-	-
Income and expenditure reserve		(81,325)	(70,732)	(98,020)	(81,682)
Non-controlling Interest		871	684	-	-
Total taxpayers' equity		**440,416**	**400,120**	**426,407**	**388,669**

The notes on pages 8 to 66 form part of these accounts.

Name
Position Chief Executive
Date **19 June 2026**

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Income and expenditure reserve	Non-controlling interest	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**399,415**	**73,581**	**(2,472)**	**(354)**	**(70,733)**	**684**	**400,120**
Surplus/(deficit) for the year	-	-	-	-	(16,025)	187	**(15,838)**
Other transfers between reserves	-	-	-	(3,348)	3,348	-	**-**
Impairments	-	(14,362)	-	-	-	-	**(14,362)**
Revaluations	-	3,721	-	-	-	-	**3,721**
Other recognised gains and losses	-	(2,121)	-	-	2,121	-	**-**
Public dividend capital received	67,124	-	-	-	-	-	**67,124**
Public dividend capital repaid	(313)	-	-	-	-	-	**(313)**
Other reserve movements	-	-	-	-	(37)	-	**(37)**
Taxpayers' and others' equity at 31 March 2026	**466,226**	**60,819**	**(2,472)**	**(3,702)**	**(81,326)**	**871**	**440,415**

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Income and expenditure reserve	Non-controlling interest	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**363,753**	**77,897**	**(2,472)**	**(4,441)**	**(38,051)**	**548**	**397,233**
Surplus/(deficit) for the year	-	-	-	-	(28,741)	136	**(28,605)**
Other transfers between reserves	-	-	-	4,087	(4,087)	-	**-**
Impairments	-	(12,779)	-	-	-	-	**(12,779)**
Revaluations	-	8,463	-	-	-	-	**8,463**
Public dividend capital received	35,662	-	-	-	-	-	**35,662**
Other reserve movements (Note a)	-	-	-	-	146	-	**146**
Taxpayers' and others' equity at 31 March 2025	**399,415**	**73,581**	**(2,472)**	**(354)**	**(70,733)**	**684**	**400,120**

Note a
Other reserves relate to South West Pathology Services LLP (SPS) & South West Pathology Services Facilities LLP (SPSF) subsidiary reserves that were fully consolidated when merged due to % owned, and during the year re-categorised into the Income and expenditure reserve.

The notes on pages 8 to 66 form part of these accounts.

Statement of Changes in Equity for the year ended 31 March 2026

Trust	Public dividend capital	Revaluation reserve	Financial assets reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**399,414**	**73,408**	**(2,471)**	**(81,682)**	**388,669**
Surplus/(deficit) for the year	-	-	-	(20,337)	**(20,337)**
Impairments	-	(14,335)	-	-	**(14,335)**
Revaluations	-	3,721	-	-	**3,721**
Other recognised gains and losses	-	(2,121)	-	2,121	**-**
Public dividend capital received	67,124	-	-	-	**67,124**
Public dividend capital repaid	(313)	-	-	-	**(313)**
Other reserve movements (Note a)	-	-	-	1,878	**1,878**
Taxpayers' and others' equity at 31 March 2026	**466,225**	**60,673**	**(2,471)**	**(98,020)**	**426,407**

Note a
Other reserve movements include £1,699k dividend received by the Trust from South West Pathology Services LLP (SPS) & South West Pathology Services Facilities LLP (SPSF) subsidiaries with the balance relating to (deficit) on Symphony Healthcare Services (SHS) IFRS16 right of use re-measurement.

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital	Revaluation reserve	Financial assets reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**363,752**	**77,573**	**(2,471)**	**(50,900)**	**387,954**
(Deficit) for the year	-	-	-	(32,328)	**(32,328)**
Impairments	-	(12,779)	-	-	**(12,779)**
Revaluations	-	8,614	-	-	**8,614**
Public dividend capital received	35,662	-	-	-	**35,662**
Other reserve movements (Note a)	-	-	-	1,546	**1,546**
Taxpayers' and others' equity at 31 March 2025	**399,414**	**73,408**	**(2,471)**	**(81,682)**	**388,669**

Note a
Other reserve movements include £1,425k dividend received by the Trust from South West Pathology Services LLP (SPS) & South West Pathology Services Facilities LLP (SPSF) subsidiaries with the balance relating to (deficit) on Symphony Healthcare Services (SHS) IFRS16 right of use re-measurement.

The notes on pages 8 to 66 form part of these accounts.

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Other reserve
This reserve relates to the Trusts' shareholdings in Southwest Pathology Services LLP, Southwest Pathology Services Facilities LLP and SW Path Services LLP.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Non-controlling interest reserve
This reserve represents the amount of equity a consolidated subsidiary that is not attributable directly or indirectly to the Trust.

Statements of Cash Flows

	Note	Group 2025/26 £000	Group 2024/25 £000	Trust 2025/26 £000	Trust 2024/25 £000
Cash flows from operating activities					
Operating (deficit)		(5,135)	(17,414)	(10,051)	(21,172)
Non-cash income and expense:					
Depreciation and amortisation	7	45,053	40,271	44,759	39,924
Net impairments	8	20,112	27,208	20,112	27,208
Income recognised in respect of capital donations	4	(938)	(2,538)	(527)	(2,538)
Amortisation of PFI deferred credit		(259)	(259)	(259)	(259)
(Increase) / decrease in receivables and other assets		(9,940)	5,723	(6,573)	6,616
(Increase) / decrease in inventories		(1,741)	(276)	(1,541)	26
Increase / (decrease) in payables and other liabilities		25,385	6,711	23,007	9,047
Increase / (decrease) in provisions		(780)	(97)	(577)	2,060
Tax (paid) / received		(770)	(776)	-	-
Net cash flows from / (used in) operating activities		**70,987**	**58,553**	**68,350**	**60,912**
Cash flows from investing activities					
Interest received		2,149	3,801	2,655	3,950
Purchase of intangible assets		(6,803)	(7,396)	(6,803)	(7,396)
Purchase of PPE and investment property		(79,118)	(69,263)	(78,296)	(78,159)
Sales of PPE and investment property		483	-	483	-
Receipt of cash donations to purchase assets		938	2,833	527	2,833
Net cash flows from / (used in) investing activities		**(82,351)**	**(70,025)**	**(81,434)**	**(78,772)**
Cash flows from financing activities					
Public dividend capital received		67,124	35,662	67,124	35,662
Public dividend capital repaid		(313)	-	(313)	-
Movement on loans from DHSC		(648)	(748)	(648)	(748)
Movement on other loans		9	(55)	-	-
Capital element of lease liability repayments		(8,102)	(8,202)	(7,714)	(8,583)
Capital element of PFI, LIFT and other service concession payments		(3,371)	(2,871)	(3,370)	(2,871)
Interest on loans		(147)	(151)	(96)	(112)
Interest paid on lease liability repayments		(1,105)	(896)	(828)	(1,061)
Interest paid on PFI, LIFT and other service concession obligations		(1,281)	(1,268)	(1,281)	(1,268)
PDC dividend (paid) / refunded		(8,181)	(7,364)	(8,181)	(7,364)
Cash flows from (used in) other financing activities		-	-	-	1,424
Net cash flows from / (used in) financing activities		**43,985**	**14,107**	**44,693**	**15,079**
Increase / (decrease) in cash and cash equivalents		**32,621**	**2,635**	**31,609**	**(2,781)**
Cash and cash equivalents at 1 April - brought forward		**79,215**	**76,580**	**66,636**	**69,417**
Cash and cash equivalents at 31 March	27	**111,836**	**79,215**	**98,245**	**66,636**

The notes on pages 8 to 66 form part of these accounts.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England (NHSE) has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

The Trust has prepared its financial plans and cash flow forecasts for the coming year on the assumption that funding will be received from the Department of Health and Social Care. Discussions to date indicate this funding will be forthcoming. These funds are expected to be sufficient to enable the Trust to meet its obligations as they fall due; and will be accessed through the nationally agreed process published by NHSE and the Department of Health and Social Care.

There has been no application to the Secretary of State for Health and Social Care for the dissolution of the Trust and following the preparation of detailed financial plans for 2026/27, no such application is planned.

The Board of Directors has therefore concluded that these financial statements should be prepared on a going concern basis as there is a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the next 12 months from the date of signing the accounts.

Note 1.3 Consolidation

Other subsidiaries

Subsidiary entities are those over which the Group is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity.

The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement Of Financial Position.

The Group wholly owns:

Symphony Healthcare Services Ltd (SHS) which forms part of the consolidated accounts. SHS provides primary care services and turnover for the period ended 31 March 2026 was £35.9m (Period ended 31 March 2025: £36.2m).

Simply Serve Ltd (SSL) which provides estates and facilities services; turnover for the period ended 31 March 2026 was £43.5m (31 March 2025: £43.1m) and forms part of the consolidated accounts.

The Group also owns a 67% share in each of Southwest Pathology Services LLP (SPS LLP), Southwest Path Services LLP (Services LLP) and SPS Facilities LLP (LLP) and is accounted for as full consolidation. The Southwest Pathology Services LLP (SPS LLP), was established to deliver and develop laboratory based pathology services throughout the region. Laboratory processing of tests is carried out by SPS LLP, whilst responsibility for the interpretation of the test results remains with the Trust.; turnover for the period ended 31 March 2026 was £30.5m (31 March 2025: £30.4m) and forms part of the consolidated accounts.

Somerset NHS Charitable Funds is not consolidated into the Trust group accounts on the grounds of materiality.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHSE based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular Integrated Care Board (ICB) is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from Commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Discontinued operations
Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
• it is expected to be used for more than one financial year;
• the cost of the item can be measured reliably;
• the item has cost of at least £5,000, or (£500 in Symphony Healthcare Services);
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially
- Land and non-specialised buildings – market value for existing use;
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual using Build Cost Information published by the RICS Building Cost Information Service. During 2025/26, a desktop valuation exercise to update the latest carrying values as at 31 March 2026 was undertaken by Cushman & Wakefield DTZ valuing the MEA re-modelled by NTW Solutions Ltd (full valuation took place 31 March 2025).

A 1% change in the valuation would have a £2.1m impact on the Statement of Financial Position (2024/25: £2.2m) with a £37k change on the PDC dividend due to be paid next year (2024/25: £38k). The majority of the Trusts estate is considered to be specialised assets as there is no open market for acute, community and mental health facilities . The modern equivalent asset valuation is based on the assumption that replacement facilities would be built on alternative sites, within the surrounding area of Somerset.

The model is owned by the Trust and there are currently three MEA models, one 3 hub model for community and mental health, a model for Musgrove Park Hospital and another model for Yeovil District Hospital.

The key judgements driving Land, buildings and dwellings valuations are:
- Building cost index reduction;
- Increased obsolescence factors, particularly in healthcare patient flow areas for ventilation health regulations;
- Valuation of buildings, dwellings and external works on the Yeovil estate associated with Simply Serve Ltd (subsidiary) have been valued net of VAT on the basis SSL can recover the associated VAT. Buildings, dwellings and external works for the Musgrove Park hospital estate, community and mental health sites centres and health centres within Symphony Healthcare Services (SHS) have been valued gross of VAT.

The value of land, buildings and dwellings is £210,380,914 (2024/25 £217,807,000). This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer; Cushman & Wakefield DTZ who have extensive knowledge of the physical estate and market factors.

