Public Board Meeting

Tuesday 8 September 2026, 09:30 - 12:45

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

NHS Somerset NHS Foundation Trust

Agenda

09:30 - 09:35
5 min

1. Welcome and Apologies for Absence

Note *Chair*

- 00 Programme for the Day - 8 September 2026 v1.5.pdf (1 pages)
- 080926 - Public Board Agenda v1.3.pdf (3 pages)

09:35 - 09:35
0 min

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

Note and Receive *Chair*

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

09:35 - 09:35
0 min

3. Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 14 July 2026

Approve *Chair*

- Enclosure 02 - Minutes of the 14 July 2026 Public Board meeting v1.2.pdf (11 pages)

09:35 - 09:35
0 min

4. Action Log and Matters Arising

Review *Chair*

- Enclosure 03 - Action Log public.pdf (2 pages)

09:35 - 09:45
10 min

5. Questions from Members of the Public and Governors

Receive *Chair*

09:45 - 09:55
10 min

6. Chair's Remarks

Note *Chair*

09:55 - 10:25
30 min

7. Patient Story: Paul’s experience of Defence Medical Welfare Service support

Receive *Krystle Pardon/Rachel Hembury/Paul Zollo/Tracy Zollo*

- Enclosure 04 - Patient Story Summary September Board Meeting FINAL 280826.pdf (12 pages)

10:25 - 10:45
20 min

8. Chief Executive and Executive Director Report

Peter Lewis

- National and Regional Developments/ Policy Updates
- Reports and Assurance updates including:
  - Executive Committee
  - Guardian of Safe Working for Postgraduate Doctors Report
  - Designated Body Annual Board Report and Statement of Compliance (Medical Appraisal and Revalidation) (Approve)
  - Winter Planning 2026/27 (Approve)
  - Use of the Corporate Seal
  - Overview of Regular Items for Consideration by the Board

Enclosure 05 - Chief Executive and Executive Director Report - September 2026 v3.pdf (14 pages)

10:45 - 10:55
10 min

9. Q1 Board Assurance Framework (BAF) and Corporate Risk Register Report

Receive *Mel Iles*

Enclosure 06 - 2026-27 Q1 Board Assurance Framework and Corporate Risk Register Report.pdf (77 pages)

10:55 - 11:10
15 min

Refreshment Break

Aim 2 – Provide the best care and support to people

11:10 - 11:30
20 min

10. Integrated Performance Exception Report

Receive *Pippa Moger*

Enclosure 07 - Integrated Performance Exception Report.pdf (74 pages)

11:30 - 11:45
15 min

11. Maternity & Neonatal Quarter 1 (2026/27) Quality & Safety Report and update on Paediatric and Maternity Services at Yeovil District Hospital

Receive *Sally Bryant/Mel Iles*

Enclosure 08 - Maternity & Neonatal Quarter 1 2627 Quality & Safety Report.pdf (71 pages)

11:45 - 12:00
15 min

12. Trust Strategy Narrative 2027-32

Approve *David Shannon/Richard Baum/Zoe Hamilton*

Enclosure 09 - Trust Strategy Narrative 2027-32.pdf (27 pages)

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

12:00 - 12:10
10 min

13. Finance Report (M4)

Receive *Pippa Moger*

Enclosure 10 - Board finance Report M4 FINAL.pdf (8 pages)

12:10 - 12:25
15 min

14. Healthset Programme

Receive *David Shannon*

Enclosure 11 - Healthset Programme - Trust Board - September 2026.pdf (5 pages)

12:25 - 12:35
10 min

15. Somerset Health and Care Academy Full Business Case (FBC) and Collaboration Agreement

Approve *Sarah Green/Tony Rackshaw*

Enclosure 12 - SFT Board Somerset Health and Care FBC and Collaboration Agreement.pdf (43 pages)

Reports from Board Committees (for discussion by exception only)

12:35 - 12:40
5 min

16. Assurance report from the Quality and Governance Assurance Committee meeting held on 29 July 2026

Receive *Inga Kennedy*

Enclosure 13 - Assurance Report from the QGAC Committee - 29 July 2026.pdf (5 pages)

12:40 - 12:40
0 min

17. Assurance report from the Audit Committee meeting held on 22 July 2026

Receive *Paul Mapson*

Enclosure 14 - Assurance Report from the Audit Committee - 22 July 2026.pdf (4 pages)

12:40 - 12:40
0 min

18. Assurance report from the Charity Committee meeting held on 23 July 2026

Receive *Graham Hughes*

Enclosure 15 - Assurance Report from the Charity Committee - 23 July 2026.pdf (4 pages)

12:40 - 12:40
0 min

19. Report from the Research and Innovation Committee meeting held on 26 June 2026

Receive *Olena Doran*

Enclosure 16 - Report from the Research and Innovation Committee - 26 June 2026.pdf (5 pages)

For Information

12:40 - 12:45
5 min

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

Receive *Chair*

12:45 - 12:45
0 min

21. Any other business

All

12:45 - 12:45
0 min

22. Risks identified

All

12:45 - 12:45
0 min

23. Evaluation of the effectiveness of the Meeting

Chair

12:45 - 12:45
0 min

24. Items to be discussed at the Confidential Board Meeting

- Minutes of the Confidential Board meeting
- Notes of the Board Seminar session
- Maternity and Neonatal 10 Point Plan
- Minutes of the Finance Committee meetings
- Mental Health South West Provider Collaborative Business Case (commercially sensitive)
- Ryalls Park Medical Centre: New Lease & Signatories Following Extension Completion

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12:45 - 12:45
0 min

25. Withdrawal of Press and Public

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

12:45 - 12:45
0 min

26. Close and Date of Next Meeting

10 November 2026

NHS
Somerset
NHS Foundation Trust

PROGRAMME FOR THE DAY

Board of Directors

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

		Timing
1	**Arrival and Coffee**	**09:15 – 09:30**
2	**Public Board of Directors**	**09:30 – 12:45**
	Refreshment Break	10:55 – 11:10
3	**Lunch**	12:45 – 13:15
4	**Confidential Board of Directors**	**13:15 – 14:40**
5	**Comfort Break**	14:40 – 14:50
6	**Seminar Session**	**14:50 – 17:35**
	Refreshment Break	15:50 – 16:00
7	**Close**	**17:35**

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

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

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

Yours sincerely

Dr Rima Makarem
Chair

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**	Note	Chair	09:30	Verbal
2.	**Register of Interests and Declarations of Interest relating to items on the agenda**	Note and Receive	Chair		Enclosure 01
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 14 July 2026**	Approve	Chair		Enclosure 02
4.	**Action Log and Matters Arising**	Review	Chair		Enclosure 03
5.	**Questions from Members of the Public and Governors**	Receive	Chair	09:35	Verbal
6.	**Chair's Remarks**	Note	Chair	09:45	Verbal
7.	**Patient Story: Paul's experience of Defence Medical Welfare Service support**	Receive	Krystle Pardon/ Rachel Hembury/ Paul Zollo/ Tracy Zollo	09:55	Enclosure 04
8.	**Chief Executive and Executive Director Report** • National and Regional Developments/ Policy Updates • Reports and Assurance updates including: • Guardian of Safe Working for Postgraduate Doctors Report		Peter Lewis	10:25	Enclosure 05

		Action	Presenter	Time	Enclosure
	• Designated Body Annual Board Report and Statement of Compliance (Medical Appraisal and Revalidation)	Approve			
	• Winter Planning 2026/27	Approve			
	• Use of the Corporate Seal				
	• Overview of Regular Items for Consideration by the Board				
9.	**Q1 Board Assurance Framework (BAF) and Corporate Risk Register Report**	Receive	Mel Iles	10:45	Enclosure 06
	Refreshment Break: 10:55 – 11:10				
	Aim 2 – Provide the best care and support to people				
10.	**Integrated Performance Exception Report**	Receive	Pippa Moger	11:10	Enclosure 07
11.	**Maternity & Neonatal Quarter 1 (2026/27) Quality & Safety Report and update on Paediatric and Maternity Services at Yeovil District Hospital**	Receive	Sally Bryant/ Mel Iles	11:30	Enclosure 08 Verbal
12.	**Trust Strategy Narrative 2027-32**	Approve	David Shannon/ Richard Baum/ Zoe Hamilton	11:45	Enclosure 09
	Aim 6: Live within our means and use our resources wisely				
13.	**Finance report (M4)**	Receive	Pippa Moger	12:00	Enclosure 10
14.	**Healthset Programme**	Receive	David Shannon	12:10	Enclosure 11
15.	**Somerset Health and Care Academy Full Business Case (FBC) and Collaboration Agreement**	Approve	Sarah Green/ Tony Rackstraw	12:25	Enclosure 12
	Reports from Board Committees (for discussion by exception only)				
16.	**Assurance report from the Quality and Governance Assurance Committee meeting held on 29 July 2026**	Receive	Inga Kennedy	12:35	Enclosure 13
17.	**Assurance report from the Audit Committee meeting held on 22 July 2026**	Receive	Paul Mapson		Enclosure 14
18.	**Assurance report from the Charity Committee meeting held on 23 July 2026**	Receive	Graham Hughes		Enclosure 15

		Action	Presenter	Time	Enclosure
19.	**Report from the Research and Innovation Committee meeting held on 26 June 2026**	Receive	Olena Doran		Enclosure 16

For Information

20.	**Follow-up questions from Members of the Public and Governors**	Receive	Chair	12:40	Verbal
21.	**Any other business**		All		Verbal
22.	**Risks identified**		All		Verbal
23.	**Evaluation of the effectiveness of the Meeting**		Chair		Verbal

24. Items to be discussed at the Confidential Board Meeting

- Minutes of the Confidential Board meeting
- Notes of the Board Seminar session
- Maternity and Neonatal 10 Point Plan
- Minutes of the Finance Committee meetings
- Mental Health South West Provider Collaborative Business Case (commercially sensitive)
- Ryalls Park Medical Centre: New Lease & Signatories Following Extension Completion

25. Withdrawal of Press and Public

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

26. Close and Date of Next Meeting 12:45

10 November 2026

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Register of Interests
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Rima Makarem, Chair
DATE:	8 September 2026

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

Executive Summary and Reason for Presentation to Committee/Board	Where a member of the Somerset NHS Foundation Trust Board has an Interest, or becomes aware of an Interest, which could lead to a conflict of interests in the event of the Board considering an action or decision in relation to that Interest, the Interest must be considered as a potential conflict and must be declared. The Register of Interests is part of the mechanism through which the Somerset NHS Foundation Trust Board will ensure the integrity of their decision-making processes. Board members are also required to orally declare at each meeting specific Interests in respect of items on the agenda Board members are reminded that any new or relinquished Interest should be advised to the Board and updated on the electronic database within 28 days of becoming known. Board members will be prompted at least annually to review declarations they have made and, as appropriate, update them or make a nil return. The Register as presented reflects the position as at 1 September 2026.

Recommendation	The Board is asked to: **Note** the Register of Interests and to make any further declarations where appropriate.

Links to Strategic Aims (Please select all that are relevant to this paper)
☐ **Aim 1:** Contribute to improving population health and reduce health inequalities
☒ **Aim 2:** Provide the best care and support to people
☐ **Aim 3:** Strengthen care and support in people's homes and in local communities
☒ **Aim 4:** Respond well to complex needs
☒ **Aim 5:** Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☐ **Aim 6:** Live within our means and use our resources wisely
☐ **Aim 7:** Transform our services through innovation, research and digital transformation

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

Equality (Please indicate whether the report has any actual or potential impact on people with protected characteristics and whether an Equality and Quality Impact Assessment (EQIA) has been completed)
This report has been assessed against the Trust's Equality and Quality Impact Assessment (EQIA) Tool and: ☐ No actual or potential adverse impacts on people with protected characteristics have been identified. ☐ Actual or potential impacts on people with protected characteristics have been identified. The following actions are planned to mitigate any identified inequalities: **Details**: An EQIA has not been undertaken as this report is presented for information and does not propose changes to services, policy or practice.

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

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

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

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

REGISTER OF INTERESTS

Trust Board as at 1 September 2026

NHS Somerset NHS Foundation Trust

Firstname	Lastname	Role	Interest Category	Interest Description	Provider	Date Arose	Date Ended	Date Updated
Rosie	Benneyworth	Trust Board Member	Loyalty Interests	Member	Royal College of GPs	01/07/2025		03/12/2025
Rosie	Benneyworth	Trust Board Member	Outside Employment	Interim CEO	Health Services Safety Investigations Body	01/08/2022		03/12/2025
Rosie	Benneyworth	Trust Board Member	Loyalty Interests	Chair	Symphony Healthcare Services Ltd	01/03/2026		
Darshan	Chandarana	Trust Board Member	Outside Employment	Managing Director	Neopath Ltd	01/02/2025		
Darshan	Chandarana	Trust Board Member	Outside Employment	Senior Vice President of AI	ThoughtWorks	12/01/2026		
Isobel	Clements	Director of People	Outside Employment	Governor, Board member	Weston College	22/01/2025		11/06/2026
Isobel	Clements	Director of People	Loyalty Interests	Sister-in-Law employed as Technician, Pharmacy	Somerset NHS Foundation Trust	10/09/2004		11/06/2026
Isobel	Clements	Director of People	Loyalty Interests	Nephew employed as Physiotherapist Apprentice	Somerset NHS Foundation Trust	03/05/2023		11/06/2026
Olena	Doran	Trust Board Member	Outside Employment	Professor in Biomedical Research, and Dean for Research and Enterprise	University of the West of England (UWE), Bristol	01/04/2024		11/06/2026
Deirdre	Fowler	Chief Nurse	Nil Declaration			23/10/2025		
Deirdre	Fowler	Chief Nurse	Nil Declaration			24/08/2026		
Tom	Frederick	Trust Board Member	Outside Employment	Director	Oliver Wyman	01/01/2025		
Andrew	Heron	Chief Operating Officer/Deputy Chief Executive	Loyalty Interests	Wife works for Avon and Wiltshire Mental Health Partnership NHS Trust	Avon and West Wiltshire MH Partnership NHS Trust	17/03/2022		02/01/2026
Andrew	Heron	Chief Operating Officer/Deputy Chief Executive	Loyalty Interests	Member of the Board of Directors and line manager to the Managing Director as a wholly owned subsidiary of Somerset NHS Foundation Trust.	Symphony Healthcare Services	01/04/2024		02/01/2026
Graham	Hughes	Trust Board Member	Outside Employment	Chairman SSL	Simply Serve Ltd	01/01/2022		11/06/2026
Melanie	Iles	Chief Medical Officer	Nil Declaration			24/08/2026		
Inga	Kennedy	Trust Board Member	Outside Employment	Director-Trustee	The White Ensign Association	01/04/2024		29/06/2026
Peter	Lewis	Chief Executive	Loyalty Interests	Director and Management Board Member, representing Somerset NHSFT	Somerset Strategic Estates Partnership Project Company Limited	01/04/2022		19/06/2026
Peter	Lewis	Chief Executive	Loyalty Interests	Management Board Member of the Somerset Estates Partnership (SEP) Board	Somerset Estates Partnership	01/04/2023		19/06/2026
Peter	Lewis	Chief Executive	Loyalty Interests	Director, Somerset Estates Partnership Project Co Limited	Somerset Estates Partnership Project Co Limited	01/04/2023		19/06/2026
Rima	Makarem	Trust Chairman Trust Board	Outside Employment	Lay member (remunerated) since 2019	General Pharmaceutical Council	01/01/2025	31/03/2026	12/06/2025
Rima	Makarem	Trust Chairman Trust Board	Outside Employment	Chair (remunerated) since 2020	Queen Square Enterprises	01/01/2025		16/06/2026
Rima	Makarem	Trust Chairman Trust Board	Loyalty Interests	Chair (unremunerated) since 2021	Sue Ryder	01/01/2025		16/06/2026
Rima	Makarem	Trust Chairman Trust Board	Loyalty Interests	Visiting Professor	University of the West of England (UWE), Bristol	01/09/2025		16/06/2026
Rima	Makarem	Trust Chairman Trust Board	Loyalty Interests	Trustee	NHS Providers	01/06/2025		16/06/2026
Paul	Mapson	Non Exec. Members	Nil Declaration			31/03/2026		
Pippa	Moger	Chief Financial Officer	Outside Employment	NED SSL	Non Executive for Simply Serve Limited	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Outside Employment	SPS Board member	Member of Southwest Pathology Services (SPS) Board	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Outside Employment	Director on JV	Shepton Mallet Health Partnership	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Loyalty Interests	Step daughter employed as Ward Manager	Somerset NHS Foundation Trust	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Loyalty Interests	Son employed as Payroll lead and technical support	Somerset NHS Foundation Trust	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Outside Employment	Director of JV - SEP	Director of SEP Project Co Ltd	04/04/2025		16/06/2026

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

REGISTER OF INTERESTS

Trust Board as at 1 September 2026

NHS Somerset NHS Foundation Trust

Firstname	Lastname	Role	Interest Category	Interest Description	Provider	Date Arose	Date Ended	Date Updated
Alexander	Priest	Trust Board Member	Outside Employment	Chief Executive	Mind in Somerset	01/04/2018		24/11/2025
Alexander	Priest	Trust Board Member	Outside Employment	Non-Executive Director	Dorset Healthcare University NHS Foundation Trust	20/07/2026		
Jade	Renville	Director of Corporate Services	Loyalty Interests	I am Joint Director of Corporate Affairs/Services across Somerset ICB as well as Somerset NHS Foundation Trust.	NHS Somerset ICB	06/07/2024		11/06/2026
Jade	Renville	Director of Corporate Services	Loyalty Interests	Richard Huish Multi Academy Trust Director (Chair of Trust from January 2023)	Richard Huish Multi Academy Trust	01/09/2019		11/06/2026
Jade	Renville	Director of Corporate Services	Loyalty Interests	Father is Director and Owner of Renvilles Costs Lawyers	Renvilles Costs Lawyers	01/08/2003		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Company Director of PHI Ltd (Predictive Health Informatics). The Trust is a shareholder in the Company and this directorship represents the Trust in its shareholding.	Predictive Health Intelligence LTD	14/03/2022		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Wife is employed as a PA within the Neighbourhoods and Primary Care Directorate	Somerset NHS Foundation Trust	01/12/2022		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Director of SHS - a subsidiary of SFT providing primary care services	Symphony Healthcare Services	01/03/2021		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Board member of the Joint venture between Synlab uk and Somerset FT for the provision of pathology services	Somerset Pathology Services	10/01/2022		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Board member of the Somerset Estates Partnership with Prime Plc	Somerset Estates Partnership	01/04/2023		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Daughter is employed as a Healthcare assistant	Somerset NHS Foundation Trust	23/12/2020		11/06/2026
David	Shannon	Director of Strategy and Digital Development	Loyalty Interests	Shareholder Director	Simply Serve Limited	01/07/2024		11/06/2026
Owen	Woodley	Trust Board Member	Loyalty Interests	Member of the Governing Council providing oversight on the management of the university	University of Leicester	15/03/2026		

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

NHS Somerset NHS Foundation Trust

PUBLIC BOARD MEETING

MINUTES OF THE SOMERSET NHS FOUNDATION TRUST PUBLIC BOARD MEETING HELD ON 14 JULY 2026 IN THE JOHN MEIKLE ROOM, DEANE HOUSE, BELVEDERE ROAD, TAUNTON, TA1 1HE

PRESENT

Dr Rima Makarem	Chair
Rosie Benneyworth	Non-Executive Director
Olena Doran	Non-Executive Director
Tom Frederick	Associate Non-Executive Director
Graham Hughes	Non-Executive Director
Inga Kennedy	Non-Executive Director
Alexander Priest	Non-Executive Director
Peter Lewis	Chief Executive
Isobel Clements	Chief People Officer
Deirdre Fowler	Chief Nurse and Midwife
Abbie Furnival	Service Group Director, Neighbourhoods & Community Services (Deputising for Andy Heron)
Mark Hocking	Deputy Chief Finance Officer (Deputising for Pippa Moger)
Mel Iles	Chief Medical Officer
Jade Renville	Chief of Staff to the Chief Executive
David Shannon	Director of Strategy & Digital Development

IN ATTENDANCE

Sally Bryant	Director of Midwifery and Deputy to the Chief Nurse for Somerset
Lee Cornell	Associate Director of Planning and Performance
Emma Davey	Director of Patient Experience & Engagement
Nikki Drake	ACP Podiatrist
Julie Hutchings	Board Secretary and Corporate Services Manager
Anthony Joyce	Podiatry Clinical Director and Consultant Podiatric Surgeon
Fiona Reid	Director of Communications
John Sutton	Interim Associate Director of Patient Care, Neighbourhoods Service Group
Richard Watkins	Member of the Public (Patient Story)

APOLOGIES

Darshan Chandarana	Non-Executive Director
Andy Heron	Chief Operating Officer/Deputy Chief Executive
Paul Mapson	Non-Executive Director
Pippa Moger	Chief Finance Officer
Owen Woodley	Non-Executive Director

1. WELCOME AND APOLOGIES FOR ABSENCE

1.1. The Chair opened the meeting at 9:30 am and welcomed all present to the Public Board meeting, included members of the public, Governors and representatives from partner organisations. Apologies for absence were noted as above and the Chair confirmed that the meeting was quorate.

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

2.1. The Board received and noted the Registers of Interests. The Chair reminded members to ensure that any changes to their declared interests were notified to the Board Secretary and Corporate Services Manager. The Chair invited members to declare any interests relating to items on the agenda. No additional declarations were made.

3. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S PUBLIC BOARD MEETING HELD ON 12 MAY 2026

3.1. The minutes of the Public Board meeting held on 12 May 2026 were **approved** as a true and accurate record.

4. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S EXTRAORDINARY PUBLIC BOARD MEETING HELD ON 9 JUNE 2026

4.1. The minutes of the Extraordinary Public Board meeting held on 9 June 2026 were **approved** as a true and accurate record.

5. MINUTES OF THE SOMERSET NHS FOUNDATION TRUST'S EXTRAORDINARY PUBLIC BOARD MEETING HELD ON 19 JUNE 2026

5.1. The minutes of the Extraordinary Public Board meeting held on 19 June 2026 were **approved** as a true and accurate record.

6. ACTION LOG AND MATTERS ARISING

6.1. The Board reviewed the Action Log and noted that the action relating to the Quarter 3 Maternity and Neonatal Report would be discussed later in the meeting. It was also noted that the Board Development Session on productivity remained scheduled for October 2026.

6.2. Inga Kennedy sought an update on the proposed review of the Integrated Performance Report. It was acknowledged that further work was required to ensure the Board received the appropriate level of information and scrutiny, whilst remaining focused on the issues that mattered most. The Chair proposed that a small group of Board members consider how the report could be refined and how information should be best presented between Board and Committee meetings. **ACTION:** Small working group to be established to consider development of the Integrated Performance Report (Lead: Pippa Moger/Lee Cornell).

6.3. The Board **noted** the Action Log and matters arising.

7. QUESTIONS FROM MEMBERS OF THE PUBLIC AND GOVERNORS

7.1. The Chair invited questions from members of the public and Governors. The Board noted that no questions had been received in advance of the meeting.

7.2. The Board **noted** that there were no questions from members of the public or Governors.

8. CHAIR'S REMARKS

8.1. The Chair provided an update on recent visits to Yeovil District Hospital and community hospitals following the staff survey results. Whilst many positive examples of teamwork, innovation and pride in services were observed, concerns were raised regarding workforce shortages, estates challenges and a perceived lack of staff empowerment. The Chair highlighted the importance of supporting colleagues to drive improvements locally.

8.2. The Chair noted concerns raised by staff on Ward 6A regarding career development opportunities and advised that this would be explored further. Feedback from community hospital visits was generally positive, although concerns remained regarding Urgent Treatment Centres and the utilisation of community facilities. The Chair suggested that these areas may benefit from further Board consideration.

8.3. The Chair also highlighted learning from recent external events and webinars relating to ageing populations, transformation and patient voice, noting their relevance to the Trust's strategic priorities. An update was provided on recent external engagement activities, including positive feedback following the publication of the Chair and Chief Executive's podcast and an invitation to speak at the Integrated Care Delivery Forum later in the year.

8.4. In discussion, Mel Iles outlined work underway to engage consultants and clinical leaders at Yeovil District Hospital in identifying practical improvements to working conditions and patient pathways. Deirdre Fowler reported that increased senior nursing visibility at the site was already yielding positive feedback from staff. Rosie Benneyworth highlighted the importance of maintaining a strong identity for colleagues working at Yeovil District Hospital, whilst Peter Lewis and Mel Iles reflected on the balance between local identity and developing a shared Somerset NHS Foundation Trust culture.

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

9. PATIENT STORY: RICHARD'S EXPERIENCE OF PODIATRY SERVICE TRANSFORMATION

9.1. Emma Davey introduced the patient story and the podiatry team, including Tony Joyce, Nikki Drake and John Sutton. The Board heard how the service had been transformed through a consultant-led model focused on proactive care, early intervention and improved management of patients at high risk of foot ulceration. This had resulted in improved patient outcomes, reduced demand on services, increased discharge rates and improved staff morale.

9.2. Richard Watkins shared his experience of living with diabetes and recurring foot ulcers over many years. Despite ongoing podiatry support, his condition had progressively worsened and required frequent appointments. Following assessment through the redesigned service, Richard underwent corrective surgery on both feet, which successfully resolved the underlying problems. Richard spoke positively about the care he received, describing the staff as supportive, friendly and highly professional, and explained that the treatment had significantly improved his quality of life.

9.3. John Sutton highlighted the importance of personalised care, listening to patients and using patient feedback to inform service improvement and transformation across the Neighbourhoods and Community Services Service Group.

9.4. In discussion, Board members explored the factors that had contributed to the success of the service. Tony Joyce emphasised the importance of listening to staff and patients, supporting workforce development and making better use of specialist skills within community settings. Nikki Drake highlighted the value of aspirational clinical roles in supporting recruitment, retention and staff development.

9.5. Rosie Benneyworth welcomed the improvements achieved and sought assurance that the Trust was looking across whole pathways to understand the wider benefits of the service, including impacts on acute care. Peter Lewis acknowledged the challenges associated with linking pathway data across systems but agreed that improving care in community settings should reduce demand on acute services.

9.6. Board members also discussed opportunities to share learning from the service more widely, make greater use of community facilities and strengthen advanced practice roles. Richard Watkins noted that the only significant challenge he had encountered was travelling to Minehead for treatment, suggesting that a more centrally located theatre facility would improve patient experience.

9.7. The Chair thanked Richard Watkins for sharing his experience and thanked the team for demonstrating how innovation, personalised care and effective use of specialist skills could improve outcomes for patients whilst supporting service transformation.

9.8. The Board **noted** the patient story.

10. CHIEF EXECUTIVE AND EXECUTIVE DIRECTOR REPORT

10.1. Peter Lewis introduced the report and highlighted the publication of the Baroness Amos Review into maternity services. He acknowledged the distressing experiences described by families and staff and advised that NHS England had subsequently issued a 10-point improvement plan, which the Trust was reviewing alongside its existing improvement programme. During the discussion, Rosie Benneyworth declared that she was a member of the National Maternity and Neonatal Taskforce Investigators and Regulators Subgroup.

10.2. The Board noted that the resident doctors' dispute had been resolved, although consultants had voted in favour of industrial action. Peter Lewis also highlighted recent national developments, including NHS staff standards, the NHS Leadership

and Management Framework and guidance relating to unlawful access to patient records.

10.3. An update was provided on continuing operational pressures across urgent and emergency care services, with Peter Lewis noting that Emergency Department performance continued to be a particular challenge across the South West. The Board also welcomed the successful reaccreditation of Triangle of Care within Mental Health Services and noted the Quarter 4 Learning from Deaths Report, including a slight increase in mortality at Yeovil District Hospital which remained within the expected range.

10.4. In discussion, Rosie Benneyworth sought assurance regarding support available to staff during the recent heatwave and requested further Board development in relation to post-death care and learning from national reviews. Mel Iles and Deirdre Fowler advised that a programme of work was already in place, including regular reporting to Board and Committees. David Shannon highlighted the impact of extreme temperatures on elements of the Trust's infrastructure and the need for longer-term resilience planning.

10.5. The Board discussed unlawful access to patient records. Graham Hughes emphasised the need for a robust approach, whilst Peter Lewis confirmed that the Trust continued to communicate expectations to staff, proactively monitor access and investigate concerns. Mel Iles advised that a consistent and proportionate approach remained important, whilst reinforcing that inappropriate access to records was unacceptable.

10.6. Alexander Priest welcomed the reaccreditation of Triangle of Care and stressed the importance of maintaining focus on engagement with carers. Peter Lewis and Deirdre Fowler confirmed that this would continue to be monitored through existing governance arrangements.

10.7. The Board also discussed the implications of the Amos Review, the associated NHS England 10-point plan and the wider burden of maternity reporting and scrutiny. During this discussion, Rosie Benneyworth declared that she was a member of the National Maternity and Neonatal Taskforce Investigators and Regulators Subgroup. Members highlighted the importance of ensuring that activity remained focused on meaningful improvement rather than compliance alone.

10.8. The Chair suggested that future Trust OSCA awards categories could be reviewed to better align with the Trust's strategic priorities and ambitions.

10.9. The Board **approved** the Mortuary Assurance Statement and **noted** the report.

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

11.1. Mel Iles provided an update following publication of the Baroness Amos Review. She acknowledged the distressing experiences described by families and staff and advised that the Trust had welcomed the opportunity to participate in the review and share learning. Whilst significant improvements had been made since the Care

Quality Commission inspection in 2023, continued focus was required to ensure that improvements were consistently embedded.

11.2. The Board noted progress in strengthening leadership arrangements, governance processes and safety oversight, together with the safe reopening of services at Yeovil District Hospital. Mel Iles also outlined the national recommendations arising from the review and NHS England's subsequent 10-point improvement plan, which the Trust was reviewing alongside its existing improvement programme.

11.3. Deirdre Fowler advised that an unannounced quality leadership visit had recently taken place at Yeovil District Hospital and had identified positive feedback regarding triage services and patient experience, whilst also highlighting opportunities for further improvement with regards to communication, links with leadership teams and environment.

11.4. In discussion, Rosie Benneyworth sought assurance regarding the quality of patient safety investigations and organisational learning. Mel Iles and Deirdre Fowler advised that work was underway to strengthen investigation processes and develop a more robust learning framework including a change to the model of patient safety specialists. Inga Kennedy welcomed an increase in incident reporting within maternity services, noting that this reflected growing staff confidence in raising concerns.

11.5. The Board **noted** the update.

12. 2026/27 BOARD ASSURANCE FRAMEWORK UPDATE AND RISK APPETITE REVIEW

12.1. Mel Iles presented the report and advised that the Board Assurance Framework was undergoing its annual refresh and would be finalised following approval of the Trust Strategy. As Strategic Aims 1 and 7 report directly to the Board, members were asked to approve the proposed risk appetites for these two aims and note the risk appetites already agreed by the relevant Committees for the remaining strategic aims.

12.2. Mel Iles explained that a risk appetite of ‘Seek’ was proposed for Aim 1: Contribute to improve health and wellbeing of population and reducing health inequalities. A risk appetite of ‘Significant’ was proposed for Aim 7: Delivering the vision of the Trust by transforming our services through research, innovation and digital technologies .

12.3. In discussion, Inga Kennedy sought clarification regarding the differing risk appetites applied across the strategic aims. Mel Iles and Deirdre Fowler explained that the lower appetite for Aim 2 reflected the need to stabilise the fundamental standards, whereas other aims required a greater degree of innovation and transformation.

12.4. Rosie Benneyworth sought assurance that the agreed risk appetites would inform practical decision-making, whilst Alexander Priest emphasised the importance of supporting long-term population health and prevention. Olena Doran highlighted the importance of wider partnership working to support research and innovation, which David Shannon agreed would be reflected in future iterations of the framework.

12.5. The Board **approved** the risk appetite levels for strategic aims 1 and 7 and **endorsed** the recommended risk appetite levels for strategic aims 2-6.

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

13.1. Graham Hughes presented the report and highlighted the support arrangements in place for colleagues affected by changes to visa and sponsorship requirements, noting the impact that national policy changes could have on workforce sustainability.

13.2. The Committee continued to monitor sickness absence levels, particularly stress-related absence, and noted that a deeper review of sickness absence and hard-to-fill vacancies would be undertaken at a future Committee meeting.

13.3. Graham Hughes also highlighted ongoing work relating to the Trust's role as an anchor institution, including collaboration with a range of major local employers and organisations across Somerset.

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

14. INTEGRATED PERFORMANCE EXCEPTION REPORT

14.1. Peter Lewis presented the report and highlighted changes to the NHS Oversight Framework for 2026/27, noting that the number of indicators relevant to Somerset NHS Foundation Trust had increased significantly, particularly across community and mental health services.

14.2. The Board noted that performance remained strong across several areas. However, concerns remained regarding Talking Therapies, out of area placements, urgent and emergency care performance, cancer standards and the reduction of temporary staffing expenditure. Peter Lewis advised that additional capacity was being introduced within Talking Therapies and that recent out of area placements had reduced. It was also noted that regional pressures continued to impact urgent and emergency care performance, with demand increasing, particularly at Yeovil District Hospital.

14.3. The Board discussed ongoing challenges relating to emergency care, patient flow and delays in discharge. Peter Lewis advised that a range of improvement work was underway, including a review of emergency care pathways and a focus on the first 72 hours of a patient's admission.

14.4. Rosie Benneyworth welcomed progress with direct GP access to diagnostics and sought assurance regarding Advice and Guidance arrangements. Peter Lewis confirmed that the Trust was not mandating the use of Advice and Guidance routes and that performance and capacity were being closely monitored.

14.5. Graham Hughes raised concerns regarding delays in discharging Dorset residents from Yeovil District Hospital. Peter Lewis advised that discussions were ongoing with system partners to improve local authority presence and support on site to facilitate more timely discharges.

14.6. Inga Kennedy suggested that future Board development sessions should focus on preventing avoidable admissions and strengthening community-based alternatives to hospital care. Abbie Furnival and Deirdre Fowler highlighted ongoing work relating to frailty, virtual wards and urgent and emergency care transformation.

14.7. The Chair highlighted the need for a broader Board discussion regarding urgent and emergency care, community services and Urgent Treatment Centres to better understand changing patterns of demand and patient flow. **ACTION:** Board Development session to be scheduled on urgent and emergency care transformation, including admission avoidance, community services, Urgent Treatment Centres and patient flow (Lead: Andy Heron/Deirdre Fowler).

14.8. The Board **noted** the Integrated Performance Exception Report.

15. ASSURANCE REPORTS FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETINGS HELD ON 29 APRIL 2026, 27 MAY 2026 AND 24 JUNE 2026

15.1. Inga Kennedy presented the reports and advised that the Committee had revised its meeting structure to include focused sessions, enabling more detailed scrutiny of key areas.

15.2. The Committee noted that quality intelligence continued to mature and was helping to identify recurring themes, including listening to patients, deterioration, learning from incidents and deaths, safe staffing and organisational learning. Inga Kennedy noted that whilst there was increasing assurance that issues were being identified and understood, the focus now needed to be on demonstrating that learning was embedded and resulting in measurable improvement.

15.3. In response, Mel Iles outlined work underway to strengthen governance arrangements, patient safety capability and quality oversight across service groups. Deirdre Fowler added that the Trust was continuing to strengthen its quality governance framework, leadership development and organisational culture to support sustainable improvement.

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

16. ASSURANCE REPORT FROM THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 16 JUNE 2026

16.1. Alexander Priest presented the report and advised that Mental Health inpatient services continued to operate within an increasingly challenging environment.

16.2. The Committee noted three key areas of concern. These included ongoing professional differences with the Approved Mental Health Professional Hub regarding assessment processes, continuing challenges relating to the Tier 4 Child and Adolescent Mental Health Services pathway and findings arising from the recent Care Quality Commission inspection of Pyrland Ward 2.

16.3. Alexander Priest advised that, whilst a robust action plan had been developed in response to the Pyrland Ward 2 inspection findings, implementation and progress would continue to be closely monitored through the Committee.

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

17. MATERNITY & NEONATAL QUARTER 4 (2025/26) QUALITY & SAFETY REPORT

17.1. Sally Bryant presented the report and advised that progress had continued throughout Quarter 4 despite ongoing operational pressures. Improvements had been made in governance, safety oversight, delivery of the Maternity and Neonatal Improvement Programme and the safe reopening of services at Yeovil District Hospital.

17.2. The Board noted that workforce fragility, patient flow, culture and escalation, and neonatal staffing remained key areas of risk. Sally Bryant also highlighted work underway to review mortality cases involving congenital anomalies to better understand local outcomes, identify any common themes and support future improvements in screening, counselling and care planning.

17.3. In discussion, Rosie Benneyworth welcomed the progress made and highlighted the importance of prevention and population health approaches for women and families. Inga Kennedy noted recent guidance regarding Board reporting arrangements and sought an update on maternity triage services.

17.4. Sally Bryant reported significant improvements in maternity triage performance across both sites, supported by dedicated leadership and focused improvement work. Several national standards had now been achieved for the first time since monitoring commenced and further work was underway to embed training across all clinical staff.

17.5. The Board **noted** the report.

18. SAFE STAFFING ESTABLISHMENT REPORT

18.1. Deirdre Fowler presented the report and advised that six monthly presentation to the Board is a National Quality Board expectation to provide Board assurance regarding nursing, midwifery and AHP staffing levels and processes.

18.2. The Board noted that staffing levels had remained broadly stable during the reporting period, although significant pressures continued within urgent and emergency care services, particularly as a result of escalation beds and unfunded capacity. Deirdre Fowler advised that a table top review of nurse staffing arrangements within the Medicine Service Group at Yeovil District Hospital had been completed and that further reviews would be undertaken across other service groups as contingency until acuity tools had been reintroduced.

18.3. The Board also noted that a dedicated Safe Staffing Lead had recently been appointed and would support the reintroduction of acuity and dependency tools. Particular areas of focus included urgent treatment centres, neonatal services and workforce models within community services.

18.4. The Board **noted** the report.

19. FINANCE REPORT (M2)

19.1. Mark Hocking presented the Month 2 Finance Report and advised that the Trust had reported a deficit of £3.3 million for the month, in line with plan. The year-to-date position remained consistent with the approved financial plan, which anticipated a deficit position during the first half of the year before improving during the second half.

19.2. The Board noted that operational pressures within urgent and emergency care services and maternity services continued to create financial challenges. Additional costs had also been incurred as a result of resident doctor industrial action. Agency expenditure remained above plan, although expenditure continued to be lower than in the previous year. Particular challenges remained in relation to medical vacancies and hard-to-recruit specialties.

19.3. Mark Hocking reported that delivery of the efficiency programme remained ahead of plan at this stage of the year, although a greater proportion of savings than planned were currently non-recurrent. Work continued to identify and deliver sustainable recurrent efficiencies to support achievement of the year-end financial position.

19.4. In discussion, Olena Doran sought assurance regarding plans to reduce agency expenditure through recruitment. Mark Hocking advised that, whilst international recruitment continued to support some workforce groups, recruitment challenges remained in several specialist areas. Work was therefore continuing to develop alternative workforce models, strengthen recruitment and retention and reduce reliance on agency staffing wherever possible.

19.5. The Board **noted** the report.

20. ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 21 APRIL 2026

20.1. The Board received an update on the activities and performance of Somerset NHS Foundation Trust Charity. It was noted that the Charity continued to benefit from a positive relationship with Somerset County Cricket Club and remained reliant on legacies as a significant source of income.

20.2. The Board also noted concerns regarding investment performance. Members were advised that the Charity's investment fund manager, CCLA, remained under enhanced scrutiny following a period of weaker investment returns. Assurance was provided that performance continued to be monitored closely and that future arrangements would be kept under review.

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

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

21. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

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

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

22. ANY OTHER BUSINESS

22.1. The Chair invited any other business. No further items of business were raised.

23. RISKS IDENTIFIED

23.1. The Chair invited members to identify any new risks arising from discussions during the meeting. It was noted that the risks discussed throughout the meeting were already captured within existing risk registers, Committee oversight arrangements and the Board Assurance Framework. No new risks were identified.

24. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

24.1. The Board reflected positively on the quality of discussion throughout the meeting and noted that governance and assurance arrangements continued to mature. Members welcomed the increasing ability to identify and triangulate themes emerging across Board and Committee reports, providing greater confidence that key issues were being consistently recognised and addressed. Whilst noting that the meeting had run beyond its scheduled finish time, members recognised that this reflected the breadth and significance of the business considered.

25. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

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

26. WITHDRAWAL OF PRESS AND PUBLIC

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

27. CLOSE AND DATE OF NEXT MEETING

21.1. The meeting closed at 1.04 pm. The next meeting will take place on 8 September 2026.

NHS Somerset NHS Foundation Trust

SOMERSET NHS FOUNDATION TRUST

ACTION NOTES FROM THE PUBLIC BOARD OF DIRECTORS MEETING

Minute	Action	By whom	Due date	Progress	Status
Public Board meeting held on 10 March 2026					
15.4 - Maternity & Neonatal Quarter 3 (2025/26) Quality & Safety Report	Review how delays in flow and pressures on obstetric and postnatal activity are reflected on the risk register, ensuring that any related risks are clearly captured and monitored	Deirdre Fowler/ Sally Bryant	July 2026	The risk register clearly captures delays and sustained pressures across obstetric and postnatal services due to demand, capacity, workforce, theatre, and estate constraints. Risks are well documented across maternity, neonatal, and obstetric services. Once YDH maternity services reopen, the cross-site pathway for antenatal, labour, and postnatal care during high-acuity periods will be reviewed, with potential to consolidate related issues into a single overarching risk to strengthen long-term oversight. Update: Maternity services have successfully re-opened in YDH. Following a month period of activity the service plans to review cross site pathway risks and consider need for potential consolidation of capacity and flow related risks to strengthen long term oversight. 24/8/26: Review of activity is embedded as BAU and risks regularly reviewed via	Complete

Minute	Action	By whom	Due date	Progress	Status
				risk surgery. The service has seen a marked improvement since YDH re-opening.	
Public Board meeting held on 12 May 2026					
13.5 – Integrated Performance Report	A Board development session on productivity to be scheduled.	Pippa Moger	December 2026	Item scheduled for October Board development session. 24/8/26: Item deferred to December.	Complete
Public Board meeting held on 14 July 2026					
6.2 – Action Log and Matters Arising – Integrated Performance Report	Small working group to be established to consider development of the Integrated Performance Report	Pippa Moger/ Lee Cornell	September 2026	Survey to be sent to Board members to gain their views on the current IPR.	Ongoing
14.7 – Integrated Performance Exception Report	Board Development session to be scheduled on urgent and emergency care transformation, including admission avoidance, community services, Urgent Treatment Centres and patient flow.	Andy Heron/ Deirdre Fowler	December 2026	Two separate sessions have been arranged – one on Urgent Care Transformation for September and another on UTCs for November/December.	Complete

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Patient Story – Paul's experience of Defence Medical Welfare Service support
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and Midwife
REPORT BY:	Emma Davey, Director of Patient Experience and Engagement
PRESENTED BY:	Krystle Pardon, Head of Patient Engagement & Involvement Rachel Hembury, Operations Manager South, Defence Medical Welfare Service Paul Zollo – patient (via recording) Tracy Zollo – patient's wife (via recording)
DATE:	8 September 2026

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

Executive Summary and Reason for Presentation to Committee/Board	Storytelling remains a powerful way of bringing the patient voice into Board and connecting lived experience directly to the quality, safety and coordination of care. This patient story has been selected to demonstrate the impact of specialist welfare support for people with an Armed Forces connection when health needs, discharge planning and wider social circumstances are complex. Paul, an Army veteran who completed basic training with the Royal Signals, was referred to Defence Medical Welfare Service (DMWS) in October 2025 while under the care of Somerset Foundation Trust. He had been diagnosed with Primary Lateral Sclerosis, a form of Motor Neurone Disease, and his mobility had deteriorated to the point that returning to his own home was no longer possible because it could not be safely adapted. What began as a referral for housing support quickly highlighted wider issues affecting Paul and his family, including financial pressure, the risk of losing access to a mobility car, the emotional toll of a prolonged hospital stay, and the need for coordinated advocacy across multiple agencies. DMWS accepted the referral and worked alongside Paul, his wife, clinical teams, local authority colleagues, housing partners, the Integrated Care Board, homelessness teams and third-sector organisations. The Welfare Officer

	completed 72 contacts and visits, helping to keep Paul's voice visible, support his wife and family, and coordinate action around housing, benefits, mobility, wellbeing and discharge planning. The story illustrates the value of person-centred, military-informed welfare support delivered alongside clinical care. DMWS describes its role as providing physical, mental health and specialist wellbeing support for people with an Armed Forces connection and, where appropriate, their immediate family. The support is free and is designed to address non-clinical issues that can affect recovery, wellbeing and discharge. The accompanying appendix slides provide further high-level detail about the DMWS offer, including support with housing, benefits, home adaptations, mental health and wellbeing, family engagement and connections with community support. For Paul and his family, the intervention contributed to a stronger discharge plan, reduced anxiety and stress, improved communication between services and a clearer route towards safe, suitable accommodation. The story demonstrates how partnership working with DMWS can support compassionate, coordinated care, reduce the risk of delayed transfer of care and readmission, and ensure that people facing life-changing illness are supported with dignity, persistence and a focus on what matters most to them.
Recommendation	The Board is asked to discuss and note the report and reflect on the impact of specialist welfare support in improving patient and family experience, and consider how learning from this partnership can inform wider approaches to complex discharge, Armed Forces Covenant responsibilities and person-centred care across pathways.

Links to Strategic Aims (Please select all that are relevant to this paper)
☐ **Aim 1:** Contribute to improving population health and reduce health inequalities
☒ **Aim 2:** Provide the best care and support to people
☒ **Aim 3:** Strengthen care and support in people's homes and in local communities
☒ **Aim 4:** Respond well to complex needs
☒ **Aim 5:** Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ **Aim 6:** Live within our means and use our resources wisely

☐ **Aim 7:** Transform our services through innovation, research and digital transformation

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☒ Patient Safety / Quality
Details: This story relates to patient safety and quality through coordinated discharge planning, compassionate communication, family support, and partnership working to address non-clinical barriers that can affect recovery, wellbeing and flow.					

Equality (Please indicate whether the report has any actual or potential impact on people with protected characteristics and whether an Equality and Quality Impact Assessment (EQIA) has been completed)
This report has been assessed against the Trust's Equality and Quality Impact Assessment (EQIA) Tool and: ☒ No actual or potential adverse impacts on people with protected characteristics have been identified. ☐ Actual or potential impacts on people with protected characteristics have been identified. The following actions are planned to mitigate any identified inequalities: **Details**: N/A

Public/Staff Involvement History (Please indicate if any consultation, service user, patient, public or staff involvement has informed any of the recommendations within the report)
This story reflects direct patient and family experience, with additional information provided by DMWS colleagues. It highlights how specialist welfare support can strengthen patient voice, family involvement and multi-agency collaboration when discharge circumstances are complex.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – e.g. in Part B)
This patient story has been developed for presentation to the September 2026 Public Board of Directors. The accompanying DMWS slide pack will be attached as an appendix to provide further high-level context about the service offer and outcomes.

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

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

SOMERSET NHS FOUNDATION TRUST

PATIENT STORY
PAUL'S EXPERIENCE OF DEFENCE MEDICAL WELFARE SERVICE SUPPORT

1. BACKGROUND AND PURPOSE

1.1. This patient story has been selected to illustrate the difference that specialist welfare support can make when a person's clinical needs, social circumstances, emotional wellbeing and discharge planning are closely connected. It brings the experience of Paul and his family to the Board and highlights the role of Defence Medical Welfare Service (DMWS) in supporting people with an Armed Forces connection during complex health pathways.

1.2. The story demonstrates the importance of seeing the whole person, not only their diagnosis or discharge destination. It reinforces that to enable a positive experience of care requires clinical care to be joined with advocacy, practical support, family communication and coordinated partnership working across health, local authority and voluntary sector services.

2. PAUL'S STORY

2.1. Paul was referred to DMWS in October 2025 after spending months in hospital. He had been diagnosed with Primary Lateral Sclerosis, a form of Motor Neurone Disease, and his mobility had deteriorated to the point that returning to his own home was no longer possible. His property could not be adapted safely to meet his needs, leaving Paul and his family facing uncertainty at an already frightening time.

2.2. Paul had completed basic training with the Army's Royal Signals, making him eligible for DMWS support. The referral from the occupational therapist at Wincanton Community Hospital initially asked for support around housing. However, DMWS identified that Paul and his wife were also managing financial pressure, benefit-related concerns, risk to their mobility car, prolonged uncertainty and the emotional impact of life-changing illness.

3. WHAT DMWS DID

- Accepted the referral and met with Paul and his wife at Wincanton Community Hospital.
- Completed 72 contacts and visits, helping to keep Paul's voice at the centre of decision-making.
- Worked with clinical teams, local authority housing colleagues, homelessness teams, the Integrated Care Board, housing associations, third-sector partners and senior health leaders to remove barriers to safe discharge.
- Escalated benefit and mobility concerns, including contact with Paul's local MP and the DWP Armed Forces Champion.
- Supported family meetings, property viewings and applications across two counties to improve access to suitable emergency housing.

- Offered mental health and wellbeing support through Got Your Six, recognising the emotional strain on Paul and his family.

4. HIGH-LEVEL DMWS CONTEXT

4.1. DMWS provides physical, mental health and specialist wellbeing support to people with an Armed Forces connection, including serving personnel, reservists and veterans, and to people in frontline public services. Immediate family can also be supported, and the support is free.

4.2. The service supports Armed Forces patients when they are on a medical pathway and non-clinical issues are affecting physical or mental wellbeing, delaying discharge or preventing recovery. Support is described as person-centred and tailored to the individual and family or carers, delivered by trained Welfare Professionals at the bedside and back home.

4.3. The accompanying slides (Appendix A) provide further detail on the DMWS offer, including support around housing, home adaptations, rehabilitation, funding and benefits, mental health and wellbeing, family engagement, community connections, discharge, readmission avoidance and Armed Forces Covenant responsibilities.

5. KEY POINTS FOR BOARD

5.1. Paul's story demonstrates how non-clinical issues, including housing, benefits, mobility, family stress and wellbeing, can directly affect discharge planning and experience of care.

5.2. DMWS helped translate Paul's wishes into coordinated action, ensuring that his voice remained visible to family members and professionals.

5.3. The intervention supported a stronger discharge plan, reduced anxiety and stress, improved communication between services and contributed to a clearer route towards safe, suitable accommodation.

5.4. The story highlights the value of specialist welfare support as part of compassionate, personalised care for veterans and their families, particularly where life-changing illness and complex discharge needs are present.

6. RECOMMENDATION

6.1. The Board is asked to discuss and note the report, reflect on the impact of specialist welfare support in improving patient and family experience, and consider how learning from this partnership can inform wider approaches to complex discharge, Armed Forces Covenant responsibilities and person-centred care across pathways.

DIRECTOR OF PATIENT EXPERIENCE AND ENGAGEMENT APPENDICES:

Appendix A: Defence Medical Welfare Service – supporting the frontline

DMWS

Defence Medical Welfare Service
Supporting the frontline

Defence Medical Welfare Service

Supporting the frontline

www.dmws.org.uk

What we do?

Defence Medical Welfare Service
DMWS
Supporting the frontline

DMWS provide physical, mental health and specialist wellbeing support to those with an **Armed Forces connection** (serving, reservists, veterans) and those in **frontline public services** (Police, NHS, Ambulance, and Fire Service) across the UK.
Immediate Family will also be supported

Our support is free

Visit: www.dmws.org.uk

What is Medical Welfare?

- Supporting Armed Forces patients when they are on a medical pathway and have non-clinical issues that are causing poor physical and mental wellbeing, delaying discharge and preventing recovery
- Support that is person-centred and tailored to the individual (and family/carers) at the bedside and back home, delivered by highly trained Welfare Professionals
- Proven outcomes including improved wellbeing, quicker discharge, reduced likelihood of crisis, and more

Outcomes - our support

Defence Medical Welfare Service
DMWS
Supporting the frontline

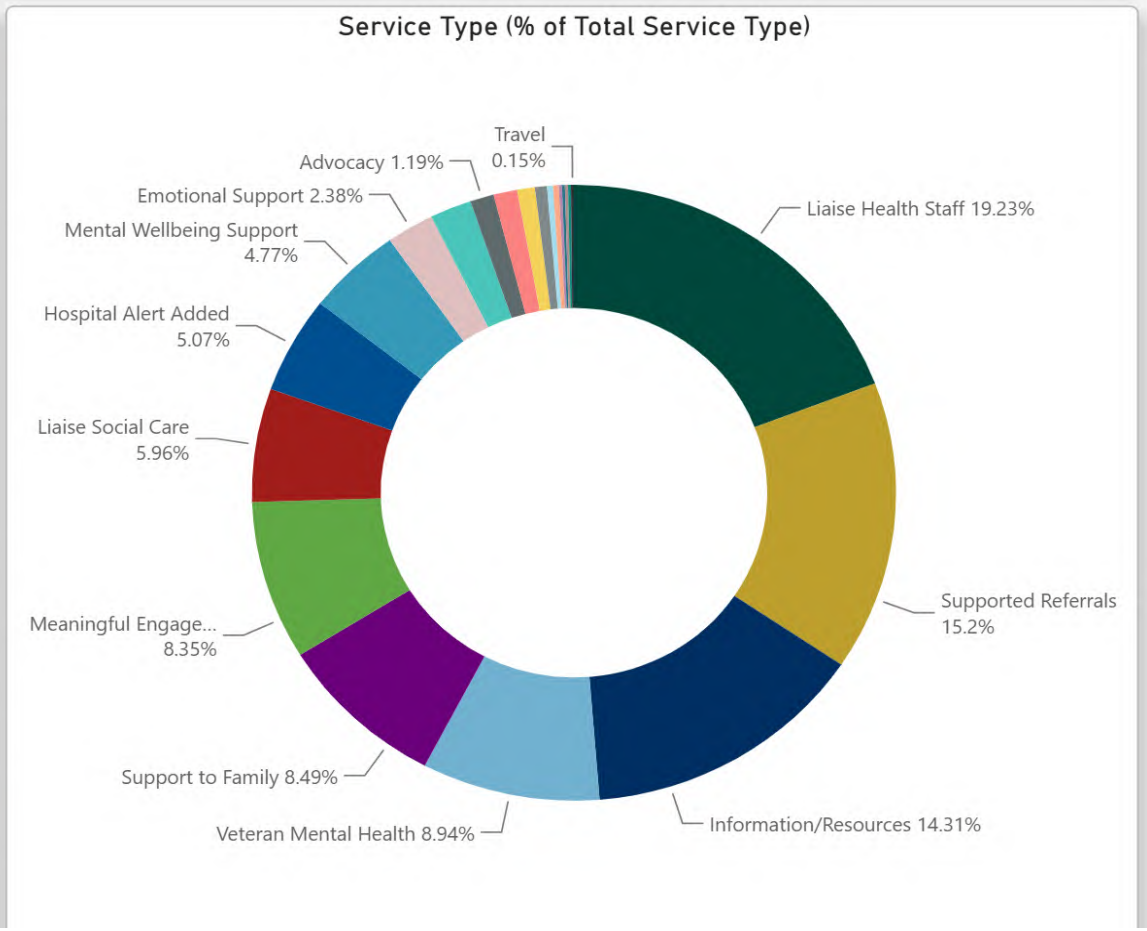
- Breaks down barriers through military informed professional support
- Reduces stress, anxiety, and loneliness, providing comfort at the bedside and set up support back home
- Improves mental health, supports with physical issues and other life stresses such as finance and housing worries
- Co-ordinate care packages including, home adaptations, rehabilitation support, funding and benefits and connections with community groups
- Lead to quicker discharge / reduce delays to transfers back home / improve bed flow
- Reduce ‘Did not attends’ and unnecessary readmissions
- Support with terminal diagnosis / bereavement
- Help to save NHS resources and to meet your Duty under the Armed Forces Covenant

Visit: www.dmws.org.uk

Services Provided

Defence Medical Welfare Service
DMWS
Supporting the frontline

Service Type	No. of SUs	% All SUs
Liaise Health Staff	129	76%
Supported Referrals	102	60%
Information/Resources	96	57%
Veteran Mental Health	60	36%
Support to Family	57	34%
Meaningful Engagement	56	33%
Liaise Social Care	40	24%
Hospital Alert Added	34	20%
Mental Wellbeing Support	32	19%
Emotional Support	16	9%
Liaised Family/Friends	14	8%
Advocacy	8	5%
Visiting - No family/friends	8	5%
Support with Docs/Forms	6	4%
Hospital Processes	4	2%
Attending Meetings	2	1%
Liaise Military Unit	2	1%
Bereavement	1	1%
Family Accommodation	1	1%
Funding Sourced	1	1%
Psychoeducation	1	1%
Travel	1	1%
Total No of SUs	**169**	**100%**



July 25 to July 26 Service Users seen plus Family and NHS Staff

Defence Medical Welfare Service
Supporting the frontline

Contract Location	No. of SUs	Beneficiaries Family	Staff Supported	Total Beneficiaries
Somerset (Taunton) - PR068	65	24	11	100
Somerset (Yeovil) - PR068	104	47	12	163
Total	**169**	**71**	**23**	**263**

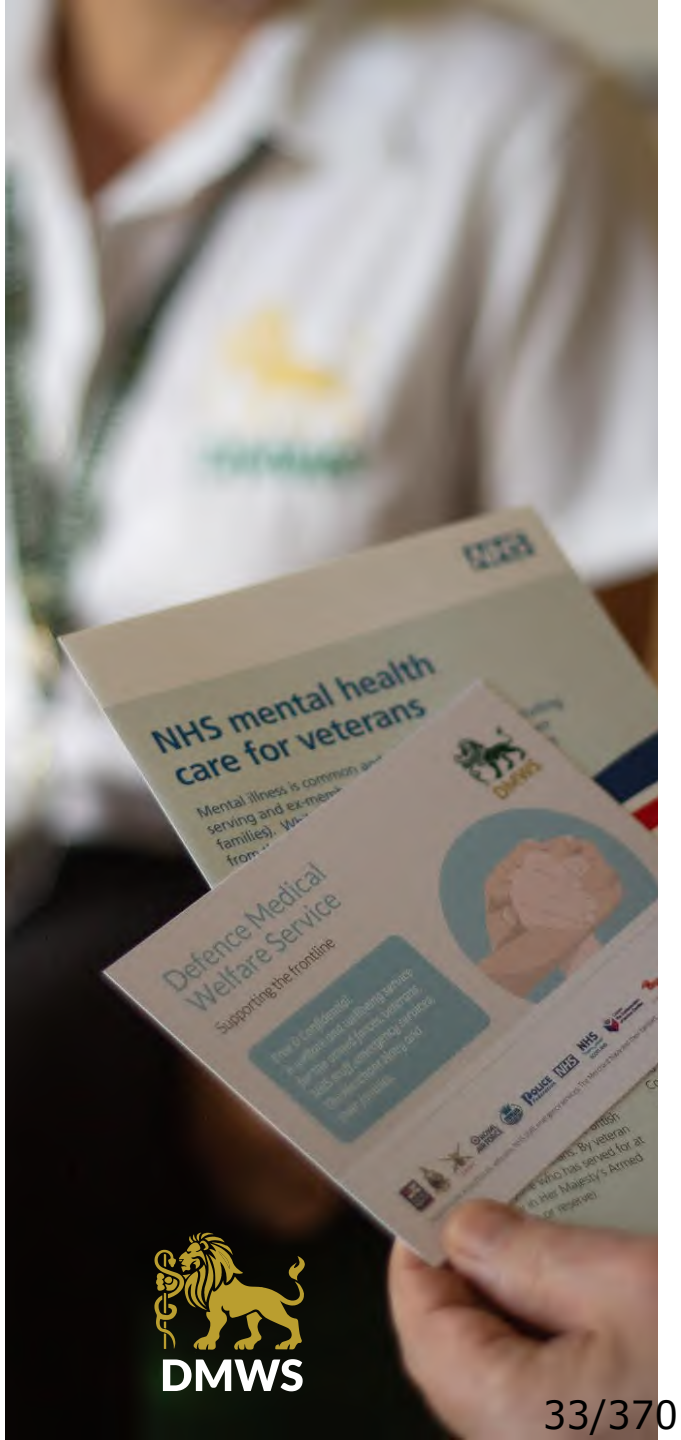
Gender	No. of SUs	% of Total
Female	27	16%
Male	142	84%
Total	**169**	**100%**

Age	No of SUs	% of Total
(Blank)	6	4%
<20	1	1%
20 - 29	3	2%
30 - 39	8	5%
40 - 49	8	5%
50 - 59	17	10%
60 - 69	21	12%
70 - 79	29	17%
Total	**169**	**100%**

Service	Police Officer Retired	Reservist	Serving Child	Serving Regular	Serving Spouse/Partner	Veteran	Veteran Family	Veteran Spouse/Partner	Total
Army				1		72	4	5	**82**
Merchant Navy						1			**1**
No Military Link	1								**1**
RAF		1				25			**26**
Royal Marines						6			**6**
Royal Navy			1			31		7	**39**
Unknown					1	13			**14**
Total	**1**	**1**	**1**	**1**	**1**	**148**	**4**	**12**	**169**

The difference we make for patients

- Reduced stress, anxiety, and loneliness
- Provide comfort at the bedside
- Identify potential mental health issues that can be impacting on communication or treatment
- Identify and arrange other support packages including housing, home adaptations, rehabilitation support, funding and benefits and connections with community groups



Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Chief Executive and Executive Director Report
SPONSORING EXEC:	Peter Lewis, Chief Executive
REPORT BY:	Jade Renville, Chief of Staff to the Chief Executive and Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Peter Lewis, Chief Executive
DATE:	8 September 2026

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

Executive Summary and Reason for Presentation to Committee/Board	This report provides information on national, regional, and local issues impacting on the organisation. It also updates the Board on the activities of the executive and senior leadership team and/or points of note which are not covered in the standing business and performance reports, including any key legal or statutory changes affecting the work of the Trust.
Recommendation	The Board is asked to: • **Note** the report • **Review and Approve** the Designated Body Annual Board Report and Statement of Compliance for Somerset NHS Foundation Trust • **Approve** delegation of final sign off of the Winter Plan to the Quality and Governance Assurance Committee..

Links to Strategic Aims
(Please select all that are relevant to this paper)

☒ **Aim 1:** Contribute to improving population health and reduce health inequalities
☒ **Aim 2:** Provide the best care and support to people
☒ **Aim 3:** Strengthen care and support in people's homes and in local communities
☒ **Aim 4:** Respond well to complex needs
☒ **Aim 5:** Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ **Aim 6:** Live within our means and use our resources wisely
☒ **Aim 7:** Transform our services through innovation, research and digital transformation

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

Equality (Please indicate whether the report has any actual or potential impact on people with protected characteristics and whether an Equality and Quality Impact Assessment (EQIA) has been completed)
This report has been assessed against the Trust's Equality and Quality Impact Assessment (EQIA) Tool and: ☐ No actual or potential adverse impacts on people with protected characteristics have been identified. ☐ Actual or potential impacts on people with protected characteristics have been identified. The following actions are planned to mitigate any identified inequalities: **Details**: N/A

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

CHIEF EXECUTIVE AND EXECUTIVE DIRECTOR REPORT

1. BACKGROUND AND PURPOSE

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

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

1.3 The following items require Board approval:

- Designated Body Annual Board Report and Statement of Compliance (Medical Appraisal and Revalidation)
- Winter Planning 2026/27 (approval to delegate final sign off to QGAC)

2. NATIONAL AND REGIONAL DEVELOPMENTS/POLICY UPDATES

NATIONAL DEVELOPMENTS

Lord Mann Review and Tackling Antisemitism in the NHS

2.1 Following publication of the Lord Mann Review into antisemitism within the NHS, NHS England issued guidance and a series of actions for NHS organisations aimed at strengthening understanding, reporting and prevention of antisemitism across the health service. The review highlights the importance of creating an inclusive culture where all colleagues feel safe, respected and supported at work, and reinforces organisational responsibilities in relation to equality, diversity and inclusion. The Trust has reviewed the requirements set out by NHS England and submitted the requested return. Whilst the Trust has not formally adopted the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism at this time, it remains committed to ensuring that all forms of discrimination, harassment and hate incidents are addressed robustly and that colleagues are able to raise concerns in an environment that promotes psychological safety, dignity and respect. The Trust will continue to monitor national guidance arising from the review and consider any further actions required through its established people and governance arrangements.

Winter Planning 2026/27

2.2 NHS England has issued its Winter Planning 2026/27 expectations and assurance framework, setting out national requirements for systems and providers to demonstrate preparedness for winter demand. The guidance places particular emphasis on urgent and emergency care resilience, patient flow, discharge improvement, vaccination programmes and system-wide escalation planning. NHS organisations are expected to provide assurance that robust arrangements are in place to maintain operational performance and patient safety throughout the winter period.

2.3 The guidance reflects the continuing national focus on reducing avoidable hospital occupancy, improving discharge pathways and ensuring organisations are able to respond effectively to periods of higher demand. The requirements reinforce the importance of collaboration across health and care systems and the need for early planning to support service resilience.

Implementation of the NHS 10 Year Health Plan

2.4 NHS England continues to progress delivery of the NHS 10 Year Health Plan, with ongoing focus on neighbourhood health services, prevention, digital transformation and productivity improvement. National priorities remain centred on shifting care closer to home, strengthening use of technology, improving patient access and supporting more sustainable models of care. The reform programme continues to emphasise greater use of the NHS App, outpatient transformation, workforce development and technology-enabled productivity as key enablers of service improvement and long-term sustainability.

New National Patient Experience Standards

2.5 NHS England has published a new set of national patient experience standards for planned care pathways. The standards establish minimum expectations regarding communication with patients, including confirmation of referrals, regular updates for those on waiting lists, clearer information about treatment pathways and improved appointment management. The standards form part of a broader programme to modernise patient interaction with NHS services and improve the experience of care.

2.6 Greater use of the NHS App is expected to support delivery of the standards, whilst maintaining alternative communication methods for those who require them. NHS trusts will be expected to assess and report on delivery against the standards, with a focus on consistency of experience, transparency and accessibility.

Maternity and Neonatal Improvement Programme

2.7 NHS England has issued a national Maternity and Neonatal 10-Point Plan assurance process to support implementation of the actions arising from the Independent National Maternity and Neonatal Investigation and other recent maternity reviews. The programme seeks to strengthen governance, leadership, workforce, safety and quality arrangements across maternity and neonatal services and forms part of the wider national maternity improvement agenda.

Digital Transformation and Information Governance

2.8 NHS England has continued to promote the adoption of digital technologies to improve productivity and patient experience, including publication of guidance relating to ambient voice technology products and their appropriate regulation and deployment in healthcare settings. These developments form part of the wider national ambition to support clinical productivity and reduce administrative burden through technology-enabled transformation.

2.9 National attention has also remained focused on information governance and the protection of patient data, following recent NHS England guidance highlighting the importance of preventing inappropriate access to patient records and maintaining public confidence in the handling of confidential information.

REGIONAL AND LOCAL DEVELOPMENTS – SOUTHWEST

Operational Resilience and System Priorities

2.10 Across the Southwest, systems have continued to experience sustained operational pressure, as the NHS has faced a summer surge in demand across urgent and emergency care and elective pathways. This reflects the national position, with high levels of activity combined with ongoing workforce and capacity constraints. Repeated periods of hot weather have also contributed to increased demand for urgent and emergency care services across the region. Regional teams remain focused on delivery of national priorities, including patient flow, discharge improvement, elective productivity and winter preparedness.

3. CORPORATE UPDATES

New surgical centre opens at Musgrove Park Hospital

3.1 Patients across Somerset are set to benefit from faster access to surgery, state-of-the-art facilities and an improved overall experience following the opening of a major new surgical centre at Musgrove Park Hospital. The development brings together operating theatres, endoscopy services and theatre admissions within a purpose-built facility, designed to support patients before, during and after surgery, as well as a new intensive care unit.

3.2 The new centre, called King's Building, includes eight operating theatres, six endoscopy rooms and a 22-bed intensive care unit, providing modern facilities for both patients and colleagues while creating additional capacity to help reduce waiting times for treatment. The opening marks a major step forward in the transformation of healthcare services in Somerset and has been designed with future developments in mind, ensuring services can continue to grow to meet the changing needs of the county's population.

IR(ME)R Inspection

3.3 The Care Quality Commission (CQC) undertook an inspection of the Breast Screening Service at Musgrove Park Hospital under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) on 18 August 2026. The inspection reviewed the Trust's arrangements for the safe delivery of medical exposures involving ionising radiation. The inspection process included review of documentation and discussions with staff, consistent with the CQC's IR(ME)R inspection approach. No major concerns were raised by the inspection team on the day of inspection. The Trust is currently awaiting receipt of the draft inspection report, which will be subject to the formal factual accuracy process before the findings are finalised.

National Recognition and Awards

3.4 The Trust received significant external recognition for quality improvement, innovation and clinical excellence during the reporting period. Most notably, teams from across the organisation were shortlisted in three categories at the HSJ Awards 2026: Patient Safety Award (Catheter Care), Acute Sector Innovation of the Year (Interactive Care Point of Care Pilot) and Towards Net Zero Award (Pee-in-Pot). The shortlistings recognise the contribution of colleagues across clinical and corporate services and reflect the Trust's continued focus on quality, innovation and sustainability.

3.5 Musgrove Park Hospital's Acute Medical Unit was ranked first nationally for overall satisfaction with doctor training in the 2026 General Medical Council National Training Survey. The unit achieved the highest rating among 189 acute medical units, reflecting the quality of supervision, education and support provided to doctors in training.

Service Development and Transformation

3.6 The Trust has reached a major milestone in the development of the Bridgwater Community Diagnostic Centre, with practical completion achieved and services commencing during August. The centre will provide additional MRI and CT capacity alongside Somerset's first dedicated urology investigation unit, delivering around 25,000 additional diagnostic investigations each year and supporting earlier diagnosis and reduced waiting times.

3.7 The spinal service established at Yeovil District Hospital has completed its first year of operation, supporting more than 300 patients. The service has restored local spinal outpatient provision to Yeovil for the first time in a generation and improved access to specialist care for local communities.

Digital Innovation and Research

3.8 The Trust continues to expand its use of digital innovation to improve patient care and organisational efficiency. Recent developments include a digital application supporting patients accessing ADHD services, implementation of technologies to improve operational efficiency and data quality, and continued collaboration in the development of artificial intelligence-enabled solutions supporting earlier diagnosis and improved outcomes.

3.9 Research activity continues across a broad range of clinical services and professional groups. Recent projects have included studies examining medication and suicidal ideation within community mental health services, improving recognition of menopausal symptoms, investigating rare anaesthetic complications and strengthening research capability across the organisation.

Quality Improvement and Patient Experience

3.10 Trust services continue to receive positive external feedback for the quality of care provided. During the reporting period, the Diabetic Eye Screening Service was commended through an NHS England quality review, recognising the continued commitment of colleagues to delivering safe, effective and patient-centred services.

3.11 Quality improvement programmes continue to deliver benefits for patients and carers across the organisation. Recent examples include redesign of orthotics services to reduce waiting times and improve patient experience, alongside the continued expansion of the Every Minute Matters programme, which supports patients to maintain independence, mobility and dignity during hospital stays.

Workforce Development and Leadership

3.12 Workforce development remains a key organisational priority. During the reporting period, the Trust hosted Somerset's first Nursing Associate Conference, bringing together nursing associates, students and educators from across the region to share learning and celebrate achievement.

3.13 The Trust's redesigned Leadership Development Programme has now completed its first year, with more than 550 colleagues participating. The programme supports current and aspiring leaders and contributes to the Trust's focus on leadership capability, culture and workforce sustainability.

Prevention and Population Health

3.14 The NHS Bowel Cancer Screening Programme marked its twentieth anniversary during the reporting period. The programme continues to support early diagnosis and prevention across Somerset, helping to improve outcomes through increased screening participation and earlier detection of disease.

3.15 The Trust has also continued to support community-based prevention and wellbeing initiatives, including falls prevention and wider public health engagement undertaken with local communities and system partners. These activities contribute to the Trust's commitment to reducing health inequalities and improving population health.

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

Assurance Report from the Executive Committee meetings held on 3 August and 1 September 2026

4.1 The Executive Committee received updates across operational performance, quality and safety, workforce, finance, estates, digital transformation and organisational risk. The Committee noted that the Trust continues to operate within a challenging financial and operational environment, with ongoing pressures relating to patient flow, urgent and emergency care performance, workforce capacity and delivery of the 2026/27 financial plan. Members also welcomed the successful opening of the King's Building and recognised the significant contribution of colleagues involved in the transition.

4.2 Financial sustainability remained a significant focus. The Committee reviewed the Trust's financial position, noting increasing pressures associated with delivery of cost improvement programmes, temporary staffing expenditure and lower-than-planned clinical activity. Members also discussed the implications of the pause to the Estates Transformation Programme and the resulting impact on the medium-term financial plan. The Committee agreed that continued focus on expenditure control, productivity and transformation delivery would be required to support long-term financial sustainability.

4.3 Operational performance and patient flow remained key priorities. The Committee reviewed performance against urgent and emergency care, elective, cancer and community services indicators, noting continued pressures in several areas alongside strong performance across community services, diagnostic waiting times and patient satisfaction measures. Winter preparedness, discharge improvement and mental health bed capacity were also discussed, with members recognising the importance of maintaining momentum in patient flow and service recovery initiatives.

4.4 The Committee received assurance regarding quality and patient safety, including Learning from Deaths, the Medical Examiner service, patient safety investigations and sepsis performance. Members noted that mortality indicators remain broadly within expected limits and welcomed actions being taken to strengthen organisational learning, reduce investigation timescales and enhance governance arrangements. The Committee also reviewed the corporate risk register, noting continued risks relating to financial sustainability, workforce capacity, patient flow, estates infrastructure and information governance.

4.5 Workforce sustainability remained an area of ongoing focus. The Committee considered updates relating to resident doctor safe working arrangements, medical appraisal capacity, the national Band 5 Nursing Fair Pay Review and the requirement to expand resident doctor training places. Members also supported investment proposals to strengthen neonatal nursing capacity and sustain the CAMHS Function Forward service, recognising their contribution to service quality, workforce resilience and patient outcomes.

4.6 The Committee received updates on strategic transformation programmes, including implementation of the Epic Electronic Patient Record, development of a revised Equality and Quality Impact Assessment framework, Green Plan delivery and future estate developments. Members received assurance that the Epic programme remains on track for implementation in April 2028 and noted the importance of maintaining robust governance and organisational readiness across all major transformation programmes.

Guardian of Safe Working for Postgraduate Doctors Report Quarterly Report 1 - 2026

4.7 The quarterly Guardian of Safe Working report for the period April to July 2026 provides assurance on working hours, exception reporting and safe staffing arrangements for postgraduate doctors in training across Somerset NHS Foundation Trust. The report notes an overall increase in exception reporting activity compared with previous quarters, alongside a significant increase in the number of Immediate Safety Concerns (ISCs). While some of this increase is attributed to improved accessibility of the Patchwork reporting system, a number of workforce and rota-related issues have been identified.

4.8 Key points:

- Exception reporting activity increased during Quarter 1 2026/27, with higher reporting levels than equivalent quarters in previous years. This is considered partly attributable to the greater accessibility and ease of use of the Patchwork system.
- Immediate Safety Concerns increased significantly compared with previous quarters and now represent a larger proportion of all exception reports. These concerns were primarily associated with rota gaps, sickness absence, staffing shortfalls and pressures arising from out-of-hours working.

- Staffing concerns were particularly evident within medicine and general surgery at Yeovil District Hospital, where issues have been escalated through governance processes. Actions include increased medical workforce engagement and the appointment of a dedicated rota coordinator.
- At Musgrove Park Hospital, Immediate Safety Concerns were largely related to gaps arising from short-term and long-term sickness absence, rota management issues and occasions where staffing levels fell below agreed standards.
- There were no work schedule reviews and no fines issued during the reporting period.
- Resident Doctor Forums highlighted concerns relating to payroll issues, rota management and workforce pressures, particularly in relation to out-of-hours and weekend working.
- The Guardians have recommended a review of the Trust's procedures for managing short-term and long-term rota gaps, including escalation arrangements, to improve staffing resilience and reduce the likelihood of future Immediate Safety Concerns.

4.9 The report also includes detailed analysis of exception reporting by specialty and trainee grade and will continue to inform workforce planning and safe staffing improvement initiatives across the Trust.

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

Designated Body Annual Board Report and Statement of Compliance (Medical Appraisal and Revalidation)

4.11 The Board is asked to review and approve the Designated Body Annual Board Report and Statement of Compliance for Somerset NHS Foundation Trust, in accordance with the requirements of the Medical Profession (Responsible Officers) Regulations 2010 (as amended). The report confirms the Trust's compliance with national standards for medical appraisal and revalidation and requires submission to NHS England South West by 30 September 2026.

4.12 For Somerset NHS Foundation Trust, the report highlights:

- Appraisal compliance remained broadly stable at 82.5%, with 634 appraisals completed from 769 doctors due an appraisal during 2025/26. Approved missed appraisals reduced to 11.7%, demonstrating some improvement in managing appraisal timeliness.

- The Trust continues to face challenges in maintaining sufficient appraisal capacity. Appraiser numbers have remained static for several years and are currently insufficient to meet demand, resulting in some appraisals being deferred into the following appraisal year.

- A total of 111 revalidation recommendations were made to the GMC, including 76 positive recommendations and 35 deferrals. While the

absolute number of deferrals has reduced compared with the previous year, appraisal capacity and incomplete supporting information remain the principal reasons for deferral.

- Progress has continued in strengthening appraisal quality assurance arrangements, with ongoing appraiser development programmes, peer review processes and governance oversight through established medical revalidation structures.

- The Trust continues to support medical leadership, workforce development and inclusion, including enhanced support for internationally recruited doctors, locally employed doctors and improved medical job planning compliance.

- Key priorities for 2026/27 include implementing a revised appraiser recruitment strategy, developing dashboard reporting to identify and support doctors at risk of non-compliance earlier in their revalidation cycle, introducing an Appraisal and Revalidation Engagement Policy, and strengthening Maintaining High Professional Standards (MHPS) arrangements through additional leadership and case management capacity.

4.13 The report has been reviewed by the Executive Committee and is presented to the Board for approval to enable timely submission to NHS England.

4.14 The full report is available within the reading room for Board members.

Winter Planning 2026/27

4.15 As we do every year, operational teams within the Trust have been drawing up plans in anticipation of the additional pressure on our services that normally comes with the winter season. Our internal planning started earlier than ever this year and formally commenced on 17 June. The plan is extensive and covers many domains associated with acute, community and mental health services. It also incorporates our plans for flu vaccination.

4.16 In addition to the standard items associated with trying to improve capacity, flow and diversion to alternative services, all Trusts in the South West region were written to by the regional NHS England team on 10 August. This letter specified a number of actions for Trusts to implement as part of the current drive to improve urgent and emergency care performance across the South West. These additional requirements have been incorporated into our winter planning process.

4.17 The Trust's plan will be incorporated into the ICB's Somerset System Plan and this will require sign off by both the ICB Board and SFT Trust Board. With the plan still in its final stages of development and the deadline for submission being 30 September, it is recommended that as was the case last year, the Trust Board delegates final sign off to the Quality and Governance Committee that is due to meet on 30 September.

Use of the Corporate Seal

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

4.19 The seal register entries over the period 1 April 2026 to 31 August 2026 are set out in the attached Appendix A.

Overview of Regular Items for Consideration by the Board

4.20 The updated schedule of regular items for consideration by the Board has been reviewed and is attached as Appendix B to this report. The document outlines the frequency, governance routes, and responsible leads for key reports and agenda items across the 2026/27 cycle. It supports Board planning and ensures appropriate oversight of statutory, strategic, and performance matters throughout the year.