Of the £210m net book value of land, buildings and dwellings subject to valuation (2024/25: £218m), £208m relates to specialised assets valued on a depreciated replacement cost basis (2024/25: £215m). Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value. Cushman & Wakefield DTZ has supplied amended estimates of the diminution in value relating to operational buildings scheduled for imminent closure and subsequent demolition. These buildings have been written down in the accounts to these values. Open market values have also been provided for land and residences.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *Financial Reporting Manual (FReM)* , are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition
In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement
Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	2	82
Dwellings	10	64
Plant & machinery	2	34
Transport equipment	2	5
Information technology	2	10
Furniture & fittings	3	10

Note 1.10 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the Income & Expenditure Reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments
Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	2	10

Note 1.11 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.12 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.
Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition. The Trust recognise our shareholding in Sensyne PLC.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.
Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 31.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in Note 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 32.
Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State for Health and Social Care can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax
The Trust does not have a corporation tax liability for the year 2025/26. Tax may be payable on activities as described below:

- the activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private healthcare falls under this legislation and is not therefore taxable;

- the activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax;

- the activity must have annual profits of over £50,000.

Within the reporting group of Somerset NHS Foundation Trust, subsidiary companies will have a corporation tax liability for 2025/26 financial year.

The net amount of any corporation tax payable by the subsidiaries for the period is immaterial to the Group accounts. Tax payable is disclosed in full in the notes to the subsidiaries individual statutory accounts.

Note 1.20 Climate change levy
Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange
The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• Monetary items are translated at the spot exchange rate on 31 March;
• Non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and;
• Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 Third party assets
Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.23 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note 36; is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted
The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £213m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £213m at 31 March 2026. The Trust is not able to quantify the impact of this change at this time.

Note 1.27 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

It should be noted that while management must make judgements in relation to applying the recognition of balance sheet items (trade payables; provisions, deferred and accrued income) these are not considered significant judgements.

The purpose of evaluation is to consider whether there may be a significant risk of causing material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements.

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Land, buildings and dwellings
Value of land, buildings and dwellings is £210,380,914 (2024/25 £217,807,000). This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer; Cushman & Wakefield DTZ with extensive knowledge of the physical estate and market factors.

The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

The majority of the Trusts estate is considered to be specialised assets as there is no open market for acute, community and mental health facilities . The modern equivalent asset valuation is based on the assumption that replacement facilities would be built on alternative sites, within the surrounding area of Somerset.

The model is owned by the Trust and there are currently three MEA models, one 3 hub model for community and mental health, a model for Musgrove Park Hospital and another model for Yeovil District Hospital.

The key judgements driving Land, buildings and dwellings valuations are:
- Building cost index reduction;
- Increased obsolescence factors, particularly in healthcare patient flow areas for ventilation health regulations; and
- Valuation of buildings, dwellings and external works on the Yeovil estate associated with Simply Serve Ltd (subsidiary) have been valued net of VAT on the basis SSL can recover the associated VAT. Buildings, dwellings and external works for the Musgrove Park hospital estate, community and mental health sites centres and health centres within Symphony Healthcare Services (SHS) have been valued gross of VAT.

A 1% change in the valuation would have a £2.1m impact on the Statement of Financial Position (2024/25: £2.2m) with a £37k change on the PDC dividend due to be paid next year (2024/25: £38k). There are multiple assumptions built into the 3 MEA models accross the Trust sites, changes to these assumptions would materially affect the financial statements from the valuation.

Revisions to accounting estimates are recognised in the period in which the estimate is revised.

Key factors impacting on the Land and Property Valuation
In arriving at the replacement build cost rates used in the DRC Desktop Update valuations, the Valuer has used the RICS Building Costs Information Service 'All in' Tender Price Index, together with a Location Factor, and adjusted the remaining useful lives for each element within a building to take account of the anticipated physical depreciation since the previous valuation. The indices used are shown below:

All in' Tender Price Index (TPI) - 410
Location Factor - 97 (based on 3-year average

A sensitivity analysis of these assumptions allows the Trust to understand the impact on materiality, given the estimation uncertainty implicit in the valuation. The table below sets out the impact of a high level sensitivity of these key assumptions on the 31 March 2026 valuation of £210.4m. A 5% movement in the TPI and Location Factor would not result in a material impact

Assumption	Baseline Assumption	Sensitivity Assumption +5%	+ 5% Impact on Value £m	Sensitivity Assumption -5%	- 5% Impact on Value £m
TPI	410	430.5	£10.0m	389.5	£(10.0)m
Location Factor	97	101.9	£9.9.m	92.2	£(£9.9)m

Note 2 Operating Segments

Operating segments are reported in a manner consistent with the internal reporting provided to the Chief Operating Decision Maker. The Chief Operating Decision Maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board that makes strategic decisions. Somerset NHS Foundation Trust is managed by the Board of Directors, which is made up of both Executive and Non-Executive Directors. The Board is responsible for strategically and operationally leading the work of the Trust. The Non-Executive Directors bring external expertise to the organisation and provide advice and guidance to the Executive Directors. The Executive Directors take care of the day to day running of the Trust.

The Board is therefore considered to be the Chief Operating Decision Maker (CODM) of the Trust.

The monthly financial information presented to the Board includes a Trust level Statement of Comprehensive Income, a Statement Of Financial Position, a Statement of Cash flows and a number of other financial indicators including, capital expenditure, performance against cost improvement plans, agency spend and debt analysis. The segmental expenditure data is included by way of a separate note reporting achievement against planned expenditure inclusive of any service group specific income and highlighting any variances. It is acknowledged that the analysis of figures included below is different to that used for the remainder of the financial statements. The detail includes current budget and year to date data, in each case comparing actual data to plan. The commentary also includes the service group's contribution to Trust wide initiatives, such as cost improvement programmes. Other information reported to the Board is specifically analysed for its purpose, for example Trust pay spend against budget analysed by employee groups and income stream expectations by type (NHS Clinical, non NHS etc) compared to actual achieved. Information such as delivery of the savings plan is a Trust wide position paper but detailed into the areas tasked with implementing savings.

The Trust has used three key factors in its identification of its reportable operating segments. The key factors are that the reportable operating segment:

a) Engages in activities from which it earns revenues and incurs expenses;
b) Reports financial results which are regularly reviewed by the Trust's Board of Directors to make decisions about allocation of resources to the segment and to assess its performance; and
c) Has discrete financial information.

The Trust's reportable segments and services provided are:

Medical Services
The services provided by this operating segment include A&E, Cardiology, Care of the Elderly, Endocrinology, Neurology, Dermatology, Rehabilitation, Respiratory, Nephrology, Acute Medicine, Rheumatology and Stroke services.

Surgical Services

The services provided by this operating segment include Gastroenterology, Upper and Lower GI Surgery, Vascular, Breast Care, Urology, Head and Neck Services, Orthopaedics, Theatres, Intensive Therapy Unit/High Dependancy Unit, Anaesthetics, Sterile Services, Pre-op Assessment, Surgical Admissions, General Outpatients services.

Clinical Support and Cancer Services

The services provided by this operating segment include the dedicated Cancer Centre, Haematology & Oncology, Pharmacy, Pathology, Imaging, and other diagnostic testing.

Corporate Support Services

This segment provides corporate management for the Trust and includes the administrative aspects of governance and professional management of all clinical staff, the Trust Board, Finance, Information and Digital Services, People Services, Organisational Development, Performance Management, Operational Management, Education and Training, central clinical functions of operational managers, clinical site managers, discharge coordination, patient transport and winter response actions. It also includes the centralised estates and facilities along with subsidiaries.

Children, Young People and Families Services
The services provided by this operating segment include Reproductive Medicine, Early Pregnancy Assessment Clinic (EPAC), Gynaecology, Maternity and Paediatrics (including Somerset Neo-Natal Intensive Care Unit), Child and Adolescent Mental Health Services (CAMHS) and Primary Care Dental Service.

Mental Health and Learning Disabilities services
The services provided by this operating segment include inpatient services for adult acute including Psychiatric Intensive Care Unit (PICU), Section 136 health based places of safety; rehabilitation and older peoples mental health inpatient, commissioned inpatient services of low secure and CAMHS Tier 4; Home Treatment/Crisis services; Perinatal; Psychiatric Liaison; Community mental health services including open mental health working in collaboration with voluntary VSC; forensic liaison services; Assertive Outreach; Talking Therapies and Learning Disability services.

Neighbourhoods Services

The services provided by this operating segment include District Nursing, Rehabilitation and Therapy services, provision of dementia and older people’s mental health services, End of Life service, Community Stroke Services, Chronic Fatigue Service, Mass Vaccination service, Intermediate Care Model, Community Hospitals & Urgent Treatment Centre's (UTC's), and the Hospital at Home service (Virtual Wards).

Note 2 Operating Segments (cont-d)

The table below summarises details reported to the Board

	Group		Trust	
	2025/26	**2024/25**	**2025/26**	**2024/25**
	£'000	£'000	£'000	£'000
Operating Income	1,037,234	984,739	1,037,234	984,739
Total Corporate Income	**1,037,234**	**984,739**	**1,037,234**	**984,739**
Expenditure less sundry income				
Neighbourhoods Services	(122,605)	(92,380)	(122,488)	(92,398)
Children, Young People and Families Services	(89,058)	(88,398)	(88,450)	(87,531)
Mental Health and Learning Disability Services	(82,074)	(81,040)	(82,074)	(81,040)
Medical Services	(170,402)	(164,006)	(169,254)	(162,969)
Surgical Services	(199,139)	(196,889)	(192,995)	(190,825)
Clinical Support and Cancer Services	(122,997)	(136,626)	(152,651)	(164,250)
TOTAL OPERATING SERVICE GROUPS	**(786,275)**	**(759,339)**	**(807,912)**	**(779,013)**
Corporate Support Services	(256,030)	(243,979)	(239,373)	(227,941)
TOTAL OTHER SERVICES	**(256,030)**	**(243,979)**	**(239,373)**	**(227,941)**
Total Operating Expenditure	**(1,042,305)**	**(1,003,318)**	**(1,047,285)**	**(1,006,954)**
Trust EBITDA	**(5,071)**	**(18,579)**	**(10,051)**	**(22,215)**
Net Finance Costs	(10,767)	(10,026)	(10,286)	(10,111)
(Deficit) for the year from continuing operations	**(15,838)**	**(28,605)**	**(20,337)**	**(32,326)**
PERFORMANCE ON A CONTROL TOTAL BASIS				
Remove Capital Donations/grants I&E impact	479	(1,454)	479	(1,454)
Remove Impairments	20,112	27,209	20,112	27,209
IFRIC 12 Finance Costs/forecast interest on IAS17 basis	315	3,204	315	3,204
Remove PDC dividend benefit arising from PFI liability remeasurement	(135)	(351)	(135)	(350)
Performance on a control total basis (including non-recurrent deficit funding)	4,933	3	434	(3,717)
Less non-recurrent deficit funding	(4,915)	-	(4,915)	-
Performance on a control total basis (excluding non-recurrent deficit funding)	**18**	**3**	**(4,481)**	**(3,717)**
Other comprehensive (expenditure)/income				
Will not be reclassified to income and expenditure:				
Impairments	(14,362)	(12,779)	(14,335)	(12,779)
Revaluations	3,721	8,463	3,721	8,614
Other recognised gains and losses	(37)	-	(37)	-
Other reserve movements	-	146	-	1,546
Total comprehensive (expense) for the period	**(26,516)**	**(32,775)**	**(30,988)**	**(34,945)**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Acute services				
Income from commissioners under API contracts - variable element*	146,638	126,645	146,638	126,645
Income from commissioners under API contracts - fixed element*	467,095	461,948	467,095	461,948
High cost drugs income from commissioners	71,345	67,391	71,345	67,391
Other NHS clinical income	601	-	601	-
Mental health services				
Income from commissioners under API contracts*	166,780	152,117	166,780	152,117
Services delivered under a mental health collaborative	8,807	8,319	8,807	8,319
Community services				
Income from commissioners under API contracts*	209,633	166,895	174,666	166,895
Income from other sources (e.g. local authorities)	371	2,330	371	2,330
All services				
Private patient income	7,836	7,909	7,836	7,909
National pay award central funding***	-	1,473	-	1,473
Additional pension contribution central funding**	46,482	44,117	46,482	44,117
Other clinical income	7,074	42,372	6,837	4,476
Total income from activities	**1,132,662**	**1,081,516**	**1,097,458**	**1,043,620**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHSE. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHSE in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
Income from patient care activities received from:	£000	£000	£000	£000
NHS England	165,741	156,504	161,267	153,394
Integrated Care Boards	941,199	888,321	907,318	861,090
Other NHS providers	9,407	9,686	9,696	9,682
NHS other	20	-	3,446	3,104
Local authorities	2,874	2,330	2,231	2,330
Non-NHS: private patients	7,836	7,909	7,622	7,909
Non-NHS: overseas patients (chargeable to patient)	186	421	-	-
Injury cost recovery scheme	1,390	1,343	1,390	1,343
Non NHS: other	4,009	15,002	4,488	4,770
Total income from activities	**1,132,662**	**1,081,516**	**1,097,458**	**1,043,622**
Of which:				
Related to continuing operations	1,132,662	1,081,516	1,097,458	1,043,622