CHIEF OF STAFF TO THE CHIEF EXECUTIVE AND BOARD SECRETARY AND CORPORATE SERVICES MANAGER

APPENDICES:

Appendix A: Somerset NHS Foundation Trust - Seal Register
Appendix B: Overview of Regular Items for Consideration by the Board

Somerset NHS Foundation Trust

Appendix A

SOMERSET NHS FOUNDATION TRUST - SEAL REGISTER

1 April 2026 – 31 August 2026

Date of Sealing	No. of Seal	Nature of Document	First Signatory	Second Signatory
10/04/2026	01	MPH Generator Relocation	David Shannon	Isobel Clements
23/04/2026	02	West One Surgery Deed and Licence	Peter Lewis	Melanie Iles
05/05/2026	02a	Prime Infrastructure Management Agreement for Lease – Block C, County Hall	David Shannon	Peter Lewis
04/06/2026	03	Symphony Surgery Merger Covenant, Guarantee and Indemnity	Peter Lewis	Isobel Clements
16/06/2026	04	Agreement for Lease Block C, County Hall	David Shannon	Deirdre Fowler
16/06/2026	05	Symphony South Merge Hamdon and Buttercross/Ilchester	David Shannon	Peter Lewis
29/06/2026	06	Renewal Lease – Modular Scanning Unit MPH	David Shannon	Andy Heron

APPENDIX B

OVERVIEW OF REGULAR ITEMS FOR CONSIDERATION BY THE BOARD 2026/27

Item	Meeting Type	Frequency	Category	Lead	Reviewed prior to Board (where possible) by:	Comments	Jan	Feb*	Mar	Apr*	May	Jun*	Jul	Sep	Oct*	Nov	Dec*
Integrated Performance Exception Report	Public	Monthly	Performance	CFO	Quality Outcomes Finance and Performance Meetings/F&P Directorate meetings/Executive Committee	*Reading room when no formal board	•	•	•	•	•	•	•	•	•	•	•
Finance Report	Public	Monthly	Performance	CFO	Finance Committee	*Reading room when no formal board	•	•	•	•	•	•	•	•	•	•	•
Healthset Programme	Public	Every Meeting	Information	Director Strategy & Digital	N/A		•		•		•		•	•		•	
Chief Executive and Executive Director Report	Public	Every Meeting	Business	CEO	N/A	To include summary items shown below as coming *(via Executive*	•		•		•		•	•		•	
Chair's Remarks	Public	Every Meeting	Business	Chair	N/A	Verbal	•		•		•		•	•		•	
Register of Interests	Public	Every Meeting	Business	Board Secretary	N/A		•		•		•		•	•		•	
Patient Story/Clinical Topic	Public	Every Meeting	Business	CNO/CMO	N/A		•		•		•		•	•		•	
Audit Committee Assurance Report	Public	After Meeting	Information	Audit Committee Chair	N/A	March, May, September, November			•		•			•		•	
Quality and Governance Assurance Committee Assurance Report	Public	After Meeting	Information	QGAC Chair	N/A	January, March, May, July, September, November	•		•		•		•	•		•	
Mental Health Legislation Committee Assurance Report	Public	After Meeting	Information	MHLC Chair	N/A	January, May, July, November	•				•		•			•	
People Committee Assurance Report	Public	After Meeting	Information	People Committee Chair	N/A	January, May, July, September	•				•		•			•	
Charity Committee Assurance Report	Public	After Meeting	Information	Charity Committee Chair	N/A	March, May, September, November			•		•			•		•	
Research & Innovation Committee Report	Public	After Meeting	Information	R&I Committee Chair	N/A	January, May, July, November											
Use of the Corporate Seal	Public	Quarterly	Business	Board Secretary	N/A	*(via Executive Committee and CEO Report)*			•		•			•		•	
Board Assurance Framework (BAF) and Corporate Risk Register Report	Public	Quarterly	Performance/Strategic	Director Governance/CMO	Audit Committee and Committees with Oversight Responsibility for Strategic Aims	September (Q1), November (Q2), March (Q3), May (Q4), April deep dive into BAF/risk appetite			•	•	•			•		•	
Learning from Deaths Framework: Mortality Review Progress Report	Public	Quarterly	Performance	CMO	Quality and Governance Assurance Committee / Executive Committee	*(via Executive Committee and CEO Report) Full report in reading room - November (Q1), January (Q2), March (Q3), July (Q4)*	•		•				•			•	
Maternity & Neonatal Quality and Safety Report and update on Paediatric and Maternity Services at Yeovil District Hospital	Public	Quarterly	Performance	Director Maternity	Quality and Governance Assurance Committee	September (Q1), November (Q2), March (Q3), May (Q4)			•		•			•		•	
Guardian of Safe Working Report	Public	Quarterly	Performance	CMO	Executive Committee	*(via Executive Committee and CEO Report)*			•		•			•		•	
Trust Strategy 2026-2031: Delivery, Milestones and Assurance Report	Public	Six Monthly	Strategic	Director Strategy & Digital	N/A				•					•			
Safe Staffing Establishment Report	Public	Six Monthly	Performance	CNO	Executive Committee	Summary, full report in reading room	•						•				
Freedom to Speak Up Guardian Report	Public	Six Monthly	Performance	CPO/FTSU	People Committee	*(via Executive Committee and CEO Report)*					•					•	
Wellbeing Guardian Report	Public	Six Monthly	Performance	CPO	Executive Committee						•					•	
Audit Committee Annual Report	Public	Annual	Information	Audit Chair	Audit Committee								•				
Revenue Budget - Final	Public	Annual	Strategic	CFO	Finance Committee	March, subject to planning guidance			•								
Capital Programme	Public	Annual	Strategic	CFO	Finance Committee	March or May, subject to planning guidance			•		•						
Staff Survey Report	Public	Annual	Strategic	CPO	People Committee				•								
Going Concern Statement	Public	Annual	Performance	CFO	Audit Committee						•						
NHS England Annual Self-Declaration: Continuity of services condition 7 – availability of resources	Public	Annual	Business	Board Secretary	N/A						•						
Modern Slavery and Human Trafficking Act 2015 Policy Statement	Public	Annual	Business	Board Secretary	N/A				•								
Review of BAF objectives allocated to the Board	Public	Annual	Strategic	Director Governance/CMO	N/A	June Board Development and July Board						•	•				
Fit & Proper Person Test Declaration	Public	Annual	Business	Board Secretary	N/A							•	•				
Board and Committee Terms of Reference - Annual Review	Public	Annual	Business	Board Secretary	N/A								•				
Winter Plan	Public	Annual	Performance	COO	N/A									•			
Annual Medical Appraisal & Revalidation Report	Public	Annual	Performance	CMO	N/A	*(via Executive Committee and CEO Report)*								•			
Overview of Regular Items	Public	Annual	Strategic	Board Secretary	N/A	*(via Executive Committee and CEO Report)*								•			
Constitution and Standing Orders	Public	Annual	Business	Board Secretary	Council of Governors											•	
Scheme of Delegation and Standing Financial Instructions	Public	Annual	Business	Board Secretary	N/A											•	
Finance Committee Minutes	Confidential	After Meeting	Information	Finance Chair	Finance Committee		•		•		•		•	•		•	
Finance Committee Verbal Update	Confidential	Every Meeting	Information	Finance Chair	Finance Committee		•		•		•		•	•		•	
Quarterly Investigation, Disciplinary and Employment Tribunal Oversight Report	Confidential	Quarterly	Performance	CPOD	N/A				•		•			•		•	
Annual Plan (Revenue, Activity, Workforce and Performance; 4 Year Capital Programme, 5 Year Narrative)	Confidential	Annual	Strategic	CFO	Finance Committee	February Extraordinary, subject to planning guidance		•									
Annual Report and Accounts	Confidential	Annual	Performance	CFO/DCS	Audit Committee	June Extraordinary						•					
Audit Committee Annual Report	Confidential	Annual	Information	Audit Committee Chair	Audit Committee	June Extraordinary						•					
Board Effectiveness Review	Confidential	Annual	Strategic	Board Secretary	N/A									•			
Extraordinary Audit Committee Assurance Report (Annual Report and Accounts)	Confidential	Annual	Information	Audit Committee Chair	N/A								•				
Symphony Healthcare Updates	Confidential	As Required	Performance	Kerry White	N/A												
Simply Serve Updates	Confidential	As Required	Performance	Katie Mattravers	N/A												
Clinical Plan	Development	Annual	Core Plan							•							
People Plan	Development	Annual	Core Plan							•							
Finance Plan	Development	Annual	Core Plan							•							
Digital Plan	Development	Annual	Supporting Plan							•							
Estates Facilities & Capital Development Plan	Development	Annual	Supporting Plan							•							
Green Plan	Development	Annual	Supporting Plan							•							
Communications & Engagement Plan	Development	Annual	Supporting Plan							•							
Research Plan	Development	Annual	Supporting Plan							•							

(* Development Session)

Key:

Public Board
Confidential Board
Development

The Board has delegated responsibility for oversight of the following annual reports to the Quality and Governance Assurance Committee:

- Safeguarding Adults and Children
- Health & Safety
- Emergency Preparedness, Resilience and Response
- Information Governance
- Organ Donation
- Infection Control
- Complaints and Patient Experience

The Board has delegated responsibility for oversight of the following annual report to the Mental Health Legislation Committee:

- Mental Health Act Report

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2026/27 Q1 Board Assurance Framework
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Ben Edgar-Attwell, Director of Governance
PRESENTED BY:	Ben Edgar-Attwell, Director of Governance
DATE:	8 September 2026

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

Executive Summary and Reason for presentation to Committee/Board	This paper presents the Quarter 1 2026/27 Board Assurance Framework (BAF) to the Board of Directors. The BAF provides a structured overview of the Trust's principal strategic risks, controls and sources of assurance in relation to delivery of the Trust's strategic aims and objectives. It is intended to support Board oversight of strategy delivery, risk management and organisational performance. The 2026/27 BAF has been revised to align with the emerging Trust Strategy 2026-2031. As a result, the strategic objectives included within this version remain draft and are subject to further refinement through engagement with service groups and stakeholders, including a planned workshop on 3 September 2026. The final BAF structure will be reviewed once the Trust Strategy has been finalised and approved. This first-quarter report establishes the baseline position against the proposed seven strategic aims and identifies the key programmes of work intended to support delivery. While many objectives remain in the early stages of development, there is evidence of progress across a number of priority areas, including population health, community transformation, frailty services, personalised care, workforce development, digital transformation and implementation of the Healthset programme. Equally, some programmes remain at an early stage of maturity and require further development of delivery plans, measures and trajectories. The report also identifies strategic risks associated with each aim and provides an assessment of the adequacy of controls and assurance currently in place. The majority of strategic risks remain rated as requiring continued oversight due to the scale of transformation required, operational pressures

	across the health and care system, workforce challenges and financial constraints. Consistent with the agreed governance framework, Aim 1 (Population Health and Health Inequalities) and Aim 7 (Innovation, Research and Digital Transformation) remain reserved for direct Board oversight.
Recommendation	The Board is asked to: • Review and consider the Q1 2026/27 Board Assurance Framework. • Note that the strategic aims, objectives and measures remain draft pending completion of the Trust Strategy and planned stakeholder engagement activity. • Provide focused scrutiny of Aim 1 and Aim 7, which are reserved for Board oversight. • Note the current strategic risk profile and assurance ratings across the seven strategic aims.

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

☒ **Aim 1:** Contribute to improving population health and reduce health inequalities
☒ **Aim 2:** Provide the best care and support to people
☒ **Aim 3:** Strengthen care and support in people's homes and in local communities
☒ **Aim 4:** Respond well to complex needs
☒ **Aim 5:** Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ **Aim 6:** Live within our means and use our resources wisely
☒ **Aim 7:** Transform our services through innovation, research and digital transformation

Implications/Requirements (Please select any which are relevant to this paper)

☒ Financial	☒ Legislation	☒ Workforce	☒ Estates	☒ ICT	☒ Patient Safety/Quality

Details: N/A

Equality
(Please indicate whether the report has any actual or potential impact on people with protected characteristics and whether an Equality and Quality Impact Assessment (EQIA) has been completed)

This report has been assessed against the Trust's Equality and Quality Impact Assessment (EQIA) Tool and:

☐ No actual or potential adverse impacts on people with protected characteristics have been identified.
☐ Actual or potential impacts on people with protected characteristics have been identified. The following actions are planned to mitigate any identified inequalities:

Details: An EQIA has not been undertaken as this report is presented for assurance and does not propose changes to services, policy or practice.

Public/Staff Involvement History (Please indicate if any consultation/service user/patient and public/staff involvement has informed any of the recommendations within the report)
The strategic aims and objectives within the draft 2026/27 Board Assurance Framework have been developed from the emerging Trust Strategy 2026-2031. Further engagement with Service Groups and stakeholders is planned during September 2026 to support refinement of the objectives, measures and associated programmes of work prior to finalisation of the framework.

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – e.g. in Part B]
The Board Assurance Framework is presented to the Board on a quarterly basis. This report represents the first quarter review of the 2026/27 Board Assurance Framework and reflects the emerging strategic position in line with the development of the Trust Strategy 2026-2031.

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

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

SOMERSET NHS FOUNDATION TRUST

2026/27 Q1 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1. This report presents the Quarter 1 2026/27 Board Assurance Framework (BAF) and provides the Board of Directors with an assessment of the Trust's strategic risks, controls, assurances and delivery against its proposed strategic aims.

1.2. The report supports the Board in fulfilling its responsibilities for strategic oversight, risk management and assurance. It highlights areas of progress, emerging risks, key delivery challenges and areas requiring continued Board attention.

1.3. This version of the BAF represents the first iteration aligned to the emerging Trust Strategy 2026-2031. As the Strategy has not yet been finalised, the objectives and measures within the BAF should be regarded as draft and subject to further refinement following engagement with service groups and stakeholders during September 2026.

2. OVERVIEW OF STRATEGIC AIMS AND OBJECTIVES

2.1. The Q1 BAF establishes a baseline position against the Trust's proposed strategic aims and demonstrates early progress in embedding the priorities that will underpin delivery of the new Trust Strategy.

2.2. A number of objectives remain focused on establishing governance arrangements, defining programmes of work and developing longer-term outcome measures. This is particularly relevant where success is dependent on population-level outcomes, system-wide collaboration or multi-year transformation programmes.

2.3. Key themes emerging from the Quarter 1 review include:

- Establishment of the Population Health Programme and associated workstreams focused on prevention, health inequalities and improving healthy life expectancy.
- Continued development of community-based and neighbourhood models of care aligned to national policy and the NHS 10-Year Plan.
- Progress in services supporting people with complex needs, particularly through frailty pathways, personalised care and the Complex Emotional Needs strategy.
- Continued investment in workforce development, leadership capability and workforce sustainability.
- Maintenance of a challenging financial environment, with ongoing focus on recurrent savings, productivity and estate sustainability.
- Strong progress in digital transformation and mobilisation of the Healthset Electronic Health Record programme.
- Continued development of research, innovation, data and artificial intelligence capability across the organisation.

Aim 1: Contribute to Improving Population Health and Reducing Health Inequalities

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

2.5. Significant progress has been made in establishing governance arrangements through the Population Health Programme Board and defining priority workstreams focused on cardiometabolic health, mental health, children and young people, anchor institution responsibilities and organisational enablers. Work is underway to develop a Population Health Delivery Plan and supporting outcome measures. Given the long-term nature of population health improvement, most programmes remain in establishment and development phases. Overall progress is currently assessed as on plan.

Aim 2: Provide the Best Care and Support to People

2.6. Progress is mixed across this aim. Positive development can be seen in cancer early diagnosis initiatives, strengthened primary care integration through Symphony and early work to establish community family hub models. However, further development work is required in relation to dementia pathways and associated delivery plans. Risk exposure remains above appetite in key areas relating to quality, access and pathway integration.

Aim 3: Strengthen Care and Support in Local Communities

2.7. This aim reflects the Trust's commitment to shifting care closer to home through neighbourhood-based models of care and greater integration across health and care services. A strategic framework has been established and alignment with national neighbourhood health policy is clear. However, several programme components require further development and refinement as part of the wider strategic planning process during Q2.

Aim 4: Respond Well to Complex Needs

2.8. Good progress is being demonstrated in areas including frailty services, personalised care and delivery of the Complex Emotional Needs strategy. Evidence suggests improvements in coordination of care, discharge pathways and personalised approaches to care planning. A number of objectives relating to learning disabilities, autism, ADHD and complex children's services require further programme development and reporting arrangements before progress can be fully assessed.

Aim 5: Support Our Colleagues to Deliver the Best Care and Support Through a Compassionate, Inclusive and Learning Culture

2.9. Delivery under this aim remains on plan. Progress has been achieved in workforce supply, leadership development, apprenticeship pathways, talent development and retention initiatives. The Trust continues to focus on creating a compassionate and inclusive culture while building workforce capability to support future service models, digital transformation and organisational resilience.

Aim 6: Live Within Our Means and Use Our Resources Wisely

2.10. Financial sustainability and delivery of recurrent efficiencies remain significant challenges. Progress continues in estate development, capital investment and the utilisation of artificial intelligence and automation to improve productivity. However, financial sustainability and decarbonisation objectives remain behind schedule and continue to require close oversight through the Finance Committee.

Aim 7: Transform Our Services Through Innovation, Research and Digital Transformation

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

2.12. Delivery remains strong across digital transformation programmes, particularly mobilisation of the Healthset Electronic Health Record programme, development of data and analytics capability and expansion of AI-enabled technologies. Research capability development remains at an earlier stage and is currently assessed as behind schedule due to the need to prioritise operational research portfolio delivery. Overall, the strategic direction and programme foundations remain positive.

3. CONCLUSION

3.1. The Q1 2026/27 Board Assurance Framework establishes the initial baseline for monitoring delivery of the Trust's emerging Strategy 2026-2031.

3.2. While the framework remains in development, there is evidence that the principal strategic objectives and programmes supporting delivery of the aims are progressing appropriately. Several objectives remain in the establishment phase and will require further refinement of outcome measures, milestones and reporting arrangements as the Strategy is finalised.

3.3. The overall position is one of constructive progress alongside continued operational, workforce, transformation and financial pressures. The strategic risk profile reflects both the ambition of the proposed Strategy and the complexity of the environment in which the Trust operates.

3.4. Aims 1 and 7 continue to warrant direct Board oversight due to their strategic significance, breadth of impact and interdependencies across the organisation.

DIRECTOR OF GOVERNANCE

NHS Somerset NHS Foundation Trust

Draft Q1 Board Assurance Framework 2026/27

Ref	Exec Owner	Aim & Objectives	Overseeing Committee	Risk Appetite
1	MI	**Contribute to Improving the health and wellbeing of the population and reducing health inequalities** 1. People across Somerset will have a longer healthy life expectancy, and our focus will be on those parts of the population which experience the greatest disadvantage so that we can narrow the healthy life expectancy gap. 2. Children and young-people stay healthier, and report greater satisfaction with our services. 3. Fewer people will develop preventable long-term conditions, such as cardiovascular disease and type 2 diabetes, and those affected will stay healthier and spend less time in hospital if they become ill 4. Fewer people with Serious Mental Illness will die earlier.	Board	⇔
2	DF	**Provide the best care and support to people** 1. Families will be more satisfied with our services, and there will be a reduction in the use of secondary care services, as a consequence of more holistic pathways. 2. More cancers will be detected earlier, leading to improved survival rates and more positive outcomes for those affected 3. Patients with dementia will have the chance to be as independent as possible, because every person diagnosed with dementia will receive personalised, co-ordinated care. 4. People will be happier with the GP services we provide, and will access GP services quicker so that hospital attendances do not grow in line with the population.	QGAC	⇔
3	AH	**Strengthen care and support in local communities** 1. People will access more care in the community, and go to hospital less, because they will be served by Integrated Neighbourhood Teams and Neighbourhood Health Centres. 2. People with multiple long term conditions will go to hospital less, because they will have more joined-up care. 3. Outpatients will need to go to hospital less, and will find it easier to manage their health at home, because most outpatient care will be delivered outside of acute hospitals, and more people will have their health monitored remotely thanks to expanded digital technology.	QGAC	⇔

Ref	Exec Owner	Aim & Objectives	Overseeing Committee	Risk Appetite
4	MI	**Respond well to complex needs** 1. People living with frailty will have more opportunities to live independently, safely and with dignity, supported by targeted services and resources 2. There will be fewer hospital admissions and deaths caused by intentional self-harm. 3. Children with complex and special educational needs will be able to access appropriate care close to their home rather than in hospitals or out of Somerset. and have more psychological support, wait less time for care. 4. People with Learning Disabilities, Autism and ADHD will be able to keep healthier and live more independently, due to having better access to primary care services, and more targeted secondary care services. 5. People who frequently use our services will have personalised, coordinated care plans.	QGAC	⇔
5	IC	**Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture** 1. Our clinical services will be appropriately staffed to provide quality care because we will achieve a sustainable workforce supply. 2. There will be development opportunities for colleagues and local people to learn and work with us, to ensure the resilience of our clinical services. 3. Colleague wellbeing and experience - services will be more sustainable, and provide higher quality care, because we will be better able to retain colleagues.	People	⇔
6	PM	**Live within our means and use our resources wisely** 1. Our services will be delivered in a financially sustainable way, to ensure their viability. 2. Our services will be delivered from accommodation that is fit for purpose, to maximise the quality of care and service user satisfaction. 3. Our carbon emissions will be reduced, and our buildings will be made more resilient to the affects of climate change, so as to guarantee the resilience of our clinical services. 4. Corporate and clinical operational services will be transformed through greater use of Artificial Intelligence, so that they are more efficient and better able to serve the needs of patients.	Finance	⇔

Ref	Exec Owner	Aim & Objectives	Overseeing Committee	Risk Appetite
7	DS	**Transform our services through innovation, research and digital transformation** 1. The Healthset programme will lead to our new Electronic Health Record system being in place, meaning that every patient and clinician will have easy access to a single online care record 2. We will use new technology and artificial intelligence to improve patient experience of care, and transform enabling services and functions 3. Patients and clinicians will have more accurate and timely information so that they can make better decisions about care 4. We will have better research capability, and grow a targeted portfolio of specialist research to help develop clinical services for our patients.	**Board**	⇔

Board Assurance Framework 2026/27

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

Narrative Overview

Our mission begins with the words "To improve the health and wellbeing of everyone in Somerset". To this end, we have established a Population Health Programme Board chaired jointly by the Chief Medical Officer and the Director of Strategy & Digital Development, with membership from across the organisation plus external representatives. The Population Health Programme Board met for the first time in November 2025. The Board will own the trust's Population Health Delivery Plan, which is currently being developed.

A diverse programme of work is being established that aims to improve the health and wellbeing of the population of Somerset and reduce health inequalities. The vision for the programme is to improve healthy life expectancy and reduce the inequality in healthy life expectancy in Somerset. 5 priority workstreams have been agreed which are based upon local data. These are:

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

We have chosen the Objectives in the BAF based on population health needs as outlined in the Somerset Joint Strategic Needs Assessment (JSNA) and date from other sources including NHSE. Further work will take place led by the Population Health Board to refine the metrics we will use to determine success against the objectives. The nature of population health necessarily means that change is more difficult to measure over short periods. As a Trust we are also only partially responsible for population health, and will work in close partnership with others including Somerset Council, the new ICB Cluster Population Health Team, the GP Support Unit and the VCFSE sector to bring about success in these areas.

SFT Objectives / Programmes

1	**People across Somerset will have a longer healthy life expectancy, and our focus will be on those parts of the population which experience the greatest disadvantage so that we can narrow the healthy life expectancy gap**	**On Plan**
	This objective represents the overarching ambition of the Population Health Programme and will be delivered through a whole-trust approach focused on prevention, action on health inequalities and addressing the wider determinants of health. Delivery will be supported by all Population Health Programme workstreams and by embedding population health principles within strategic planning,	

	service improvement and operational decision-making across the Trust. Workstreams 1 to 3 are described under the subsequent objectives; Workstreams 4 and 5 are outlined below. An Anchor Institution Workstream has been established to maximise SFT's contribution to population health through its role as a major employer, purchaser, landowner and community partner. The workstream is developing a delivery framework aligned with national and regional best practice, covering employment, procurement, estates, sustainability, partnerships and leadership. This work aims to increase SFT's social, economic and environmental impact across Somerset, supporting local economic development, reducing inequalities and improving the conditions that enable people to live healthy lives. It also seeks to strengthen collaboration with partners, including development of a future Somerset Anchor Network. A baseline assessment is underway and will inform Year 1 priorities, measures and actions within the Population Health Delivery Plan. An enablers workstream is also underway to strengthen the systems, processes and capabilities needed to embed a population health approach across the organisation. Priorities include enhancing population health intelligence; embedding population health objectives within planning and governance; strengthening EQIA processes; and maximising opportunities presented by Epic. The workstream will also support workforce development, communications, funding opportunities and research, helping ensure population health considerations are routinely incorporated into governance, service redesign, workforce development and digital transformation and research to deliver sustainable improvements in outcomes and reductions in health inequalities.	
2	**Children and young-people stay healthier, and report greater satisfaction with our services**	**On Plan**
	A dedicated Children, Young People and Life-course Inequalities Workstream is being established within the Population Health Programme to support improved outcomes for children and young people across Somerset. The workstream will align closely with the CYPF Pathways Transformation Programme, with work underway to ensure priorities are coordinated and complementary. A paediatrician with population health experience has been allocated protected time to lead the workstream, supported by a colleague who recently completed a population health fellowship. Initial work has focused on developing priorities, objectives and stakeholder relationships, with a wider multidisciplinary group being established to support delivery. Partnership working with Somerset Council and other organisations will be central to the workstream. Emerging priorities include development and education, injuries, obesity, children looked after, SEND, and transitions between child and adult services. Development of a child health dashboard is also planned to support improvement and monitoring. The workstream will incorporate maternity services, supporting a life-course approach from pregnancy through childhood and into adulthood.	
3	**Fewer people will develop preventable long-term conditions, such as cardiovascular disease and type 2 diabetes, and those affected will stay healthier and spend less time in hospital if they become ill**	**On Plan**
	A dedicated Cardiometabolic Health and Preventable Vascular Disease Workstream is being established within the Population Health Programme. A Consultant Lead and Deputy Lead have been identified and are being supported to develop priorities, objectives and delivery plans. Initial activity has focused on prevention and behavioural risk factors. A cross-trust obesity steering group has been established to strengthen prevention and management of obesity, with an initial focus on children and young people, health inequalities and promoting a more consistent, evidence-based	

	approach to weight management. A tobacco steering group will commence in September, focusing on tobacco dependency treatment, smokefree ambitions, referral pathways and reducing smoking-related inequalities. The workstream is also exploring opportunities to develop a secondary prevention service for patients at high cardiovascular risk, alongside building on existing population health approaches to support earlier identification and prevention of disease. Close alignment with existing transformation programmes, including diabetes pathway redesign, will help ensure coordinated delivery and avoid duplication.	
4	**Fewer people with Serious Mental Illness will die earlier**	**On Plan**
	A dedicated Mental Health, Substance Misuse and Inclusion Health Workstream is being established within the Population Health Programme, with permanent leadership arrangements currently being developed. In the meantime, a range of related activity is already underway across the Trust, including tobacco dependency treatment, smokefree initiatives and support for mental health inpatients. The workstream will provide oversight and coordination of related programmes, including the Patient and Carer Race Equality Framework (PCREF), helping to ensure alignment with wider population health and health inequalities objectives and supporting more equitable and person-centred services. Substance misuse and inclusion health form a key part of the workstream. A recently established Substance Misuse Steering Group is focusing on developing an equitable cross-trust service, strengthening workforce capability and improving pathways with Somerset Drug and Alcohol Service. Evaluation of the Trust's homeless health services is also underway to inform future development and ensure support is targeted towards disadvantaged and underserved populations.	

Risks - Scoring and Appetite

Risk Appetite over Time – Aim

Seek 15-16				
June 2026	**September 2026**	**December 2026**	**March 2027**	**June 2027**
Within appetite	Within appetite			

Strategic Risks to Aim

		Score
1	**Population health dependency / partnership risk** There is a risk that improvement in population health outcomes is not achieved due to reliance on system partners and wider determinants of health outside the Trust's direct control, resulting in failure to deliver strategic aims and reputational impact.	**4x4 16**
	Controls (what we are doing) • Population Health Delivery Plan being developed, aligned to JSNA and ICS priorities • Dedicated Population Health Programme Board with cross-system membership • Partnership working with Local Authority, ICB and VCFSE sector • Targeted programmes being developed across priority areas (e.g. cardiovascular disease, mental health, children and young people) • Embedding population health approach within service and operational planning processes	
	Assurance (how we know it is working) • Reporting to Improvement and Transformation Programme Board from September • Oversight from Population Health Programme Board with escalation routes	

	• External benchmarking against national and regional population health indicators • System-level reporting through governance structures	
	Assurance Rating:	**Amber**
2	**Targeting and prioritisation risk** There is a risk that interventions are not sufficiently targeted at the most disadvantaged groups, resulting in widening health inequalities and failure to improve healthy life expectancy.	**3x4 12**
	Controls (what we are doing) • Use of JSNA and health inequalities data to define priority cohorts • Adoption of Core20PLUS5 (or equivalent) approach to reducing inequalities • Equality Impact Assessments embedded in service redesign and transformation programmes • Targeted service interventions (e.g. high-risk population cohorts, deprived areas) • Collaboration with system partners to align targeting approaches	
	Assurance (how we know it is working) • Working to embed routine reporting of outcomes segmented by deprivation / protected characteristics utilising newly developed health inequalities dashboard • Committee oversight of health inequalities performance • Review of Equality Impact Assessments through governance processes • External assurance via CQC / NHSE where relevant • Deep dives into areas of variation or concern	
	Assurance Rating:	**Amber**
3	**Prevention vs demand pressure risk** There is a risk that operational and financial pressures limit capacity to move resources to support preventative activity, resulting in continued decrease in years of good health, growth in long-term conditions and demand on healthcare.	**4x4 16**
	Controls (what we are doing) • Explicit inclusion of prevention within Trust strategy and operational plans • Dedicated prevention programmes (e.g. smoking cessation, obesity, early intervention) • Resource allocation aligned to strategic priorities (where possible) • Integration of prevention into clinical pathways • Workforce training and engagement in preventative approaches	
	Assurance (how we know it is working) • Monitoring of activity and investment in prevention initiatives • Review of demand trends (e.g. non-elective admissions, long-term conditions) • Board oversight of balance between operational demand and transformation activity • Evaluation of programme outcomes (where measurable) • External reporting against national prevention indicators	
	Assurance Rating:	**Amber**

Key Actions and Areas of Focus

	Action/area of focus	Action Owner	Progress
	Agree priority interventions and targets through the Population Health Programme Board to form the Population Health Delivery Plan	Florence Lock	In progress (workstreams being established, each of

			which will develop part of the delivery plan)
	Establish baseline measures and trajectories for health life expectancy and inequality reduction	Florence Lock	In progress (Florence Lock in discussion with Richard Baum/Zoe Hamilton re trust strategy- to be discussed at future Population Health Programme Board)
	Strengthen partnership accountability arrangements with system partners and communities	Mel Iles/David Shannon	In progress (ongoing discussion with ICB leadership on oversight and place-based arrangements for the cluster)

Assurance Rating Key:

GREEN	AMBER	RED
Well-functioning controls in place to manage risks and deliver aim	Some key controls in place, but may not cover all risks or elements of aim	Clear gaps in controls for management of risks and delivery of aim
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**

Board Assurance Framework 2026/27

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

Narrative Overview

We are working with partners to develop family hubs in every community, so that there is local access to children and young people's services co-located with other health services. This will help to give children and young people a good start in life, and help us to understand and address the social determinants of health.

We are focusing on certain health conditions with the aim of preventing serious illness. These include improvements to cancer and dementia diagnosis, and better access to the GP services run by Symphony.

SFT Objectives / Programmes

1	**Families will be more satisfied with our services, and there will be a reduction in the use of secondary care services, as a consequence of more holistic pathways**	**On Plan**
	Initial scoping conversations ongoing between CYPPF and Neighbourhoods and Community Services Service Groups, including logistics of location based on service user needs and highest impact.	
2	**More cancers will be detected earlier, leading to improved survival rates and more positive outcomes for those affected**	**On Plan**
	Improving earlier cancer diagnosis remains a key priority, to support the target of 75% of cancer patients being diagnosed with a stage 1 or 2 cancer by 2028. The Trust continues to focus on rolling-out, and promoting awareness of, self-referral services for suspected cancer to support improved access, alongside evidence-led targeted case-finding of high-risk individuals within the population. This is in addition to continuing to strengthen the Trust's internal cancer pathways, and right-size service capacity, to support faster diagnosis and treatment once a patient is referred.	
3	**Patients with dementia will have the chance to be as independent as possible, because every person diagnosed with dementia will receive personalised, co-ordinated care**	**Behind Schedule**
	Further work required to develop the plan which will provide more detail on future focus.	
4	**People will be happier with the GP services we provide, and will access GP services quicker so that hospital attendances do not grow in line with the population.**	**On Plan**
	Symphony practices across South Somerset West have now merged enabling a more agile approach to access. The Symphony transformation programme is improving access to primary care through	

	centralised triage, contact hub services and integrated neighbourhood working, helping people receive the right care at the right time. Through population health management and multidisciplinary team working, Symphony is supporting earlier intervention for people at greatest risk of poor outcomes. Early evidence shows reduced emergency admissions for frailty, falls and care home residents in South Somerset West, helping to reduce demand on acute services and improve coordinated care.

Risks - Scoring and Appetite

Risk Appetite over Time – Aim

Open - 12				
June 2026	**September 2026**	**December 2026**	**March 2027**	**June 2027**
Above appetite	Above appetite			

Strategic Risks to Aim

		Score
1	**Quality and safety deterioration risk** There is a risk that the quality and safety of care is compromised due to service pressures, workforce constraints or variation in practice, resulting in harm to patients and regulatory breach.	**3x5 15**
	Controls (what we are doing) • Established governance framework • Compliance with national standards and regulatory requirements (CQC, NHSE) • Workforce models and safe staffing processes • Clinical audit programme and quality improvement initiatives • Policies, procedures and guidelines supporting safe care	
	Assurance (how we know it is working) • QGAC, Patient Safety Board and Quality Assurance Group oversight • Regular reporting of patient safety, incidents, harm and mortality data • Internal audit and external regulatory inspections (CQC) • Clinical audit outcomes and thematic reviews • Feedback from patients, carers and staff surveys	
	Assurance Rating:	**Amber**
2	**Access and timeliness risk** There is a risk that patients are unable to access timely care (e.g. cancer, dementia, primary care), resulting in poorer outcomes and failure to meet national standards.	**4x4 16**
	Controls (what we are doing) • Performance management of national access targets (RTT, cancer, diagnostics) • Demand and capacity planning processes • Improvement programmes targeting backlog reduction • Use of alternative delivery models (virtual, community-based care)	
	Assurance (how we know it is working) • Routine performance reporting to Board and committees • Oversight through operational processes	

	• Benchmarking against national standards and peer organisations • NHSE oversight and performance reviews	
	Assurance Rating:	**Amber**
3	**Integration of care pathways risk** There is a risk that services remain fragmented across pathways and organisations, resulting in poor patient experience and suboptimal outcomes.	**3x4 12**
	Controls (what we are doing) • Development of integrated care pathways across services and organisations • Programme governance for pathway redesign • Use of shared care models and multidisciplinary teams	
	Assurance (how we know it is working) • Programme reporting and governance structures • Committee oversight of pathway performance and outcomes • Patient experience feedback on continuity of care • System-level reporting through ICS governance	
	Assurance Rating:	**Amber**

Key Actions and Areas of Focus

	Action/area of focus	Action Owner	Progress
	Strengthen integrated care pathways across primary, community and acute services.		
	Increase the use of patient feedback and outcome measures to drive service improvement		
	Improve early diagnosis and intervention for priority conditions including cancer and dementia.		

Assurance Rating Key:

GREEN	AMBER	RED
Well-functioning controls in place to manage risks and deliver aim	Some key controls in place, but may not cover all risks or elements of aim	Clear gaps in controls for management of risks and delivery of aim
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**

Board Assurance Framework 2026/27

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

Narrative Overview

This aim is about delivering the transformation of care so as to provide it as close to people's homes as we can. Care will be digital by default, in a patient's home if possible, and in a Neighbourhood Health Centre when needed. The objectives will help us to deliver the government's 10 Year Health Plan for the NHS, and its 2026 Neighbourhood Health Framework, with its focus on integration, prevention, and on the provision of alternatives to hospital care.

This aim also sets out how we will improve Outpatient care, and how we will strengthen collaboration to design services around what matters to people.

SFT Objectives / Programmes

1	**People will access more care in the community, and go to hospital less, because they will be served by Integrated Neighbourhood Teams and Neighbourhood Health Centres**	**On Plan**

Delivering this objective was central to the rationale for merging the former three NHS Trusts in Somerset to form Somerset NHS Foundation Trust. Since that time the priority of this objective has become a key feature of national healthcare policy in the form of the NHS 10 Year Plan which was published in 2025. The primary purpose of this objective is to improve the health of the Somerset population to support people in living longer, healthier lives where they can enjoy more years of good health whilst living independently or with minimal community support. Important further benefits relate to improving patient satisfaction and reducing pressure on hospital based acute services which will continue to play a vital role in healthcare delivery for those patients who need to be assessed and treated at these locations.

Previous initiatives related to the development of neighbourhood services have tended to focus almost exclusively on frail, older people with one or more long term health conditions. Whilst SFT remains focussed on improving services for these people in our communities, the Trust objective here is to go beyond this definition of neighbourhood working and to seek to improve the health and wellbeing of children, young people and families. The key principles of providing easier and earlier access to services will be of vital importance here. Similarly, adults of working age including people with learning disabilities or mental health problems should also benefit from new approaches to partnership working within local communities.

As the delivery of safe and effective care in the community often requires the joining up of a team effort between statutory, voluntary and local citizens, the Trust will seek to accelerate it's work with partners to develop neighbourhood provider teams in all 13 of the primary care networks in the county. As a key anchor organisation, the Trust will seek to increasingly take on a leadership role in neighbourhood development where this is required.

	Core metrics to be monitored as part of delivering this objective within the strategy delivery plan will include: • Footfall numbers and demographic information for patients accessing care at our neighbourhood health centres and other community venues and diagnostic centres • The percentage/number of total SFT patient contacts that are delivered in a community setting or remotely • Caseload and activity numbers for integrated neighbourhood teams broken down by primary care network areas	
2	**People with multiple long term conditions will go to hospital less, because they will have more joined-up care**	**On Plan**
	The development of partnership working within integrated neighbourhood teams will facilitate the earlier identification of patients who are living with two or more long term health conditions. The Trust will embrace the use of new digital tools capable of identifying individuals within this cohort of patients who are at risk of deterioration without early and ongoing support and intervention, and also at risk of hospital admission. The new integrated neighbourhood teams will bring together colleagues from a range of professional disciplines to build care around individual patients using a holistic approach to deliver patient centred care. Where required, hospital-based specialists will be co-opted into the work of the team using new digital technologies to further refine treatment and care. A broad definition of care will be used by these teams that incorporates the vital work of voluntary sector organisations and active citizens as part of supporting health and independence at home. Core metrics to be monitored as part of delivering this objective within the strategy delivery plan will include: • Numbers of patients per PCN identified as having two or more long term health conditions • Numbers/percentage of this population receiving active care and support as part of the integrated neighbourhood team caseload • Total/percentage admissions of this patient group admitted to hospital • Length of stay/total bed days in hospital for patients with two or more conditions admitted to hospital, broken down by PCN area.	
3	**Outpatients will need to go to hospital less, and will find it easier to manage their health at home, because most outpatient care will be delivered outside of acute hospitals, and more people will have their health monitored remotely thanks to expanded digital technology**	**On Plan**
	The NHS 10-year plan published in 2025 gives an explicit commitment to end the current traditional model of hospital-based outpatient care by 2035. In line with this plan and the overarching goals stated in the 3 shifts, the Trust will continue its drive to embrace new digital technologies which have particular value within our rural county where public transport infrastructure is limited. This new approach to care will take place in partnership with Primary Care as the Trust continues to be one of the national leaders in rolling out the Advice & Refer system and capability in digital care is set to take a major step forward in 2028 with the EPIC digital healthcare system. Core metrics to be monitored as part of delivering this objective within the strategy delivery plan will include: • Percentage of total outpatient appointments delivered remotely • Percentage of total outpatient appointments delivered in a community setting	

	• Numbers of patients benefitting from remote health monitoring.

Risks - Scoring and Appetite

Risk Appetite over Time – Aim

Seek 15-16				
June 2026	**September 2026**	**December 2026**	**March 2027**	**June 2027**
Within appetite	Within appetite			

Strategic Risks to Aim

		Score
1	**Transformation delivery risk** There is a risk that the shift of care from acute to community settings is not delivered at pace or scale, resulting in continued pressure on hospital services and failure to realise strategic benefits.	**4x4 16**
	Controls (what we are doing) • Defined transformation programmes • Clear executive ownership and programme boards • Alignment with national policy and funding streams	
	Assurance (how we know it is working) • Programme reporting to Board / committees • Delivery milestones and benefits tracking	
	Assurance Rating:	**Amber**
2	**System integration risk** There is a risk that Integrated Neighbourhood Teams and partnership models are not effectively implemented, resulting in fragmented care and duplication of effort.	**3x4 12**
	Controls (what we are doing) • Development of Integrated Neighbourhood Teams • Shared objectives and aligned planning processes • Collaborative commissioning and delivery arrangements	
	Assurance (how we know it is working) • Oversight through joint boards / committees • Evaluation of integrated care outcomes • Stakeholder feedback	
	Assurance Rating:	**Amber**
3	**Capacity mismatch risk** There is a risk that community services do not have sufficient workforce or infrastructure capacity to absorb activity shifted from acute settings, resulting in service deterioration.	**4x4 16**
	Controls (what we are doing) • Workforce planning aligned to community expansion • Development of community infrastructure and services	

	• Phased transition of activity from acute sites • Service modelling and demand forecasting	
	Assurance (how we know it is working) • Workforce metrics and vacancy rates • Performance against demand and capacity indicators • Oversight via operational and Board reporting	
	Assurance Rating:	**Amber**

Key Actions and Areas of Focus

	Action/area of focus	Action Owner	Progress
	Expand delivery of care closer to home through Integrated Neighbourhood Teams.		
	Continue development of Hospital at Home and other alternatives to inpatient care.		
	Strengthen multi-professional working across community, primary and acute services.		

Assurance Rating Key:

GREEN	AMBER	RED
Well-functioning controls in place to manage risks and deliver aim	Some key controls in place, but may not cover all risks or elements of aim	Clear gaps in controls for management of risks and delivery of aim
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**

Board Assurance Framework 2026/27

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

Narrative Overview

Our focus is on improving services for people with complex health needs, those who are at high risk of harm, and those who frequently use our services have a positive experience.

We have focused on particular cohorts of people who have complex needs. Our ageing population means that there is a high risk of more frail people needing more complex care Many of our most complex service users are children, some of whom have significant needs which go beyond healthcare and encompass educational and social needs. Individuals with learning disabilities often encounter obstacles when seeking care. And as the population of people diagnosed with autism and ADHD steadily grows, there is a pressing need for more timely and effective services for these groups. Our specific objectives and metrics reflect these needs.

SFT Objectives / Programmes

1	**People living with frailty will have more opportunities to live independently, safely and with dignity, supported by targeted services and resources**	**On Plan**

Somerset has one of England's oldest populations, with over 25% of the population aged 65+. Frailty is a condition of reduced resilience that increases vulnerability to illness and loss of independence - it is not an inevitable part of ageing but becomes commoner with age. A proportion of people with frailty have concurrent dementia, and many people with dementia are also frail. With a large and expanding group of older residents in Somerset, it is important that we design and deliver effective health and social care for all older people with frailty. Frailty can to some degree be prevented, deferred and sometimes reversed through interventions at population and individual level. In addition, with proactive, coordinated care, people living with frailty can maintain independence, live well for longer, and avoid unnecessary hospitalisation. Finally, when older people with frailty do need admission to hospital, evidence-based modifications to their care before, during and after hospitalisation can reduce mortality, shorten hospital length of stay and reduce the need for long term care.

The key actions for our programme are:

- "Choose to admit" culture — only those needing 24/7 specialist input are admitted.
- All activity to be personalised, patient centred and based on patient values.
- Frailty teams at the front door providing early assessment and rapid discharge.
- Minimise ward moves and prevent hospital-acquired harms (falls, delirium, malnutrition).
- Integrate hospital and community teams for seamless discharge planning by developing shared information systems to automate flow of information between hospital and community.
- Prioritise dementia-friendly care and carer involvement.

How will we measure our success?

	These are our key metrics:
	• Length of stay (frailty cohort / over-65s) elective and non-elective
	• Length of stay readmission rates (30 days).
	• Percentage of non-elective admissions over 65 with frailty level recorded
	• Percentage of elective major surgery admissions over 65 with frailty level recorded
	• Percentage patients over 65y with NCTR
	  • Target to measure frailty in all non-elective admissions over 65
	  • Target to measure frailty in all elective admissions over 65 for major surgery
	
	A considerable amount of progress has been made and the Frailty front-door service is operational at YDH. Discussions continue this week to agree how to replicate this at MPH.
	The team is also focusing on the top 1% frailty patients within the community and how each part of the system will support this important group.	

2	**There will be fewer hospital admissions and deaths caused by intentional self harm**	**On Plan**
	Work is ongoing on a five-year Complex Emotional Needs (CEN) strategy for SFT, just entering Year 3. Year 1 focussed on inpatient mental health services, Year 2 on urgent care mental health, and Year 3 on the community. Later years will look at wider SFT services (including ED), primary care, and voluntary sector. We were directed to focus on reducing inpatient bed days for people with CEN. This shows a reduction for mean inpatient bed days of 45% between 2023 and 2026 We also found that, despite a lowest ever quarter for admissions in Q1 2026, the overall number of admissions is not reducing and continues to fluctuate We believe that this shows that despite continuing pressure of admissions, patients are being turned around quicker for discharge. Data from the National Confidential Inquiry into Suicide by People with Mental Illness show that SFT had a higher than average suicide rate between 2021 and 2023 at 6.00 per 10,000 people compared to a national median of 4.34. There was a further indication that suicide within 3 months of discharge was particularly increased. At the same time, there are some indications that the suicide rate has been falling in Somerset between 2020 and 2024, reaching parity with the rate for England overall. Data are not yet available for suicides since the CEN strategy was implemented, though we believe the number has reduced since 2023. The CEN strategy has made a number of changes, but we believe the most effective is the introduction of a weekly CEN Panel. This brings together clinicians and managers from inpatient and community services to discuss CEN patients, predominantly those on acute mental health wards where discharge is delayed. This has improved collaboration between ward and community services and given clinicians the confidence to manage risk. CEN Panel appears to have also provided more purposeful admission with early discharge planning and less need for Senior Clinical Review Panels. Despite quicker discharges, suicides do not appear to have increased, and may have decreased. We hope that improved integration of inpatient and community services around discharge will have reduced the risky period of 3 months post-discharge but will have to await more recent data. Work is going to plan, assessed at a 2-monthly CEN Steering Group. Year 3 of the CEN strategy will define more clearly and standardise the community CEN offer, increasing awareness of the existing 3 phases of care within Relational Recovery team (specialist CEN clinicians), and laying out the available interventions based on patient need rather than service availability. We are also providing training and additional interventions to support wider CMHS clinicians to manage CEN.	

	We have not so far been able to reduce the raw number of CEN admissions. Rapid review of a relative spike for Q2 2026 showed that >80% of admissions took place out of hours via emergency services (ED/police) which we could not have directly prevented. We hope that Year 3 work will support a reduction of admissions for those currently under mental health services, but this is unlikely to have a major effect on numbers for those outside services.	
3	**Children with complex and special educational needs will be able to access appropriate care close to their home rather than in hospitals or out of Somerset. and have more psychological support, wait less time for care**	**Update to be provided**
	Further work is required to define this programme.	
4	**People with Learning Disabilities, Autism and ADHD will be able to keep healthier and live more independently, due to having better access to primary care services, and more targeted secondary care services**	**On Plan**
	Coproduction is embedded throughout primary and secondary care SASS (Somerset Autism Spectrum Service) and LD services, with the aim of improving the experience of autistic people when accessing services. The team and LEPs (Lived Experience Partners) are engaged with training and awareness delivered to GPs, acute medical services and mental health colleagues in secondary care; coproduced autism passport and reasonable adjustments leaflet; and working with LeDeR to promote the use of the autism/ health passport. Our LEPs have also undertaken several walk-arounds of different services to give their thoughts and advice and reviewed service documentation and processes to support accessibility. We encourage feedback from people accessing our assessment service and continue to review and improve all aspects of our assessment process, and to offer timely post-diagnostic support. Our board game group, online drop-in, and a planned drum circle group, provide a space for autistic people to come together, and share experiences. Our consultation service for SFT colleagues working with LD, autistic and ADHD clients gives health professionals space to reflect on reasonable adjustments and working in a neurodiverse informed way. The autism/ health passport and letters of support, alongside consultation and liaison with colleagues can help to smooth the fit between the autistic person and any future input e.g. upcoming therapy, employment support etc. Mental Health inpatient services have been supported by our Rapid Intervention Team to develop LD champion roles and we actively support the Transforming Care agenda and have oversight of both the LD and ASD Dynamic Support register with the view of supporting people with LD and autism currently in inpatient facilities to return to community settings. The LD service runs a virtual resource hub, accessible to all SFT services, to support with the development of accessible information for people with LD.	

5	**People who frequently use our services will use them less due to more personalised, coordinated care planning**	**On Plan**
	The Personalised Care Programme is a key enabler of Somerset Foundation Trust's ambition to place people, their families and carers at the centre of decision making. The programme aims to embed a consistent approach to personalised care across all services, ensuring that care is shaped by "what matters" to the individual, supports shared decision making, and enables people to be equal partners in planning and managing their health and wellbeing. The programme aligns with the Trust Quality Strategy, Patient Experience and Involvement Strategy, and wider Somerset system ambitions for personalised care. Following recommendations from the 2023 personalised care audit, the Trust established the Personalised Care Improvement Group (PCiG) to provide strategic oversight and coordinate delivery of a trust-wide improvement plan. Key objectives include strengthening leadership and culture, improving the quality and consistency of personalised care and support planning, embedding shared decision making, enhancing colleague capability through training and education, improving communications and engagement, and developing digital systems that better support personalised care conversations and documentation. Progress has been made in establishing the governance, infrastructure and improvement mechanisms needed to support sustainable change. Achievements include development of a Trust-wide Personalised Care Improvement Plan for 2026 to 2029, creation of a communications strategy, development of a training offer, strengthened links with the Somerset system personalised care programme, delivery of leadership engagement sessions, and support for improvement initiatives that promote "what matters to me" conversations. Work is also progressing to standardise personalised care and support planning across Somerset, including development and testing of a shared digital care plan to improve consistency and information sharing across services. The programme has moved from strategy development into implementation and measurement. Current priorities focus on embedding personalised care behaviours within everyday practice, increasing adoption of personalised care planning, and delivering measurable improvements in patient experience, involvement and outcomes. While challenges remain around capacity, engagement and consistency of practice, the foundations are now in place to support wider cultural change and to make personalised care the "golden thread" running through all Trust services.	

Risks - Scoring and Appetite

Risk Appetite over Time – Aim

Seek 15-16				
June 2026	**September 2026**	**December 2026**	**March 2027**	**June 2027**
Above appetite	Above appetite			

Strategic Risks to Aim

		Score
1	**Rising demand complexity risk** There is a risk that increasing demand from people with complex needs (frailty, LD, autism, safeguarding) outstrips service capacity, resulting in poorer outcomes and increased risk.	**5x4 20**
	Controls (what we are doing) • Targeted service models for high-risk cohorts (frailty, LD, autism) • Identification of vulnerable individuals	

	• Investment in specialist services and pathways	
	Assurance (how we know it is working) • Monitoring of demand trends and service utilisation • Committee oversight (QGAC, safeguarding structures) • Outcome measures for key cohorts	
	Assurance Rating:	**Amber**
2	**Safeguarding and vulnerability risk** There is a risk that systems for identifying and responding to safeguarding risks are not sufficiently robust, resulting in harm to vulnerable individuals.	**3x5 15**
	Controls (what we are doing) • Safeguarding policies, training and procedures • Designated safeguarding leads and governance structures • Incident reporting and escalation processes	
	Assurance (how we know it is working) • Safeguarding committee oversight • Compliance reporting (training, incidents, reviews) • External inspection findings (CQC, safeguarding partnerships)	
	Assurance Rating:	**Amber**
3	**Personalisation failure risk** There is a risk that personalised, coordinated care plans are not consistently implemented, resulting in avoidable admissions and poor patient experience.	**3x4 12**
	Controls (what we are doing) • Implementation of personalised care plans • MDT working and care coordination processes • Engagement with patients and carers	
	Assurance (how we know it is working) • Patient experience and outcome measures	
	Assurance Rating:	**Amber**

Key Actions and Areas of Focus

	Action/area of focus	Action Owner	Progress
	• Improve coordinated care for people with frailty and other complex health needs.		
	• Strengthen personalised care planning for people who frequently use services.		
	• Improve outcomes for children and adults with complex, neurodevelopmental and learning disability needs.		
	• Improve the transition from children to adult services		

Assurance Rating Key:

GREEN	AMBER	RED
Well-functioning controls in place to manage risks and deliver aim	Some key controls in place, but may not cover all risks or elements of aim	Clear gaps in controls for management of risks and delivery of aim
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**

Board Assurance Framework 2026/27

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

Narrative Overview

We will deliver this aim through our People Strategy 2023–2028.

As an anchor organisation in Somerset, we provide careers, learning and development opportunities for local people, especially those who may find it harder to access them. We are committed to widening access and creating fair opportunities for all. We will work with partners to support people across Somerset to build skills, careers and futures locally, including increasing the number and diversity of students, apprentices and trainees learning with us.

We want Somerset FT to be a place where everyone feels welcome, valued and able to thrive. We will attract, develop and retain a diverse workforce, where our values of kindness, respect and teamwork shape everyday experiences. We are committed to a compassionate, inclusive culture where everyone belongs and is supported to succeed.

We will invest in our colleagues to have the skills they need for the future, including digital skills. We will continue to offer development opportunities for all, helping colleagues grow, progress and deliver high-quality care in our communities.

SFT Objectives / Programmes

1	**Our clinical services will be appropriately staffed to provide quality care because we will achieve a sustainable workforce supply**	**On Plan**
	We have made good progress in building a more sustainable workforce through stronger local pipelines and targeted recruitment. Partnerships with schools, colleges and universities have expanded opportunities for local people to train and work with us, increasing the number of apprentices, students and trainees entering our workforce. We have also continued to recruit internationally in key shortage areas, helping to maintain safe staffing levels while strengthening skills across the organisation. Alongside this, we are focusing on developing the right skills (including digital) within our existing workforce to meet future service needs.	
2	**More opportunities for colleagues and local people - there will be development opportunities for colleagues and local people to learn and work with us, to ensure the resilience of our clinical services**	**On Plan**
	We have expanded development opportunities for colleagues through programmes such as internal leadership development, clinical upskilling pathways, and apprenticeships across both clinical and non-clinical roles. For example, we have supported healthcare support workers to progress into nursing roles, and enabled registered staff to access advanced practice training.	

	We have also worked with local schools and colleges to introduce careers engagement initiatives, including work experience placements, T-Level opportunities and pre-employment programmes, helping local people gain insight into NHS careers and develop the skills to join our workforce. Our partnerships with universities have strengthened, increasing the number of student placements in nursing, therapies and medicine, alongside joint development of curriculums aligned to local workforce needs. In addition, we have begun exploring the development of a Somerset Medical School in collaboration with regional partners, with early work focused on feasibility, clinical placement capacity and building academic partnerships to support more doctors to train locally and remain in Somerset.	
3	**Services will be more sustainable, and provide higher quality care, because we will be better able to retain colleagues**	**On Plan**
	The rollout of the Compassionate Leadership programme is progressing as planned, with a targeted focus on key leadership roles across both service and corporate areas. This is strengthening the consistency and visibility of compassionate leadership behaviours across the organisation. Manager and leadership capability continues to improve through a structured programme of development, including enhanced training on people management practices, policies and processes. Feedback and early indicators show increased confidence among managers in addressing workforce matters effectively and consistently. The new NHS Staff Standards provides a renewed focus and framework on areas affecting colleagues, this will be reported through the oversight framework and includes the new leadership framework. A more targeted approach to coaching and mentoring has been implemented, prioritising individuals in critical leadership roles and those requiring additional support. This is enabling more personalised development, strengthening leadership effectiveness and supporting succession planning across the Trust.	

Risks - Scoring and Appetite

Risk Appetite over Time – Aim

Significant 20-25				
June 2026	**September 2026**	**December 2026**	**March 2027**	**June 2027**
Within appetite	Within appetite			

Strategic Risks to Aim

		Score
1	**Workforce supply and sustainability risk** There is a risk that the Trust is unable to recruit and retain sufficient skilled workforce, resulting in service instability and increased costs.	**4x5 20**
	Controls (what we are doing) • Workforce strategy and planning processes • Recruitment campaigns and workforce supply pipelines	

	• Robust development of apprenticeship and entry level pathways • International recruitment and partnerships with education providers • Retention initiatives and workforce wellbeing programmes	
	Assurance (how we know it is working) • Workforce metrics (vacancies, turnover, absence, bank & agency usage, rostering practice) • Reporting to People Committee, Executive Committee • Staff survey, pulse results, GMC National Training Survey (NTS), National Education & Training Survey (NETS) • External benchmarking (NHS workforce metrics) • Safer staffing assurance	
	Assurance Rating:	**Amber**
2	**Culture and engagement risk** There is a risk that colleague experience, wellbeing and culture deteriorate, resulting in reduced productivity, increased turnover and poorer patient care.	**3x4 12**
	Controls (what we are doing) • Organisational development and leadership programmes, inc the new Leadership framework • Colleague engagement initiatives • Equality, diversity and inclusion strategies, including executive inclusion objectives 26/27, • Freedom to Speak Up and colleague feedback mechanisms • Focus and reporting on the new NHS Staff Standards framework	
	Assurance (how we know it is working) • NHS Staff Survey and Pulse outcomes • Reporting on colleague experience metrics • Oversight through People Committee • External benchmarking • Freedom to Speak up cases • National Education and Training surveys • Various Student feedback opportunities • Employee Relations casework and learning • Leadership Quality visits feedback (reports through to People Committee)	
	Assurance Rating:	**Amber**
3	**Workforce transformation risk** There is a risk that the workforce does not develop the skills required (e.g. digital, new models of care), resulting in inability to adapt to future service models.	**3x4 12**
	Controls (what we are doing) • Training and development programmes (including digital, data and AI skills) • Alignment of workforce plans to service transformation – augmented workforce • Leadership development programmes linked to the new leadership framework • Role redesign focus • Healthset programme Board	
	Assurance (how we know it is working) • Tracking of training uptake and capability development	

	• Reporting on workforce transformation • Evaluation of workforce impact on service delivery • Healthset milestones	
	Assurance Rating:	**Amber**

Key Actions and Areas of Focus

	Action/area of focus	Action Owner	Progress
	• Expand leadership, learning and development opportunities.		
	• Improve colleague wellbeing, engagement and inclusion.		
	• Build workforce capability to support new models of care and digital transformation.		

Assurance Rating Key:

GREEN	AMBER	RED
Well-functioning controls in place to manage risks and deliver aim	Some key controls in place, but may not cover all risks or elements of aim	Clear gaps in controls for management of risks and delivery of aim
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**

Board Assurance Framework 2026/27

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

Narrative Overview

We have plans in place to deliver significant savings by transforming our care pathways and reducing demand for more expensive, hospital-based care.

We will maximise the productive use of our resources, obtaining best value for every pound we spend and optimise our use of workforce, infrastructure, and community assets. We will use new technology like AI and robotics to make sure that we are as productive as possible.

We will also direct our resources where they are most needed. Where there are communities that need our help more, we will provide them with appropriate levels of support. This could include areas of economic and social poverty, or population groups with poor health outcomes.

SFT Objectives / Programmes

1	**Our services will be delivered in a financially sustainable way, to ensure their viability**	**Behind Schedule**
	The percentage of recurrent efficiency savings being forecast falls below the aspiration included within the 2026/27 financial plan. This will add pressure into the 2027/28 financial planning and reducing the underlying deficit if it is not improved. Plans continue to the progressed and challenged regarding the recurrent percentage delivery within service groups and corporate areas.	
2	**Our services will be delivered from accommodation that is fit for purpose, including new healthcare buildings on hospital sites and in neighbourhoods across Somerset**	**On Plan**
	A number of new facilities have been completed this year including handover and commissioning of the Kings Building at Musgrove Park Hospital, the completion of Bridgwater diagnostics centre and opening of the extra care area within in Rydon ward. A pipeline of community and acute developments are in progress including neighbourhood hubs and development of the urgent Treatment centre in Musgrove. There remains a long-term issue of backlog maintenance across many of our sites but funding has been secured to support the refurbishment of the YDH tower over the next 4 years. However long term funding to replace the Maternity and Children's and other old building at MPH whilst part of the New Hospital Programme remains uncertain.	

3	**Our carbon emissions will be reduced, and our buildings will be made more resilient to the affects of climate change so as to guarantee the resilience of our clinical services**	**Behind Schedule**
	Overall progress has been made in reducing year on year carbon emissions through the investment in energy reduction, solar and air source heating solutions. To meet the required targets will require significant investment in large scale decarbonisation of the energy infrastructure which is not currently identified. The impact of recent heatwaves has identified challenges of infrastructure resilience and the need to implement further colling measures across our estate.	
4	**Corporate and clinical operational services will be transformed through greater use of Artificial Intelligence, so that they are more efficient and better able to serve the needs of patients**	**On Plan**
	To support the transformation of corporate and clinical operational services through greater use of Artificial Intelligence, we have partnered with Sanctuary to undertake a six-week diagnostic review across the Trust's corporate functions. This work will identify opportunities to use AI and automation to create a more integrated, efficient, and joined-up programme of work. The diagnostic will assess current processes, highlight areas for improvement, and develop recommendations for how AI can enhance productivity, streamline operations, and improve service delivery. Ultimately, this will help ensure that both corporate and clinical support services are better equipped to meet the needs of patients through more efficient and effective ways of working.	

Risks - Scoring and Appetite

Risk Appetite over Time – Aim

Financial Management - Open - 12				
Commercial – 15-16				
June 2026	**September 2026**	**December 2026**	**March 2027**	**June 2027**
FinMan – above	FinMan – above			
Comm – above	Comm – above			

Strategic Risks to Aim

		Score
1	**Financial sustainability risk** There is a risk that the Trust is unable to deliver financial balance and efficiency requirements, resulting in regulatory intervention and reduced strategic flexibility.	**4x5 20**
	Controls (what we are doing) • Financial planning and budget-setting processes • Cost improvement programmes (CIPs) • Financial governance and controls framework • Regular financial performance monitoring	
	Assurance (how we know it is working) • Finance Committee oversight	

	• Monthly financial reporting to Board • External audit and regulatory oversight • Benchmarking against system and national performance	
	Assurance Rating:	**Amber**
2	**Capital investment and funding risk** There is a risk that sufficient capital funding, resources and delivery capacity are not secured to improve and maintain the Trust's estate and infrastructure, which is not fit for purpose, resulting in an inability to address known deficiencies, deliver strategic objectives and maintain compliance with required standards.	**5x4 20**
	Controls (what we are doing) • Estate strategy and capital investment planning • Engaging with Regional and National teams on future funding streams including New Hospital Programme • Prioritised capital programme aligned to strategic objectives and risk • Programme governance for major capital schemes • Maintenance and compliance programmes • Prioritisation framework for capital allocation	
	Assurance (how we know it is working) • Reporting on capital programme delivery • Confirmed allocation for Estates Safety fund for 2026/27 and constitutional standards funding 2026-2028 • Estate performance metrics (e.g. backlog maintenance) • External assurance (regulators, auditors) • Finance Committee oversight of capital programme and funding • Premisis Assurance Model	
	Assurance Rating:	**Amber**
3	**Estate deterioration and infrastructure failure risk** There is a risk that the condition of the Trust's estate and infrastructure continues to deteriorate, resulting in service disruption, patient safety concerns, increased operational costs, reduced colleague experience and failure to provide environments that support high-quality care.	**3x5 15**
	Controls (what we are doing) • Planned preventative maintenance programmes • Statutory compliance and safety inspections processes • Backlog maintenance management and prioritisation • Estates risk assessments and resilience planning • Business continuity arrangements • Escalation and monitoring of significant estates-related risks	
	• Backlog maintenance reporting • Compliance performance against statutory and mandatory requirements • Estates performance indicators/metrics • Monitoring of significant estate incidents, infrastructure failures and business continuity events	

	• Audit and inspection outcomes • Finance Committee oversight	
	Assurance Rating:	**Amber**
4	**Transformation delivery risk** There is a risk that strategic programmes are not delivered successfully or fail to realise expected benefits, resulting in failure to modernise services and reduce underlying deficit	**3x4 12**
	Controls (what we are doing) • Defined transformation portfolio aligned to Trust Strategy • Programme management methodology and reporting • Defined benefits, milestones and success measures for each programme • Alignment of transformation to financial plans	
	Assurance (how we know it is working) • Monitoring of programme milestones and benefits realisation • Reporting to Executive Committee, Finance Committee and Board • Regular reporting on portfolio delivery, risks and dependencies through the Transformation Programme Board • Internal audit / programme reviews	
	Assurance Rating:	**Amber**
5	**Productivity delivery risk** There is a risk that planned productivity improvements are not delivered at the scale and pace required resulting in deterioration of financial performance and inability to achieve financial plans	**4x4 16**
	Controls (what we are doing) • Defined productivity targets and improvement programmes • Clearly identified productivity programmes with executive ownership • Use of technology and service redesign to drive efficiency • Programme management and tracking of benefits realisation • Alignment of transformation to financial plans • Benefits realisation methodology and tracking	
	Assurance (how we know it is working) • Monitoring of productivity metrics • Reporting to Finance Committee and Board • External benchmarking • Internal audit / programme reviews	
	Assurance Rating:	**Amber**

Key Actions and Areas of Focus

	Action/area of focus	Action Owner	Progress
	• Deliver the agreed financial recovery and productivity plans.		
	• Implementation of Improvement and Transformation Programme	David Shannon	Programme in place.

	• Implementation of existing estate development plans, Kings Building, Urgent Treatment Centre development	David Shannon	Current year plans in place
	• Increase the effective use of technology and automation to improve productivity and patient experience.	Isobel Clements / David Shannon	

Assurance Rating Key:

GREEN	AMBER	RED
Well-functioning controls in place to manage risks and deliver aim	Some key controls in place, but may not cover all risks or elements of aim	Clear gaps in controls for management of risks and delivery of aim
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**

Board Assurance Framework 2026/27

7	**Aim:**	Transform our services through research, innovation and digital technologies
	Executive Owner:	David Shannon, Director of Strategy and Digital Development
	Overseeing Committee:	Board of Directors

Narrative Overview

Using technology, our clinical services can do more, and provide people with a better experience of care. This is why much of our focus is on the Epic single Electronic Health Record, due to go live in 2028. When in place, we will be able to provide seamless, integrated care using only one system.

This is part of a broader transformation of services with technology over the next five years. Through the use of data, AI and technology, we will provide access to modern treatments, seamless care via digital solutions, and enable people to manage more of their care themselves, at home, with apps and wearable devices.

At the same time, we will continue to develop our expertise in innovation and research, helping our services maximise the potential of advances in technology and research outcomes.

SFT Objectives / Programmes

1	**The Healthset programme will lead to our new Electronic Health Record system being in place, meaning that every patient and clinician will have easy access to a single online care record**	**On Plan**
	The programme is on track against the programme agreed milestones. The implementation phase formally commences on 7th July 2026. Good progress has been made on recruitment to the programme team including technical and clinical subject matter experts to commence the initial system build. The governance process has been updated to reflect the phase of the programme and key leadership roles within the programme have been appointed to. Clinical / Operational and Technical design authorities have been established to support programme delivery and assurance through to programme board.	
2	**We will use new technology and artificial intelligence to improve patient experience of care, and transform enabling services and functions**	**On Plan**
	Development of the AI and automation roadmap continues to evolve, with a focus on corporate and clinical-ops transformation. Sanctuary Health are supporting a 6-week diagnostic review of use cases and scoping has started for a digital front door, building on the digital, data and technology service, initially expanding to people services, as a foundation from which to progress the roadmap and to provide a more joined up experience for colleagues. Development of the AI lab are progressing, bringing together expertise within the Trust to support the roadmap delivery.	

3	**Patients and clinicians will have more accurate and timely information so that they can make better decisions about care**	**On Plan**
	Data reporting portal is live, bringing together data and reporting into a central location for easier access. An assessment of the data skills within our data teams has been undertaken, to support the development of our data professionals and to build our data capabilities. A new operating model for data professional is in development, to provide a data/decision support unit for the organisation. Work is also underway to scope a wider support offer to colleagues with digital, data and AI literacy.	
4	**We will have better research capability, and grow a targeted portfolio of specialist research to help develop clinical services for our patients**	**Behind Schedule**
	The first meeting of our research committee was held earlier the year to develop our long term research infrastructure programme. There has been good engagement from local researchers and academic and system partners to develop an integrated research offer. To ensure a sustainable approach to research delivery has a required a focus of the research portfolio which will reduce the capacity to support the strategic development of research for the remainder of the year.	

Risks - Scoring and Appetite

Risk Appetite over Time – Aim

Significant 20-25				
June 2026	**September 2026**	**December 2026**	**March 2027**	**June 2027**
Within appetite	Within appetite			

Strategic Risks to Aim

		Score
1	**Digital transformation delivery risk (EHR)** There is a risk that major digital programmes (including Healthset) do not deliver the intended outcomes, resulting in the inability to deliver integrated care operational disruption, financial loss and fragmentation of patient records.	**3x4** **12**
	Controls (what we are doing) • Formal programme governance for major digital programmes – Programme Board and Partnership board for assurance to Executive and Board. • NHSE assurance process and independent assurance of programme initiated • Dedicated programme teams and leadership • Risk and dependency management processes • Benefits management developed as part of programme delivery	
	Assurance (how we know it is working) • Programme reporting to Board / committees –Partnership Board meeting in September • Independent assurance reviews (including NHSE gateway reviews and external assurance) • Internal audit of programme governance • Milestone and delivery tracking	
	Assurance Rating:	Green

2	**Technology adoption risk** There is a risk that AI-enabled technologies and data-driven approaches are not adopted effectively, resulting in failure to realise informed decision-making, efficiency and quality benefits.	**3x4** **12**
	Controls (what we are doing) • Training and support for staff • Change management and engagement strategies • Iterative implementation approaches • Integration with operational workflows • Benefits management and delivery • Training and development programmes (including digital, data and AI skills)	
	Assurance (how we know it is working) • Monitoring of adoption and utilisation rates • Staff feedback and satisfaction measures • Evaluation of benefits realisation	
	Assurance Rating:	**Amber**
3	**Research and innovation capability risk** There is a risk that the Trust does not develop a sufficiently balanced research and innovation capability, resulting in missed opportunities for improving care and attracting funding.	**3x5** **15**
	Controls (what we are doing) • Research strategy and partnerships with academic institutions and other partnerships • Dedicated research infrastructure and teams to delivery core research • Processes for identifying and adopting innovation • Access to funding and grant programmes	
	Assurance (how we know it is working) • Reporting on research activity and outputs • Benchmarking of research performance • Oversight via Research and Innovation Committee • External recognition and accreditation	
	Assurance Rating:	**Amber**

Key Actions and Areas of Focus

	Action/area of focus	Action Owner	Progress
	Deliver key milestones within the Healthset programme.	David Shannon	Programme on plan currently & in mobilisation phase
	Increase adoption of digital, data and AI-enabled solutions.	David Shannon	Update noted above

	Develop research capability and participation across the Trust.	David Shannon	Update noted above

Assurance Rating Key:

GREEN	AMBER	RED
Well-functioning controls in place to manage risks and deliver aim	Some key controls in place, but may not cover all risks or elements of aim	Clear gaps in controls for management of risks and delivery of aim
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
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Somerset NHS Foundation Trust	
REPORT TO:	Public Board
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Chief Medical Officer
REPORT BY:	Trust Risk Manager
PRESENTED BY:	Director of Governance
DATE:	21st August 2026

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

Executive Summary and Reason for presentation to Committee/Board	The Board of Directors are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust. They will: … ***receive and review the Corporate Risk Register via the Board Assurance Committees*** *and the Assurance Framework quarterly, which identify the principal risks and any gaps in assurance regarding those risks.* The highest areas of risk for the organisation are: • Insufficient capacity to meet demand, deliver against referral to treatment times and reduce waiting lists • Workforce recruitment and retention • Financial position • Aging estates - acute and community • Pressures in social care; intermediate care; and primary care • Delivery of digital transformation The compound risks to the organisation are: • Demand, capacity and flow constraints across services • Clinical safety and continuity of services • Workforce sustainability and wellbeing • Maternity and neonatal service pressures • Infrastructure and estate failures • Infection Prevention Control • Digital and information governance • Financial sustainability and strategic delivery If the compound risks were realised at the same time, the combined impact could be severe because these would interact and amplify each other. These risks are not isolated and if they materialise together, they can cascade into system wide failures. The potential consequences for the Trust from the compound risks are: • Increased patient safety and quality of care concerns • Reduced service resilience and ability to continue to deliver services • Reduced workforce wellbeing and ability to retain colleagues and recruit • Financial pressures and inability to achieve strategic aims • Increased regulatory interest and reputational concerns

	The combined effect can lead to loss of public confidence, regulatory intervention and strategic derailment. Of particular note under the remit of the Quality & Governance Assurance Committee since the last report: **<u>Corporate Risk Register (CRR) Highlights:</u>** • There are currently twenty-two risks (as of 21st August 2026) on the CRR, compared to twenty as reported in April 2026. • Three new corporate risks were identified in reporting period. • One corporate risk increased in scoring. • One corporate risk decreased in scoring but remained a corporate risk. • Two corporate risks were closed.
Recommendation	The report covers those risks detailed on the Somerset NHS Foundation Trust CRR on 21st August. The report focuses on the high risks scoring 15+ on the risk matrix and includes corporate risks and service group risks. The Committee is asked to note the report and the risks identified. The Committee should highlight any risks that they would expect to see on the CRR or any changes that are required following the discussions within the Committee meeting.

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

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

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

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

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

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

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

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

SOMERSET NHS FOUNDATION TRUST
CORPORATE RISK REGISTER REPORT 21ST AUGUST 2026

1. INTRODUCTION

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

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

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

1.4 The report also includes the corporate risks identified by Simply Serve Limited (SSL) and Symphony Healthcare Services (SHS) which are wholly owned subsidiary companies of SFT. These risks will either be shown as additional corporate risks for SFT or mapped into existing SFT corporate risks.

2. PURPOSE OF THE REPORT

2.1 To present the Corporate Risk Register to the Executive Committee

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 21st August 2026 as shown within Appendix 1.

3. CORPORATE RISK REGISTER

3.1 There are currently twenty-two risks on the Corporate Risk Register and 137 mapped and unmapped risks.

Risks Summary and Narrative

3.2 The most significant and recurring theme within the August high-scoring risks remains workforce capacity and resilience. Multiple risks highlight vacancies, sickness absence, recruitment challenges, maternity leave and limited succession planning across clinical and support services. The cumulative effect is increased pressure on existing teams, reduced resilience, growing reliance on temporary staffing solutions and an increased risk to service sustainability, quality of care and regulatory compliance.

3.3 A second prominent theme relates to the ongoing imbalance between service demand and available capacity. Risks describe growing backlogs, waiting list pressures, delayed diagnostics and challenges in maintaining timely access to care across a range of acute, community and specialist services. Increasing patient complexity and activity levels continue to place additional strain on constrained services, while delays in assessment, diagnostics and treatment create downstream pressures elsewhere in the system, affecting operational performance and patient experience.

3.4 The risk register also demonstrates a strong and sustained theme relating to estate, infrastructure and environmental resilience. Several risks concern ageing infrastructure, ventilation systems, electrical resilience, water safety, structural deterioration, unsuitable clinical environments, fire safety and evacuation arrangements. Environmental risks linked to overheating, humidity and extreme weather also feature, particularly where they could compromise the operation of diagnostic equipment and specialist clinical areas.

3.5 Another notable theme concerns digital systems and information management. Several risks identify limitations arising from fragmented IT systems, incomplete interoperability, inadequate alerting mechanisms, manual workarounds, data visibility challenges and system reliability concerns.

3.6 **3 New Corporate risks identified**
(period 21 April – 26 August 2026)

- **RSK-003852 Non-Urgent Patient Transport**
  Risk of: Inefficient patient flow across all SFT sites
  Due to: Current transport provider not meeting contractual requirements
  Corporate Risk 20 *Awaiting approval*

- **RSK-003975** Inability to Meet NCTR Reduction Trajectory Impacting Capacity and Flow
  There is a risk that continued high NCTR levels and failure to meet agreed reduction trajectories will impact hospital capacity and patient flow, leading to delays in admissions, discharges and hospital processes, increasing operational pressure and potential risks to patient care.
  Corporate Risk 20

- **RSK-003956** Nursing agency market contraction causing safer staffing risk
  Risk of: Unsafe staffing levels and or inappropriate skill mix on clinical shifts.
  Hazard: Pre-mature contraction or collapse of the external agency market as a result of the NHS ambition to reach zero agency by 2029 and in year agency cost reduction targets. Alongside our local reliance on travelling nurses, dataset requested, who are expected to settle closer to home as agency opportunities diminish.
  Corporate Risk 16 *Awaiting approval*

1 Corporate risk score increased

3.7 (period 21 April – 27 August 2026)

- **RSK-000004** Demand
  Demand - if demand for services continues to increase in-line with demographic trends then the Trust will not have sufficient capacity.
  Score increased from 12 to 15.

1 Corporate risk score reduced

3.8 (Period 21 April – 27 August 2026)

- **RSK-003775 -** Safer staffing standards are not maintained
  Risk of degradation of the safety of patient and service user care, for example increased likelihood of clinical errors, delayed interventions, or unsafe skills

mix. This would be due to the hazard that is a care environment where safer staffing standards cannot be maintained in one or more areas across the trust Score changed from 20 to 16 but remains a corporate risk.

1 Corporate risk closed

3.9 (period 21 April – 27 August 2026)

- **RSK-003563** Inability to deliver a robust claims and inquest provision - 16 Risk closed following the appointment of a Claims and Inquests Manager to the previously vacant role.
- **RSK-003673** Critical Staffing Gaps due to the collapse of the agency market. This risk was closed and replaced by RSK-003956 as outlined above.

4. Risk Appetite & Risk Tolerance

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

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

5. Service Group & Corporate Function Risks

5.1 Excluding the 21 corporate risks there are 137 risks scoring 15 or more identified at Service Group and departmental levels. Some of these risks have been mapped to risks on the Corporate Risk Register as shown in Appendix 1. The movement of these risks since the last report has also been included within Appendix 1.

6. Compound Risks

6.1 Compound risks happen when more than one problem occurs at the same time, or one after another, and they make each other worse. For example, a winter surge in patients combined with staff shortages and a system outage can create a much bigger impact than any one of those issues on its own.

6.2 Because these risks are linked, they can quickly put extra pressure on services, staff, and patient care.

6.3 Understanding compound risks helps us plan better by looking at how different risks connect, rather than treating them separately.

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

- Demand, capacity and flow constraints across services
- Clinical safety and continuity of services
- Workforce sustainability and wellbeing

- Maternity and neonatal service pressures
- Infrastructure and estate failures
- Infection Prevention Control
- Digital and information governance
- Financial sustainability and strategic delivery

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

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

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

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

7. POSITIVE RISK TAKING

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

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

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

8. RISK MANAGEMENT ARRANGEMENTS UPDATE

8.1 The Risk Management Strategy 2026-2029. Has now been ratified and the Risk Team met on the 13 May 2026 to plan a timetable for the strategy deliverables. This has been shared with the Director of Governance.

8.2 Work continues to implement the aligned risk management processes with training and support being provided to individuals and teams across the organisation. The Audit Committee will be kept up-to-date on a regular basis through this report on the

progress with the implementation plan included within the Trust's Risk Management Strategy and Policy.

8.3 Overall compliance with Level 1 Risk Management mandatory training for July (latest figures) shows steady progress, with the latest data showing Trust-wide compliance rising to 87.9% up from 86.9% in the previous report.

8.4 Work is ongoing to review all risks on Radar to ensure these meet the minimum standards as specified within the approved Risk Management Policy.

9. CONCLUSION

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

10. RECOMMENDATION

10.1 The Executive Committee are asked to review the Corporate Risk Register.

Corporate Risk Register 21st August 2026

People Committee

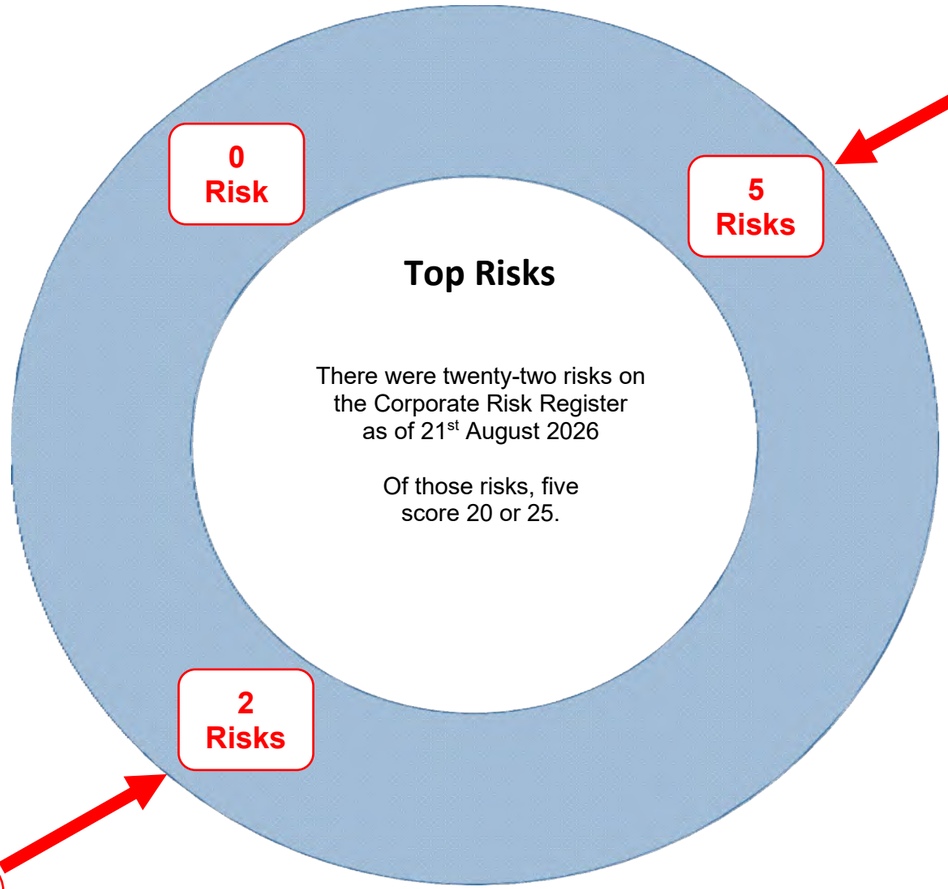
16 RSK-003775 If safer staffing standards are not maintained, risk of degradation of the safety of patient and service user care, for example increased likelihood of clinical errors, delayed interventions, or unsafe skills mix.

16 RSK-002770 Inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients due to systemic discrimination

16 RSK-003222 Inconsistent provision of rest/wellbeing spaces across SFT impacting on colleague health and wellbeing

16 RSK-003956 Nursing agency market contraction causing safer staffing risk

16 RSK-001815 Workforce metrics such as vacancies, retention & sickness affecting delivery of care



Financial Committee

20 RSK-001611 Failure to secure necessary infrastructure due to the assurance of availability of capital funding either locally or through national programmes

20 RSK-002192 SHS not becoming self-sustaining ***(SHS Risk)***

Quality & Governance Committee

20 RSK-000012 Waiting Times

20 RSK-001517 Risk of enforcement action from the Information Commissioners Office as a result of non-compliance with Data Protection Act due to the increased volume of subject access requests

20 RSK-001789 Unsafe premises and environment

20 RSK-003852 – Non-Urgent Patient Transport

20 RSK-003975 – Inability to Meet NCTR Reduction Trajectory Impacting Capacity and Flow

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

16 RSK-000007 Referral to Treatment Times

16 RSK-001878 Inefficient use of Safeguarding resource due to the current need to develop workarounds for using the multiple systems to ensure delivery of a safe Safeguarding Service

16 RSK-002923 Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas

16 RSK-000673 Current capacity and future resilience of primary care in Somerset

16 RSK-003616 Risk of regulatory action due to non-compliance with Health & Safety (Sharps Instruments in Healthcare) Regulations 2013

15 RSK-000004 If demand for services continues to increase in-line with demographic trends then the Trust will not have sufficient capacity.