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	**186**	**421**
Cash payments received in-year	94	149
Amounts written off in-year	-	129

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	4,885	-	**4,885**	4,199	-	**4,199**
Education and training	49,762	-	**49,762**	52,234	-	**52,234**
Non-patient care services to other bodies	10,486	-	**10,486**	11,845	-	**11,845**
basis	781	-	**781**	1,152	-	**1,152**
Receipt of capital grants and donations and peppercorn leases	-	938	**938**	-	2,538	**2,538**
Charitable and other contributions to expenditure	-	-	**-**	-	1	**1**
Revenue from operating leases	-	177	**177**	-	331	**331**
Amortisation of PFI deferred income / credits	-	259	**259**	-	259	**259**
Other income (Note a)	11,939	-	**11,939**	9,471	-	**9,471**
Total other operating income	**77,853**	**1,374**	**79,227**	**78,901**	**3,129**	**82,030**
Of which:						
Related to continuing operations			79,227			82,030

Note a

Other income includes £5.7m provision linked to clawback for clinical income services, (2024/25: £0k), £2.5m staff recharges - staff secondments to Somerset Council/Department of Work and Pensions' deaf members, early intervention, medical staff recharging and the temporary re-sited commissioning of maternity services (2024/25: £2.3m), £1.8m staff accommodation rental (2024/25: £1.8m), £1.3m car parking (2024/25: £1.3m) and £1.5m catering (2024/25: £1.5m).

Note 4.1 Other operating income (Trust)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	4,885	-	**4,885**	4,199	-	**4,199**
Education and training	54,309	-	**54,309**	52,234	-	**52,234**
Non-patient care services to other bodies	11,044	-	**11,044**	12,043	-	**12,043**
Income in respect of employee benefits accounted on a gross basis	781	-	**781**	1,152	-	**1,152**
Receipt of capital grants and donations and peppercorn leases	-	527	**527**	-	2,538	**2,538**
Revenue from operating leases	-	177	**177**	-	331	**331**
Amortisation of PFI deferred income / credits	-	259	**259**	-	259	**259**
Other income (Note a)	12,638	-	**12,638**	13,688	-	**13,688**
Total other operating income	**83,657**	**963**	**84,620**	**83,316**	**3,128**	**86,444**
Of which:						
Related to continuing operations			84,620			86,444

Note a

Other income includes £5.7m provision linked to clawback for clinical income services, (2024/25: £0k), £2.5m staff recharges - staff secondments to Somerset Council/Department of Work and Pensions' deaf members, early intervention, medical staff recharging and the temporary re-sited commissioning of maternity services (2024/25: £2.3m), £1.8m staff accommodation rental (2024/25: £1.8m), £1.5m catering (2024/25: £1.5m), £1.3m car parking (2024/25: £1.3m),and £0.6m for the recharge linked to SSL (2024/25: £0.5m).

Note 5 Income from activities arising from commissioner requested services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Income from services designated as commissioner requested services	1,117,381	1,065,913	1,081,705	1,029,600
Income from services not designated as commissioner requested services	94,508	97,634	100,373	100,466
Total	**1,211,889**	**1,163,547**	**1,182,078**	**1,130,066**

Note 5.1 Profits and losses on disposal of property, plant and equipment

During 2025/26, there was £13k loss on disposal of a building that was surplus to requirements. NBV of £496k with disposal proceeds of £483k.

(2024/25: there was £1,041k loss on disposal of the Trust investment in SSL. Transacted to allign the treatment in the Group and Trust accounts where the Trust accounts had previously re-measured at fair value (Trust: £14,988k, SSL: £13,948k, Group: £0k after consolidation)).

Note 6 Operating leases - Somerset NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where No trust selected is the lessor.

Note 6.1 Operating leases income (Group & Trust)

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	177	331
Total in-year operating lease income	**177**	**331**

Note 6.2 Future lease receipts (Group & Trust)

	2026	2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	177	331
Total	**177**	**331**

Note 7 Operating expenses

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	554	417	781	335
Purchase of healthcare from non-NHS and non-DHSC bodies	27,785	13,466	49,473	47,110
Staff and executive directors costs	837,713	797,397	796,507	757,417
Remuneration of non-executive directors	158	152	158	152
Supplies and services - clinical (excluding drugs costs)	85,827	82,339	90,517	83,546
Supplies and services - general	37,113	37,029	30,389	29,797
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	84,749	95,779	88,933	87,969
Consultancy costs	51	66	20	48
Establishment	13,324	12,192	11,560	10,341
Premises	24,158	20,644	18,144	17,993
Transport (including patient travel)	1,518	2,054	1,425	1,317
Depreciation on property, plant and equipment	36,562	31,169	36,306	30,909
Amortisation on intangible assets	8,491	9,102	8,453	9,015
Net impairments	20,112	27,208	20,112	27,208
Movement in credit loss allowance: contract receivables / contract assets	87	87	87	87
Movement in credit loss allowance: all other receivables and investments	(137)	(386)	(200)	(386)
Increase/(decrease) in other provisions	(327)	2,967	(4)	2,448
Change in provisions discount rate(s)	107	(65)	107	(65)
Fees payable to the external auditor				
audit services- statutory audit	283	260	226	207
Internal audit costs	171	184	171	184
Clinical negligence	22,396	22,083	22,754	22,083
Legal fees	772	1,411	586	1,214
Insurance (as a policy holder)	1,024	970	740	713
Research and development	11	21	11	20
Education and training	2,538	2,915	2,415	2,791
Expenditure on low value leases	1,140	862	1,075	917
Redundancy	947	562	943	562
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	6,582	5,469	5,716	5,470
Car parking & security	493	426	188	426
Hospitality	-	20	-	20
Losses, ex gratia & special payments	88	253	86	253
Subscriptions	406	409	388	399
Interpreting costs	799	853	799	853
Other	1,529	12,645	3,263	9,885
Total	**1,217,024**	**1,180,960**	**1,192,129**	**1,151,238**
Of which:				
Related to continuing operations	1,217,024	1,180,960	1,192,129	1,151,238

Note 7.1 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 8 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	8,975
Changes in market price (Note a)	20,112	18,233
Total net impairments charged to operating surplus / deficit	**20,112**	**27,208**
Impairments charged to the revaluation reserve (Note a)	14,362	12,779
Total net impairments	**34,474**	**39,987**

Note a

During 2025/26, a desktop valuation exercise to update the latest carrying values of Land, Buildings and Dwellings with a valuation date of 31 March 2026 was undertaken by Cushman & Wakefield DTZ valuing the MEA re-modelled by NTW Solutions Ltd. The Trust's specialised buildings and associated land were valued using the depreciated replacement cost method, based upon provision of a modern equivalent asset (MEA). The changes in market price: £20,112k reflected the building cost index reduction (locality factor).

During 2024/25; a full valuation was booked in the accounts in March 2025 and changes in market price equated to £18,233k.

Note 9 Employee benefits

	Group		Trust	
	2025/26 Total £000	2024/25 Total £000	2025/26 Total £000	2024/25 Total £000
Salaries and wages	584,954	559,853	548,797	523,331
Social security costs	80,210	59,578	76,293	58,663
Apprenticeship levy	2,953	2,827	2,900	2,776
Employer's contributions to NHS pensions *	121,489	112,354	117,550	111,283
Pension cost - other	91	2,610	83	111
Termination benefits	947	562	943	562
Temporary staff (including agency)	54,680	67,010	50,884	61,253
Total gross staff costs	**845,324**	**804,794**	**797,450**	**757,979**
Total staff costs	**845,324**	**804,794**	**797,450**	**757,979**
Of which				
Costs capitalised as part of assets	6,664	6,835	6,606	6,835

*Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHSE. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHSE on providers' behalf. The full cost of employer contributions; 23.7%, (2024/25: 23.7%) and related NHSE funding; 9.4%, (2024/25: 9.4%) have been recognised in these accounts.

Note 9.1 Retirements due to ill-health (Group & Trust)

During 2025/26 there were 16 early retirements from the Trust agreed on the grounds of ill-health (14 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £637k (£1,017k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Interest on bank accounts	2,149	3,801	2,149	3,314
Interest income on finance leases	-	-	506	636
Total finance income	**2,149**	**3,801**	**2,655**	**3,950**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing. The Trust incurred no late payments for commercial debts (interest) during 2025/26

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Interest expense:				
Interest on loans from the Department of Health and Social Care	91	106	91	106
Interest on other loans	151	39	1,032	1,075
Interest on lease obligations	1,105	960	1,152	856
Finance costs on PFI, LIFT and other service concession arrangements:				
Main finance costs	1,355	1,268	1,355	1,249
Remeasurement of the liability resulting from change in index or rate	411	2,767	410	2,767
Total interest expense	**3,113**	**5,140**	**4,040**	**6,053**
Unwinding of discount on provisions	102	50	166	(15)
Other finance costs	-	-	-	20
Total finance costs	**3,215**	**5,190**	**4,206**	**6,058**

Note 13 Other gains / (losses)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Losses on disposal of assets (Note a)	(13)	(1,039)	(13)	(1,041)
Total gains / (losses) on disposal of assets	**(13)**	**(1,039)**	**(13)**	**(1,041)**

Note a

During 2025/26, there was £13k loss on disposal (cost of sale) of a building that was surplus to requirements. NBV of £496k with disposal proceeds of £483k.

(2024/25: there was £1,039k loss on disposal of the Trust investment in SSL. Transacted to allign the treatment in the Group and Trust accounts where the Trust accounts had previously re-measured at fair value (Trust: £14,987k, SSL: £13,948k, Group: £0k after consolidation).