15 RSK-000862 Use of escalation beds across SFT

15 RSK-002462 Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for decontamination.

15 RSK-002677 Passive fire protection breaches, dampers & non compliant fire doors across inpatient services

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

Appendix 1

NHS Somerset NHS Foundation Trust

Mapped Risks Summary and Narrative

Service Group and Corporate Function Risks 15+

The most significant and recurring theme within the August high-scoring risks remains **workforce capacity and resilience.** Multiple risks highlight vacancies, sickness absence, maternity leave, recruitment challenges and limited succession planning across both clinical and support services. This is evident within transfusion services, sonography, paediatric nursing, neonatal medical staffing, obstetrics and gynaecology, district nursing, occupational therapy, paediatric dietetics, diabetes services, GP services and specialist paediatric respiratory provision. A number of risks continue to identify single points of failure where key services rely on one or two highly specialised individuals, creating vulnerabilities if staff are absent or leave. The cumulative effect is increased pressure on existing teams, growing reliance on temporary staffing solutions, reduced resilience and a heightened risk to patient safety, service sustainability and regulatory compliance.

A second prominent theme relates to the ongoing imbalance between **service demand and available capacity**. High-scoring risks continue to describe growing backlogs, waiting list pressures, delayed diagnostics and challenges in maintaining timely access to care. This is particularly evident across dermatology, glaucoma, ultrasound, DEXA, cancer pathways, women's health services, emergency departments, medical admissions, paediatric dietetics and community services. Several risks highlight increasing patient complexity alongside rising activity levels, creating additional strain on already constrained services. There is also evidence that delays in assessment, diagnostics or treatment are creating downstream pressures elsewhere in the system, reinforcing the cycle of demand exceeding capacity and impacting both operational performance and patient outcomes.

The risk register also demonstrates a strong and sustained theme relating to **estate, infrastructure and environmental resilience**. Numerous risks concern fire safety, evacuation arrangements, ageing infrastructure, ventilation systems, filtration failures, electrical resilience, water safety, structural deterioration and unsuitable clinical environments. Particular emphasis is placed on fire safety and evacuation challenges affecting paediatric and critical care areas, as well as the risks associated with ageing buildings, roof deterioration and estate limitations that compromise service delivery. Environmental risks linked to overheating, humidity and extreme weather continue to feature, particularly where they threaten the safe operation of diagnostic equipment and specialist clinical areas. Collectively, these risks reflect increasing organisational reliance on infrastructure that is either ageing, constrained or operating close to its safe limits.

Another notable theme concerns **digital systems and information management,**. Several risks identify limitations arising from fragmented IT systems, incomplete interoperability, inadequate alerting mechanisms, manual workarounds, data visibility challenges and system reliability concerns. Examples include issues associated with patient identification systems, diabetes records, training compliance monitoring, cancer tracking, blood product management and wider data strategy delivery. These weaknesses increase the potential for delays, human error, missed opportunities for learning and reduced confidence in service performance and compliance.

Appendix 1

NHS Somerset NHS Foundation Trust

QUALITY & GOVERNANCE ASSURANCE COMMITTEE 21 AUGUST 2026

Service Group and Corporate Function Risks 15+

RSK-000012	20 ↔	If we are unable to provide sufficient capacity to enable us to meet clinically acceptable waiting times for patients for non-admitted and admitted care, including follow up intervals, then this has the potential to impact on the clinical outcomes for patients
SA2		

RSK-003716	**20**	↔	Dermatology Advice & Guidance (Cinapsis) Capacity	**Medical**
~~**RSK-003785**~~	~~**20**~~		**Closed.** Symphony - Clinical vacancies in workforce - Symphony North Healthcare	**Symphony**
RSK-003932	**16**	↔	If Yeovil glaucoma capacity does not increase, Patients may suffer substandard outcomes due to delayed assessment and treatment.	**Surgical**
RSK-002123	**16**	↔	Increased wait time for Corneal ophthalmology patients due to increased referrals and limited clinical consultant resource	**Surgical**
RSK-002615	**16**	↔	Inability to meet Ambulance handovers trajectories at YDH due to lack of throughput (flow through ED) and output in ED (flow out of ED)	**Medical**
RSK-002697	**16**	↔	Inability to meet waiting times for Young Adult Diabetes Service (MPH)	**Medical**

RSK-003631	**16**	↔	Risk of prioritising long waiting patients over clinically urgent patients due to operational pressures and external pressures to deliver national targets	**Surgical**
RSK-003599	**16**	↔	Delay to patient care and treatment due to increase in demand, capacity and backlog.	**Symphony**
RSK-001504	**15**	↔	High referral rates into The Children and Young Person's Neurodevelopmental Pathway (CYPNP). The numbers of accepted referrals to the service are double the number of assessments that are commission	**CYP&F**
RSK-003033	**15**	↔	Risk of delayed or cancelled elective Caesarean Sections at MPH maternity due to insufficient obstetric medical staffing capacity.	**CYP&F**

RSK-001789	**20** ↔	The Trust is required to manage and maintain its premises and infrastructure such that it complies with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Regulation 12 (Safe Care and Treatment) and Regulation 15 (Premises and Equipment) as well as other Health and Safety legislation. Failure to meet these standards could lead to significant harm/injury being caused to patients, staff and visitors using our premises and services	
SA2			

~~**RSK-000532**~~	~~**15**~~		**Closed.** External cold water tank - Crewkerne Difficult access for cleaning & temp monitoring. Access restricted due to other major roofing refurb works	
RSK-003403	**20**	↔	In the event of a HAZMAT/CBRN incident at MPH, there would be a failure in the delivery of safe and timely emergency department services as decontamination area is situated outside the main entrance to ED which would lead to delayed or denied emergency care	**Corporate Function**

RSK-001849	**20**	↔	Outbreak of Carbapenemase-producing organisms (CPO) due to an environmental reservoir of CPO	**CSCS**
RSK-003032	**20**	↔	Increased risk of morbidity/mortality for mothers, birthing people and their babies due to significantly limited theatre capacity in Maternity (MPH) requiring the use of non-theatre environment being used to perform surgical procedures leading to increased risk of surgical site infections and poor experience for families	**CYP&F**
RSK-001648	**16**	↔	Risk of water systems not being safe/non-compliant with Health Technical Memorandum	**Estates**
RSK-002259	**16**	↔	Condition and security of Shepton Mallet Community hospital site	**Estates**
RSK-002264	**16**	↔	Inadequate environment to provide inpatient Colposcopy services resulting in the Trust being non-compliant with standards	**CYP&F**
RSK-002519	**16**	↔	Loss of orthopaedic restroom and preparation room due to leaks in roof (MPH)	**Estates**
RSK-002692	**16**	↔	Electrical testing of electrical equipment and infrastructure to YDH site wide exposed aged and failing systems	**Estates**
RSK-001562	**16**	↔	Non-compliance of statutory maintenance of thermostatic mixing values	**Estates**
RSK-001256	**16**	↔	Contamination due to water droplets/aerosols from toilets/macerators/drains due to poor ventilation	**Estates**

~~RSK-003260~~	~~16~~		**Closed.** With increasing electrical loads required for YDH, T5, Modular theatres and other projects, the current electrical infrastructure will be insufficient to allow these loads to be connected safely. the delay in HV system to YDH has some part in this risk	Estates
RSK-003375	**16**	↔	Increased risk of infection from lack of air changes due to the lack of ventilation within the recovery area of the main theatres which could result in the closure of recovery	**Estates**
~~RSK-003392~~	~~16~~		**Closed.** Risk to colleague/patient wellbeing due to failures in heating, ventilation and air conditioning as a result of poor maintenance of services by the Landlords (Oaklands Surgery)	Symphony
RSK-003533	**16**	↔	If the airborne contamination from mould spores in the Old Building corridor (MPH) is not rectified, patients, visitors and staff with severe immunosuppression or significant underlying respiratory conditions may experience adverse health effects following prolonged exposure	**Estates**

RSK-003852	**20** ↔	Non Urgent Patient Transport. Risk of: Inefficient patient flow across all SFT sites Due to: Current transport provider not meeting contractual requirements. impacts patient flow, patient experience and has financial costs to SFT
SA2		

Somerset NHS Foundation Trust

RSK-003975	20 ↔	Inability to Meet NCTR Reduction Trajectory Impacting Capacity and Flow. There is a risk that continued high NCTR levels and failure to meet agreed reduction trajectories will impact hospital capacity and patient flow, leading to delays in admissions, discharges and hospital processes, increasing operational pressure and potential risks to patient care.
SA2		

RSK-002866	20	↔	Poor outward flow and exit blocks leading to patient harm and poor experience (ED)	Medical

Appendix 1

Somerset NHS Foundation Trust

QUALITY & GOVERNANCE ASSURANCE COMMITTEE 21 AUGUST 2026

Service Group and Corporate Function Risks 15+

RSK-001936	**16**	If delays in reviewing controlled documents continue and overdue documents cannot be reduced, then inconsistent practice may occur, affecting care quality, regulatory ratings, and inquest outcomes.
SA2	↔	***No Risks are currently mapped to this CRR***
RSK-002923	**16**	Inability to isolate inpatients in accordance with national IPC requirements due to lack of capacity within Trust inpatient areas which could lead to increased infection transmission with cross transmission of infectious agents among patients, staff and visitors particularly for airborne, droplet, or contact-based infections
SA2	↔	***No Risks are currently mapped to this CRR***
RSK-003616	**16**	Risk of regulatory action due to non-compliance with Health & Safety (Sharps Instruments in Healthcare) Regulations 2013
SA2	↔	***No Risks are currently mapped to this CRR***
RSK-001517	**20**	Risk of enforcement action from the Information Commissioners Office as a result of non-compliance with Data Protection Act due to the increased volume of subject access requests
SA7	↔	***No Risks are currently mapped to this CRR***
RSK-002462	**15**	Lack of knowledge, skill and resource to demonstrate compliance with national guidance and legislation for decontamination due to not having a dedicated decontamination lead in place which will result in poor decontamination practice; inability to demonstrate compliance with national guidance and legislation; and increased patient harm due to inadequate decontamination of critical and non critical medical devices
SA2	↔	***No Risks are currently mapped to this CRR***

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QUALITY & GOVERNANCE ASSURANCE COMMITTEE

Service Group and Corporate Function Risks 15+

	RSK-000007	16	If we do not have sufficient capacity and resource currently allocated to meet demand for non-admitted and admitted care then waiting times will continue to lengthen.	
	SA2	↔		
RSK-003816	15	↔	Absence of a local Tier 4 CAMHS inpatient offer for children and young people	CYP&F
RSK-003920	15	↔	SFT Neonatal service Provision Risk – Workforce, Capacity and Environment	CYP&F
RSK-003811	15	↔	Demand exceeding capacity within District Nursing Teams across Somerset	Neighbourhoods
RSK-001815	15	↔	Workforce metrics such as vacancies, retention & sickness affecting delivery of care	Corporate Function
RSK-003881	20	↔	Microbiology SPS safety and quality	CSCS
RSK-003878	15	↔	Risk that the service is unable to meet operational data, population health and Healthset demands due to failure to deliver core components of the data strategy.	IT & Digital

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RSK-002677	15		Passive fire protection breaches, dampers & non-compliant fire doors across inpatient services
SA2	↔		

RSK-001897	20	↔	Patient outcomes potentially compromised due to current evacuation plan for Neonatal Unit	CYP&F
RSK-001746	15	↔	Evacuation of patients – lack of appropriate equipment to support vertical evacuation in community hospitals	Neighbourhoods
RSK-002094	15	↔	Evacuation of patients – Wards 6 to 9	Estates
RSK-002822	15	↔	Inappropriate storage, charging and use of Li-ion Batteries causing batteries rupturing and creating thermal explosions resulting in fires and exhaust of flammable and toxic gases	Estates
RSK-003090	15	↔	Due to the lack of robust fire compartmentation and non-compliant escape routes, there could be significant loss of life due to the inability to safely evacuate patients, visitors and colleagues (Level 10 YDH)	Estates
RSK-003377	15	↔	In the event of a fire on level 5, due to the lack of fire compartmentation and suitable evacuation for very high dependency patients, this could result in significant casualties and prolonged disruption of essential healthcare services	Medical
RSK-003507	15	↔	If there is a fire on ward 10 (YDH) due to the lack of robust compartmentation and non-compliant escape routes, there could be a significant loss of life due to the inability to safety evacuate patients, visitors and staff	CYP&F

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	RSK-001878	16	Inefficient use of Safeguarding resource due to the current need to develop workarounds for using the multiple systems to ensure delivery of a safe Safeguarding Service. Risk to patient safety due to potential for missing key information	
	SA7	↔		
RSK-003684	16	↔	Risk that safeguarding responsibilities within maternity and neonatal services are not consistently or effectively fulfilled due to workforce capacity pressures, variable safeguarding confidence, system interoperability issues and environmental constraints leading to delays, omissions, inconsistent safeguarding practices and increasing the potential for harm to unborn and newborn babies	CYP&F
RSK-000004	15		If demand for services continues to increase in line with demographic trends, then the Trust will not have sufficient capacity to keep pace and the quality of services will be affected which could result in poor outcomes, increase the risk of the number of medical outliers and impact on achievement of key targets, leading to regulatory action	
SA2				
RSK-002229	20	↔	Insufficient capacity to meet demand in the Rheumatology service	
RSK-001343	20	↔	Quality of Discharge Summaries	
RSK-000372	16	↔	Inability to respond in a timely responsive and safe manner due to difficulties in coordination; ability to escalate; demand in services and lack of continuous low leading to overcrowding; delays for patients and patient safety compromised (MPH ED)	

RSK-002450	**16**	↔	Inability to maintain service delivery due to demand on the epilepsy service and workforce issues	
RSK-002035	**16**	↔	Inability to meet demand for virtual macular reviews within the Ophthalmology service	
RSK-002864	**16**	↔	Inability to meet increasing demand in Emergency Department due to lack of physical space and supporting staffing establishment	
RSK-003705	**16**	↔	Lack of space to clinically review patients and no regular theatre sessions at MPH for dermatology	
RSK-000562	**15**	↔	Insufficient capacity to meet demand in diabetes specialist podiatry service	
RSK-002905	**15**	↔	Inability to meet the requirements of the paediatric transition service	
RSK-002917	**15**	↔	Inability to deliver a quality and safe paediatric dietetic outpatient service due to insufficient capacity to meet the increasing demand resulting in increased waiting times, reduced quality of patient care and negative effect on colleague wellbeing	

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RSK-000862	15	Risks to patient safety and patient experience from increased need for escalation beds across SFT due to the increasing demand, acuity of patients, increased level of no criteria to reside. This could result in; the quality of care and safety being compromised; impact of colleague experience leading to reduced morale, increased absence and inability to achieve safe staffing levels.	
SA2	↔		

RSK-002267	**16**	↔	Risk of: Increased demand resulting in escalation areas open and cancellation of elective activity due to bed capacity	
~~**RSK-003505**~~	~~**16**~~		**Closed**. Use of POAC as escalation beds	**Medical Service Group**
RSK-002782	**15**	↔	Inappropriate space against a wall used for escalation bed impacting on the ability to deliver patient care (Acute Frailty Ward)	
RSK-003511	**15**	↔	If an escalation ward is opened to alleviate emergency department overcrowding without adequate staffing; clinical safeguards; funding and governance arrangements; then patient may experience delayed or suboptimal care; colleagues may face burnout; and the organisation may be exposed to regulatory, reputational, safety and financial risks (Freya Escalation Ward)	
RSK-002267	**16**	↔	Use of escalation areas and cancellation of elective activity on YDH site	
RSK-002782	**15**	↔	Inappropriate space against a wall used for escalation bed impacting on the ability to deliver patient care (Acute Frailty Ward)	

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~~RSK-003476~~	~~15~~		**Closed.** Risk of increased patient harm whilst onboarding patients due to an increased workloads and patients staying on the unit in non-assigned bedspaces (Triscombe older persons unit, MPH) resulting in patient safety risks, failure to meet care standards, reduced colleague morale	**Medical Service Group**
RSK-003511	**15**	↔	If an escalation ward is opened to alleviate emergency department overcrowding without adequate staffing; clinical safeguards; funding and governance arrangements; then patient may experience delayed or suboptimal care; colleagues may face burnout; and the organisation may be exposed to regulatory, reputational, safety and financial risks (Freya Escalation Ward)	**Medical Service Group**

PEOPLE COMMITTEE

Service Group and Corporate Function Risks 15+

RSK-003775	**16**	Safer Staffing - Risk of degradation of the safety of patient and service user care, for example increased likelihood of clinical errors, delayed interventions, or unsafe skills mix.
SA5		***No Risks are currently mapped to this CRR***
RSK-003956	**16**	Nursing agency market contraction causing safer staffing risk ***Pending Approval***
RSK-002770	**16**	Inability to become the equitable and inclusive organisation we aspire to be for our colleagues and patients if having systems, policies and processes that have not been designed to be inclusive and therefore create inequitable outcomes are in place. This could result in an inequality across our workforce; no reduction in health inequalities across Somerset; an inability to identify and make systemic changes in our systems, policies and processes
SA5		***No Risks are currently mapped to this CRR***
	16	Workforce metrics such as vacancies, retention & sickness affecting delivery of care

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SA5		***No Risks are currently mapped to this CRR***
RSK-003222	**16**	Inconsistent provision of rest/wellbeing spaces across SFT could lead to a risk of higher absence under stress and burnout leaving a shortage of colleagues to cover care and potentially compromising skill mix in areas. This could also impact on the achieving the People strategic aim
SA5		***No Risks are currently mapped to this CRR***

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FINANCE COMMITTEE

Service Group and Corporate Function Risks 15+

RSK-002192	**20**		SHS not becoming self-sustaining due to costs exceeding its contract income which could result in a deficit or loss making performance which is adverse to the long term plan
SA6	↔		***No Risks are currently mapped to this CRR***
RSK-001611	**20**		Failure to secure necessary infrastructure to meet current and future demands of the population and the clinical strategy due to the assurance of availability of capital funding either locally or through national programmes. This will result in not achieving the Trust's strategic aims; failure to improve services for the population for the workforce; and failure to meet the populations expectations in relation to the delivery of healthcare
SA6	↔		
RSK-003398	**20**	↔	Risk of reduction in Radiotherapy capacity of 33% for at least 18 months from end of 2028 due to the replacement of linear accelerators (Linacs) without a spare bunker into which activity can be decanted leading to delays in patients being seen and operational disruption
RSK-000003	**16**	↔	Inability to reduce backlog maintenance risks
~~**RSK-002409**~~	~~**16**~~		**Closed.** Insufficient investment from main contractor to reduce levels of backlog maintenance

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UNMAPPED RISKS

Service Group and Corporate Function Risks 15+

RSK-003819	**20**	↔	Effect of medicines/radiopharmaceutical supply chain on radiology business continuity	**Clinical Support & Cancer Services**
RSK-004058	**20**	↔	There is a risk of effectiveness of the transfusion service at SFT due to a lack of robust operating model and capacity to deliver the service the Trust requires of this team.	**Clinical Support & Cancer Services**
RSK-002411	**20**	↔	Difficulties with formal triage within 15 mins of patient arrival in community UTC's	
RSK-003637	**20**	↔	130 hour vacancy in PSA team	**Symphony**
RSK-003990	**16**	↔	Extreme weather effects on radiology business continuity	**Clinical Support & Cancer Services**
RSK-004068	**16**	↔	Inability to provide accurate assurance of clinical training compliance for Paediatrics (Resus)	**CYP&F**
RSK-004056	**16**	↔	Incorrect blood products or delay due to mis-matching of patient ID between ICE and Winpath	**Clinical Support & Cancer Services**
RSK-004035	**16**	↔	Women's Health Hub - staff sickness impacting service delivery and care to patients	**Symphony**
RSK-004034	**16**	↔	PSIRF delays in Paeds & CAMHS highlight need for stronger governance, oversight and learning.	**Clinical Support & Cancer Services**

RSK-003512	**15**	↔	Jubilee Surgical Wards Broken Blinds. In the affected patient areas, the room blinds on the doors cannot be opened and patients in those rooms cannot be safely observed	**Surgical**
RSK-004020	**15**	↔	Delays for patients to be seen at the SSW PCN Women's Health Hub due to staff sickness	**Symphony**
RSK-003989	**15**	↔	Pyrland Ward. The extra-care area within ward 2 has environmental limitations that may prevent safe and effective seclusion in line with Chapter 26 of the Mental Health Act Code of Practice.	**MH&LD**
RSK-004030	**15**	↔	Sickle cell patients who are admitted to the trust without an alert on their record	**Clinical Support & Cancer Services**
RSK-004048	**15**	↔	There are only 2 Transfusion Practitioners (TPs) in SFT, 0.9 WTE at MPH and 0.5 WTE in YDH (The YDH staff member is 0.5 WTE Anaemia Specialist Nurse). Due to staffing they are unable to provide cross county cover when one or other is absent.	**Clinical Support & Cancer Services**
RSK-002053	**15**	↔	Trust-wide risk associated with episode of care pressure ulcers	**Neighbourhoods**

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NHS Somerset NHS Foundation Trust

Service Group and Corporate Function Risks 15+

(excl. 21 Corporate Risks)

August Report

	Number of Risks by Current Score			
Service Group	**15**	**16**	**20**	**Total**
Children & Young People & Families Service Group	7	17	6	30
Medical Service Group	8	11	7	26
Clinical Support & Cancer Services	6	7	7	20
Estates & Facilities	11	9		20
Neighbourhoods Service Group	5	6	1	12
Surgical Service Group	2	6		8
Symphony Healthcare Services	2	3	2	7
Finance Team	1	2		3
Mental Health & Learning Disabilities Service Group	3			3
People Team	2			2
Clinical Leadership Team		1	1	2
Simply Serve Limited		1		1
EPRR			1	1
Governance		1		1
IT & Digital	1			1
Grand Total	**48**	**64**	**25**	**137**

7. BOARD ASSURANCE FRAMEWORK & CORPORATE RISK REGISTER

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

Board Assurance Framework

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

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

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

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

Corporate Risk Register

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

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

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

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

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

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

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

8. VALIDATION OF RISKS

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

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

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

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

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

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

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

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

9. RISK APPETITE AND RISK TOLERANCE

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

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

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

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

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

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

9.7 Each of the risks on the Corporate Risk Register have been assigned to the most relevant strategic aim (*figure 1*) for the organisation 2026/27, including for SSL where relevant (*figure 2*) for 2025/26. The risk has then been RAG rated to

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

Figure 1

Somerset NHS Foundation Trust Strategic Aims 2026/27		Risk Appetite
1	Contribute to improving the physical health and wellbeing of the population and reducing health inequalities	**Significant (5)**
2	Provide the best care and support to people	**Open (3)**
3	Strengthen care and support in local communities	**Seek (4)**
4	Respond well to complex needs	**Seek (4)**
5	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	**Significant (5)**
6	Live within our means and use our resources wisely	**Financial Management - Open (3)** **Commercial – Seek (4)**
7	Deliver the vision of the Trust by transforming our services through innovation, research and digital transformation	**Seek (4)**

Figure 2

Simply Serve Limited Strategic Objectives 2026/27		Risk Appetite
1	Support SFT to deliver the clinical strategy	**Seek (4)**
2	Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture	**Significant (5)**
3	Live within our means and use our resources wisely	**Financial Management - Open (3)** **Commercial - Seek (4)**
4	Develop a high performing organisation delivering the vision of the trust	**Seek (4)**

9. COMPOUND RISKS

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

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

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

9.4 The compound risks below have been identified through review of the Corporate Risk Register together with significant operational risks held within service group, departmental and subsidiary risk registers. Whilst individual risks may be managed locally, the interaction between these risks has the potential to result in wider organisational consequences.

Demand, Capacity & Flow Constraints Across Services

Risks Involved	• Insufficient capacity and resource (RSK-000007, RSK-003643) • Demand on services (RSK-000012, RSK-003043, RSK-003599, RSK-003633, RSK-003706) • ED throughput/output blockages (RSK-000372, RSK-002615, RSK-002866, RSK-003709) • Waiting time breaches in multiple specialties (e.g., diagnostics RSK-000009, diabetes RSK-002697, urology RSK-002063, ophthalmology RSK-002123, ophthalmology RSK-002035, physiotherapy RSK-001037) • Specialty service capacity issues (e.g. Rheumatology RSK-002229, Orthotics RSK-002316, Epilepsy RSK-002450, Dermatology RSK-003705) • Reduced primary care capacity (RSK-000673) • Escalation, discharge delays and NCTR pressures (RSK-000862, RSK-002267, RSK-002782, RSK-003476, RSK-003511, RSK-003706, RSK-003975)
Compound Risk	Increasing demand, rising patient complexity, discharge delays, no criteria to reside pressures, workforce shortages and limited physical capacity are combining to create system-wide flow constraints. These risks reinforce one another, causing ambulance handover delays, overcrowding, lengthening waiting times, elective care backlogs, increased patient harm and increased regulatory scrutiny.

Clinical Safety and Continuity of Services

Risks Involved	• ED delays and documentation issues (RSK-000363, RSK-000372, RSK-003725) • Radiotherapy service disruptions (RSK-003398) • Lack of clinical pathways (RSK-003586, RSK-003589)

	• Prioritisation of national targets over clinically urgent patients (RSK-003631) • Transfusion safety and service resilience (RSK-004058) • Microbiology safety, quality and staffing pressures (RSK-003881) • Delayed or missed cancer diagnosis across pathways (RSK-003841)
Compound Risk	Delays in diagnostics, treatment, and care coordination are increasing the risk of patient harm and poor outcomes.

Workforce Sustainability & Wellbeing

Risks Involved	• Consultant and specialist vacancies across multiple services (paediatrics RSK-002090, gastroenterology RSK-002776, neurology RSK-000343) • GP shortages (RSK-003315, RSK-003525, RSK-003690) • High stress and reduced resilience (RSK-003222) • Unsafe staffing in high-acuity areas (RSK-003355) • Staffing levels (RSK-002374, RSK-002777, RSK-002892, RSK-003067, RSK-003329, RSK-003405, RSK-003496, R3532, R3538, R3559, RSK-003561, RSK-003585, RSK-003624) • Non-medical vacancies (RSK-003636, RSK-003637) • Employee relations and discrimination concerns (RSK-003394) • Administration vacancies (RSK-003636) • Safer Staffing (RSK-003775) • Workforce metrics affecting delivery of care (RSK-001815) • Nursing agency market contraction causing safer staffing risk (RSK-003956) • Equality, diversity and inclusion risks impacting attraction and retention (RSK-002770)
Compound Risk	Chronic staffing shortages, recruitment difficulties, agency market pressures, sickness absence and retention challenges are reducing organisational resilience and increasing reliance on temporary staffing solutions. Combined with service pressures and workforce wellbeing concerns, these risks can create a reinforcing cycle of burnout, reduced service quality, patient safety concerns and further workforce attrition.

Maternity & Neonatal Service Pressures

Risks Involved	• Reduced obstetric medical staffing (RSK-003033) • Staffing levels/shortages (RSK-003480, RSK-003482, RSK-003489) • Triage assessments (RSK-003514) • Limited theatre capacity (RSK-003032) • Demand on services (RSK-003354) • Safeguarding responsibilities (RSK-003684)
Compound Risk	Service relocation + workforce shortages + higher case complexity could produce unsafe care environments, increase adverse outcomes, and heighten media/regulatory scrutiny.

Infrastructure & Estate Failures

Risks Involved	• Estate condition and maintenance (RSK-000534, RSK-001789, RSK-001907) • Power/electrical system fragility (RSK-002692, RSK-003260, RSK-003263, RSK-003518)

	• Ventilation issues (RSK-003375, RSK-003392) • Water quality and legionella risks (RSK-001648, RSK-002971) • Asbestos degradation (RSK-003011) • Fire safety and compartmentation breaches (RSK-001897, RSK-003090, RSK-003377, RSK-003507) • Space constraints (RSK-000332, RSK-003580)
Compound Risk	Ageing, poorly maintained, or non-compliant infrastructure is creating safety hazards, service disruptions, and regulatory risks. Multiple failures could overlap (e.g., electrical outage during a heatwave causing IT and clinical equipment shutdown in a poorly fire-compartmented building) — creating life safety hazards and major operational disruption.

Infection Prevention & Control Risk

Risks Involved	• Lack of isolation capacity (RSK-002923) • Environmental reservoirs of resistant organisms (RSK-001849, RSK-002971, RSK-003613) • Poor water systems (RSK-001648) • Delayed decontamination processes (RSK-002462) • Poor ventilation in theatre recovery area (RSK-003375) • Cleaning service staffing shortages (RSK-003444) • Regulatory action – safer sharps (RSK-003616)
Compound Risk	Environmental and operational factors are increasing the risk of infection transmission within Trust facilities. An outbreak could spread rapidly if coupled with capacity shortages, affecting multiple sites and specialties, especially in the absence of rapid isolation and adequate staffing.

Digital, Information and Data Resilience Risk

Risks Involved	• Delivery of data strategy and digital transformation (RSK-003878, RSK-003537, RSK-003548) • Frontline Digitisation funding risk (RSK-002800) • Subject access request volume and compliance (RSK-001517)
Compound Risk	Fragmented digital systems, interoperability limitations, data quality concerns, information governance pressures and delays in delivery of digital transformation are impacting patient safety, operational effectiveness and regulatory compliance. If these risks materialise alongside high operational demand, clinical decision-making, patient flow and service resilience could be significantly compromised.

Financial Sustainability & Strategic Delivery Risks

Risks Involved	• Financial plan and efficiency programme delivery (RSK-003752, RSK-003754) • Capital funding shortfalls (RSK-001611) • SHS contract sustainability (RSK-002192) • Shortfalls in equipment required (RSK-003398) • Contract delivery (RSK-002812)
Compound Risk	Operational pressures, delayed efficiencies, and infrastructure investment gaps are threatening the Trust's financial viability. Financial deficits can lead to delayed capital investment in critical estates and IT, worsening infrastructure risks, while also forcing staff reductions that increase operational pressures.

9.5 If the compound risks were realised at the same time, the combined impact could be severe because these would interact and amplify each other. These risks are not isolated and if they materialise together, they can cascade into system wide failures. The potential consequences for the Trust from the compound risks are:

Increased patient safety and quality of care concerns

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

Reduced service resilience and ability to continue to deliver services

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

Reduced workforce wellbeing and ability to retain colleagues and recruit

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

Financial pressures and inability to achieve strategic aims

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

	innovation which will lead to a failure to deliver strategic aims

Increased regulatory interest and reputational concerns

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

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

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

Somerset NHS Foundation Trust	
REPORT TO:	Trust Board
REPORT TITLE:	Integrated Performance Exception Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Lee Cornell, Associate Director – Planning and Performance Ian Clift, Senior Performance Manager Isobel Clements, Chief of People and Organisational Development Xanthe Whittaker, Director of Elective Care Stacy Barron-Fitzsimons, Director for Medical Services Group Sally Bryant, Director of Midwifery Leanne Ashmead, Director of Children, Young People and Families Mark Arruda-Bunker, Service Director, Mental Health and Learning Disabilities Abbie Furnival, Service Group Director – Neighbourhoods and Communities Kerry White, Managing Director – Symphony Healthcare Services Emma Davey, Director of Patient Experience and Engagement
PRESENTED BY:	Pippa Moger, Chief Finance Officer
DATE:	8 September 2026

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

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

	• performance against the 28-day cancer Faster Diagnosis standard. • patient satisfaction levels across our Symphony Healthcare practices remain high. • the percentage of patients waiting under six weeks to be seen by our community mental health services remained high. • compliance in respect of the diagnostic six week waiting times standard remained above the operational plan. National priority areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • the percentage of patients waiting no longer than 18 weeks for acute treatment was above the planned level. • Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Recovery. • inappropriate Out of Area Placements for non-specialist mental health inpatient care. • compliance against the A&E delivery standard in respect of patients being admitted, discharged or transferred within four hours and within 12 hours of attendance. • cancer 31 day wait from a Decision To Treat / Earliest Clinically Appropriate Date to First or Subsequent Treatment. • compliance in respect of the 62-day cancer standard.

Recommendation	The Board is asked to discuss and note the report.

Links to Strategic Aims (Please select all that are relevant to this paper)
☒ **Aim 1:** Contribute to improving population health and reduce health inequalities
☒ **Aim 2:** Provide the best care and support to people
☒ **Aim 3:** Strengthen care and support in people's homes and in local communities
☒ **Aim 4:** Respond well to complex needs
☒ **Aim 5:** Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture

☒ **Aim 6:** Live within our means and use our resources wisely ☒ **Aim 7:** Transform our services through innovation, research and digital transformation

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

Equality (Please indicate whether the report has any actual or potential impact on people with protected characteristics and whether an Equality and Quality Impact Assessment (EQIA) has been completed)
This report has been assessed against the Trust's Equality and Quality Impact Assessment (EQIA) Tool and: ☒ No actual or potential adverse impacts on people with protected characteristics have been identified. ☐ Actual or potential impacts on people with protected characteristics have been identified. The following actions are planned to mitigate any identified inequalities: **Details**: Click or tap here to enter text.

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

INTEGRATED PERFORMANCE EXCEPTION REPORT: JULY 2026

TABLE OF CONTENTS

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

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

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

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

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

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

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

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

CHIEF FINANCE OFFICER

NARRATIVE REPORT

NHS ENGLAND NATIONAL PRIORITIES AND SUCCESS MEASURES FOR 2026/27

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

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

- community service waiting times: at least 78% of community health service activity occurring within 18 weeks (excludes dental).
- Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Improvement.
- maintain performance against the 28-day cancer Faster Diagnosis standard at 80%.
- improve performance against the diagnostics six-week wait standard: every system delivering a minimum 3% improvement in performance or performance of 80% or better, whichever level of improvement is greater.

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

- Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Recovery.
- inappropriate Out of Area Placements for non-specialist mental health inpatient care.
- improve A&E waiting times, with a minimum of 82% of patients admitted, discharged and transferred from ED within 4 hours in March 2027.
- improve A&E waiting times, in respect of patients admitted, discharged and transferred from ED within 12 hours with at least 94.7% of patients inside of 12 hours.
- improve performance against the headline 62-day cancer standard to 80% by March 2027.
- cancer 31 day wait from a Decision to Treat / Earliest Clinically Appropriate Date to First or Subsequent Treatment: every trust delivering 94% performance by March 2027.
- improve the percentage of patients waiting no longer than 18 weeks for treatment: every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater.
- reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems.

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

These latter two measures are covered in the Finance report.

The national reporting standard in respect of Talking Therapies patients completing a course of treatment for anxiety and depression achieving Reliable Recovery increased from 48% to 51% from April 2026. During July 2026 compliance of 46.5% was achieved, a decrease from 47.6% reported during June 2026. Four whole time equivalents (WTEs) are now in post, with a further two awaiting start dates. A further four High Intensity Cognitive Behavioural Therapy trainees are due to start in December 2026. This will support a reduction in waiting times at Step 3, and shorter waiting times are known to improve outcomes and reduce drop-out rates.

As at 31 July 2026 a total of three male patients remained placed out of area due to the lack of availability of suitable beds, and safety considerations. One patient, placed out of area on 5 February 2026, was assessed and accepted for medium secure care and was transferred to that placement on 5 August 2026. The other two patients were placed out of area during June and July 2026 respectively remain in their placements. All three are males who require a single sex environment, due to their potential risk to females.

Compliance in respect of the A&E and UTC four-hour reporting standard increased slightly, from 70.6% in June 2026 to 71.0% in July 2026 but was below the Recovery Trajectory level for July 2026 of 71.5%. For the reporting period 1 April to 31 July 2026 compliance in respect of patients admitted, discharged and transferred from ED within 12 hours improved to 94.2% from 93.4% for the period 1 April to 30 June 2026, but was below the required target of 94.7%. A range of actions and developments are in progress to improve the position at both sites, including new consultants commencing in post at MPH in August and September 2026, and three SAS and one Trust Fellow commencing in post at YDH.

Compliance reported during June 2026, the latest validated data available, in respect of the 62-day cancer standard was 70.6%, below the current national standard of 75%, and below our Operational Plan trajectory of 75.8%. The main breaches of the 62-day combined cancer standard were in urology (31% of breaches), skin (15%), colorectal (14%) and breast (14%). The main cause of the breaches for urology continues to be high demand which cannot be accommodated within available capacity. This is mainly for the diagnostic phase of cancer pathways.

The reported compliance in respect of cancer 31-day waits from a Decision to Treat / Earliest Clinically Appropriate Date to First or Subsequent Treatment for June 2026 was 90.7%, below the national reporting standard of 96% and also below the Operational Plan of 94.7%. There were 67 breaches of the standard, of which 26 (39% of breaches) were for breast and 21 (31%) were for skin. There has been a reduction in breast capacity because of annual leave and a reduction in available cover due to a recent departure from the team. This has impacted on surgical treatment capacity. There has been an increase in breaches of the 31-day standard for skin patients due to

a significant early but prolonged surge in suspected cancer referrals in the last few months. This is possibly related to the extended period of good weather last year; we have also seen a higher volume of patients being upgraded to a suspected cancer via the routine referral route. An insourcing provider is being used to provide additional capacity within the dermatology service; a locum was appointed and started in June 2026 but has since left; a replacement locum is being sought.

Compliance in respect of patients waiting under 18 weeks RTT reduced to 64.9% in July 2026, 0.7% below plan. The total waiting list size at 54,854 was also above plan of 49,170. This is mainly due to the plan being set when the impacts of Advice & Refer were still emerging, but in the context of a period of increased activity. The number of patients waiting over 52 weeks also increased to 1,474 against an original plan of 541, representing 2.7% of the waiting list against the plan of 1.1%. This mainly represents an increase in the maxillo facial waiting list due to gaps in service capacity. Actions to improve the position include expanding service capacity for treating patients awaiting surgery, through 15 additional theatre sessions running each week, starting in early September 2026, supported by the opening of the King's building.

Response

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

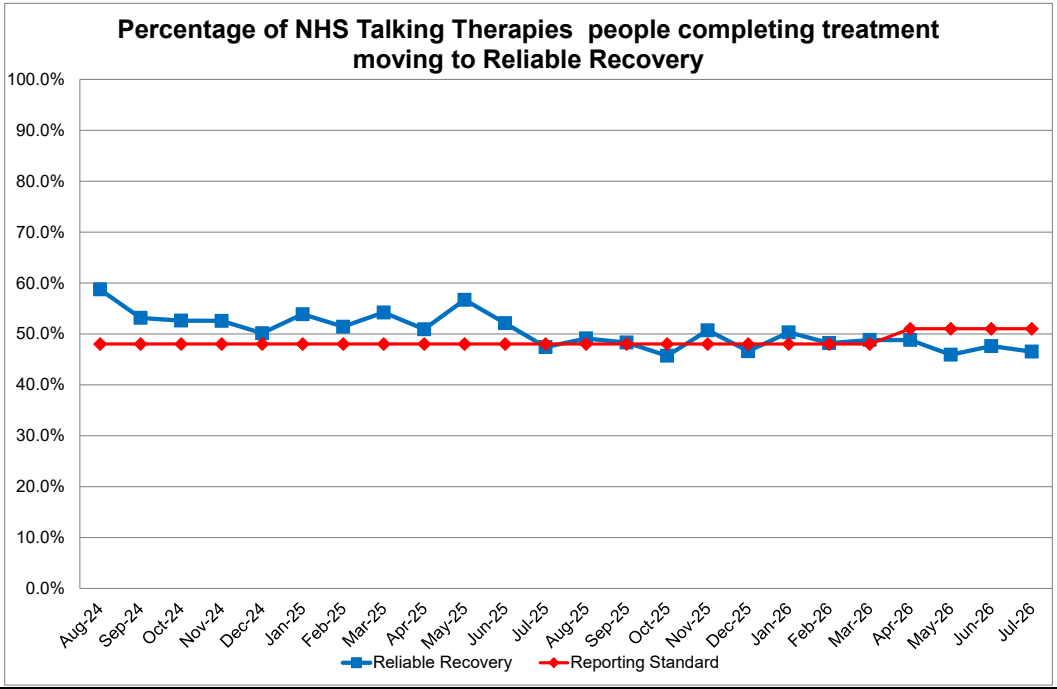
Current performance (including factors affecting this)

- During July 2026, of a total of 510 patients discharged, 237 were recorded as moving to Reliable Recovery, a rate of 46.5%.
- From 1 April 2026 the national reporting standard increased from 48% to 51%.

Focus of improvement work

- Increase workforce at Step 3 with expansion monies. Four whole time equivalents (WTEs) are now in post, with a further two awaiting start dates. A further four High Intensity Cognitive Behavioural Therapy trainees are due to start in December 2026. Utilising vacancy factor to outsource 150 treatments at step 3.
- Health inequalities need to be addressed to improve referral rates in respect of over 65s. A meeting with Integrated Care Board (ICB) and GP Support Unit (GPSU) colleagues was held on 18 June 2026 to support GP engagement, with a practice manager meeting booked. Communications to go out to GPs with six-weekly meetings with the ICB/GPSU to monitor progress/impact. Communications out in GP newsletter on rolling basis particularly targeting over 65 population.
- Recovery-focused supervision for all staff, with bespoke training for supervisors on the importance of outcome measures, is planned for August 2026. Training has been booked for supervisors on 27 August 2026.
- Productivity and recovery focus in line management supervision, clear expectations set in service update on what counts as patient facing activity.
- A request has been submitted to our Data Analytics team for individual therapist dashboards.

Line Chart



How do we compare

National average performance for providers was 48.1% in June 2026, the latest data available. Our performance was 47.6%.