Note 14 Intangible assets - 2025/26

Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**66,425**	**10,242**	**76,668**
Additions	3,192	22,809	**26,001**
Reclassifications	(2,987)	-	**(2,987)**
Disposals / derecognition	(19,991)	-	**(19,991)**
Cost at 31 March 2026	**46,639**	**33,051**	**79,691**
Amortisation at 1 April 2025 - brought forward	**45,976**	**-**	**45,976**
Provided during the year	8,491	-	**8,491**
Reclassifications	(980)	-	**(980)**
Disposals / derecognition	(19,991)	-	**(19,991)**
Amortisation at 31 March 2026	**33,496**	**-**	**33,496**
Net book value at 31 March 2026	**13,143**	**33,051**	**46,195**
Net book value at 1 April 2025	**20,449**	**10,242**	**30,692**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 14.1 Intangible assets - 2024/25

Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**58,193**	**9,643**	**67,837**
Additions	3,839	4,992	**8,831**
Reclassifications	4,393	(4,393)	**-**
Valuation / gross cost at 31 March 2025	**66,425**	**10,242**	**76,668**
Amortisation at 1 April 2024 - as previously stated	**36,874**	**-**	**36,874**
Provided during the year	9,102	-	**9,102**
Amortisation at 31 March 2025	**45,976**	**-**	**45,976**
Net book value at 31 March 2025	**20,449**	**10,242**	**30,692**
Net book value at 1 April 2024	**21,319**	**9,643**	**30,963**

Note 15 Intangible assets - 2025/26

Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**65,168**	**9,854**	**75,022**
Additions	3,193	22,809	**26,002**
Reclassifications	(2,987)	-	**(2,987)**
Disposals / derecognition	(19,991)	-	**(19,991)**
Cost at 31 March 2026	**45,383**	**32,663**	**78,046**
Amortisation at 1 April 2025 - brought forward	**44,370**	**-**	**44,370**
Provided during the year	8,455	-	**8,455**
Reclassifications	(980)	-	**(980)**
Disposals / derecognition	(19,991)	-	**(19,991)**
Amortisation at 31 March 2026	**31,854**	**-**	**31,854**
Net book value at 31 March 2026	**13,529**	**32,663**	**46,192**
Net book value at 1 April 2025	**20,798**	**9,854**	**30,652**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 15.1 Intangible assets - 2024/25

Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**56,938**	**9,255**	**66,193**
Additions	3,837	4,992	**8,829**
Reclassifications	4,393	(4,393)	**-**
Valuation / gross cost at 31 March 2025	**65,168**	**9,854**	**75,022**
Amortisation at 1 April 2024 - as previously stated	**35,348**	**-**	**35,348**
Provided during the year	9,022	-	**9,022**
Amortisation at 31 March 2025	**44,370**	**-**	**44,370**
Net book value at 31 March 2025	**20,798**	**9,854**	**30,652**
Net book value at 1 April 2024	**21,590**	**9,255**	**30,845**

Note 16 Property, plant and equipment - 2025/26

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**7,461**	**226,828**	**6,569**	**146,281**	**146,854**	**124**	**40,871**	**10,410**	**585,397**
Additions	-	11,883	81	67,521	2,259	-	1,797	898	**84,439**
Impairments	(3)	(42,985)	(827)	-	-	-	-	-	**(43,815)**
Reversals of impairments	221	1,336	-	-	-	-	-	-	**1,557**
Revaluations	23	3,319	70	-	-	-	-	-	**3,412**
Reclassifications	(8)	2,056	264	(22,467)	(3,341)	(4)	818	209	**(22,473)**
Disposals / derecognition	-	-	-	-	(392)	-	-	-	**(392)**
Valuation/gross cost at 31 March 2026	**7,694**	**202,437**	**6,157**	**191,335**	**145,380**	**120**	**43,486**	**11,517**	**608,125**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**11,378**	**721**	**-**	**90,944**	**102**	**31,721**	**8,302**	**143,167**
Provided during the year	-	9,507	225	-	12,974	7	4,859	829	**28,401**
Impairments	-	(7,319)	(181)	-	-	-	-	-	**(7,500)**
Reversals of impairments	-	(284)	-	-	-	-	-	-	**(284)**
Revaluations	-	(305)	(4)	-	-	-	-	-	**(309)**
Reclassifications	-	(10,903)	-	-	(11,672)	(2)	(1,510)	(393)	**(24,480)**
Disposals / derecognition	-	-	-	-	(392)	-	-	-	**(392)**
Accumulated depreciation at 31 March 2026	**-**	**2,074**	**761**	**-**	**91,854**	**107**	**35,070**	**8,738**	**138,603**
Net book value at 31 March 2026	**7,694**	**200,364**	**5,396**	**191,335**	**53,526**	**13**	**8,416**	**2,779**	**469,522**
Net book value at 1 April 2025	**7,461**	**215,451**	**5,848**	**146,281**	**55,910**	**22**	**9,150**	**2,108**	**442,230**

Note 16.1 Property, plant and equipment - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**9,555**	**233,061**	**7,414**	**129,836**	**133,582**	**124**	**37,283**	**9,535**	**560,389**
Additions	-	10,047	-	52,109	7,343	-	2,871	540	**72,910**
Impairments	(2,716)	(42,440)	(1,024)	(8,975)	-	-	-	-	**(55,155)**
Reversals of impairments	331	3,314	31	-	-	-	-	-	**3,676**
Revaluations	291	4,177	148	-	-	-	-	-	**4,616**
Reclassifications	-	19,708	-	(26,689)	5,929	-	717	335	**-**
Disposals / derecognition	-	(1,039)	-	-	-	-	-	-	**(1,039)**
Valuation/gross cost at 31 March 2025	**7,461**	**226,828**	**6,569**	**146,281**	**146,854**	**124**	**40,871**	**10,410**	**585,397**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**17,819**	**984**	**-**	**80,183**	**92**	**28,392**	**7,654**	**135,123**
Provided during the year	-	8,338	267	-	10,761	10	3,329	648	**23,353**
Impairments	-	(9,363)	(433)	-	-	-	-	-	**(9,796)**
Reversals of impairments	-	(1,659)	(7)	-	-	-	-	-	**(1,666)**
Revaluations	-	(3,757)	(90)	-	-	-	-	-	**(3,847)**
Accumulated depreciation at 31 March 2025	**-**	**11,378**	**721**	**-**	**90,944**	**102**	**31,721**	**8,302**	**143,167**
Net book value at 31 March 2025	**7,461**	**215,451**	**5,848**	**146,281**	**55,910**	**22**	**9,150**	**2,108**	**442,230**
Net book value at 1 April 2024	**9,555**	**215,243**	**6,430**	**129,836**	**53,399**	**32**	**8,891**	**1,881**	**425,266**

Note 16.2 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,693	177,895	5,396	181,683	40,528	12	8,415	2,779	**424,400**
On-SoFP PFI contracts and other service concession arrangements	-	16,836	-	-	9,790	-	-	-	**26,626**
Owned - donated/granted	-	5,631	-	9,657	3,208	-	-	-	**18,496**
NBV total at 31 March 2026	**7,693**	**200,362**	**5,396**	**191,340**	**53,526**	**12**	**8,415**	**2,779**	**469,522**

Note 16.3 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	7,460	189,823	5,848	143,306	41,145	19	9,149	1,937	**398,686**
On-SoFP PFI contracts and other service concession arrangements	-	17,611	-	-	10,372	-	-	-	**27,983**
Owned - donated/granted	-	8,015	-	2,980	4,393	2	-	171	**15,561**
NBV total at 31 March 2025	**7,460**	**215,449**	**5,848**	**146,286**	**55,910**	**21**	**9,149**	**2,108**	**442,230**

Note 16.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	7,693	200,362	5,396	191,340	53,526	12	8,415	2,779	**469,522**
NBV total at 31 March 2026	**7,693**	**200,362**	**5,396**	**191,340**	**53,526**	**12**	**8,415**	**2,779**	**469,522**

Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	7,460	215,449	5,848	146,286	55,910	21	9,149	2,108	**442,230**
NBV total at 31 March 2025	**7,460**	**215,449**	**5,848**	**146,286**	**55,910**	**21**	**9,149**	**2,108**	**442,230**

Note 17 Property, plant and equipment - 2025/26

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**6,561**	**197,572**	**5,984**	**147,988**	**128,472**	**117**	**38,640**	**8,570**	**533,904**
Additions	-	11,884	81	67,520	2,259	-	1,766	329	**83,839**
Impairments	(11)	(38,199)	(820)	-	-	-	-	-	**(39,030)**
Reversals of impairments	221	1,328	-	-	-	-	-	-	**1,549**
Revaluations	24	3,221	70	-	-	-	-	-	**3,315**
Reclassifications		2,195	122	(22,467)	(3,341)		818	209	**(22,464)**
Disposals / derecognition	-	(1,014)	-	-	(64)	-	-	-	**(1,078)**
Valuation/gross cost at 31 March 2026	**6,795**	**176,987**	**5,437**	**193,041**	**127,326**	**117**	**41,224**	**9,108**	**560,035**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**1,130**	**(0)**	**-**	**76,150**	**96**	**29,903**	**7,164**	**114,442**
Provided during the year	-	8,736	225	-	12,869	7	4,828	714	**27,379**
Impairments	-	(6,653)	(181)	-	-	-	-	-	**(6,834)**
Reversals of impairments	-	(280)	-	-	-	-	-	-	**(280)**
Revaluations	-	(203)	(4)	-	-	-	-	-	**(207)**
Reclassifications	-	(10,896)	-	-	(11,672)		(1,510)	(393)	**(24,471)**
Disposals / derecognition	-	-	-	-	(64)	-	-	-	**(64)**
Accumulated depreciation at 31 March 2026	**-**	**(8,166)**	**40**	**-**	**77,283**	**103**	**33,221**	**7,485**	**109,965**
Net book value at 31 March 2026	**6,795**	**185,153**	**5,397**	**193,041**	**50,043**	**14**	**8,003**	**1,623**	**450,069**
Net book value at 1 April 2025	**6,561**	**196,442**	**5,984**	**147,988**	**52,322**	**21**	**8,737**	**1,406**	**419,462**

Note 17.1 Property, plant and equipment - 2024/25

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**8,245**	**195,167**	**6,695**	**129,973**	**116,824**	**117**	**35,065**	**7,991**	**500,077**
Additions	-	10,047	-	53,679	5,719	-	2,858	244	**72,547**
Impairments	(2,306)	(34,661)	(1,024)	(8,975)	-	-	-	-	**(46,966)**
Reversals of impairments	331	3,287	31	-	-	-	-	-	**3,649**
Revaluations	291	4,158	148	-	-	-	-	-	**4,597**
Reclassifications (Note a)	-	20,613	134	(26,689)	5,929	-	717	335	**1,039**
Disposals / derecognition (Note a)	-	(1,039)	-	-	-	-	-	-	**(1,039)**
Valuation/gross cost at 31 March 2025	**6,561**	**197,572**	**5,984**	**147,988**	**128,472**	**117**	**38,640**	**8,570**	**533,904**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**6,649**	**262**	**-**	**65,468**	**86**	**26,588**	**6,652**	**105,704**
Provided during the year	-	7,346	267	-	10,682	10	3,315	512	**22,132**
Impairments	-	(7,424)	(432)	-	-	-	-	-	**(7,856)**
Reversals of impairments	-	(1,686)	(7)	-	-	-	-	-	**(1,693)**
Revaluations	-	(3,755)	(90)	-	-	-	-	-	**(3,845)**
Accumulated depreciation at 31 March 2025	**-**	**1,130**	**(0)**	**-**	**76,150**	**96**	**29,903**	**7,164**	**114,442**
Net book value at 31 March 2025	**6,561**	**196,442**	**5,984**	**147,988**	**52,322**	**21**	**8,737**	**1,406**	**419,462**
Net book value at 1 April 2024	**8,245**	**188,518**	**6,433**	**129,973**	**51,356**	**31**	**8,477**	**1,339**	**394,373**

Note a

2024/25: there was £1,039k loss on disposal of the Trust investment in SSL. Transacted to allign the treatment in the Group and Trust accounts where the Trust accounts had previously re-measured at fair value (Trust: £14,987k, SSL: £13,948k, Group: £0k after consolidation.

Note 17.2 Property, plant and equipment financing - 31 March 2026

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	6,795	179,522	5,397	183,384	46,835	14	8,003	1,212	**431,162**
Owned - donated / granted	-	5,631	-	9,657	3,208	-	-	411	**18,907**
Total net book value at 31 March 2026	**6,795**	**185,153**	**5,397**	**193,041**	**50,043**	**14**	**8,003**	**1,623**	**450,069**

Note 17.3 Property, plant and equipment financing - 31 March 2025

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	6,561	170,816	5,984	145,008	37,557	19	8,737	1,235	**375,918**
On-SoFP PFI contracts and other service concession arrangements	-	17,611	-	-	10,372	-	-	-	**27,983**
Owned - donated / granted	-	8,015	-	2,980	4,393	2	-	171	**15,561**
Total net book value at 31 March 2025	**6,561**	**196,442**	**5,984**	**147,988**	**52,322**	**21**	**8,737**	**1,406**	**419,462**

Note 17.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	6,795	185,153	5,397	193,041	50,043	14	8,003	1,623	**450,069**
Total net book value at 31 March 2026	**6,795**	**185,153**	**5,397**	**193,041**	**50,043**	**14**	**8,003**	**1,623**	**450,069**

Note 17.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Not subject to an operating lease	6,561	196,442	5,984	147,988	52,322	21	8,737	1,406	**419,462**
Total net book value at 31 March 2025	**6,561**	**196,442**	**5,984**	**147,988**	**52,322**	**21**	**8,737**	**1,406**	**419,462**

Note 18 Donations of property, plant and equipment

During 2025/256, £938,000 was donated to the Group, £411,000 donated for general renovations for furniture and fittings, £372,000 for carbon efficiency fund and £110,000 for an ultrasound machine.

(2024/25: donations of £2,538,000 were donated to the Trust; £1,285,000 donated for the Breast Care Centre, Yeovil, £954,000 for carbon efficiency scheme with the balance relating to buildings (2023/24: donations of £3,159,000 were donated to the Trust, £1,400,000 donated for the Breast Care Centre, Yeovil, £1,400,000 for the Surgical Robot with the balance relating to equipment).

There were no restrictions on the use of donated assets.

Note 19 Revaluations of property, plant and equipment

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. During 2025/26, a desktop valuation exercise to update the latest carrying values of Land, Buildings and Dwellings with a valuation date of 31 March 2026 was undertaken by Cushman & Wakefield DTZ valuing the MEA re-modelled by NTW Solutions Ltd.

The changes in market price: £20,112k was amended to draw out the MEA changes, there are currently three MEA models, one 3 hub model for community and mental health, a model at Musgrove Park Hospital and another model at Yeovil District Hospital.

The key judgements driving Land, buildings and dwellings valuations are:

- Building cost index reduction;
- Increased obsolescence factors, particularly in healthcare patient flow areas for ventilation health regulations;
- Valuation of buildings, dwellings and external works on the Yeovil estate associated with Simply Serve Ltd (subsidiary) have been valued net of VAT on the basis SSL can recover the associated VAT. Buildings, dwellings and external works for the Musgrove Park hospital estate, community and mental health sites centres and health centres within Symphony Healthcare Services (SHS) have been valued gross of VAT.

A 1% change in the valuation would have a £2.1m impact on the Statement of Financial Position (2024/25: £2.2m) with a £37k change on the PDC dividend due to be paid next year (2024/25: £38k). There are multiple assumtions built into the 3 MEA models accross the Trust sites, changes to these assumptions would materially affect the financial statements from the valuation.

(2024/25: Full valuation exercise took place, changes in market price equated to £18,233k)

Note 20 Right of use assets - 2025/26

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**110,982**	**2,860**	**427**	**114,269**	**19,220**
Additions	1,377	-	118	**1,495**	-
Remeasurements of the lease liability	6,144	-	-	**6,144**	438
Valuation/gross cost at 31 March 2026	**118,503**	**2,860**	**545**	**121,908**	**19,658**
Accumulated depreciation at 1 April 2025 - brought forward	**22,719**	**829**	**254**	**23,802**	**5,666**
Provided during the year	7,751	226	184	**8,161**	1,841
Accumulated depreciation at 31 March 2026	**30,470**	**1,055**	**438**	**31,963**	**7,507**
Net book value at 31 March 2026	**88,033**	**1,805**	**107**	**89,945**	**12,151**
Net book value at 1 April 2025	**88,263**	**2,031**	**173**	**90,467**	**13,554**
Net book value of right of use assets leased from other NHS providers					371
Net book value of right of use assets leased from other DHSC group bodies					11,501

Note 20.1 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**96,945**	**2,483**	**227**	**99,655**	**17,193**
Additions	8,672	377	200	**9,249**	-
Remeasurements of the lease liability	5,365	-	-	**5,365**	2,027
Valuation/gross cost at 31 March 2025	**110,982**	**2,860**	**427**	**114,269**	**19,220**
Accumulated depreciation at 1 April 2024 - brought forward	**15,281**	**612**	**93**	**15,986**	**3,712**
Provided during the year	7,438	217	161	**7,816**	1,954
Accumulated depreciation at 31 March 2025	**22,719**	**829**	**254**	**23,802**	**5,666**
Net book value at 31 March 2025	**88,263**	**2,031**	**173**	**90,467**	**13,554**
Net book value at 1 April 2024	**81,664**	**1,871**	**134**	**83,669**	**13,481**
Net book value of right of use assets leased from other NHS providers					742
Net book value of right of use assets leased from other DHSC group bodies					12,533

Note 21 Right of use assets - 2025/26

Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**108,623**	**7,122**	**478**	**227**	**268**	**116,718**	**19,221**
Additions	1,377	-	103	-	-	**1,480**	-
Remeasurements of the lease liability	5,438	-	-	-	-	**5,438**	438
Impairments	(4,731)	-	-	-	-	**(4,731)**	-
Reversal of impairments	8	-	-	-	-	**8**	-
Revaluations	96	-	-	-	-	**96**	-
Disposals / derecognition	-	(328)	-	-	-	**(328)**	-
Valuation/gross cost at 31 March 2026	**110,811**	**6,794**	**581**	**227**	**268**	**118,681**	**19,659**
Accumulated depreciation at 1 April 2025 - brought forward	18,151	3,720	289	227	252	**22,639**	4,186
Provided during the year	6,627	288	128	-	12	**7,055**	1,841
Impairments	(640)	-	-	-	-	**(640)**	-
Reversal of impairments	(4)	-	-	-	-	**(4)**	-
Revaluations	(103)	-	-	-	-	**(103)**	-
Disposals / derecognition	-	(328)	-	-	-	**(328)**	
Accumulated depreciation at 31 March 2026	**24,031**	**3,680**	**417**	**227**	**264**	**28,619**	**6,027**
Net book value at 31 March 2026	**86,780**	**3,114**	**164**	**-**	**4**	**90,062**	**13,632**
Net book value at 1 April 2025	**90,472**	**3,402**	**189**	**-**	**16**	**94,079**	**15,035**
Net book value of right of use assets leased from other NHS providers							371
Net book value of right of use assets leased from other DHSC group bodies							11,576

Note 21.1 Right of use assets - 2024/25

Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**102,705**	**6,745**	**368**	**227**	**268**	**110,313**	**17,194**
Additions	8,672	377	110	-	-	**9,159**	-
Remeasurements of the lease liability	5,265	-	-	-	-	**5,265**	2,027
Impairments	(8,037)	-	-	-	-	**(8,037)**	-
Revaluations	18	-	-	-	-	**18**	-
Valuation/gross cost at 31 March 2025	**108,623**	**7,122**	**478**	**227**	**268**	**116,718**	**19,221**
Accumulated depreciation at 1 April 2024 - brought forward	**13,407**	**3,434**	**161**	**227**	**232**	**17,461**	**2,679**
Provided during the year	6,710	286	128	-	20	**7,144**	1,507
Impairments	(1,044)	-	-	-	-	**(1,044)**	-
Revaluations	(922)	-	-	-	-	**(922)**	-
Accumulated depreciation at 31 March 2025	**18,151**	**3,720**	**289**	**227**	**252**	**22,639**	**4,186**
Net book value at 31 March 2025	**90,472**	**3,402**	**189**	**-**	**16**	**94,079**	**15,035**
Net book value at 1 April 2024	**89,298**	**3,311**	**207**	**-**	**36**	**92,852**	**14,515**
Net book value of right of use assets leased from other NHS providers							742
Net book value of right of use assets leased from other DHSC group bodies							12,609

Note 21.2 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 30.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	**89,871**	**83,395**	**103,846**	94,696
Lease additions	1,495	9,249	5,094	9,219
Lease liability remeasurements	6,144	5,365	2,405	5,206
Interest charge arising in year	1,105	960	828	1,697
Lease payments (cash outflows)	(9,207)	(9,098)	(8,542)	(9,351)
Other changes	630	-	(8)	2,379
Carrying value at 31 March	**90,038**	**89,871**	**103,623**	**103,846**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 21.3 Maturity analysis of future lease payments at 31 March 2026

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	8,718	1,751	10,109	1,751
- later than one year and not later than five years;	29,821	5,523	32,665	5,523
- later than five years.	65,228	5,505	82,019	5,505
Total gross future lease payments	**103,767**	**12,779**	**124,793**	**12,779**
Finance charges allocated to future periods	(13,729)	(499)	(21,169)	(499)
Net lease liabilities at 31 March 2026	**90,038**	**12,280**	**103,624**	**12,280**
Of which:				
Leased from other NHS providers		817		817
Leased from other DHSC group bodies		11,463		11,463

Note 21.4 Maturity analysis of future lease payments at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	7,306	2,435	7,839	1,532
- later than one year and not later than five years;	27,635	5,863	30,057	5,485
- later than five years.	69,245	6,668	89,573	6,668
Total gross future lease payments	**104,186**	**14,966**	**127,469**	**13,685**
Finance charges allocated to future periods	(14,315)	(628)	(23,623)	(405)
Net finance lease liabilities at 31 March 2025	**89,871**	**14,338**	**103,846**	**13,280**
Of which:				
Leased from other NHS providers		1,116		1,116
Leased from other DHSC group bodies		13,222		13,222

Note 22 Investments in associates and joint ventures

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**14**	**14**	**-**	**-**
Carrying value at 31 March	**14**	**14**	**-**	**-**

Note 23 Other investments / financial assets (non-current)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**14**	**14**	**14**	**14**
Carrying value at 31 March (Note a)	**14**	**14**	**14**	**14**

Note a

On 4 May 2021 the Trust received 1,428,571 of ordinary shares in Sensyne Plc. The agreement allows for the Trust to provide anonymised datasets, compliant to Information Commissioner Officer's standards, and to undertake jointly funded research across all parties. The share price at the Initial Price Offering (IPO) was 174p per share giving the Trust an investment value of £2,485,714 however the Trust is locked into holding the shares for up to 2 years. The Trust has made the decision to recognise the investment as Fair Value through other comprehensive income (FVOCI) given the equities are not held for trading and as part of a long term strategic relationship. The Trust has recognised the initial investment, under IFRS 15, fully as revenue in 2021/22 as the Trust has received the shares and satisfied all explicit performance obligations contained within the Strategic Relationship Agreement and continue to work in partnership with Sensyne Plc. The Trust will treat any subsequent gains or losses through the Financial Assets reserve.

During 2025/26: no change in share holding or value.

(2024/25: Arcturis secured Sensyne Health plc through a refinancing deal that involved secured loans and, ultimately, a significant restructuring of the company's ownership and operations. This included a conversion of shareholder loans. Arturis delisted from the AIM during 2024/25).