Performance over the last six months

Area	Feb	Mar	Apr	May	Jun	Jul
Compliance	48.2%	48.8%	48.8%	45.9%	47.6%	46.5%

Safe

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

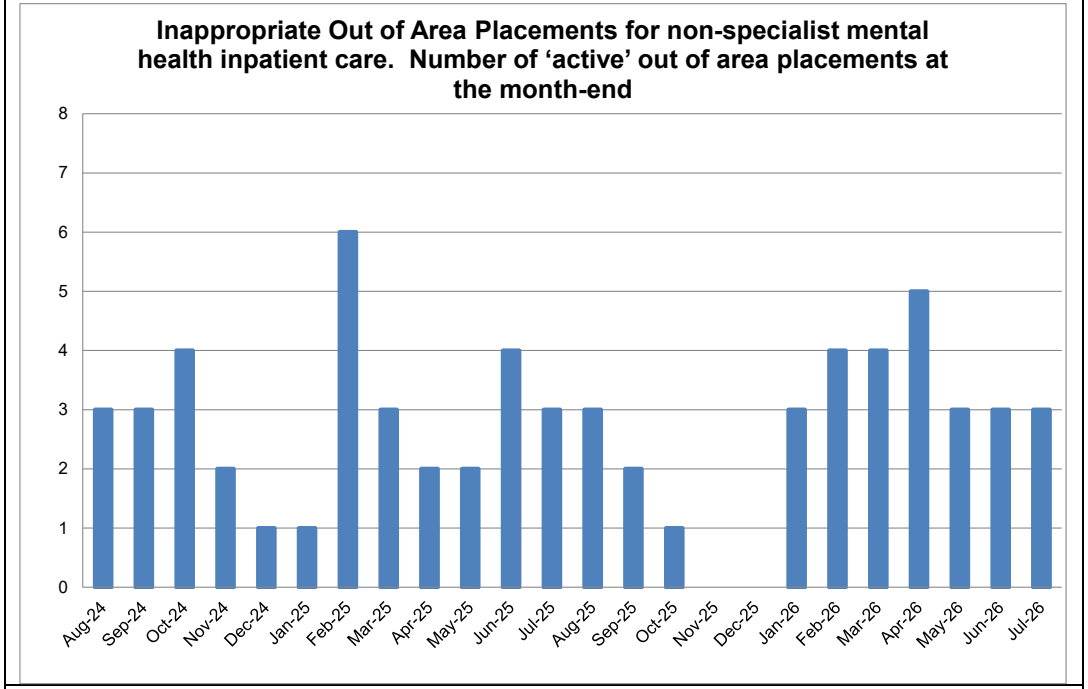
Current performance (including factors affecting this)

- As at 31 July 2026 a total of three male patients remained placed out of area due to the lack of availability of suitable beds, and safety considerations.
- One patient, placed out of area on 5 February 2026, was assessed and accepted for medium secure care, and was transferred to that placement on 5 August 2026.
- The other two patients, who were placed out of area during June and July 2026 respectively, remain in their placements.
- All three patients required a single sex environment, due to their potential risk to females.

Focus of improvement work

- The leadership team visted Dorset services in July 2026 to explore options for utilising their new female-only Psychiatric Intensive Care Unit (PICU). Currently, they would only be able to support a maximum of one female at a time from Somerset. Our usual admission numbers are two, thus this is not a option that can be explored further. The lack of a single-sex PICU environment has been escalated to the ICB cluster to request the exploration of options, as the numbers do not support a local female PICU.
- A new patient flow dashboard has been created with 'Live' data to increase the visibility of those with a long length of stay, to target input and clinical decision-making.
- The Associate Medical Director and Inpatient Clinical Director are supporting new inpatient consultants in decision-making and risk-based decisions to support community care and improve flow.

Line Chart



How do we compare

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

Performance over the last six months

Area	Feb	Mar	Apr	May	Jun	Jul
Reported number	4	4	5	3	3	3

Responsive

The Accident & Emergency (A&E) 4-hour standard is a measure of the length of wait from arrival in an Emergency Department (ED) to the time the patient is discharged, admitted or transferred to another provider. The target is that at least 82% of patients will wait less than four hours in the Emergency Department, by March 2027.

Current performance (including factors affecting this)

- Trust-wide A&E 4-hour performance for our EDs was 52.7% during July 2026, up from 49.5% in June 2026. With Urgent Treatment Centres (UTCs) compliance included at 94.1%, the overall compliance was 71.0%, slightly below our Operational Plan recovery trajectory of 71.5%.
- Compliance in respect of our two A&E departments was:
    - Musgrove Park Hospital (MPH): 51.6%.
    - Yeovil District Hospital (YDH): 54.3%.
- In July 2026 a total of 1,463 out of 1,520 patients (96.3%) were discharged, admitted or transferred with four hours at the YDH UTC.
- Between 1 and 31 July 2026, 94.2% of patients spent less than 12 hours in the EDs, slightly below the Operational Plan target of 94.7%.

Focus of improvement work

Both

- Digital ordering of CT scans on a portal to go live in September 2026; this will significantly reduce waiting times for processing scans.
- AI reporting of CT heads to go live in September 2026.

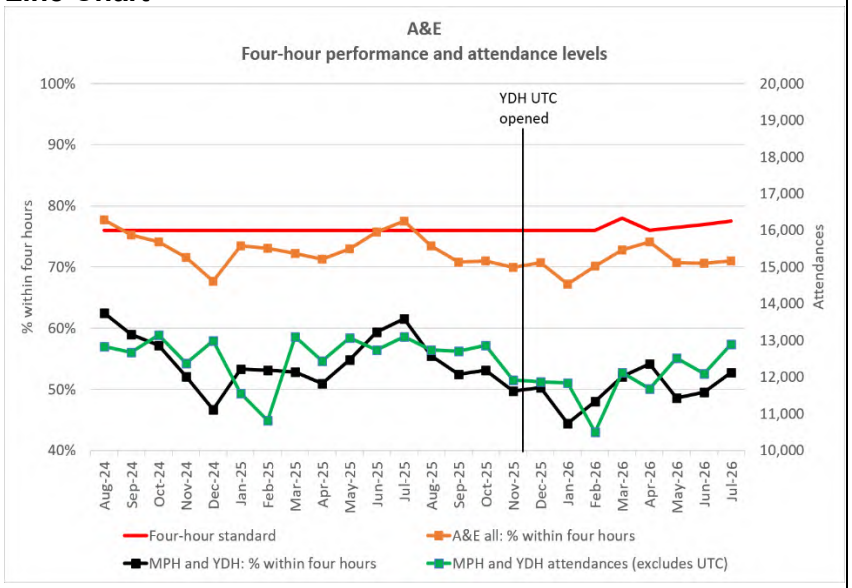
MPH:

- Senior EPIC clinical lead started in MPH ED. New dynamic distribution of workload is being trialled for focus on minors patients (within the medical workforce).
- Redirection of suitable patients to more suitable services (e,g out of hours).
- Utilising the Orthopaedics area out of hours for ED paediatric patients.
- Dedicated registrar to Paediatrics.
- Additional middle tier for a four-week period overnight.
- New Operational Support Manager started in the role as a job share, training ongoing.

YDH:

- Working with community GPs to reduce negative DVT scans attending Same Day Emergency Care (SDEC), freeing up capacity to pull from the ED.
- ED Rota co-ordinator appointed and will start in September 2026, with the focus on medical teams.
- Newly appointed doctors across all grades have now completed the supernumerary period, with a positive impact on staffing.

Line Chart



How do we compare

In July 2026, the national average performance for Trusts with a major Emergency Department was 61.7%. Our performance was 52.7%. We were ranked 96 out of 121 trusts. With Urgent Treatment Centre attendances included, we were ranked 74 with performance of 71.0%. National average performance was 73.3%.

Recent performance

Area	Feb	Mar	Apr	May	Jun	Jul
A&E only	48.0%	52.1%	54.1%	48.6%	49.5%	52.7%
Including UTC	70.1%	72.8%	74.1%	70.7%	70.6%	71.0%

Responsive

62-day Cancer is a measure of the length of wait from referral from a GP, screening programme or consultant, through to the start of first definitive treatment. The target is for at least 85% of patients to be treated within 62 days of referral. The 28-day Faster Diagnosis is the first part of the 62-day pathway.

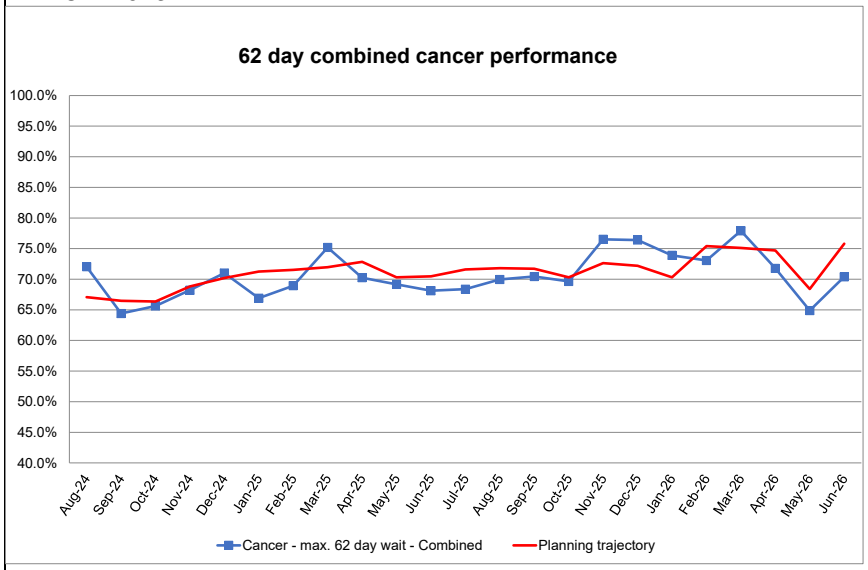
Current performance (including factors affecting this)

- The percentage of patients treated for a cancer within 62 days of referral was 70.6% in June 2026, which is below the current national standard of 75%, and below our Operational Plan trajectory of 75.8%, but a significant improvement on the performance of the previous month.
- The main breaches of the 62-day combined cancer standard were in urology (31% of breaches), skin (15%), colorectal (14%) and breast (14%).
- The main cause of the breaches for urology continues to be high demand which cannot be accommodated within available capacity. This is mainly for the diagnostic phase of cancer pathways.
- The main causes of the breaches for skin also relate to higher than forecast levels of demand, compounded by capacity gaps.
- The colorectal breaches of the standard largely relate to CT colon and colonoscopy waits, as well as insufficient theatre capacity to consistently meet bulges in demand for surgery.
- The breast breaches of the standard relate to service capacity (please see the 31-day standard report).
- Twenty-four GP-referred patients were treated in June 2026 on or after day 104 (the national 'backstop'); please see Appendix 1.

Focus of improvement work

- Urology job planning is complete, however there have been recent departures from the team and the capacity plan is being revisited.
- Additional dermatology capacity is being established to respond to the increased demand, as set out in the 31-day standard report.
- Colorectal 62-day waiting times are heavily affected by the diagnostic capacity, the actions for which are set-out in the Elective Care narrative report.
- Self-referral services are being rolled out for patients with symptoms of cancer, to encourage patients to come forward sooner to get checked out; this will also help to smooth demand.

Line Chart



How do we compare

National average performance for providers was 69.9% in June 2026, the latest data available. Our performance was 70.6%. We were ranked 78 out of 143 trusts.

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

Recent performance

62-day GP cancer performance

Area	Jan	Feb	Mar	Apr	May	Jun
% Compliance	73.7%	73.1%	77.9%	71.8%	64.9%	70.6%
Trajectory	70.3%	75.4%	75.1%	74.7%	68.4%	75.8%

Responsive

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

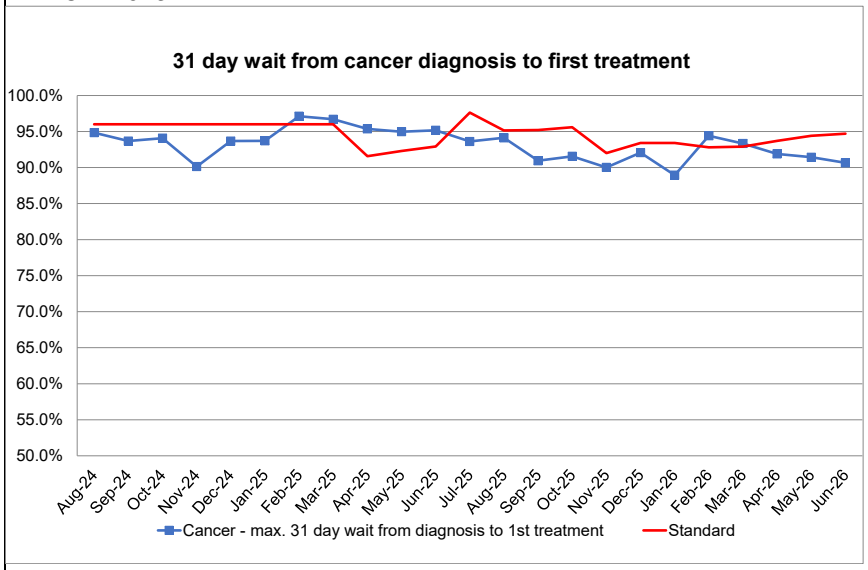
Current performance (including factors affecting this)

- Performance against the 31-day first combined treatment standard was 90.7% in June 2026, below the 96% national standard and below the planning trajectory of 94.7%.
- There were 67 breaches of the standard, of which 26 (39% of breaches) were for breast and 21 (31%) were for skin. There were smaller volumes of breaches across a range of tumour sites.
- There has been a reduction in breast capacity because of annual leave and a reduction in available cover due to a recent departure from the team. This has impacted on surgical treatment capacity.
- There has been an increase in breaches of the 31-day standard for skin patients due to a significant early but prolonged surge in suspected cancer referrals in the last few months. This is possibly related to the extended period of good weather last year; we have also seen a higher volume of patients being upgraded to a suspected cancer via the routine referral route.
- One consultant retired from the skin service in December 2025, and there has also been an unexpected extended absence.

Focus of improvement work

- An insourcing provider is being used to provide additional capacity within the dermatology service; a locum was appointed and started in June 2026 but has since left; a replacement locum is being sought.
- We are exploring the use of Artificial Intelligence based systems to support the triage of referrals for suspected skin cancer, to enable patients with the highest suspicion of cancer to be prioritised.
- The demand on the breast service will continue to be reviewed and posts recruited to as required, to maintain service capacity.
- Additional theatre capacity will come on line from early September 2026, with the opening of the King's Building; the 11 additional theatre sessions each week will provide greater flexibility for increasing specialties' operating capacity as needed.

Line Chart



How do we compare

National average performance for providers was 92.2% in June 2026, the latest data available. Our performance was 90.7%. We ranked 109 out of 136 providers.

Recent performance

Performance in recent months was as follows:

31-day GP cancer performance

Area	Jan	Feb	Mar	Apr	May	Jun
Trajectory	93.4%	92.8%	92.9%	93.7%	94.4%	94.7%
Compliance	89.2%	94.4%	93.3%	91.9%	91.4%	90.7%

Responsive

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

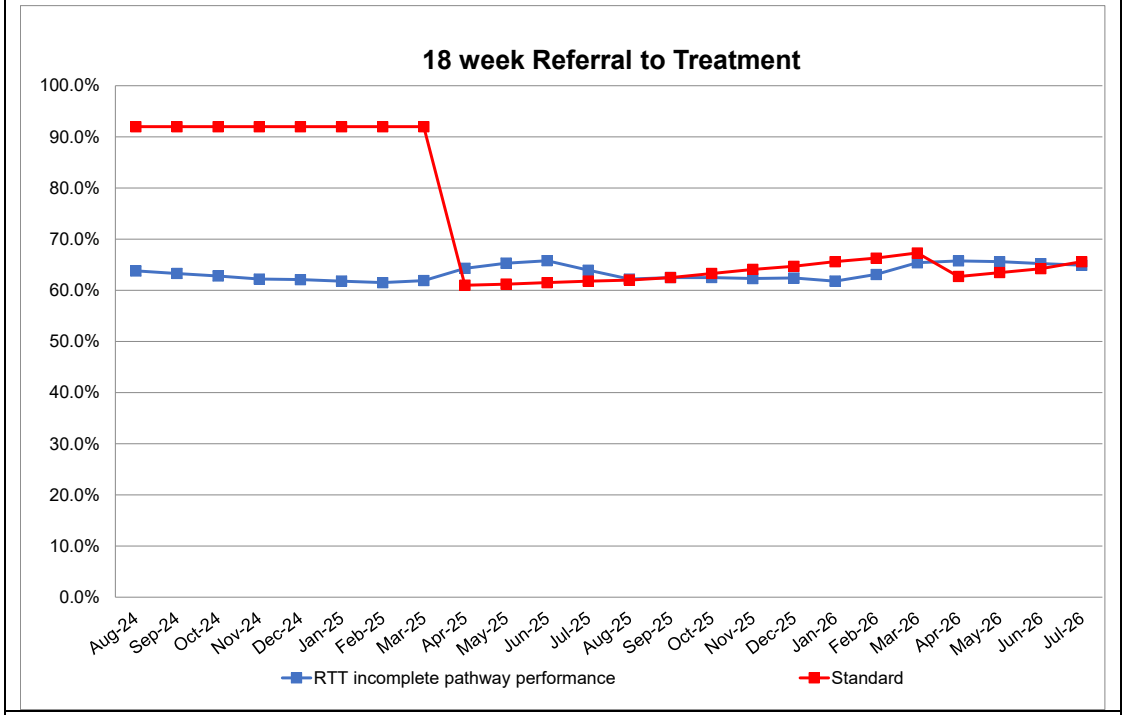
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT reduced to 64.9% in July 2026. This was 0.7% below (i.e. worse than) plan. The percentage of patients waiting under 18 weeks for a first appointment was 73.4% and was above the plan level of 73.2%.
- The total waiting list size increased by 1,330 pathways and is 5,684 worse than trajectory (54,854 actual vs. 49,170 plan). This is mainly due to the plan being set when the impacts of Advice & Refer were still emerging, but in the context of a period of increased activity.
- The number of patients waiting over 52 weeks increased to 1,474 against an original plan of 541. This represents 2.7% of the waiting list against the plan of 1.1%. This mainly represents an increase in the maxillo facial waiting list due to gaps in service capacity.
- The number of patients waiting over 65 weeks decreased to 29 at the end of July 2026 against a national expectation of zero; one patient had waited over 78 weeks RTT.

Focus of improvement work

- Expanding service capacity for treating patients awaiting surgery, through 15 additional theatre sessions running each week, starting in early September 2026 supported by the opening of the King's building.
- Use of the machine learning RTT missed stops App, to prioritise pathways for validation on both hospital sites, to make sure the RTT waiting list is up to date and as 'clean' as it can be, within the available administrative resources we have.
- Continuing to progress the outpatient transformation work, focusing on delivering the Getting it Right First Time (GIRFT) national median numbers of clinic slots, application of GIRFT follow-up protocols, maximising utilisation through the roll-out of Ambient Voice technology, piloting of the machine learning DNA/short notice cancellation predictor App, and Patient Initiated Follow-Up utilisation, alongside the ongoing roll-out of Advice & Refer to specialties including paediatrics and MSK.

Line Chart



How do we compare

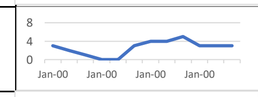
The national average performance against the 18-week RTT standard was 65.8% in June 2026, the latest data available; our performance was 65.2%. National performance remained improved by 0.2% between May and June 2026; our performance decreased by 0.4%. The number of patients waiting over 52 weeks across the country increased by 977 to 105,711 (1.4% of the national waiting list compared with 2.4% for the Trust). The number of patients waiting over 78 weeks nationally decreased by 45 to 1,090.

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

Area	Feb	Mar	Apr	May	Jun	Jul
18-week trajectory	66.3%	67.3%	62.7%	63.5%	64.2%	65.6%
18-week actual	63.1%	65.4%	65.8%	65.6%	65.2%	64.9%
First OPA 18 weeks trajct.	78.8%	80.3%	71.8%	72.0%	72.3%	73.2%
First OPA 18 weeks actual	72.4%	73.9%	76.2%	73.9%	73.4%	73.4%
52-week trajectory	1.7%	1.5%	1.5%	1.4%	1.2%	1.1%
52-week actual	2.1%	2.0%	2.1%	2.4%	2.4%	2.7%

SOMERSET NHS FOUNDATION TRUST

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

No.	Priority	Success Measure	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
NP1	Improve waiting times for community services	Community service waiting times: at least 78% of community health service activity occurring within 18 weeks (excludes dental)	1,2,3	95.8%	95.7%	94.3%	93.9%	93.9%	95.8%	90.8%	89.1%	88.2%	91.4%	91.9%	92.5%	From April 2026 >78% = Green <78% = Red		P
NP2	Improve mental health and learning disability care	Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Improvement	1,2,3	74.3%	70.8%	70.9%	74.1%	69.6%	76.5%	72.2%	69.9%	71.5%	71.5%	72.6%	71.2%	From April 2026 >=69%= Green <69% =Red		P
NP3		Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Recovery	1,2,3	49.1%	48.3%	45.7%	50.7%	46.6%	50.3%	48.2%	48.8%	48.8%	45.9%	47.6%	46.5%	From April 2026 >=51%= Green <51% =Red		F
NP4		Inappropriate Out of Area Placements for non-specialist mental health inpatient care. Number of 'active' out of area placements at the month-end	1,2	3	2	1	0	0	3	4	4	5	3	3	3	=<1= Green >1 = Red		F
NP5	Improve A&E waiting times	Improve A&E waiting times, with a minimum of 82% of patients admitted, discharged and transferred from ED within 4 hours in March 2027: **Trust-wide performance**	2	73.5%	70.8%	71.0%	70.0%	70.7%	67.2%	70.1%	72.8%	74.1%	70.7%	70.6%	71.0%	From April 2026 >=trajectory = Green <trajectory but >=70% =Amber <70% = Red		F
NP6		Improve A&E waiting times, with a higher proportion of patients admitted, discharged or transferred from ED within 12 hours across 2026/27 - **Trust-wide performance**	2	95.5%	95.5%	95.0%	95.1%	94.9%	94.4%	94.2%	94.2%	94.0%	93.8%	93.4%	94.2%	>=94.7% = Green <94.7% = Red		F
NP7	Reduce the time people wait for elective care	Improve performance against the diagnostics six-week wait standard: every system delivering a minimum 3% improvement in performance or performance of 80% or better, whichever level of improvement is greater	1,2	78.4%	79.7%	81.3%	77.7%	72.5%	73.0%	79.1%	80.7%	78.0%	79.6%	83.3%	83.1%	From April 2026 >=trajectory = Green <trajectory = Red		P
NP8		Improve performance against the headline 62-day cancer standard to 80% by March 2027	1,2	70.0%	70.4%	69.6%	76.5%	76.4%	73.7%	73.1%	77.9%	71.8%	64.9%	70.6%	Data not yet due	Above trajectory >=75% = Green Above trajectory but <75% = Amber Below trajectory = Red		?
NP9		Maintain performance against the 28-day cancer Faster Diagnosis Standard at 80%	1,2	71.3%	71.9%	77.8%	78.5%	79.0%	76.2%	80.8%	78.1%	78.6%	78.0%	83.9%	Data not yet due	Above trajectory or >= 80% = Green Above trajectory but < 80% = Amber below trajectory = Red		?
NP10		Cancer 31 day wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment: every trust delivering 94% performance by March 2027	1,2	94.1%	90.9%	91.6%	90.0%	92.1%	89.2%	94.4%	93.3%	91.9%	91.4%	90.7%	Data not yet due	Above trajectory >=94% = Green Above trajectory but < 94% = Amber below trajectory = Red		F
NP11		Improve the percentage of patients waiting no longer than 18 weeks for treatment: every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%)	1,2	62.2%	62.5%	62.5%	62.3%	62.4%	61.8%	63.1%	65.4%	65.8%	65.6%	65.2%	64.9%	From April 2026 >=trajectory = Green <trajectory = Red		?
NP12	Live within the budget allocated, reducing waste and improving productivity	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	6	-36.8% £8,247K	-35.8% £9,731K	-38.2% £11,040K	-39.2% £12,341K	-38.6% £13,798K	-38.5% £15,185K	-35.4% £17,293K	-36.8% £18,270K	-29.4% £1,290K	-20.7% (£2,767K	-16.3% (4,265K)	-14.9% (5,743K)	>=30% reduction= Green >=25% - <30% reduction =Amber <25% reduction =Red		F
NP13		Reduce use of bank staffing, with a minimum 10% reduction on current spending across systems	6	New measure from April 2026. Exceptions reported in the Finance report.								63.0% higher than plan	62.8% higher than plan	59.1% higher than plan	53.2% higher than plan	>=10% reduction= Green >=5% - <30% reduction =Amber <5% reduction =Red		F

Sector-Based Performance Summaries

NARRATIVE REPORT

NEIGHBOURHOODS AND COMMUNITY SERVICES

Key points for Neighbourhoods and Community Services:

Achievements

- Community Rehabilitation Service wait times improved for the fourth consecutive month.
- Urgent Community Response (UCR) performance remains strong, with 60% of activity delivered by District Nursing.
- Elective recovery is progressing, with community waiting times within acceptable thresholds and no 52-week waits.
- Patient safety remains strong, with no MRSA or E. coli infections and low, stable C. difficile levels.
- Community hospital pressure ulcer performance improved, with two provisionally reported in July 2026; safety huddles are now being extended into neighbourhood teams.
- Workforce performance remains stable, with strong mandatory training and appraisal compliance and agency spend within plan.
- RTT recovery continues in chronic pain, MSK physiotherapy and podiatry.
- Community bed waits remain low: 14 people were waiting as at 28 June 2026.
- Urgent Treatment Centre (UTC) Emergency Nurse Practitioner (ENP) recruitment is progressing, with 13 applicants interviewed for six development posts.

Challenges

- Wellbeing support is in place for people waiting, and new diagnosis pathways are being tested with South Somerset Complex Care GPs.
- Pain service performance has deteriorated; a full service and recovery plan review is scheduled for 7 September 2026.
- The service group has the third-highest vacancy volume, with average time to hire at 56 days.
- UTC staffing remains fragile, with 8.66 whole time equivalent (WTE) ENP vacancies, 10% sickness absence in July 2026, and reduced opening hours most affecting Burnham-on-Sea and Shepton Mallet.
- Elective and RTT delivery remains variable, with pain below trajectory but MSK physiotherapy improving.

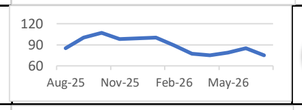
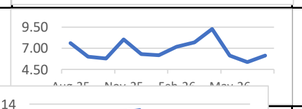
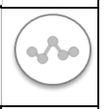
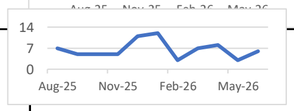
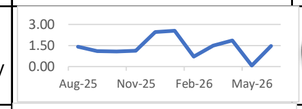
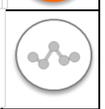
- Hospital at Home remains below planned utilisation; a remodelling plan is in development.
- Community hospitals average 2.3 WTE bank/agency use, but unplanned night sickness continues to trigger red flags and affect morale.
- Pressure ulcer reduction of episode of care incidents community and community hospitals – heat wave noted to be impactful on the increase in episodes.

Actions to Address Underperformance:

- A UTC workforce plan and a Quality and Equality Impact Assessment (QEIA) are being developed, alongside ICB discussions and wider same-day urgent care engagement.
- Service group governance has assurance that all neighbourhoods and community hospitals have implemented monthly pressure ulcer huddles to review cases of episode of care, this has realised bespoke training, reviews of equipment and in areas where established huddles have been in place for more than two months have seen a reduction in incidents. Tissue viability nurses and wider MDT attend these huddles.
- Discharge pathways are being strengthened, including a Pathway 2 test-and-learn to speed transfers from referral.
- Workforce actions are under way in MSK physiotherapy and podiatry.
- People metrics and staff survey actions continue to be reviewed through sector business and performance meetings.
- Hospital at Home remodelling continues; Lead Advanced Clinical Practitioner interviews are on 1 September 2026 and consultation to merge with rapid response starts in September 2026.

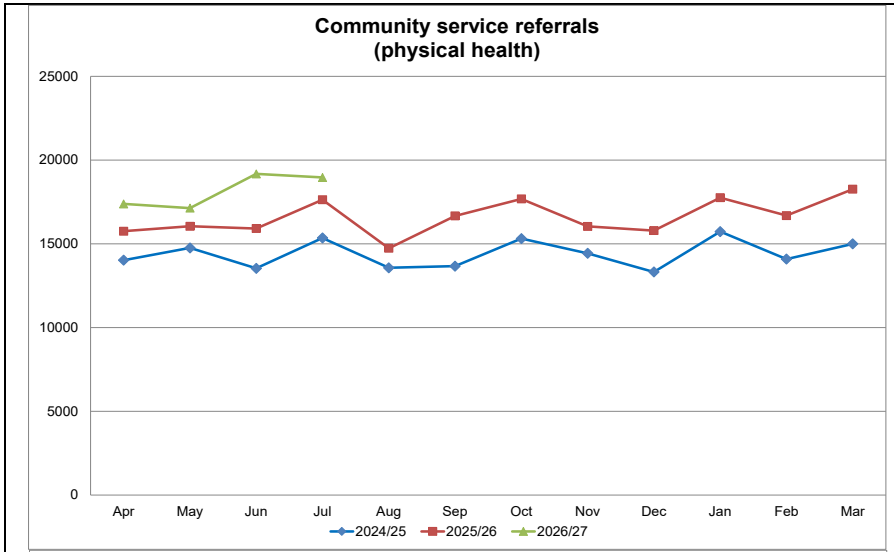
SOMERSET NHS FOUNDATION TRUST

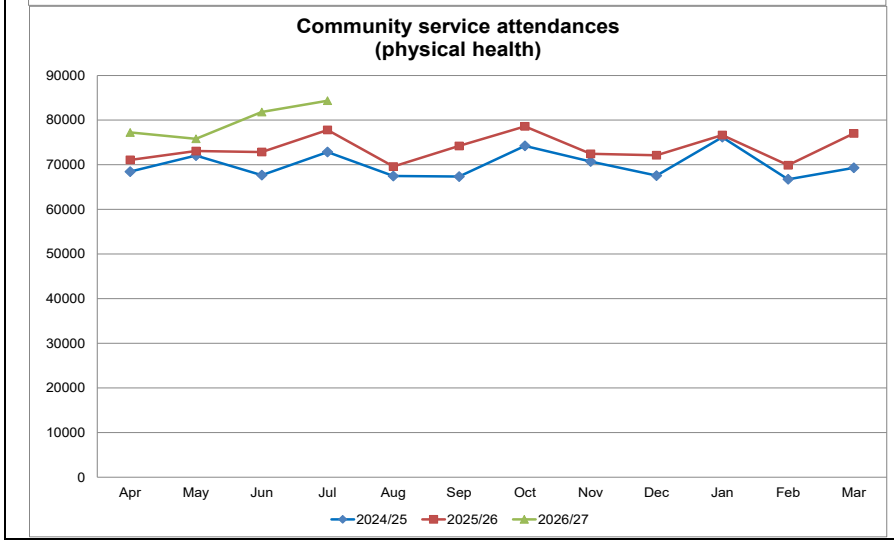
NEIGHBOURHOODS AND COMMUNITY SERVICES

No.	Description	Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
NC1	Mental health referrals offered first appointments within 6 weeks — Older Persons mental health services	ICB	1,2,3	97.2%	99.0%	97.9%	95.8%	97.1%	95.7%	94.5%	90.7%	92.6%	94.9%	96.9%	97.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
NC2	Intermediate Care - Patients all ages discharged home from acute hospital beds on pathway 0 or 1	HDS	1,2,3	95.3%	95.3%	93.8%	95.2%	95.0%	94.1%	94.3%	94.3%	93.3%	93.3%	93.0%	93.7%	>=95%= Green >=85% - <95% =Amber <85% =Red		
NC3	Urgent Community Response: percentage of patients seen within two hours	NHSC	1,2,3	92.0%	92.7%	91.2%	93.9%	91.9%	91.6%	93.4%	93.6%	94.3%	93.3%	92.3%	91.5%	>=70%= Green >=60% - <70% =Amber <60% =Red		
NC4	Hospital at Home - Caseload Size	VWOF	1,2,3	85	100	107	98	99	100	89	77	75	79	85	75	>167 = Green >134 - <167 =Amber <134 =Red		
NC5	Hospital at Home - Admissions	VWOF	1,2,3	288	308	364	304	313	342	254	251	227	247	241	234	>419 = Green >377 - <419 =Amber <377 =Red		
NC6	Total number of patient falls - community hospitals	NHSC	2	38	27	27	36	28	29	30	36	40	26	22	26	Monitored using Statistical Process Control rules >57 = Red		
NC7	Rate of falls per 1,000 occupied bed days - community hospitals	NHSC	2	7.62	5.99	5.78	8.06	6.29	6.16	7.16	7.71	9.28	6.14	5.36	6.14	Monitored using Statistical Process Control rules >6.95 = Red		
NC8	Community hospitals - number of pressure ulcers	NHSC	2	7	5	5	5	11	12	3	7	8	3	6	Data not yet due	From April 2026 <=5 = Green >5 = Red		
NC9	Community hospitals - rate of pressure ulcer damage per 1,000 occupied bed days	NHSC	2	1.40	1.11	1.07	1.12	2.47	2.55	0.72	1.50	1.86	0.07	1.46	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC10	District nursing - number of pressure ulcers	NHSC	2	72	66	77	74	64	99	92	90	118	100	113	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC11	Rate of pressure ulcer damage per 1,000 district nursing contacts	NHSC	2	2.27	2.12	2.37	2.40	2.00	3.05	3.02	2.95	3.75	3.14	3.52	Data not yet due	Monitored using Statistical Process Control rules. Report by exception.		
NC12	Total number of medication incidents in a community setting	NHSC	2	27	44	34	34	29	26	21	29	28	25	27	25	From April 2026 <=55 = Green >55 = Red		

Operational context

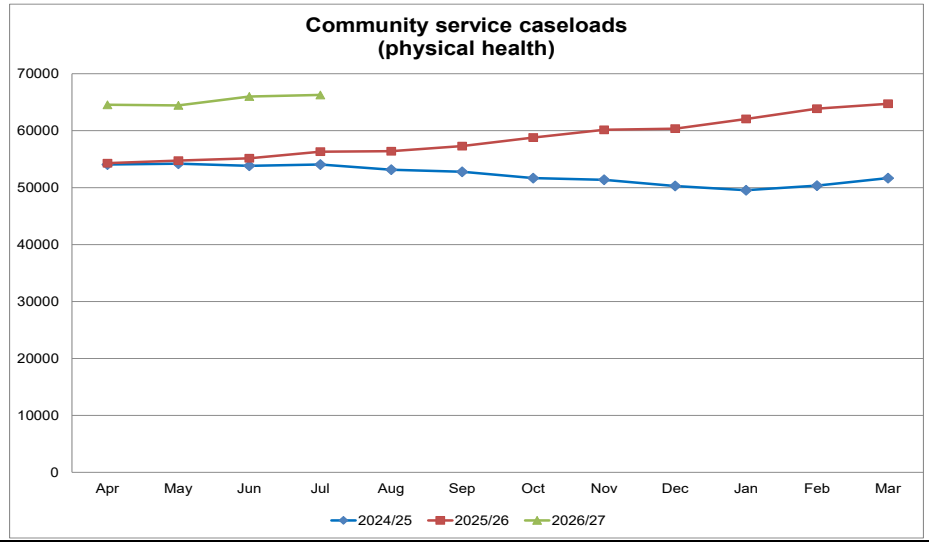
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





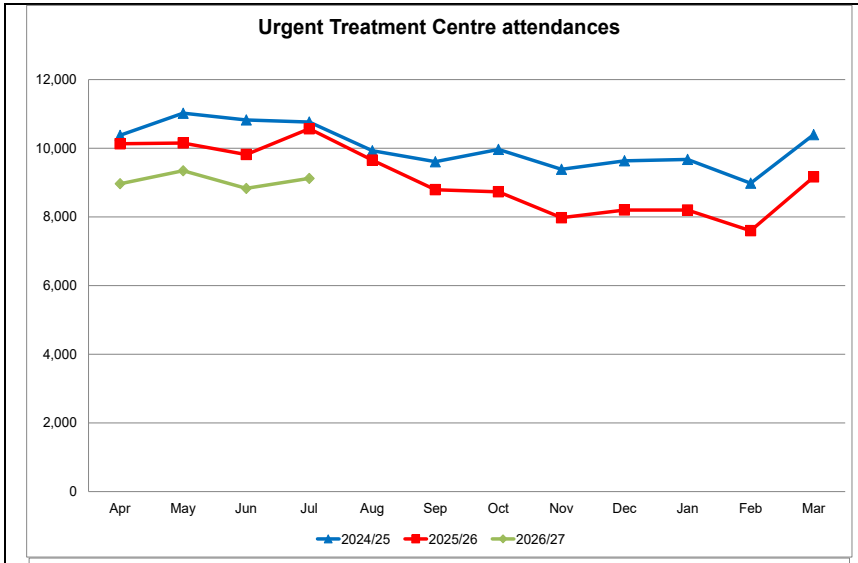
Summary:

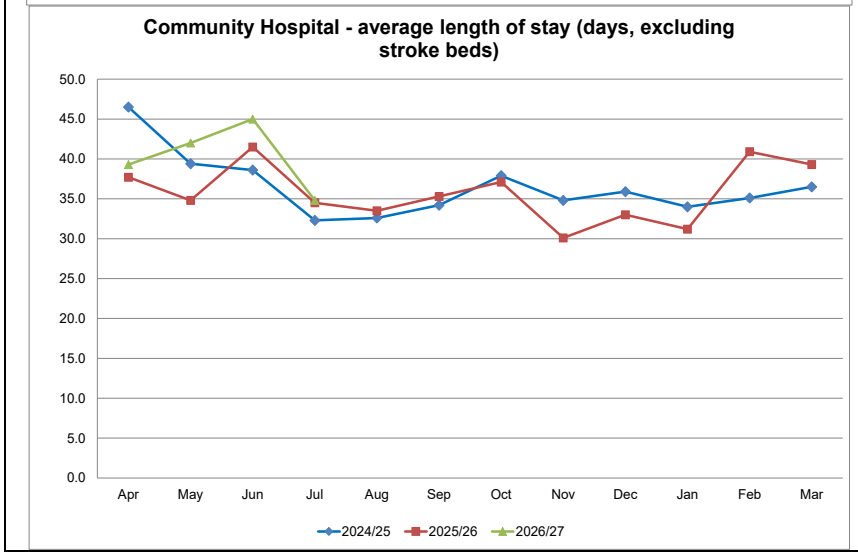
- Direct referrals to our community physical health services between 1 April and 31 July 2026 were 11.2% higher than the same months of 2025 and 26.0% higher than the same months of 2024.
- Attendances between 1 April and 31 July 2026 were 8.3% higher than the same months of 2025 and 13.6% higher than the same months of 2024.
- Community service caseload levels as at 31 July 2026 were 17.7% higher than as at 31 July 2025, and 22.6% higher than as at 31 July 2024.
- The increases are primarily due to some areas of the Musculoskeletal Physiotherapy service, which were previously reported under acute services, now being reported via the Community Services Dataset.