Note 23.1 Movement in Investment in Subsidiary Undertakings

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	-	-	13,948	14,988
Disposals	-	-	-	(1,039)
Carrying value at 31 March	**-**	**-**	**13,948**	**13,948**

Note 24 Inventories

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Drugs	4,400	4,257	3,637	3,565
Consumables	8,256	6,796	6,744	5,413
Energy	366	229	360	220
Total inventories	**13,022**	**11,281**	**10,741**	**9,198**

Inventories recognised in expenses for the year were £95,944k (2024/25: £95,779k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 25 Receivables

	Group		Trust	
	2026	2025	2026	2025
	£000	£000	£000	£000
Current				
Contract receivables	19,957	11,777	17,728	6,022
Amounts owed by group undertakings	-	-	3,748	3,216
Capital receivables	17	17	17	17
Allowance for impaired contract receivables / assets	(140)	(149)	(140)	(149)
Allowance for other impaired receivables	(689)	(826)	(626)	(826)
Prepayments (non-PFI)	6,943	7,135	5,544	5,718
PDC dividend receivable	62	603	63	603
VAT receivable	5,348	5,550	6,271	5,104
Other receivables	1,756	26	1,722	5,310
Total current receivables	**33,254**	**24,133**	**34,327**	**25,015**
Non-current				
Contract receivables	3,111	2,641	2,940	2,566
Amounts owed by group undertakings	-	-	9,583	13,139
Allowance for impaired contract receivables / assets	(723)	(627)	(724)	(627)
Other receivables	953	1,049	1,075	1,075
Total non-current receivables	**3,341**	**3,063**	**12,874**	**16,153**
Of which receivable from NHS and DHSC group bodies:				
Current	10,961	10,226	10,961	10,226
Non-current	953	1,049	953	1,049

Note 25.1 Allowances for credit losses - 2025/26

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2025 - brought forward	**776**	**826**	**776**	**826**
New allowances arising	140	689	140	626
Changes in existing allowances	5	-	5	-
Reversals of allowances	(58)	(826)	(58)	(826)
Allowances as at 31 Mar 2026	**863**	**689**	**863**	**626**

Note 25.2 Allowances for credit losses - 2024/25

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2024 - as previously stated	**780**	**1,212**	**780**	**1,212**
New allowances arising	149	826	149	826
Changes in existing allowances	41	-	41	-
Reversals of allowances	(103)	(1,212)	(103)	(1,212)
Utilisation of allowances (write offs)	(91)	-	(91)	-
Allowances as at 31 Mar 2025	**776**	**826**	**776**	**826**

Note 26 Non-current assets held for sale and assets in disposal groups

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**496**	**466**	**496**	**466**
Assets sold in year	(496)	-	(496)	-
Reversal of impairment of assets held for sale	-	30	-	30
NBV of non-current assets for sale and assets in disposal groups at 31 March	**0**	**496**	**-**	**496**

During 2025/26: there was £13k loss on disposal of a building that was surplus to requirements. NBV of £496k with disposal proceeds of £483k.

2024/25: the building held for sale was revalued as part of the Trust valuation of its Land, buildings and dwellings.

Note 27 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**79,215**	**76,580**	**66,636**	**69,417**
Net change in year	32,621	2,635	31,609	(2,781)
At 31 March	**111,836**	**79,215**	**98,245**	**66,636**
Broken down into:				
Cash at commercial banks and in hand	13,807	12,900	216	321
Cash with the Government Banking Service (Note a)	98,029	66,315	98,029	66,315
Total cash and cash equivalents as in SoFP	**111,836**	**79,215**	**98,245**	**66,636**
Total cash and cash equivalents as in SoCF	**111,836**	**79,215**	**98,245**	**66,636**

Note a

Included in cash and cash equivalents is £28,155k held on behalf of partner Trusts for EHR suppplier payments under the Trust's role as lead provider. The corresponding entry sits in Trade and other payables "other payables".

Note 27.1 Third party assets held by the trust

Somerset NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients (£54k (2024/25: £53k). This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Bank balances	54	53
Total third party assets	**54**	**53**

Note 28 Trade and other payables

	Group		Trust	
	2026	2025	2026	2025
	£000	£000	£000	£000
Current				
Trade payables	17,293	9,318	19,738	22,143
Amounts owed by group undertakings	-	-	2	50
Capital payables	42,354	18,183	40,199	14,955
Accruals	56,892	64,460	53,168	50,297
Social security costs	8,678	7,150	8,536	7,045
VAT payables	-	343	-	-
Other taxes payable	7,477	7,786	7,617	7,172
Pension contributions payable	10,928	9,439	9,898	9,301
Other payables (Note a)	33,431	3,580	30,302	3,264
Total current trade and other payables	**177,053**	**120,259**	**169,460**	**114,227**
Of which payables from NHS and DHSC group bodies:				
Current	4,005	2,997	4,005	2,997

Note a

Included in other payables is £28,155k held on behalf of partner Trusts for EHR suppplier payments under the Trust's role as lead provider. The corresponding entry sits in Cash and cash equivalents.

Note 29 Other liabilities

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	11,815	18,196	10,800	17,481
Deferred PFI credits / income	259	259	259	259
Total other current liabilities	**12,074**	**18,455**	**11,059**	**17,740**
Non-current				
Deferred PFI credits / income	1,164	1,423	1,164	1,423
Total other non-current liabilities	**1,164**	**1,423**	**1,164**	**1,423**

Deferred PFI credits relate to a public private partnership project (PPP) for the building of a car park (completed in October 2006) and the provision of services for 25 years. The ownership of the building will pass to the Trust after the 25 year concession period. The residual value (assessed by professional valuation) is £4,468,000. Throughout this period, the operator pays an agreed proportion of the car parking fees to the Trust; no other financial transactions take place. Since 2009/10, this has been accounted for under International Financial Reporting Standards and the asset together with the outstanding liability is required to be accounted for in the Statement of Financial Position.

Note 30 Borrowings

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Loans from DHSC	671	675	671	675
Other loans	41	74	-	-
Lease liabilities	1,772	6,445	7,528	5,717
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	4,731	4,443	4,731	4,443
Total current borrowings	**7,215**	**11,637**	**12,930**	**10,835**
Non-current				
Loans from DHSC	2,928	3,576	2,928	3,576
Other loans	885	843	-	-
Lease liabilities	88,266	83,426	96,096	98,131
Obligations under PFI, LIFT or other service concession contracts	25,509	29,555	25,509	29,555
Total non-current borrowings	**117,588**	**117,400**	**124,533**	**131,262**

Note 30.1 Reconciliation of liabilities arising from financing activities

Group - 2025/26	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**4,251**	**917**	**89,871**	**33,998**	**129,037**
Cash movements:					
Financing cash flows - payments and receipts of principal	(648)	9	(8,102)	(3,371)	**(12,112)**
Financing cash flows - payments of interest	(96)	(51)	(1,105)	(1,281)	**(2,533)**
Non-cash movements:					
Additions	-	-	1,495	345	**1,840**
Lease liability remeasurements	-	-	6,144	-	**6,144**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	-	411	**411**
Application of effective interest rate	92	151	1,105	1,355	**2,703**
Change in effective interest rate	-	-	-	(1,217)	**(1,217)**
Other changes	-	(100)	630	-	**530**
Carrying value at 31 March 2026	**3,599**	**926**	**90,038**	**30,240**	**124,803**

Group - 2024/25	Loans from DHSC	Other loans	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**5,005**	**972**	**83,395**	**36,841**	**126,213**
Cash movements:					
Financing cash flows - payments and receipts of principal	(748)	(55)	(8,202)	(2,871)	**(11,876)**
Financing cash flows - payments of interest	(112)	(39)	(896)	(1,268)	**(2,315)**
Non-cash movements:					
Additions	-	-	9,249	1,655	**10,904**
Lease liability remeasurements	-	-	5,365	-	**5,365**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	-	2,767	**2,767**
Application of effective interest rate	106	39	960	1,268	**2,373**
Early terminations	-	-	-	(2,906)	**(2,906)**
Other changes	-	-	-	(1,488)	**(1,488)**
Carrying value at 31 March 2025	**4,251**	**917**	**89,871**	**33,998**	**129,037**

Note 30.2 Reconciliation of liabilities arising from financing activities

Trust - 2025/26	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2025	4,251	103,846	33,998	**142,095**
Cash movements:				
Financing cash flows - payments and receipts of principal	(648)	(7,714)	(3,370)	**(11,732)**
Financing cash flows - payments of interest	(96)	(828)	(1,281)	**(2,205)**
Non-cash movements:				
Additions	-	1,479	344	**1,823**
Lease liability remeasurements	-	6,021	-	**6,021**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	411	**411**
Application of effective interest rate	91	828	-	**919**
Other changes	-	(8)	139	**131**
Carrying value at 31 March 2026	**3,598**	**103,624**	**30,241**	**137,463**

Trust - 2024/25	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2024	**5,005**	**94,696**	**36,841**	**136,542**
Cash movements:				
Financing cash flows - payments and receipts of principal	(748)	(8,583)	(2,871)	**(12,202)**
Financing cash flows - payments of interest	(112)	(1,061)	(1,268)	**(2,441)**
Non-cash movements:				
Additions	-	9,218	1,655	**10,873**
Lease liability remeasurements	-	5,206	-	**5,206**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	2,767	**2,767**
Application of effective interest rate	106	1,696	1,268	**3,070**
Early terminations	-	-	(2,906)	**(2,906)**
Other changes	-	2,674	(1,488)	**1,186**
Carrying value at 31 March 2025	**4,251**	**103,846**	**33,998**	**142,095**

Note 31 Provisions for liabilities and charges analysis (Group)

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**457**	**1,269**	**136**	**10,449**	**12,311**
Change in the discount rate	13	93	-	(74)	**32**
Arising during the year	44	9	162	1,446	**1,661**
Utilised during the year	(75)	(109)	(95)	(205)	**(484)**
Reversed unused	-	(28)	(60)	(1,963)	**(2,051)**
Unwinding of discount	13	61	-	90	**164**
At 31 March 2026	**452**	**1,295**	**143**	**9,743**	**11,633**
Expected timing of cash flows:					
- not later than one year;	68	105	72	8,663	**8,908**
- later than one year and not later than five years;	255	395	71	248	**969**
- later than five years.	129	795	-	832	**1,756**
Total	**452**	**1,295**	**143**	**9,743**	**11,633**

Pensions: early departure costs

Pensions - early departure costs relate to Pre1995 early retirements. These are calculated on figures supplied by the NHS Pensions Agency and a significant amount of the payments are expected to be greater than one year.

Pensions: injury benefits

Injury Benefit provisions are based on figures supplied by the NHS Pensions Agency. A significant amount of the payments are expected to be for a period greater than 1 year.

Legal Claims

The provisions are based on the expected values and probabilities quantified by NHS Resolution. The outcome of these cases are inherently uncertain and the timing of payments is dependant on the progression of each case. The figures included in the summary are based purely on the Trust's excess reflecting the fact that the NHS Resolution makes the majority of payments direct. See also note 31.2.

Other

Provisions arising in year include clinical pension tax reimbursement (NHSE and the Government fully fund these payments), potential HMRC tax liabilities and potential workforce pension liabilities.

Note 31.1 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**458**	**1,269**	**137**	**9,633**	**11,497**
Change in the discount rate	12	93	-	(75)	**30**
Arising during the year	44	9	161	1,539	**1,753**
Utilised during the year	(75)	(109)	(95)	(108)	**(387)**
Reversed unused	-	(28)	(60)	(2,022)	**(2,110)**
Unwinding of discount	13	61	-	62	**136**
At 31 March 2026	**452**	**1,295**	**143**	**9,029**	**10,919**
Expected timing of cash flows:					
- not later than one year;	68	105	72	7,579	**7,824**
- later than one year and not later than five years;	255	395	71	121	**842**
- later than five years.	129	795	-	1,329	**2,253**
Total	**452**	**1,295**	**143**	**9,029**	**10,919**

Pensions: early departure costs

Pensions - early departure costs relate to Pre1995 early retirements. These are calculated on figures supplied by the NHS Pensions Agency and a significant amount of the payments are expected to be greater than one year.