Operational context

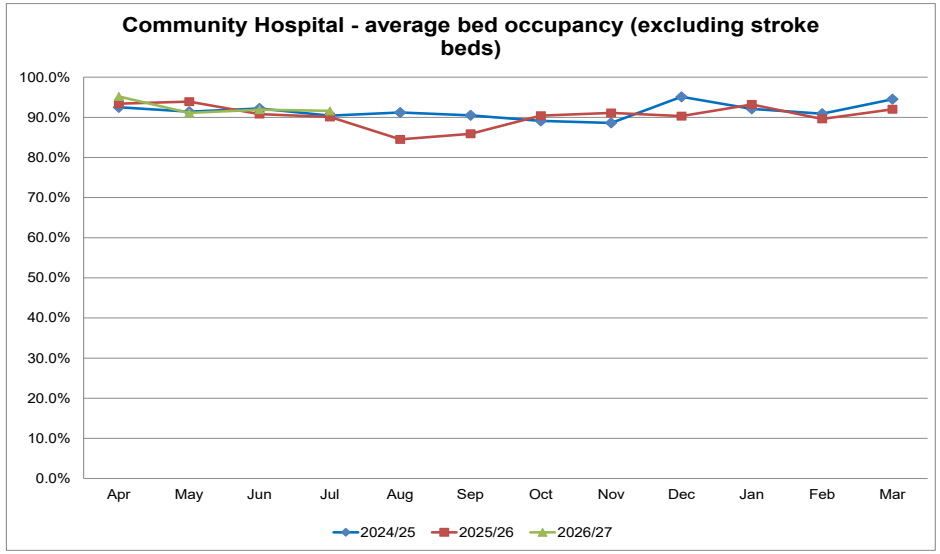
Community Physical Health: This section of the report provides a high-level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





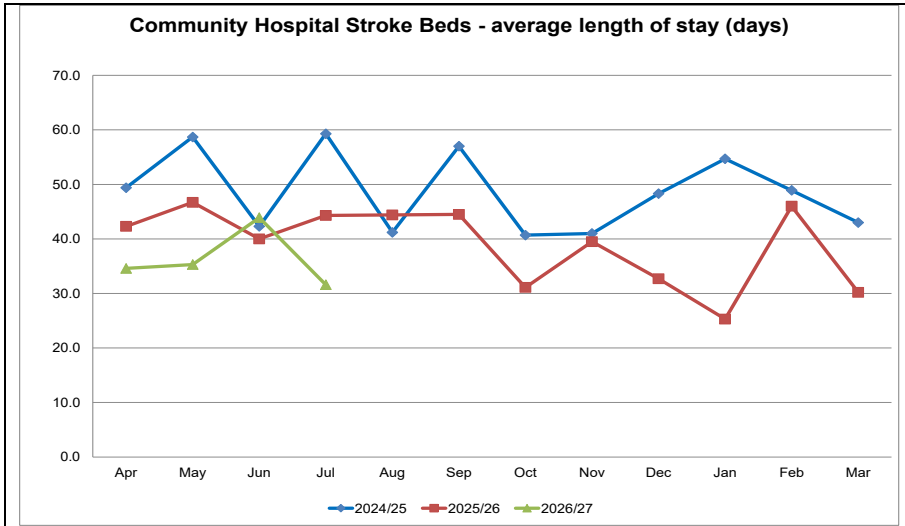
Summary:

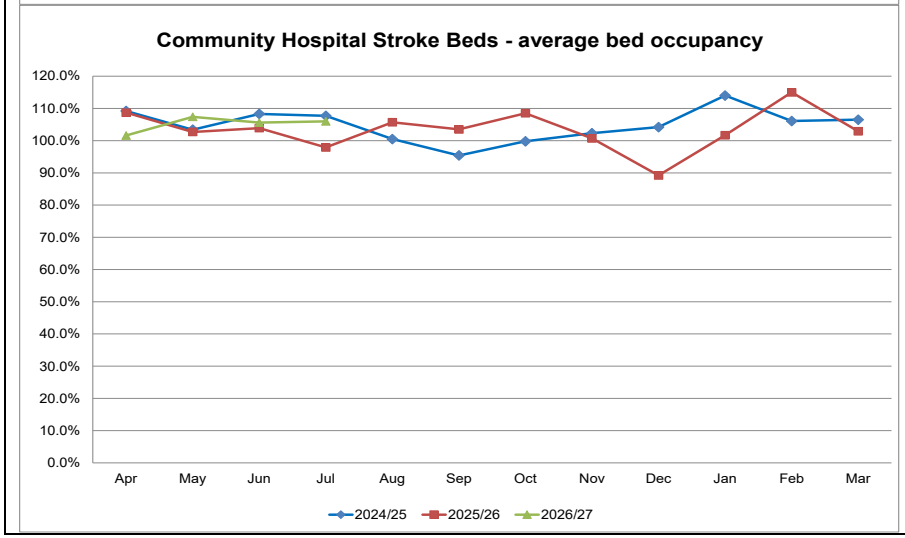
- Between 1 April and 31 July 2026, the number of Urgent Treatment Centre (UTC) attendances (excluding the YDH UTC) was 10.8% lower than the same months of 2025 and 15.6% lower than the same months of 2024. During July 2026, 93.7% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 78%.
- The average length of stay for non-stroke patients in our community hospitals in July 2026 was 34.8 days; a decrease compared to June 2026. During July 2026 no discharged patients had a length of stay of 100 days or more. The rolling 12-month average length of stay in respect of non-stroke patients as at 31 July 2026 was 36.3 days, compared to 35.8 days for the 12-month period ending 31 July 2025.
- The community hospital bed occupancy rate for non-stroke patients in July 2026 decreased to 91.6%, from 91.9% in June 2026.



Operational context

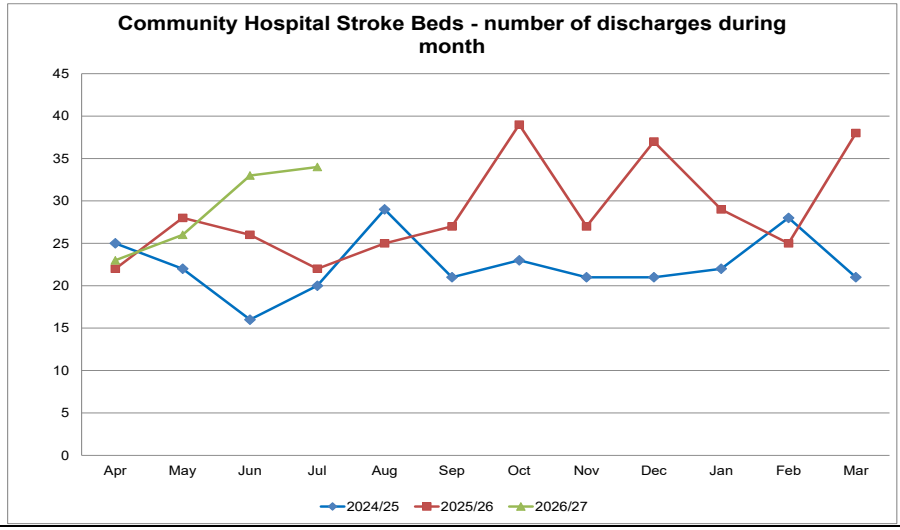
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay for stroke patients in our community hospitals in July 2026 significantly decreased to 31.6 days, from 43.9 days in June 2026. No patients discharged had a length of stay of 100 days or more. The rolling 12-month average length of stay in respect of stroke patients for the period ending 31 July 2026 was 36.0 days, compared to 45.5 days for the 12-month period ending 31 July 2025.
- Stroke bed occupancy in July 2026 remained similar to June 2026.
- During July 2026 there were 34 discharges of stroke patients, up from 33 in June 2026.



NARRATIVE REPORT

SYMPHONY HEALTHCARE SERVICES

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

What is Going Well

- Most indicators are achieving the performance aims.
- **Average time for calls in queue (S7)** The average wait time for phone call responses is at its lowest level on record. However, performance is expected to decline during August 2026 due to staff departures and the increased level of annual leave typically taken during this period.

What Requires Improvement and Planned Actions

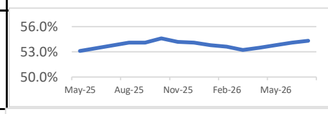
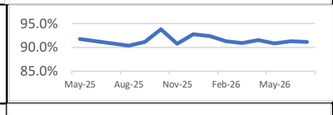
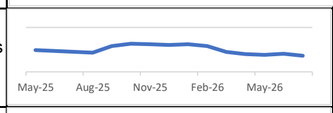
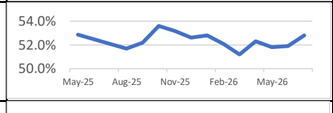
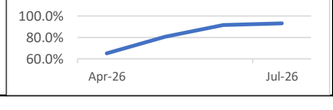
- **GP vacancy rate (S4)**
  The GP vacancy rate remains high, although several appointments have been made and are awaiting start dates. The main risk remains in Symphony South, where some candidates have withdrawn after accepting roles closer to home. The recruitment process is being reviewed with the Symphony People Team to strengthen candidate commitment before appointment.

Other updates

- On track for Cost Improvement Programme (CIP) delivery.
- July 2026 saw a 13% increase in demand compared to July 2025. There was a contractual change in September 2025 that requires us to keep our online consultation system open daily from 08:00 to 18:30, whereas in the past we could switch them off earlier in the day as our capacity was reached. This has led to an increase in demand this year, which was exacerbated in July 2026 by the heatwave. Online access has been the bigger driver of the increase in demand.

SOMERSET NHS FOUNDATION TRUST

SYMPHONY HEALTHCARE SERVICES

No.	Description	Source	Links to strategic aims	May-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
S1	Dementia diagnosis rates for patients aged 65 years plus	OPG	1,3,4	53.1%	54.1%	54.1%	54.6%	54.2%	54.1%	53.8%	53.6%	53.2%	53.5%	53.8%	54.1%	54.3%	>=66.7%= Green >=61.7% - <66.7% =Amber <61.7% =Red		
S2	Increase the % of patients with hypertension treated according to NICE guidance	OPG	1,2,3	72.0%	72.4%	73.1%	72.3%	72.7%	74.4%	75.2%	77.8%	82.8%	80.8%	72.0%	72.8%	75.2%	Profiled target: 85% by year end		
S3	Increase the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance	OPG	1,2,3	65.0%	61.0%	61.0%	62.3%	63.1%	63.9%	65.0%	67.0%	68.1%	67.0%	66.0%	66.8%	68.8%	>=50%= Green >=40% - <50% =Amber <40% =Red. Target to be achieved by year end		
S4	GP Vacancy rate	SHS	6	6.8%	3.5%	5.6%	5.0%	6.0%	7.5%	9.4%	9.5%	5.6%	5.4%	17.4%	12.1%	14.6%	=<5%= Green >5% - <10% =Amber >10% =Red		
S5	Percentage of total Quality and Outcomes Framework (QOF) points	SHS	1,2,3	75.0%	76.4%	77.4%	78.9%	81.5%	83.7%	86.8%	90.6%	93.9%	76.0%	77.0%	77.7%	77.7%	Profiled target: 95% by year end		
S6	Patient satisfaction rate	SHS	2,3	91.8%	90.4%	91.1%	93.8%	90.8%	92.7%	92.4%	91.3%	90.9%	91.5%	90.9%	91.3%	91.1%	>=85%= Green >=75% - <85% =Amber <75% =Red		
S7	Average time for calls in the queue	SHS	2,3	05:52	05:12	06:58	07:36	07:30	07:15	07:27	06:57	05:23	04:49	04:38	04:54	04:21	=<4 minutes = Green >4 minutes - =<6 minutes = Amber >6 minutes = Red		
S8	Ask My GP/Klinik/AccuRX/Anima – percentage of requests raised online	SHS	2,3	52.9%	51.7%	52.2%	53.6%	53.2%	52.6%	52.8%	52.1%	51.2%	52.3%	51.8%	51.9%	52.8%	>=50%= Green >=40% - <50% =Amber <40% =Red		
S9	Percentage of requests deemend "clinically urgent" seen on same day	SHS										65.1%	80.6%	91.5%	93.1%	92.2%	>=90%= Green >=80% - <90% =Amber <80% =Red		

NARRATIVE REPORT

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

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

What is going well

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

Inpatient follow-up within 72 hours of discharge remains well above the compliance standard. Talking Therapies Reliable Improvement continues to meet the required standard.

Staffing metrics continue to demonstrate good performance. Appraisal rates increased slightly in July to 87.8%. Heads of Service have been asked to focus on those significantly out of date to book these in, and a letter has been written to support staff to remind them of their joint responsibilities for completing these. Similar focused work is taking place with mandatory training, as whilst the service group continues to overall perform well with overall compliance at 94.2%, work is required to improve compliance with Basic Life Support and Safeguarding Children.

Finances remain in a good position for the service group, continuing to manage within budget at Month 4, with strong Cost Improvement Programme (CIP) delivery projected for the year, although with a slightly reduced recurrent projection of 74%, but with the full target still projected to be met. Work is ongoing regarding a further CIP scheme with roster reviews, which is expected to identify the preferred changes in August, which can then be implemented to improve the recurrent position. The Employment Support Service significantly improved in July 2026 to 577 patients accessing the service, which is now just three below the target of 580.

What is going less well

There were three inappropriate out of area placements at the end of July 2026; all of these are males who require a single sex environment, due to their potential risk to females. A visit to Dorset services took place in July 2026 to explore options for utilising their new female-only PICU. Currently they would only be able to support a maximum of one female at a time from Somerset, whereas our

usual admission numbers are two, and so this is not a current option that can be explored further. The lack of a single-sex PICU environment has been escalated to the ICB cluster to request exploration of options, as the numbers do not support a local female PICU.

Bed demand and flow continues to be challenging, and both service lines are now exceeding the trajectory for Length of Stay (LoS). For the adult/PICU wards, this has significantly increased from 62.3 days during the three months ending 30 June 2026 (lower than the target of 67.5 days) to 105.0 days for the three months ending 31 July 2026. This is predominantly due to the discharge of a Psychiatric Intensive Case Care Unit patient, who had been 'nominally recalled' by the Ministry of Justice in September 2019, however continued to reside in the community on section 17 leave, and only had the leave rescinded in October 2025, with discharge this month. This will continue to affect this metric for another two-months.

For the older adult wards, the LoS for the rolling three months ending 31 July 2026 increased further to 114.3 days against a target of 77.6 days. The Clinically Ready for Discharge (CRFD) Standard Operating Procedure (SOP) has now been approved and enacted, which includes expected standards and timescales for social care activities, agreed with the Local Authority, to support improvement in this area. Regular senior manager meetings are also now scheduled to improve joint working and any required escalations. The escalation routes of this new SOP are being activated, and it is expected that this will increase oversight and activity to support timely placements and discharges.

There has been an increase in the number of restraints compared to the average, however these are very dependent on the presentations of those admitted. There are two individuals with complex needs, who account for over 50% of the recorded restraints in July 2026. One of these requires restraint to support nasogastric feeding and a longer-term placement is being explored for the other. We have also seen an increase in the number of violent incidents against staff from patients on our wards. Of the 27 reported in the month, the majority were threats or verbal aggression which resulted in no harm to staff, however some did include racial abuse and low reported physical harm. All staff are provided with support following incidents, including support to report to the police where appropriate, and patients' treatment plans are reviewed, including speaking to them about the incidents, when appropriate to do so.

Talking Therapies continues to be challenged in meeting some of its targets, consistently.

Focus of improvement work

Inpatient

A full review of admission and discharge processes has been undertaken to improve bed capacity and flow.

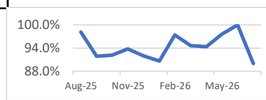
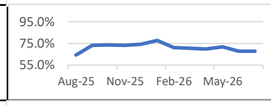
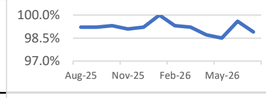
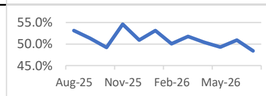
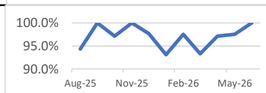
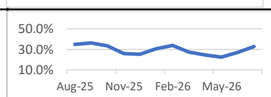
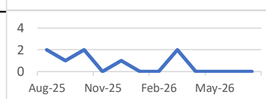
- A new weekly meeting has been introduced in the West between the Home Treatment Team and Inpatient Consultants to support patient flow. The meeting aims to strengthen decision-making for complex and high-risk patients, support earlier discharge planning, and help reduce overall lengths of stay. If this proves successful, then a similar meeting will be established in the East.
- Progress with the CRFD SOP will be monitored through the weekly CRFD call to ensure timely action and reduce discharge delays.
- SFT has registered for the nationally-funded Quality Transformation Housing Clinics programme, which provides targeted improvement support to mental health trusts, local authorities, and system partners where housing-related barriers significantly affect patient discharge and flow. The programme will run from September 2026 to March 2027. Key stakeholders identified to participate include inpatient wards, the Urgent Care Hub, the inpatient social work team, and service group management.
- An ongoing review of the MH&LD Patient Flow Dashboard is being undertaken to ensure it provides effective oversight of discharge delays and patients with extended lengths of stay. The aim is to improve visibility of barriers to discharge, support timely interventions, and enable more proactive management of patient flow across services.
- The current Step-Up facility tender has concluded and the new contract from November 2026, will refocus this as a crisis house, which will support admission avoidance, and Facilitated Early Discharge, with the aim to improve bed occupancy and use.
- Regular sessions are now being provided to inpatient medics, by the Clinical Director and Associate Medical Director, to support risk management and support positive risk decisions

Talking Therapies
Work is continuing with the GPSU and ICB to support older people having a Healthcare Professional referral, rather than being asked to self-refer to Talking Therapies, as feedback is that this is their preferred method. Referral rates from this group are lower than the expected population health rates; currently 8% against 20% for the population. Data also shows that this cohort tends also to have higher recovery rates.

Community Services
The transformation project is continuing, with workstreams being identified to deliver the required changes identified from the engagement events with service users/Lived Experience Partners (LEPs), and colleagues, as well as aligning with the “Mental health personalised care framework: the modern care programme approach”.

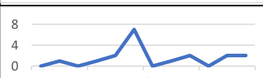
SOMERSET NHS FOUNDATION TRUST

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description		Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
MH1	Mental health referrals offered first appointments within 6 weeks	Adult mental health services	ICB	1,2,3	98.2%	91.9%	92.2%	93.8%	92.0%	90.7%	97.4%	94.6%	94.4%	97.6%	100.0%	90.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
MH2		Learning disabilities service	ICB		100.0%	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			P
MH3	Percentage of women accessing specialist community Perinatal Mental Health service - 12 month rolling reporting		LTP	1,2	642	658	658	653	668	702	726	709	709	714	716	731	>=640 = Green <640 = Red		P
MH4	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		NHSC	1,2,3	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Data awaited	>=60%= Green <60% =Red		P
MH5	Talking Therapies RTT : percentage of people waiting under 6 weeks		NHSC	1,2,3	64.3%	73.1%	73.7%	73.1%	74.1%	77.7%	71.2%	70.5%	69.7%	71.9%	67.9%	67.7%	>=75%= Green <75% =Red		F
MH6	Talking Therapies RTT: percentage of people waiting under 18 weeks		NHSC	1,2,3	99.2%	99.2%	99.3%	99.1%	99.2%	100.0%	99.3%	99.2%	98.7%	98.5%	99.6%	98.9%	>=95%= Green <95% =Red		P
MH7	Talking Therapies Recovery Rates		NHSC	1,2,3	53.1%	51.3%	49.2%	54.6%	50.9%	53.1%	50.1%	51.8%	50.4%	49.3%	50.9%	48.4%	>=50%= Green <50% =Red		?
MH8	Adult mental health inpatients receiving a follow up within 72 hours of discharge		NHSC	1,2	94.3%	100.0%	97.1%	100.0%	97.7%	93.1%	97.5%	93.3%	97.1%	97.5%	100.0%	Data awaited	>=80%= Green <80% =Red		P
MH9	Percentage of urgent crisis response patients to receive face to face care within 24 hours		NHSC	1,2	76.8%	77.2%	73.7%	72.9%	73.1%	73.2%	68.9%	72.6%	71.5%	77.8%	74.0%	79.5%	>=70% = Green <70% = Red		P
MH10	Overall Length of stay - Reduce average LOS by March 2027 - Adult awards and PICU only		PAF	2,6	68.1	78.4	71.2	62.5	56.7	63.9	65.4	64.1	59.5	62.5	62.3	105.0	From April 2026 at or below trajectory = Green above trajectory = Red		?
MH11	Overall Length of stay - Reduce average LOS by March 2027 - Older Persons wards only		PAF	2,6	78.2	69.5	84.2	80.3	75.4	81.0	104.8	117.5	107.8	92.3	97.6	114.3	From April 2026 at or below trajectory = Green above trajectory = Red		F
MH12	Percentage of adult inpatients discharged with a length of stay exceeding 60 days		NOF, PAF	2,3	34.8%	36.2%	33.3%	25.8%	25.0%	30.6%	33.7%	27.3%	24.4%	22.4%	27.1%	32.6%	SPC <=29.8% = Green >29.8% = Red		?
MH13	Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours		NOF, PAF	1,2,3	90.1%	91.2%	91.2%	91.0%	90.6%	91.1%	90.8%	91.2%	90.3%	90.2%	90.0%	90.5%	>=90%= Green >=80% - <90% =Amber <80% =Red		P
MH14	Number of people accessing community mental health services with serious mental illness - rolling 12 month number.		NOF, PAF	1,2,3,4	10,141	10,143	10,255	10,202	10,227	10,276	10,349	10,439	10,415	10,305	10,277	10,178	No stated target		
MH15	Number of patients who remain in an emergency department for over 24 hours while awaiting a mental health admission		PAF	2,3	2	1	2	0	1	0	0	2	0	0	0	0	No stated target		

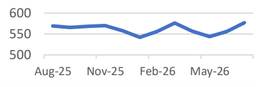
SOMERSET NHS FOUNDATION TRUST

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
MH16	Percentage of people with suspected autism awaiting contact for over 13 weeks (aged 18 or over)	NOF, PAF	2,3,4	98.2%	97.6%	97.6%	97.1%	97.0%	97.7%	97.4%	97.7%	96.6%	96.5%	97.3%	97.1%	To be confirmed		
MH17	Percentage of adults over the age of 65 with a length of stay beyond 90 days at discharge (Older Person wards only)	NOF, PAF	2,3	34.6%	37.0%	41.4%	39.3%	28.0%	21.4%	54.5%	66.7%	65.2%	53.8%	56.7%	57.7%	SPC <=60.9% = Green >60.9% = Red		
MH18	Total number of patient falls - mental health inpatient wards	NHSC	2	11	6	17	24	12	16	9	15	15	12	14	8	Monitored using Statistical Process Control rules >30 = Red		
MH19	Rate of falls per 1,000 occupied bed days	NHSC	2	3.15	1.87	5.10	7.26	3.73	4.88	3.02	4.53	4.72	3.60	4.39	2.37	Monitored using Statistical Process Control rules >9.07 = Red		
MH20	Restrictive Interventions - total number of incidents	NOF, NHSC	2	43	70	48	58	25	32	44	34	20	62	47	73	Monitored using Statistical Process Control rules >61 = Red		
MH21	Restrictive Interventions per 1,000 occupied bed days	NHSC	2	12.3	21.8	14.4	17.6	7.8	9.0	14.8	10.3	6.3	18.6	14.4	21.7	Monitored using Statistical Process Control rules >17.95 = Red		
MH22	Number of prone restraints	NHSC	2	3	2	11	15	3	10	6	8	5	8	6	9	Monitored using Statistical Process Control rules >22 = Red		
MH23	Prone restraints per 1,000 occupied bed days	NHSC	2	0.86	0.62	3.30	4.54	0.93	2.80	2.02	2.41	1.57	2.40	1.84	2.67	Monitored using Statistical Process Control rules >6.31 = Red		
MH24	Total number of medication incidents in a mental health setting	NHSC	2	21	15	3	8	10	12	13	11	16	19	19	17	Monitored using Statistical Process Control rules >23 = Red		
MH25	Ligatures: Total number of incidents	NHSC	2	133	54	15	10	15	7	15	5	9	17	27	59	Monitored using Statistical Process Control rules >80 = Red		
MH26	Number of ligature point incidents	NHSC	2	0	0	0	0	0	0	2	0	0	1	0	3	Monitored using Statistical Process Control rules >4 = Red		
MH27	Violence and Aggression: Number of incidents patient on patient (inpatients only)	NHSC	2	2	3	3	0	6	5	1	4	3	4	4	4	Monitored using Statistical Process Control rules >5 = Red		
MH28	Violence and Aggression: Number of incidents patient on staff	NHSC	2	24	20	13	19	15	13	14	11	17	15	18	27	Monitored using Statistical Process Control rules >25 = Red		
MH29	Number of Type 1 -Traditional Seclusion	NHSC	2	11	9	22	24	20	21	19	14	16	14	17	29	Monitored using Statistical Process Control rules >29 = Red		
MH30	Number of Type 2 -Short term Segregation	NHSC	2	0	1	0	1	2	7	0	1	2	0	2	2	Monitored using Statistical Process Control rules >5 = Red		

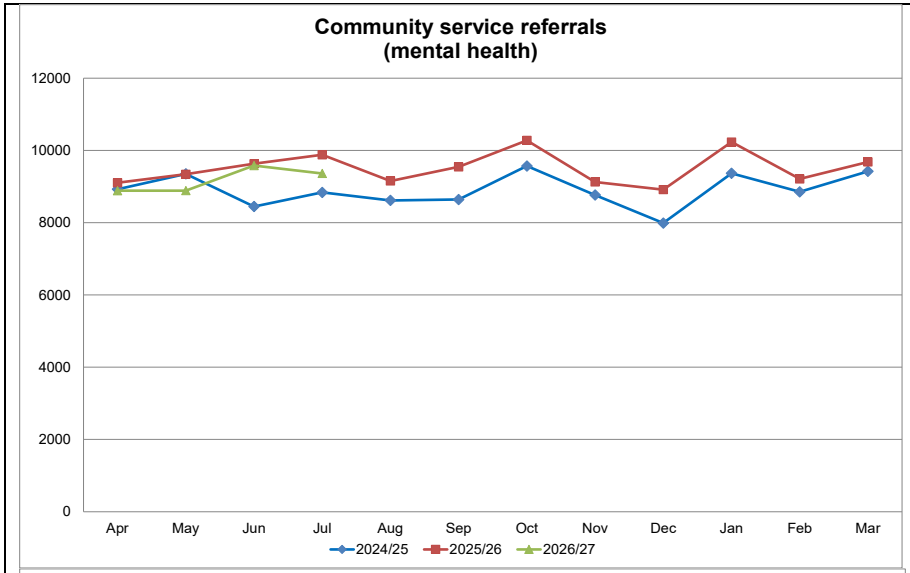
SOMERSET NHS FOUNDATION TRUST

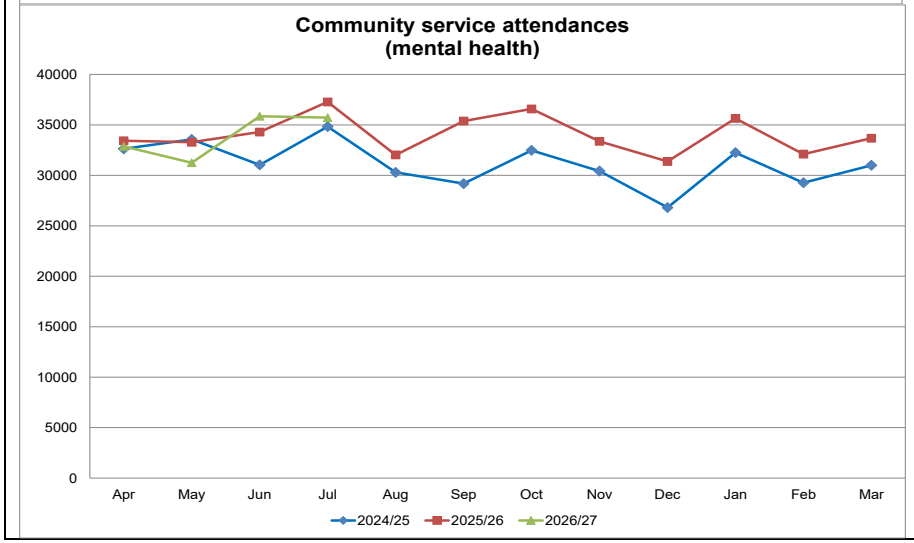
MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
MH31	Employment Service - Patients accessing service against NHSE plan	NHSC	2	569	566	568	570	558	542	556	576	557	544	556	577	From April 2026 >=580 = Green <580 = Red		

Operational context

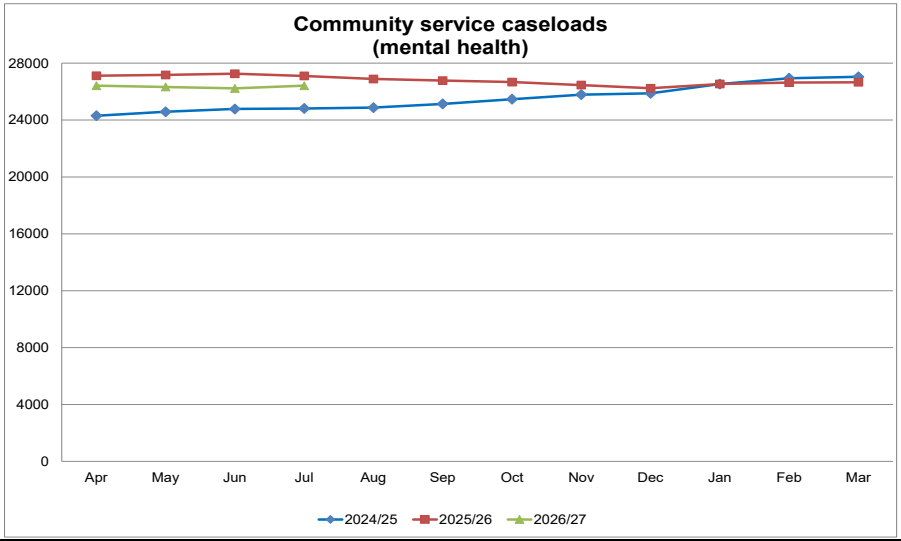
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





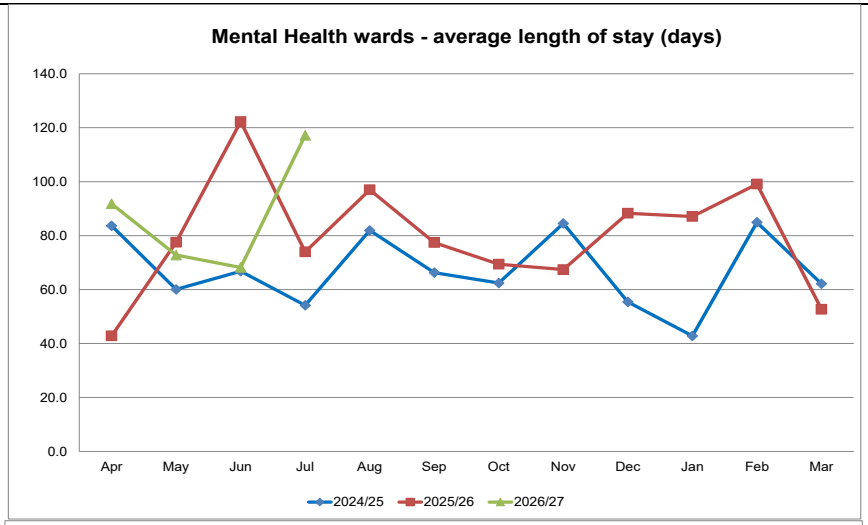
Summary:

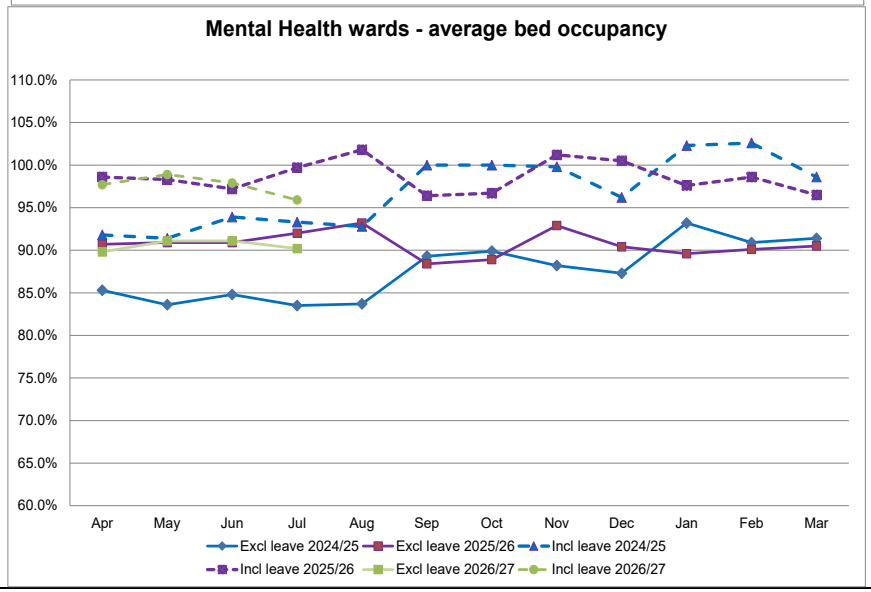
- Direct referrals to our community mental health services between 1 April and 31 July 2026 were 3.3% lower than the same months of 2025 but 3.2% higher than the same months of 2024.
- Attendances between 1 April and 31 July 2026 were 1.9% lower than the same months of 2025 but 2.6% higher than the same months of 2024.
- Community mental health service caseloads as at 31 July 2026 2.5% lower than as at 31 July 2025 but were 6.4% higher than as at 31 July 2024.



Assurance and Leading Indicators

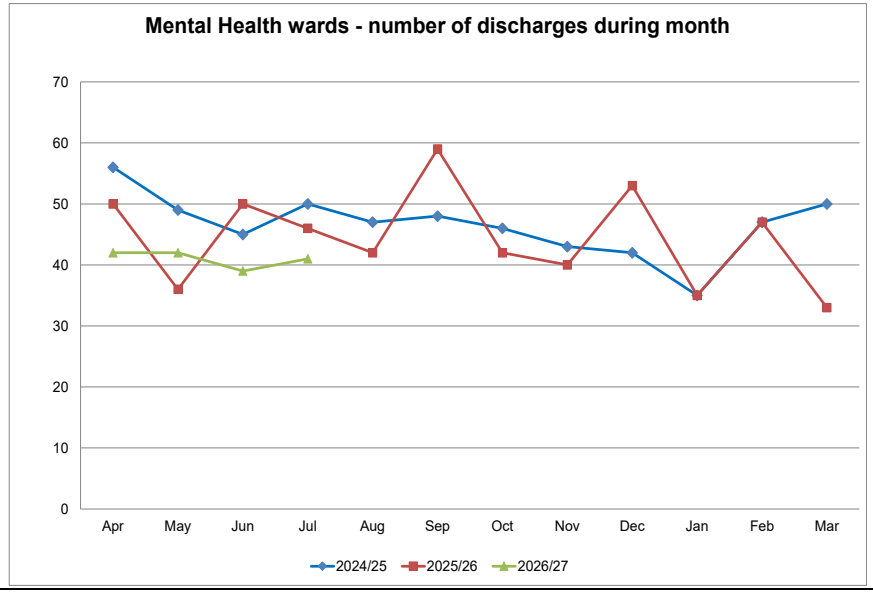
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay across all of our mental health wards in July 2026 was 117.2 days, up from 68.2 days in June 2026. This increase was mainly due to a patient discharged from Rydon Two, one of our adult acute wards, who had a length of stay of 809 days. During July 2026, a total of 15 patients were discharged with lengths of stay of 100 days or more. The rolling 12-month average length of stay for the period ending 31 July 2026 was 79.5 days, compared to 65.4 days for the 12-month period ending 31 July 2025.
- The mental health bed occupancy rates excluding leave and including leave decreased when compared to June 2026.
- A total of 41 patients were discharged in July 2026, an increase from 39 in June 2026.



NARRATIVE REPORT

URGENT AND EMERGENCY CARE SERVICES

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

Ambulance handovers
In July 2026, performance for ambulance handovers taking more than 15 minutes improved at the MPH site, by 7.6% to 54.9%, and slightly improved at YDH, by 0.6% compared to June 2026. Overall, the Trust remains better than the Operational Plan Recovery Trajectory. The Trust-wide average ambulance handover time in July 2026 was 21.1 minutes, an improvement of 2.8 minutes compared to June 2026.

Front Door
In July 2026, both Emergency Departments (EDs) continued to see exceptional increases in attendances, compared to 2025. Trust-wide growth in ED attendances in January to July 2026 was 8% compared to the prior year, with the Trust-wide number of admissions increasing only by 3%.

January – July total ED attendances, Admissions, and Community UTC attendances

	Jan - July 2025	Jan - July 2026	%
ED	86,905	94,171	8%
Admissions	20,896	21,613	3%
UTC	67,632	59,067	-13%

The front door continues to see consistent pressure, particularly at YDH, where there continues to be a significant month-on-month rise in ED attendances; for July 2026 this represents a 18% increase compared to July 2025.

The growth of Community UTC four-hour breaches and reduction of attendances compared to the prior year, is having a detrimental impact on the overarching four-hour performance position.

	MPH ED Attendance	MPH ED Admissions	MPH ED Breaches (Over 4 hrs)	YDH ED Attendance (inc UTC)	YDH ED Admissions	YDH ED Breaches (Over 4 hrs)	Community MIU/UTC Attendance (Unplanned)	Community MIU/UTC Breaches (Over 4 hrs)
July 2026 to July 2025 difference: increase / (reduction)	292	-87	500	1002	66	611	-1446	451
%	3.85%	-4.43%	15.1%	18.07%	5.96%	35.07%	-13.69%	406.31%

Focus of improvement work:

- The Trust continues to work with colleagues from South Western Ambulance Service NHS Foundation Trust (SWAST) to support a reduction in the levels of conveyances to hospital, in addition to supporting the Integrated Care Bard (ICB) to improve 'call before conveyance' rates.
- YDH development of a Paediatric Assessment Unit (PAU) to support timely paediatric care, and a refocus on pathways and escalation on the MPH site.
- As a result of increased demand, additional escalation beds were in use across both acute sites during the month.

No criteria to reside (NCTR)

During July 2026, the percentage of occupied bed days lost due to patients not meeting the criteria to reside was 23.7% at MPH and 22.8% at YDH. This remains significantly above the system plan ambition for NCTR. The average Length of Stay (LOS) at MPH increased to 6.9 days but decreased at YDH to 8.9 days, from 9.6 days in June 2026. Despite the challenges; SFT continues to perform well against the target of discharging 85% of our patients on a Pathway 0; in July 2026, this was 87% at MPH and 86% at YDH.

As part of the UEC transformation works, encompassing Every Minute Matters, Model discharge and acute pathways, there is a revised focus on metrics including ensuring that 30% of patients to be discharged are in the discharge lounge by 12pm. During July at YDH, 33% of patients went via the discharge lounge, and 43% of patients on the MPH site. At YDH 13% of all discharges occurred before midday, compared to 12.8% at MPH; the work is ongoing in relation to Every Minute Matters will focus on improving this further.

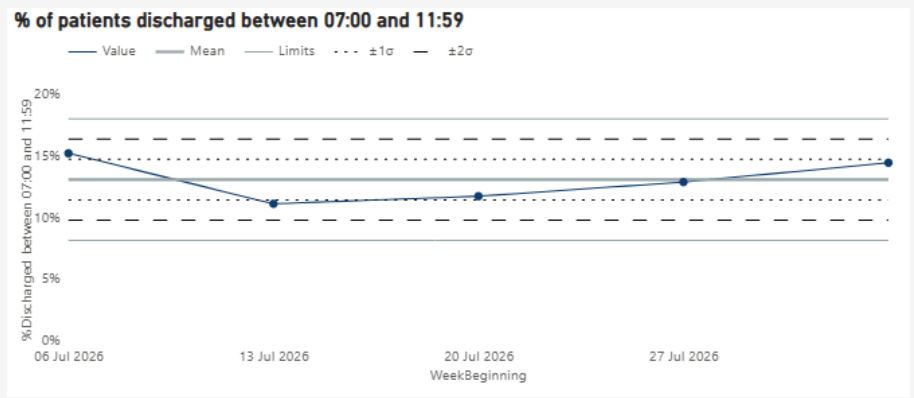
Stroke

The percentage of patients admitted to a stroke ward within four hours was 64.0% at MPH during July 2026, and 36.1% at YDH. The YDH stroke ward continues to experience a significant number of patients who are delayed awaiting ward care. The percentage of patients assessed by a specialist consultant in stroke was 65.8% at YDH and 54.5% at MPH.

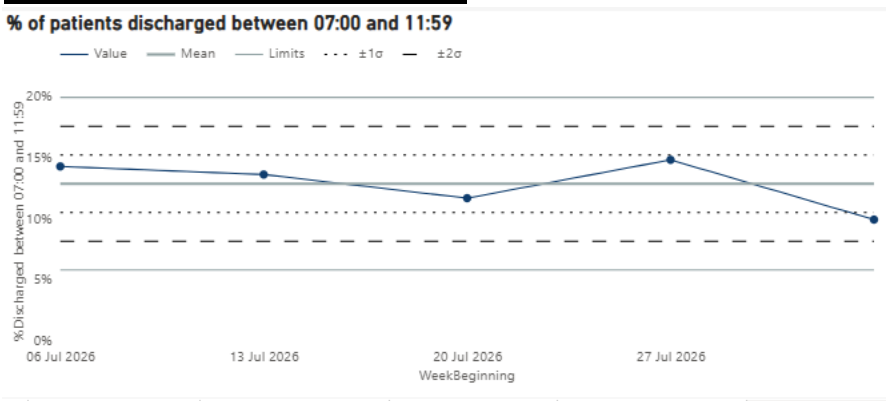
Focus of improvement work

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

YDH Discharge before Midday



MPH Discharge before midday



Focus of improvement work

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

Pressure Ulcer Damage (Episodes of Care)

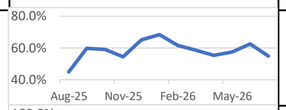
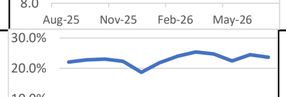
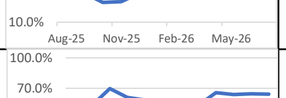
This area of reporting is a month retrospectively, to allow time for reported incidents to be reviewed and validated by the Tissue Viability Team to ensure all cases resulting from episodes of care are correctly noted. During June 2026 the number of reported incidents at MPH increased compared to May 2026, which had been the lowest since July 2025. Numbers reported at YDH increased significantly in May 2026 to the highest reported since January 2025, but reduced slightly in June 2026.

Focus of improvement work

- Develop a Pressure Ulcer Strategy;
- Review detailed Learning Responses (After Action Reviews) to consider system learning about contributory factors and identify remedial actions required;
- Continue to work on the inpatient targets through targeted work and Quality Improvement (QI) methodology;
- Pressure Ulcers has been added as a standing agenda item at Somerset Nursing Assurance Group, to ensure Service Groups are providing updates and assurance.