Pensions: injury benefits

Injury Benefit provisions are based on figures supplied by the NHS Pensions Agency. A significant amount of the payments are expected to be for a period greater than 1 year.

Legal Claims

The provisions are based on the expected values and probabilities quantified by NHS Resolution. The outcome of these cases are inherently uncertain and the timing of payments is dependant on the progression of each case. The figures included in the summary are based purely on the Trust's excess reflecting the fact that the NHS Resolution makes the majority of payments direct. See also note 31.2.

Other

Provisions arising in year include clinical pension tax reimbursement (NHSE and the Government fully fund these payments), potential HMRC tax liabilities and potential workforce pension liabilities.

Note 31.2 Clinical negligence liabilities

At 31 March 2026, £339,602k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Somerset NHS Foundation Trust (31 March 2025: £336,440k).

Note 32 Contingent assets and liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities				
NHS Resolution legal claims	(57)	(35)	(57)	(35)
Gross value of contingent liabilities	**(57)**	**(35)**	**(57)**	**(35)**

Note 33 Contractual capital commitments

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	8,555	16,171	6,255	11,054
Intangible assets (Note a)	41,163	813	41,163	670
Total	**49,718**	**16,984**	**47,418**	**11,724**

Note a
Intangible assets includes £41.1m of contractual committments for the Trust EHR system.

Note 33 On-SoFP PFI, LIFT or other service concession arrangements

Note 33.1 The Beacon Centre

The project agreement is with the Taunton Linac Company Limited (the operator) for the provision of an Oncology and Haematology Centre on the Musgrove Park Hospital site (The Beacon Centre) including the supply and maintenance of the building and major medical equipment within the facility. The facility opened in May 2009 and provides state of the art non-surgical cancer services to the residential population of Somerset, in a suitable location and setting at Somerset NHS Foundation Trust. The new Oncology and Haematology Centre provides:

- Two Linear Accelerators (a third has been purchased by the Trust);
- One simulation suite with processing and treatment planning facilities;
- 18 bed Oncology Ward;
- Chemotherapy suite for 22 day patients;
- Outpatients suite with 4 consulting and 8 examination rooms.

Key Features of the Scheme:

In return for an agreed monthly payment, the following facilities are provided to the Trust by the Operator plus associated hard Facilities Management and asset renewal services:

- Inpatient and Outpatient facilities;
- Radiotherapy treatment area;
- Administrative offices;
- Public spaces.

Under the Project Agreement, the above facilities are provided at a pre-determined level of quality for the 30 year term (excluding the construction period).

The operator has also procured, installed, and will maintain and replace major medical equipment for the full 30 years of the operating period. The major equipment requirements include two Linear Accelerators. However, soft Facilities Management services such as portering, catering and cleaning are provided by the Trust and are outside the scope of this PFI project.

Nature of Payment

The Operator provides the services in return for an annual service charge. In covering payment for facilities, other services and financing, the annual service charge is unitary in nature. The Trust has agreed a payment mechanism that incorporates the principles of the NHS Standard Form contract. This relates payment to the successful (or otherwise) achievement of the service and quality standards set out in the output specification. The unitary payment can be abated for instances of non-performance against the standards in the output specification up to a maximum of 100% of the unitary fee, which fall into three areas:

i) Failure events – where there is a failure to meet a specific service standard relating to a particular area of the hospital;
ii) Failure events – relating to the Radiotherapy Equipment;
iii) Quality failures – where there is a failure to supply a service across a wider range of parameters, which cannot be attributed to a specific area of the hospital.

The unitary payment relating to the Beacon Centre is set by the contract between the Trust and the operator and is subject to an inflationary uplift based on the Retail Price Index (RPI). The total unitary payment for 2025/26 amounted to £5,405,238 (2024/25: £3,984,387) and for 2026/27 will be £6,689,179. The value of the liability at 31 March 2026 was £21,550,847 (31 March 2025: £22,925,810). The net book value of the assets was £17,660,000 (31 March 2025: £17,964,708).

Property ownership

The site on which the new Oncology facilities have been built is in the freehold ownership of the Trust.

Expiry of contract

On expiry of the contract (May 2039), the facility will revert to the ownership of the Trust for no payment.

Note 33.2 Provision of Multi-Storey Car Park

This is a public private partnership project (PPP). It relates to the building of a car park (completed in October 2006) and the provision of services for 25 years. The ownership of the building will pass to the Trust after the 25 year concession period. The residual value (assessed by professional valuation) is £4,468,000. Throughout this period, the operator pays an agreed proportion of the car parking fees to the Trust; no other financial transactions take place. The asset and outstanding liability is reported in the Statement Of Financial Position and summarised summarised below:

	31 March 2026	31 March 2025
	£000	£000
Net Book Value of asset (included in property, plant and equipment, note 16)	9,248	9,646
Liability (see deferred PFI income, note 29)	1,423	1,941

Note 33.3 Managed Equipment Solution for Diagnostic Imaging

The Trust has two Managed Equipment Solution contracts.
1) On 20 July 2017 (previously held under Taunton and Somerset NHS FT and merged into Somerset NHS FT upon merger 1 April 2020) and;
2) On 1 April 2019, (previously held under Yeovil District Hospital NHS FT and merged into Somerset NHS FT upon merger 1 April 2023)

The contracts are for the following services:

- A Facilities Infrastructure Replacement Programme (FIRP), which includes the replacement, installation and decommissioning of all assets within the department along with an increase of modalities for ultrasound, MRI and CT scanning;
- The provision of a fully inclusive “Gold Standard” maintenance cover for the department, that includes all parts, durables and labour;
- The provision of a guaranteed uptime availability of the facility to perform diagnostic testing and reporting;
- A consumables management service;
- A full inventory management service;
- Technical training for all modalities;
- Professional training availability for radiographer reporting courses;
- Data collection and analysis to allow for patient level costing within the department;
- Market, professional, technical and analytical intelligence to work in partnership with the Trust, for the purposes of delivering continual improvement in quality and practice across the diagnostic imaging department.

The service provider receives payment in two elements:

- A managed facility service paid for through a unitary payment fixed for the duration of the contract apart from annual RPI indexation, paid quarterly in advance, and agreed variations to the original equipment replacement programme.

- A consumables management service paid for through a quarterly payment in advance based on an estimate of annual consumption. An assessment of actual consumables provided is made each quarter and either a balancing invoice or credit note raised as appropriate.

A set of performance parameters has been agreed with the managed service provider. Penalties will apply if performance failures are not corrected within the agreed remedial period.

The accountancy treatment is that ownership of the Trust’s existing asset portfolio within the scope of the managed service has been transferred to the managed service provider at fair market value. The assets have been recapitalised to the balance sheet under IFRIC 12. New equipment bought by the service provider has been capitalised under IFRIC 12 where their useful lives are fully utilised during the 10 years of the managed equipment solution agreement. Where new asset lives extend beyond the 10 years of the agreement equipment has been accounted for as operating leases.

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities from 1 April 2023. When payments for the asset are uplifted for inflation, the imputed lease liability recognised on the SoFP is remeasured to reflect the increase in future payments. Such increases were previously recognised as contingent rent as incurred.

The change in measurement basis has been applied retrospectively without restatement of comparatives and with the cumulative impact on 1 April 2023 recognised in the income and expenditure reserve.

The total unitary payment made to the managed equipment solution providers during the 2025/26 financial year for the managed facility services was £5,903,401 (2024/25: £5,258,309). The total unitary payment for 2026/27 will be £4,180,992. The value of the liability at 31 March 2026 was £8,689,674 (31 March 2025: £11,072,638) and the net book value of the assets was £8,880,000 (31 March 2025 £10,372,000).

Note 34 On-SoFP PFI, LIFT or other service concession arrangements

Note 34.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**61,406**	**71,635**	**61,406**	**71,635**
Of which liabilities are due				
- not later than one year;	9,869	10,049	9,869	10,049
- later than one year and not later than five years;	23,767	26,947	23,767	26,947
- later than five years.	27,770	34,639	27,770	34,639
Finance charges allocated to future periods	(31,166)	(37,637)	(31,166)	(37,637)
Net PFI, LIFT or other service concession arrangement obligation	**30,240**	**33,998**	**30,240**	**33,998**
- not later than one year;	4,731	4,443	4,705	4,443
- later than one year and not later than five years;	12,197	14,879	11,670	14,879
- later than five years.	13,312	14,676	13,865	14,676

Note 34.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**135,739**	**151,363**	**135,737**	**151,363**
Of which payments are due:				
- not later than one year;	15,627	15,626	15,626	15,626
- later than one year and not later than five years;	50,178	56,188	50,177	56,188
- later than five years.	69,934	79,549	69,934	79,549

Note 34.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Unitary payment payable to service concession operator	**11,308**	**9,608**	**11,308**	**9,608**
Consisting of:				
- Interest charge	1,355	1,268	1,355	1,268
- Repayment of balance sheet obligation	3,371	2,871	3,371	2,871
- Service element and other charges to operating expenditure	6,582	5,469	6,582	5,469
Total amount paid to service concession operator	**11,308**	**9,608**	**11,308**	**9,608**

Note 35 Financial instruments

Note 35.1 Financial risk management

IFRS 9, dealing with financial instruments, require disclosure of the role that financial instruments have had during the year in creating or changing the risks the Trust faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local ICB's and the way those ICB's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which these standards mainly apply.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest-rate risk

The Trust has the power to borrow for capital expenditure subject to affordability as confirmed by NHSE, the independent regulator. Some of the financial instruments have a fixed interest rate which means the Trust is exposed to interest rate risk. If the interest rate moves interest paid could be higher than the market rates, and/or interest received could be lower than the market rates.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in the Receivables note (Note 25).

Cash deposited with financial institutions outside the Government Banking Service at 31 March 2026 was £92,072 (2024/25: £124,088). These balances relate to the Private Patient wings.

Liquidity risk

The Trust's net operating costs are incurred under contracts with local ICB's, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from retained surpluses and funds obtained from the Independent Trust Financing Facility or central funding from the Department of Health and Social Care in the form of Public Dividend Capital. The Trust has undertaken a going concern review involving a year's future cash flow assessment. Following this review, the Trust has concluded that it is not exposed to significant liquidity risks.

The Trust's operating costs are incurred under contracts with ICB's and Specialist Commissioners, which are financed from resources voted annually by Parliament .

The Trust currently finances its capital expenditure from funds made available from cash surpluses generated by the Trust's activities. The PFI project relating to the Beacon Centre has created liabilities on the Statement of Financial Position that the Trust is committed to meeting for the duration of the service concession. This liability is subject to an annual inflationary uplift. The Trust has also entered into radiology managed facility services; both for periods of 10 years and the Trust is committed to meeting the liabilities created on the Statement of Financial Position for the duration of the agreement.

Investment risk

The Trust has the ability to invest surplus cash; the risks resulting from transactions of this nature are mitigated by the Trust's treasury and investment policies and protocols and by the reporting of performance against financial targets to NHSE.

Note 35.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	23,134	**23,134**
Other investments / financial assets	14	**14**
Cash and cash equivalents	111,836	**111,836**
Total at 31 March 2026	**134,984**	**134,984**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	13,908	**13,908**
Other investments / financial assets	14	**14**
Cash and cash equivalents	79,215	**79,215**
Total at 31 March 2025	**93,137**	**93,137**

Note 35.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	35,327	**35,327**
Other investments / financial assets	14	**14**
Cash and cash equivalents	98,245	**98,245**
Total at 31 March 2026	**133,586**	**133,586**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	24,433	**24,433**
Other investments / financial assets	14	**14**
Cash and cash equivalents	66,636	**66,636**
Total at 31 March 2025	**91,083**	**91,083**

Note 35.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	3,599	**3,599**
Obligations under leases	90,038	**90,038**
Obligations under PFI, LIFT and other service concessions	30,240	**30,240**
Other borrowings	926	**926**
Trade and other payables excluding non financial liabilities	136,549	**136,549**
Total at 31 March 2026	**261,352**	**261,352**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,251	**4,251**
Obligations under leases	89,871	**89,871**
Obligations under PFI, LIFT and other service concessions	33,998	**33,998**
Other borrowings	917	**917**
Trade and other payables excluding non financial liabilities	88,262	**88,262**
Total at 31 March 2025	**217,299**	**217,299**

Note 35.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	3,599	**3,599**
Obligations under leases	103,624	**103,624**
Obligations under PFI, LIFT and other service concessions	30,240	**30,240**
Trade and other payables excluding non financial liabilities	135,227	**135,227**
Total at 31 March 2026	**272,690**	**272,690**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	4,251	**4,251**
Obligations under leases	103,846	**103,846**
Obligations under PFI, LIFT and other service concessions	33,998	**33,998**
Trade and other payables excluding non financial liabilities	90,708	**90,708**
Total at 31 March 2025	**232,803**	**232,803**

Note 35.6 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement Of Financial Position which are discounted to present value.

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	155,849	107,260	154,122	109,272
In more than one year but not more than five years	56,345	57,174	51,924	59,596
In more than five years	94,098	104,895	97,819	125,223
Total	**306,292**	**269,329**	**303,865**	**294,091**

Note 36 Losses and special payments

	Group				Trust			
	2025/26		2024/25		2025/26		2024/25	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**	**Number**	**£000**	**Number**	**£000**
Losses								
Cash losses	3	0	3	-	3	0	3	-
Bad debts and claims abandoned	152	58	236	208	151	56	236	208
Stores losses and damage to property	11	2	3	-	11	2	3	-
Total losses	**166**	**60**	**242**	**208**	**165**	**58**	**242**	**208**
Special payments								
Compensation under court order or legally binding arbitration award	2	4	-	-	2	4	-	-
Ex-gratia payments	38	24	52	45	38	24	52	45
Special severance payments	1	35	-	-	1	35	-	-
Total special payments	**41**	**63**	**52**	**45**	**41**	**63**	**52**	**45**
Total losses and special payments	**207**	**123**	**294**	**253**	**206**	**121**	**294**	**253**
Compensation payments received								

Note 37 Related parties

Transactions between the Trust and its related parties are reviewed each year and declared below.

During the year, there were no related party transactions relating to Board members or members of the key management staff or parties related to them.

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group.

This note therefore sets out the individuals and entities which we have assessed as meeting the IAS 24 definition of Related Parties for the year ending 31 March 2026 to assist group bodies in preparing disclosures compliant with IAS 24.

	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
	2025/26 £000	2025/26 £000	31/03/2026 £000	31/03/2026 £000
NHS England	34	121,236	977	607
NHS Somerset ICB	187	945,944	191	6,037
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	-	1,752	-	48
NHS Bristol, North Somerset and South Gloucestershire ICB	-	2,143	-	63
NHS Dorset ICB	-	28,785	-	1,484
NHS Cornwall and the Isles of Scilly ICB	-	817	-	-
NHS Devon ICB	-	12,167	-	108
Devon Partnership NHS Trust	56	7,633	10	1,456
NHS North West London ICB	-	281	-	-
NHS Sussex ICB	-	196	-	-
North Bristol NHS Trust	852	338	109	62
Royal United Hospitals Bath NHS Foundation Trust	271	480	15	-
Dorset County Hospitals NHS Foundation Trust	1,235	948	945	120
Dorset Healthcare University NHS Foundation Trust	179	23	179	5
Hertfordshire Partnership University NHS Foundation Trust	-	45	-	6
University Hospitals Plymouth NHS Trust	263	292	437	-
NHS Hampshire and Isle of Wight ICB	-	651	-	359
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	-	259	-	1
Gloucester Hospitals NHS Foundation Trust	2	208	2	92
Great Western Hospitals NHS Foundation Trust	25	53	-	-
Royal Devon University Healthcare NHS Foundation Trust	808	3,151	125	142
Avon & Wiltshire Mental Health NHS Trust	24	947	24	-
University Hospitals Bristol and Weston NHS Foundation Trust	1,107	316	222	90
NHS Resolution	22,789	-	-	-
NHS Property Services	3,406	179	1,113	-
Other NHS bodies	2364	7,101	575	196
Charitable Funds	-	843	-	-
Simply Serve Ltd	63,719	11,041	2	-
Symphony Healthcare Services Ltd	410	118	-	-
IPP Facilities	867	1,103	-	88
SPS Facilities	15,092	316	-	53
South West Pathology Services LLP	15,546	316	-	53

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

NHS Pension Scheme	121,489	0	10,928	-
HM Revenue & Customs	84,065	5,348	16,155	5,348
Somerset Council	1,362	5,464	2,501	285
Other central and local government bodies	2,651	472	37	283

The equivalent disclosures made for 2024/25 were as follows:

	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
	2024/25 £000	2024/25 £000	31/03/2025 £000	31/03/2025 £000
NHS England	22	159,343	-	2,413
NHS Somerset ICB	12	849,093	21	1,680
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	89	1,627	89	134
NHS Bristol, North Somerset and South Gloucestershire ICB	326	2,626	326	330
NHS Dorset ICB	-	23,393	2,855	342
NHS Cornwall and the Isles of Scilly ICB	-	265	-	-
NHS Devon ICB	78	11,900	78	87
Devon Partnership NHS Trust	-	8,576	-	3,062
NHS North West London ICB	-	217	-	156
NHS Sussex ICB	-	167	-	-
North Bristol NHS Trust	763	607	380	118
Royal United Hospitals Bath NHS Foundation Trust	294	389	74	50
Dorset County Hospitals NHS Foundation Trust	1,240	414	425	-
Dorset Healthcare University NHS Foundation Trust	350	22	149	-
Hertfordshire Partnership University NHS Foundation Trust	-	139	-	25
University Hospitals Plymouth NHS Trust	609	151	246	90
NHS Hampshire and Isle of Wight ICB	-	294	-	-
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	-	235	-	1
Gloucester Hospitals NHS Foundation Trust	78	19	-	19
Great Western Hospitals NHS Foundation Trust	-	54	-	-
Royal Devon University Healthcare NHS Foundation Trust	806	3,450	136	841
Avon & Wiltshire Mental Health NHS Trust	3	803	-	-
University Hospitals Bristol and Weston NHS Foundation Trust	1,210	326	503	65
NHS Resolution	22,265	-	-	-
NHS Property Services	2,867	-	179	17
Other NHS bodies	6,608	6,789	2,268	167
Charitable Funds	-	3,236	-	-
Simply Serve Ltd	62,635	12,979	3	40
Symphony Healthcare Services Ltd	239	227	-	36
IPP Facilities	97	1,044	-	94
SPS Facilities	14,089	316	47	53
South West Pathology Services LLP	14,711	316	-	53
In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.				
NHS Pension Scheme	112,354	-	9,448	-
HM Revenue & Customs	63,163	5,550	15,278	5,500
Somerset Council	7,409	5,886	4,384	317
Ministry Of Defence	20	-	-	-
Other central and local government bodies	3,741	195	216	285

Simply Serve Limited – Company Number: 10847254

Registered office – Yeovil District Hospital, Yeovil, Somerset, BA21 4AT

Simply Serve Ltd (SSL) was incorporated on 3 July 2017 and became operational on 1 February 2018. Simply Serve Ltd is 100% owned by Somerset NHS Foundation Trust.

SSL has been set up to support the Group's strategic objectives, improve efficiency and develop more cost effective ways of working. SSL provides a full range of professional estates and facilities services along and procurement services to Somerset NHS Foundation Trust and other clients.

The key objectives of establishing SSL are as follows:

- Maintain and improve quality of services;
- Free up Group management to focus on healthcare;
- Develop a more efficient and cost effective service;
- Retain staff within the SFT group providing opportunities and security;
- Enhance the ability to recruit and retain key staff groups;
- Enhance focus and flexibility on developing additional income generation opportunities.

SSL operates as an arm's length organisation with its own Board of directors and governance structure. Services are provided under contractual arrangements with detailed service specifications and key performance indicators.

Symphony Healthcare Services Ltd – Company Number: 06633460
Registered office – Wynford House, Yeovil, Somerset, BA22 8HR

During 2016/17 Yeovil District Hospital NHS Foundation Trust acquired Pathways Healthcare and Social Care Alliance Ltd, the company was renamed to Symphony Healthcare Services Ltd.

As at 31 March 2026 Symphony Healthcare Services operates primary care services at locations within Somerset; Ilchester GP practice, Buttercross Health Centre, Highbridge Medical Centre, Crewkerne Health Centre, Oaklands Surgery, Hamdon Medical Centre, Wincanton Health Centre, Crewkerne West One Surgery, The Meadows Surgery, Martock Surgery, South Petherton Surgery, Bruton Surgery, Ryalls Park Medical Centre, Creech Medical Centre, Lister House Surgery, North Petherton Surgery, Burnham and Berrow Medical Centre and Warwick House Medical Centre.

Somerset NHS Foundation Trust owns 100% of the equity and no goodwill arose in respect of the acquisitions. As per the NHS Act 2006 section 259 no goodwill can arise as part of the sale of primary care businesses.

	£000's
Consideration paid	0
Net Assets Aquired	**0**
Goodwill	**0**

Somerset Estates Partnership LLP – Company Number: OC396172
Registered office – 5 The Triangle, Worcester, Worcestershire, WR5, 2QX

During 2014/15 Yeovil District Hospital NHS Foundation Trust procured a Strategic Estates Partner and as a result established the Joint Venture Yeovil Estates Partnership LLP to undertake strategic estates activity on behalf of the Group.

Yeovil Estates Partnership LLP was established on 29 October 2014. Somerset NHS Foundation Trust owns 50% of the equity of Yeovil Estates Partnership LLP and holds 50% of the voting rights. Upon merger with Somerset NHS Foundation Trust the name was changed to Somerset Estates Partnership LLP.

No goodwill arose in respect of the subsidiary as the reporting Group established the company and received an interest in the company equal to the fair value of assets on its formation.

Southwest Pathology Services LLP – Company Number: OC370482
Registered office – 1 Kingdom Street, London, W2 6BD

The subsidiary is Southwest Pathology Services LLP incorporated in the United Kingdom with its principal place of business being Somerset.

Southwest Pathology Service LLP provided pathology testing for the Group and other clients up until 28 February 2015. From 1 March 2015 it provides the analytical elements of pathology testing for the Group and other clients.

Somerset NHS Foundation Trust owns 66.7% of the equity of Southwest Pathology Services LLP and holds 66.7% of the voting rights on matters not requiring unanimous consent of members as identified within the contractual arrangements.

SPS Facilities LLP – Company Number: OC397788
Registered office – 1 Kingdom Street, London, W2 6BD

The subsidiary is SPS Facilities LLP incorporated in the United Kingdom with its principle place of business being Somerset.

SPS Facilities LLP was established 1 March 2015 and provides the facilities elements of pathology testing for the Group and other clients and is expected to continue to do so for the long term.
Somerset NHS Foundation Trust owns 66.7% of the equity of SPS Facilities LLP and holds 66.7% of the voting rights on matters not requiring unanimous consent of members as identified within the contractual arrangements.

SW Path Services LLP – Company Number: OC383198
Registered office – 1 Kingdom Street, London, W2 6BD

The subsidiary is SW Path Services LLP incorporated in the United Kingdom with its principle place of business being Somerset.

Somerset NHS Foundation Trust owns 66.7% of the equity of SW Path Services LLP and holds 66.7% of the voting rights on matters not requiring unanimous consent of members as identified within the contractual arrangements.

www.somersetft.nhs.uk