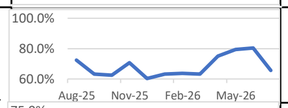
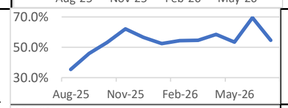
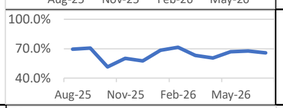
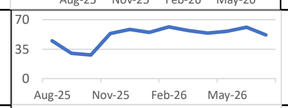
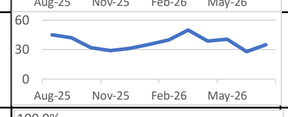
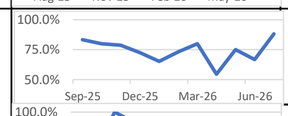
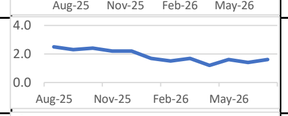
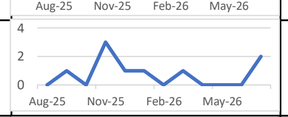
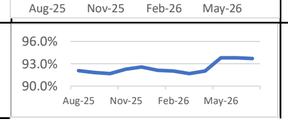
SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
UEC1	Percentage of ambulance handovers over 15 minutes	MPH	NHSC	2	44.9%	59.8%	59.1%	54.5%	65.1%	68.5%	61.6%	58.8%	55.4%	57.4%	62.5%	54.9%	From April 2026 >=trajectory = Green <trajectory = Red		P
UEC2		YDH			85.2%	88.1%	87.5%	86.4%	88.6%	89.2%	88.9%	88.5%	90.5%	88.6%	89.8%	89.2%			F
UEC3		Overall			58.6%	69.6%	69.1%	65.8%	73.9%	76.1%	72.2%	69.5%	67.9%	69.1%	72.3%	67.2%			?
UEC4	Percentage of ambulance handovers over 45 minutes	MPH	NHSC	2	5.6%	5.3%	4.9%	4.7%	8.0%	10.0%	3.8%	2.6%	1.7%	4.2%	6.6%	1.9%			P
UEC5		YDH			12.2%	11.8%	10.1%	4.9%	9.7%	12.1%	9.2%	6.1%	8.4%	7.0%	8.2%	5.3%			?
UEC6		Overall			7.8%	7.5%	6.7%	4.8%	8.6%	10.8%	5.9%	3.8%	4.0%	5.2%	7.2%	3.2%			?
UEC7	Ambulance - Average handover times (minutes)	MPH	NHSC	2	18.7	20.5	20.4	19.2	22.7	24.3	19.9	19.1	18.1	19.6	21.7	18.2			P
UEC8		YDH			30.3	28.9	28.5	25.1	28.3	29.3	28.0	26.2	28.0	27.4	28.0	26.2			F
UEC9		Overall			22.6	23.4	23.3	21.3	24.8	26.1	23.0	21.7	21.6	22.5	23.9	21.1			P
UEC10	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	SFT	2,6	6.6	6.6	6.6	6.8	6.1	6.5	7.2	6.5	6.3	6.3	6.3	6.9	Monitored using Statistical Process Control rules. Report by exception.		
UEC11		YDH			8.3	8.8	9.6	8.5	9.3	9.2	9.0	9.5	9.6	9.4	9.6	8.9			
UEC12	Patients not meeting the criteria to reside: percentage of occupied bed days lost	MPH	SFT	2,6	22.1%	22.8%	23.0%	22.3%	18.7%	21.9%	24.0%	25.4%	24.7%	22.5%	24.5%	23.7%	<=9.8%= Green >15% =Red		F
UEC13		YDH			21.3%	19.6%	16.5%	16.8%	19.5%	20.4%	26.2%	22.8%	24.4%	24.5%	22.8%	22.8%			F
UEC14	Percentage of Stroke Patients directly admitted to a stroke ward within four hours	MPH	NSG	1,2,4	45.3%	53.3%	69.6%	60.7%	58.3%	46.2%	56.2%	52.9%	65.5%	63.6%	64.3%	64.0%	>=90%= Green >=75% - <90% =Amber <75% =Red		F
UEC15		YDH			26.5%	33.3%	27.8%	20.8%	24.3%	32.3%	34.6%	25.0%	28.9%	40.5%	30.3%	36.1%			F

SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
UEC16	Percentage of patients spending >90% of time in stroke unit - acute services	MPH	NSG	1,2,4	72.3%	63.3%	62.5%	70.7%	60.3%	63.3%	63.8%	63.3%	75.0%	79.3%	80.4%	65.7%	>=80%= Green >=70% - <80% =Amber <70% =Red		F
UEC17		YDH			62.5%	74.4%	61.0%	52.4%	50.9%	48.6%	40.0%	48.6%	51.4%	55.6%	46.3%	50.0%			F
UEC18	Percentage of patients scanned within 20 minutes of clock start	MPH	NSG	1,2,4	46.2%	46.0%	44.7%	5.4%	60.9%	62.7%	50.9%	49.1%	56.9%	56.7%	61.0%	47.3%	>=32%= Green >=27% - <32% =Amber <27% =Red		P
UEC19	Percentage of patients scanned within 20 minutes of clock start	YDH	NSG	1,2,4	19.4%	24.4%	21.6%	24.0%	17.8%	5.3%	14.3%	26.3%	23.3%	16.7%	24.3%	28.9%	>=32%= Green >=27% - <32% =Amber <27% =Red		F
UEC20	Percentage of patients assessed by a Stroke Specialist Consultant within 14 hours of clock start	MPH	NSG	1,2,4	35.4%	46.0%	53.2%	62.1%	56.5%	52.5%	54.4%	54.5%	58.6%	53.3%	69.5%	54.5%	>=70%= Green >=60% - <70% =Amber <60% =Red		F
UEC21		YDH			69.4%	70.7%	51.4%	60.0%	57.4%	68.4%	71.4%	63.2%	60.5%	66.7%	67.6%	65.8%			F
UEC22	Stroke: Median number of minutes of total therapy received per inpatient day	MPH	NSG	1,2,4	45	30	28	54	59	55	61	57	54	56	61	52	>=42= Green >=32 - <42 =Amber <32 =Red		P
UEC23	Stroke: Median number of minutes of total therapy received per inpatient day	YDH	NSG	1,2,4	45	42	32	29	31	36	40	50	39	41	28	35	>=42= Green >=32 - <42 =Amber <32 =Red		F
UEC24	Percentage of patients with a National Early Warning Score (NEWS) of 5 or more acted upon appropriately - The registered nurse should immediately inform the medical team caring for the	MPH, YDH, Community Hospitals and Mental Health wards	NHSC	1,2,4	58.3%	83.3%	80.0%	78.6%	72.7%	65.2%	73.3%	80.0%	54.5%	75.0%	66.7%	88.2%			F
UEC25	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	NHSC	1,2,4	92.0%	88.9%	100.0%	97.1%	79.4%	90.0%	90.3%	88.2%	88.9%	96.6%	96.9%	95.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		?
UEC26	Percentage of emergency patients that present with a NEWs score of 5 and above screened for sepsis within 60 minutes - Emergency Departments				100.0%	66.7%	52.5%	69.7%	66.7%	70.7%	58.6%	62.5%	46.2%	67.5%	72.9%	82.5%			F
UEC27	Percentage of patients admitted as an emergency within 30 days of discharge		NOF, PAF	2,3	9.5%	8.7%	7.3%	8.4%	9.1%	9.0%	9.2%	9.1%	9.6%	9.6%	8.9%	8.9%	To be confirmed.		
UEC28	Average number of days between planned and actual discharge date		NOF, PAF	2,3	2.5	2.3	2.4	2.2	2.2	1.7	1.5	1.7	1.2	1.6	1.4	1.6	To be confirmed.		
UEC29	Monthly number of inpatients to suffer a new hip fracture		PAF	2	0	1	0	3	1	1	0	1	0	0	0	2	Monitored using Statistical Process Control rules >2 = Red		
UEC30	Percentage of mental health patients spending under 12 hours in A&E		PAF	2,3	92.1%	91.8%	91.7%	92.3%	92.6%	92.1%	92.0%	91.7%	92.0%	93.8%	93.8%	93.7%	From April 2026 >=trajectory = Green <trajectory = Red		P

SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

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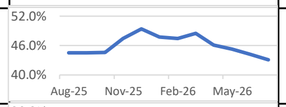
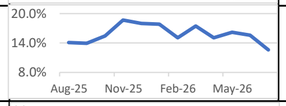
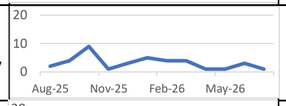
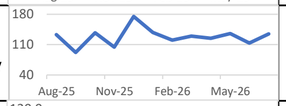
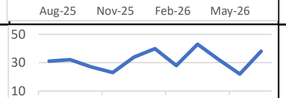
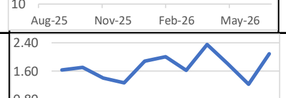
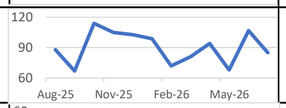
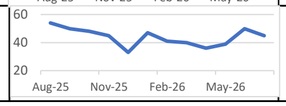
UEC31	Percentage of over 65s attending emergency departments to be admitted		PAF	2,3	44.5%	44.5%	44.6%	47.4%	49.4%	47.8%	47.4%	48.5%	46.1%	45.3%	44.2%	43.1%	To be confirmed.		
UEC32	Percentage of under 18s attending emergency departments to be admitted		PAF	2,3	14.1%	14.0%	15.4%	18.7%	18.0%	17.8%	15.0%	17.5%	15.1%	16.2%	15.6%	12.6%	To be confirmed.		
UEC33	Average daily number of medical and surgical outliers in acute wards during the month	MPH	NHSC	2	2	4	9	1	3	5	4	4	1	1	3	1	Monitored using Statistical Process Control rules. Report by exception.		
UEC34		YDH	NHSC	2	11	9	9	9	9	10	7	9	9	10	13	9	Monitored using Statistical Process Control rules. Report by exception.		
UEC35	Number of patients transferred between acute wards after 10pm	MPH	NHSC	2	82	103	61	67	78	143	102	80	42	67	111	74	Monitored using Statistical Process Control rules. Report by exception.		
UEC36		YDH	NHSC	2	133	92	137	104	175	138	120	130	125	136	114	135	Monitored using Statistical Process Control rules. Report by exception.		
UEC37	Summary Hospital-level Mortality Indicator (SHMI)		NOF, NHSC	2	107.3	109.4	108.8	106.8	104.7	110.2	107.5	110.5	105.4	Data not yet due - May 2026 to be reported after July 2026			Monitored using Statistical Process Control rules. Report by exception.		
UEC38	Total number of patient falls - acute services		NHSC	2	168	163	164	113	160	184	179	167	164	175	162	181	Monitored using Statistical Process Control rules >206 = Red		
UEC39	Rate of falls per 1,000 occupied bed days - acute services		NHSC	2	5.86	5.72	5.53	4.00	5.66	6.02	6.64	5.74	5.86	6.09	5.59	6.41	Monitored using Statistical Process Control rules >6.99 = Red		
UEC40	Number of pressure ulcers	MPH	NOF, NHSC	2	31	32	27	23	34	40	28	43	32	22	38	Data not yet due	Monitored using Statistical Process Control rules >44 = Red		
UEC41	Rate of pressure ulcer damage per 1,000 occupied bed days	MPH	NOF, NHSC	2	1.63	1.70	1.40	1.27	1.89	2.01	1.62	2.35	1.81	1.23	2.09	Data not yet due	Monitored using Statistical Process Control rules >2.27 = Red		
UEC42	Number of pressure ulcers	YDH	NOF, NHSC	2	18	9	12	13	18	14	14	18	13	26	22	Data not yet due	Monitored using Statistical Process Control rules >29 = Red		
UEC43	Rate of pressure ulcer damage per 1,000 occupied bed days	YDH	NOF, NHSC	2	1.86	0.93	1.15	1.28	1.76	1.31	1.45	1.66	1.26	2.39	2.02	Data not yet due	Monitored using Statistical Process Control rules >2.67 = Red		
UEC44	No. ward-based cardiac arrests - acute wards	MPH	NHSC	2	3	3	6	2	4	5	1	7	1	1	2	0	Monitored using Statistical Process Control rules. Report by exception.		
UEC45	No. ward-based cardiac arrests - acute wards	YDH	NHSC	2	3	2	5	0	2	1	0	1	3	1	0	0	Monitored using Statistical Process Control rules. Report by exception.		

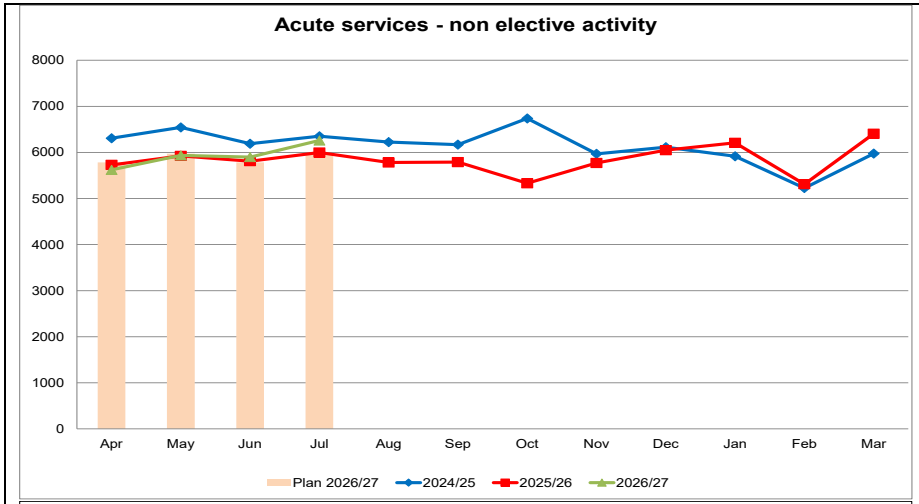
SOMERSET NHS FOUNDATION TRUST

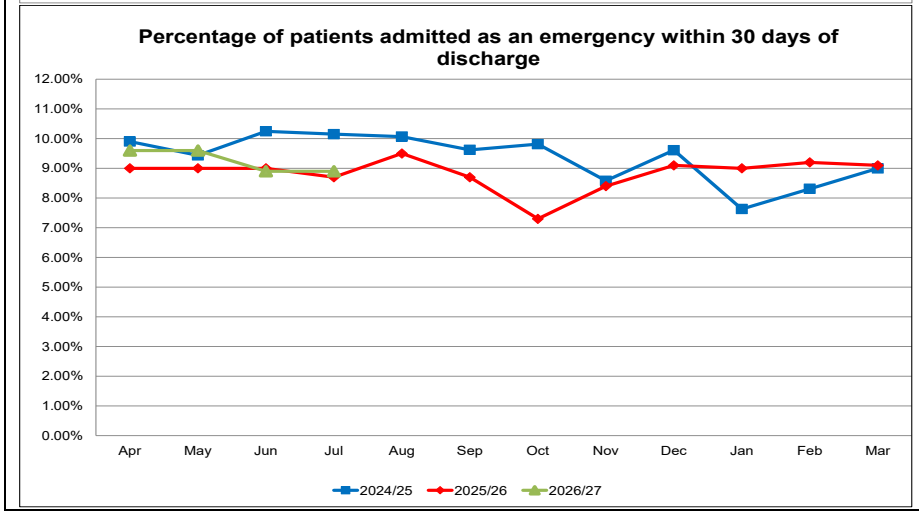
URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
UEC46	Total number of medication incidents	MPH	NHSC	2	88	67	114	105	103	99	72	81	94	68	107	85	Monitored using Statistical Process Control rules >119 = Red		
UEC47	Total number of medication incidents	YDH	NHSC	2	54	50	48	45	33	47	41	40	36	39	50	45	Monitored using Statistical Process Control rules >63 = Red		

Operational context

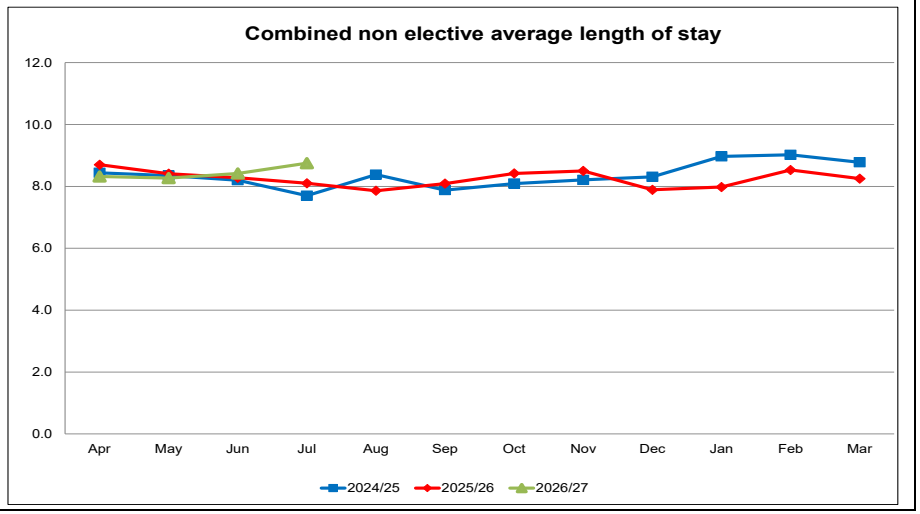
Acute services: This section of the report provides a summary of the levels of non-elective activity, emergency readmissions within 30 days, and non-elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- Between 1 April and 31 July 2026, non-elective admissions increased by 1.1% compared to the same months of 2025 but decreased by 6.6% compared to the same months of 2024. Activity for 1 April and 31 July 2026 was 0.9% above the planned level.
- Between 1 April and 31 July 2026, emergency readmissions totalled 4,768, 2.7% higher than the same period in 2025, when there were 4,644 readmissions.
- The trust-wide monthly non-elective average length of stay increased in July 2026 to 8.8 days, up from 8.4 days in June 2026.



NARRATIVE REPORT

ELECTIVE CARE SERVICES

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

1) The percentage of patients receiving the diagnostic test they need within six weeks of the request being made was 83.1% at the end of July 2026, compared with 83.3% at the end of June 2026. This is better than plan (80.4%). The number of patients waiting over six weeks for a diagnostic test stayed broadly the same across June and July 2026, at 2,033 for the end of July, and was better than plan (2,220), but the total waiting list size was higher than plan (12,017 versus a plan of 11,310). The main reasons for the six week wait backlogs continue to be capacity shortfalls related to staff vacancies and sickness.

Additional actions being taken in the coming months include:

- Completion of the Bridgwater Diagnostic Centre (now open), providing an increase in complex CT and MRI scanning capacity.
- King's Building opening at Musgrove (September 2026), which will provide an additional endoscopy room and reduce the impact of the scope decontamination capacity limit at Bridgwater.
- Continued endoscopy insourcing at weekends.
- Additional trainee nurse endoscopists recently recruited, to be trained (around six months).
- Apprentice and trainee radiographer for the DEXA service in progress.
- Additional locum sonographer being sought, to increase ultrasound canning capacity.

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

	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
MRI	96	136	88	105	143	262	206	221	320	252	290	278
CT	293	278	252	212	239	167	79	40	20	16	38	45
Ultrasound	191	141	61	91	70	91	71	121	372	337	363	371
Barium Enema	21	21	12	19	10	4	4	18	18	15	6	3
DEXA	243	309	337	355	387	360	234	150	148	145	201	240
Audiology	111	120	79	117	239	161	148	92	166	277	119	87
Echo	328	142	130	296	564	757	639	766	654	427	73	13
Neurophysiology	28	62	26	35	50	33	16	37	75	74	87	104
Sleep studies	53	14	8	20	6	22	15	19	4	8	13	19
Urodynamics	24	26	30	25	58	65	68	68	58	52	70	101
Colonoscopy	447	442	465	520	618	628	501	460	322	251	271	310
Flexi sigmoid.	215	222	224	225	247	263	181	163	189	205	197	172
Cystoscopy	16	19	19	27	27	22	26	16	14	4	12	7
Gastroscopy	324	332	398	538	523	409	291	348	428	459	312	283

2) The RTT plan has been re-set as part of the medium-term plan for the next three years. Current performance against the core RTT target is as follows:
    - 18-weeks RTT (actual 64.9%; plan 65.6%).

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

- First OPA within 18 weeks (actual 73.4%; plan 73.2%)
- 52-week waits (actual 2.7% of total waiting list; plan 1.1% or less).
- 65-week waits (29 against a national requirement of zero).

18-week RTT performance (i.e. the percentage of patients waiting under 18 weeks on a Referral to Treatment pathway), is currently worse than plan. The percentage of patients waiting under 18 weeks for a first outpatient appointment remains above plan. The total waiting list size is, however, significantly above plan (54,854 versus a plan of 49,981). We remain better than plan for treatments (clock stops), but demand (clock starts) are significantly above plan. The reasons for the above plan waiting list size are multifactorial but include:

- the plan being set at a point where we were seeing a dramatic reduction in total waiting list size, with the combined impacts of Advice & Refer reduction in clock starts, and additional capacity established, which have not been sustained.
- a seasonal rise in referrals, especially referrals for suspected skin, and additions to the RTT waiting list due to addressing some of the Advice & Refer triage backlogs which have built-up; we have also seen a reduction in advice & guidance rates back to primary care (i.e. the onward referral rate onto an RTT waiting list has gone up).
- a reduction in RTT pathway validation due to vacancies in the team.
- several consultant vacancies in high volume specialties including neurology (now filled but not yet in post), maxillo facial and urology.

The number of over 52-week waiters has increased (from 1,310 at the end of June 2026 to 1,474 at the end of July 2026). Over 40% of the increase is explained by a shortfall in maxillo facial service capacity due to clinician vacancies. Actions to reduce long waiters include:

- appointment to a maxillo facial consultant vacancy (starts November 2026), with an SAS grade clinician starting in September 2026; Saturday clinics in August, September and October 2026.
- fifteen additional theatre sessions being established each week from the beginning of September 2026 (five lists above plan), covering orthopaedics, ENT, upper GI and urology.
- continued outpatient appointment insourcing in ENT, dermatology and orthopaedics.
- continued weekend orthopaedic surgery insourcing.

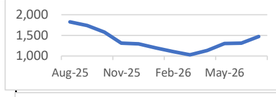
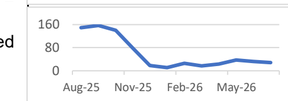
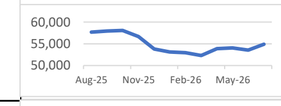
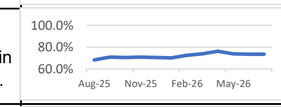
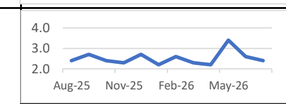
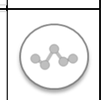
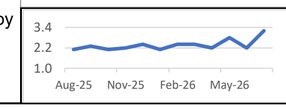
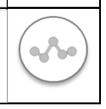
- clinical vacancies appointed to including consultant neurologists, consultant orthopaedic surgeons and a urology specialty doctor.

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

- Continued implementation of the Advice & Refer (Cinapsis) advice & guidance (A&G) platform, which will enable enhanced referrals for all routine GP requests for secondary care opinion. In addition to sixteen specialties already live with written A&G, work is ongoing on the pathway design and onboarding process for Paediatrics, Respiratory and General Surgery. A single point of access is also being developed for the Ophthalmology service, incorporating optometrist direct referral. Additional services going live will further reduce the number of patients needing to have an outpatient appointment. However, in the short term 18-week and first appointments within 18 weeks, performance is being affected because of fewer shorter waiting patients being on the waiting list.
- Clinic template standardisation and increased utilisation, including the development of a machine learning DNA predictor tool to support the backfilling of predicted underutilised clinics.
- Enhanced cross-site management of capacity to smooth demand and reduce maximum waiting times across Musgrove and Yeovil; this should reduce 52-week waiters (Cardiology, Gynaecology and Neurology); we continue to explore ways of supporting cross-site use of capacity in the context of still having two Patient Administration Systems (PASs).
- Ambient Voice Technology (AVT) utilisation in clinic, to replace dictation of letters and increase patient throughput of clinics. We have now deployed this in with champions in a range of specialties, including neurology, ENT, T&O, pain management, cardiology respiratory, haematology, oncology and gynaecology. We have re-visited the deployment process, to speed up the establishment of AVT in as wide a group of specialties as possible, with a seven-day implementation process now in place for fully engaged services. Additional project support is being put in place to support implementation and benefits realisation.
- Review and development with commissioners of a new service delivery model for endocrinology weight management services, which remains under discussion.

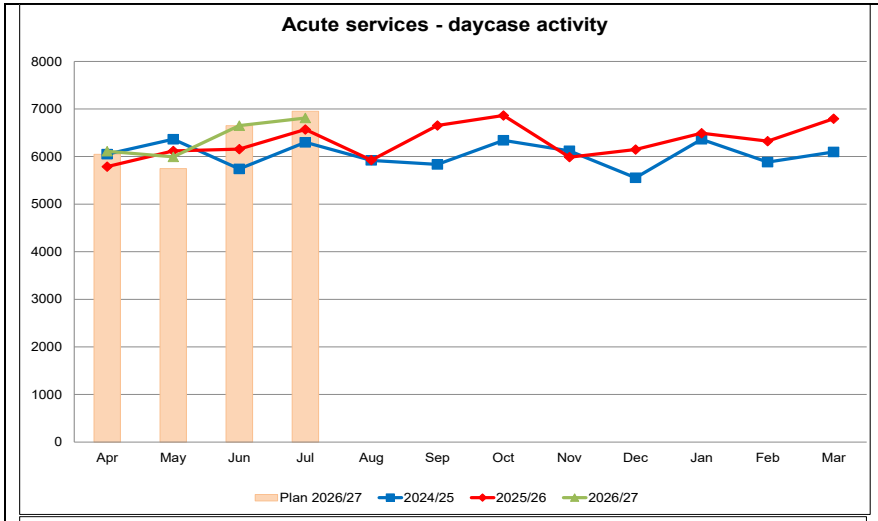
SOMERSET NHS FOUNDATION TRUST

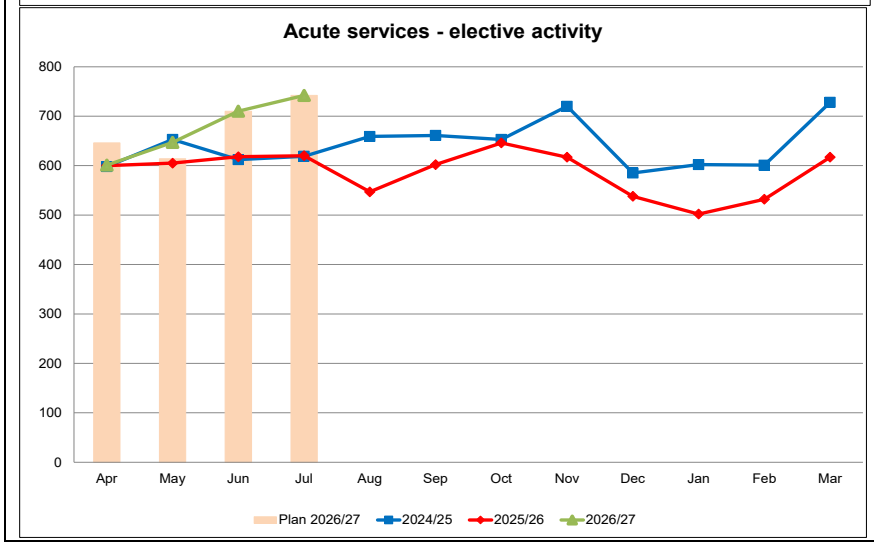
ELECTIVE CARE

No.	Description		Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
EC1	Reduce the proportion of people waiting over 52 weeks for treatment to zero March 2027		OPG	1,2	3.2%	3.0%	2.7%	2.3%	2.4%	2.2%	2.1%	2.0%	2.1%	2.4%	2.4%	2.7%	From April 2026 <=trajectory = Green >trajectory = Red		
EC2	52 week RTT breaches - Patients of all ages		OPG		1,826	1,740	1,575	1,313	1,290	1,195	1,111	1,028	1,135	1,304	1,310	1,474	From April 2023 At or below trajectory = Green Above trajectory = Red		
EC3	52 week RTT breaches - Patients aged under 18		OPG		138	124	106	81	81	84	96	120	142	138	127	148			
EC4	65 week RTT breaches - Patients of all ages		NHSC		149	157	141	79	18	11	26	17	23	37	32	29			
EC5	Referral to Treatment (RTT) incomplete pathway waiting list size - all ages		NHSC	1,2	57,715	57,935	58,068	56,659	53,781	53,143	52,985	52,302	53,891	54,011	53,524	54,854			
EC6	Referral to Treatment (RTT) incomplete pathway waiting list size - under 18		NHSC		4,027	3,967	4,005	3,918	3,820	3,762	3,803	3,868	4,098	4,013	4,039	4,079	From April 2025 at or below trajectory = Green above = Red		
EC7	Rate of annual growth in under 18s elective activity - Rolling 12 months comparison of previous 12 months		NOF, PAF		-4.0%	-4.5%	-6.1%	-5.1%	-6.3%	-14.1%	-9.3%	-7.6%	-6.7%	-8.4%	-7.5%	-10.0%	To be confirmed		
EC8	Improve the percentage of patients waiting longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline				68.2%	70.6%	70.3%	70.7%	70.3%	70.2%	72.4%	73.9%	76.2%	73.9%	73.4%	73.4%	Per the planning trajectory, culminating in 80.0% in March 2027.		
EC9	Average length of stay of patients discharged from acute wards - (Excludes daycases, non acute services, ambulatory/SDEC care and hospital spells discharged from maternity and paediatrics wards).	MPH	SFT	2,6	2.4	2.7	2.4	2.3	2.7	2.2	2.6	2.3	2.2	3.4	2.6	2.4	Monitored using Statistical Process Control rules. Report by exception.		
EC10		YDH			2.1	2.3	2.1	2.2	2.4	2.1	2.4	2.4	2.2	2.8	2.2	3.2			

Operational context

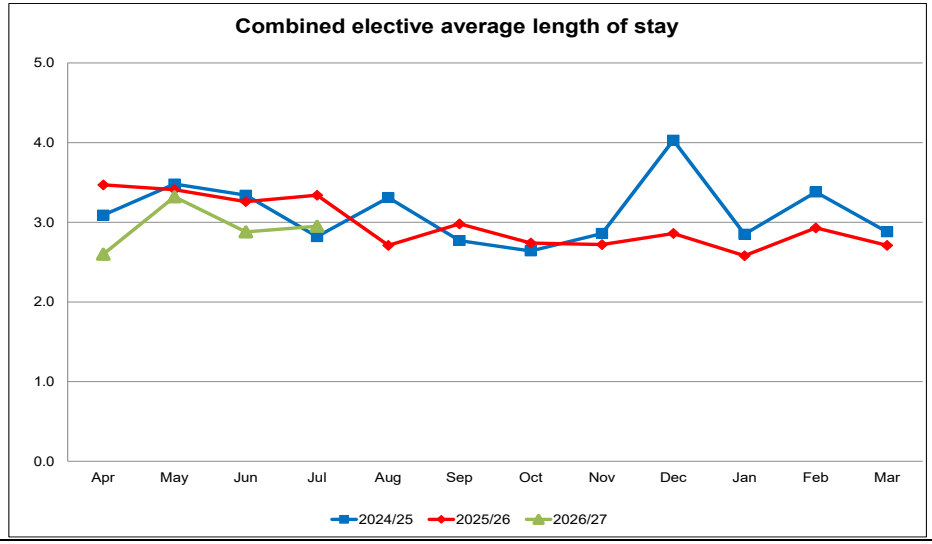
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





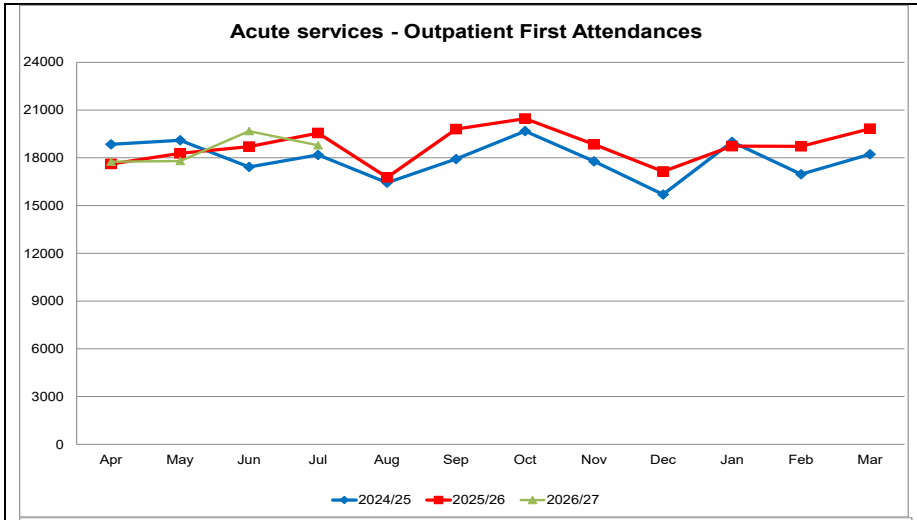
Summary:

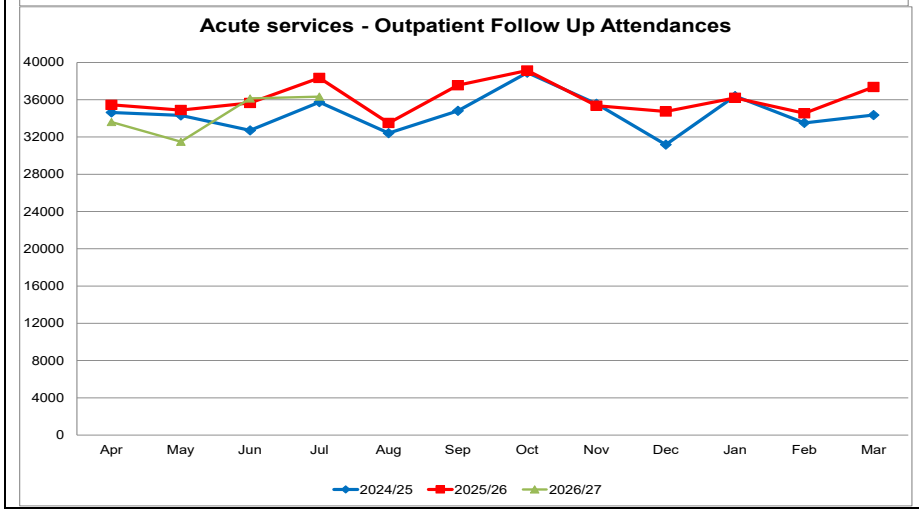
- The number of day cases undertaken by our acute services between 1 April and 31 July 2026 increased by 3.8% compared to the same months of 2025 and increased by 4.5% compared to the same months of 2024. Activity for the year to date was 0.7% above the current year plan.
- Between 1 April and 31 July 2026, elective admissions were 10.5% higher than the corresponding months of 2025 and 8.8% higher compared to the same months of 2024. Activity for the year to date was 0.4% below the current year plan.
- The trust-wide monthly elective average length of stay was 3.0 days in July 2026, a slight increase from 2.9 days in June 2026.



Operational context

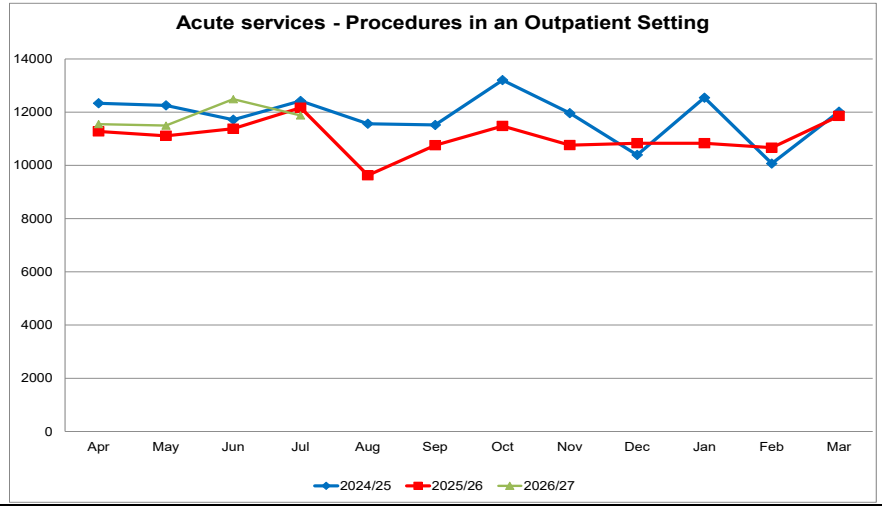
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- The number of first outpatient attendances undertaken by our acute services between 1 April and 31 July 2026 decreased by 0.2% compared to the same months of 2025 but was 0.6% higher than the same months of 2024.
- Between 1 April and 31 July 2026, follow up outpatient attendances were 4.7% lower than the corresponding months of 2025 but 0.1% higher than the same months of 2024.
- Between 1 April and 31 July 2026, the reported number of procedures undertaken within an outpatient setting increased by 3.2% compared to the same months of 2025 but were 2.7% lower than the same months of 2024. Any backlog in respect of coding means that the current numbers will be understated



NARRATIVE REPORT

CANCER SERVICES

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

1) 28-day Faster Diagnosis Standard (FDS) performance was 83.9% in June 2026, above both the national standard (80.0%), and our planning trajectory of 80.7%. Colorectal made up a quarter of all the breaches of the standard in June 2026, as shown in Table 1 below.

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

Tumour sites	Breaches (May 26)	Performance (May 26)	% of breaches (May 26)	Breaches (June 26)	Performance (June 26)	% of breaches (June 26)
Colorectal	135	63%	23%	124	76%	25%
Gynaecology	63	74%	11%	79	75%	16%
Head & Neck	52	82%	9%	77	77%	16%
Skin	196	73%	33%	61	91%	13%
Urology	67	75%	11%	60	75%	12%

FDS performance has been affected over the last few months by very high levels of skin suspected cancer referrals. This has come on top of the retirement of a consultant in December 2025 and the extended leave of another consultant due to a family emergency. Although June's performance was more typical of skin's usual performance of above 90%, we are expecting a deterioration in this position due to waits for first appointments lengthening in July. Longer than optimal endoscopy waiting times have also been a factor, which is impacting on colorectal performance. The main actions being taken are:

Skin:

- A locum was appointed to support the dermatology service, although they have since left due to a bereavement; a further locum is being sought.
- Insourcing is continuing to be used to run additional weekend clinics, with further insourcing capacity being sought.

- Options are being reviewed to increase senior support for the triage of benign tele-dermatology requests being received via the Advice & Refer system; whilst not directly supporting the skin cancer service this is helping to relieve pressure with the wider dermatology service.
- Artificial Intelligence (AI) is being explored to support triage of suspected cancer referrals. This will help to ensure the right patients are being prioritised.
- The consultant who was on an extended period of absence has returned to work.

Colorectal:

- Project Manager has now commenced, to support pathway improvement work.
- Weekly Colorectal Improvement Programme established to re-visit and continue the 100-Day Challenge work.
- Pathway analysis being undertaken, supported by SWAG Cancer Alliance; the analysis of the pathways will help to identify bottlenecks and issues which will then be used by the Improvement Group.
- Delays associated with best interests meeting are being investigated.
- Progressing discussions on the implementation of ColoFIT, which uses patient specific factors to refine the risk calculation and reduce the need for a colonoscopy to be undertaken in some patients.
- Review and refinement of the general anaesthetic colonoscopy pathway at YDH to reduce delays.
- Additional physical capacity for colonoscopy lists will be in place once the King's building opens in September; at the same time our locum returns from extended leave.
- Surgical Centre (King's Building) opening in September 2026, which will provide more flexibility in the physical space to undertaken colonoscopy lists.
- Endoscopy booking team vacancies have now been appointed to and have moved to a central workforce to flex across the two sites.

2) 62-day referral to cancer treatment performance was 70.6% in June 2026, below the current national standard of 75% and our planning trajectory of 75.8%. Urology, skin and colorectal are the main tumour sites contributing to breaches.
   Additional actions to improve 62-day performance, which are in addition to those related to FDS are as follows:
   - Urology capacity – two additional operating sessions per week from the beginning of September 2026, once the King's Building opens, with the team picking up extras where possible in the interim; a specialty doctor is being considered, to fill team gaps from the resignation and retirement of two consultants in the team.
   - Four additional theatre sessions per week going into Head & Neck (ENT) from September 2026.

- Lung – ring-fenced PET scan slots; one-stop echo slots for two-week wait patients; AI for chest x-rays (February 2027); streamlining MDT discussion effectiveness by ensuring only those patients with new results are discussed.
- Skin – additional surgical insourcing being sought as part of a wider insourcing contract.
- Colorectal - demand and capacity review for theatre sessions; additional theatre lists to be identified.
- Weekend operating sessions until Musgrove Surgical Centre opens (September 2026) – mainly for benign pathways but again alleviates pressure.
- Pathology – an additional consultant has been appointed, with expertise in dermatology, which should reduce delays.

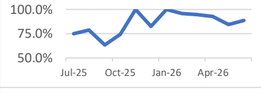
Table 2. 62-Day Cancer performance September 2024 to June 2026.

	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26
Trajectory (%)	66.5	66.4	68.8	70.2	71.3	71.5	72.0	72.8	70.3	70.5	71.6	71.8	71.7	71.7	72.6	72.3	70.3	75.5	75.1	74.7	68.4	75.8
Actual (%)	64.4	65.6	68.2	71.0	66.9	68.9	75.2	70.2	69.2	68.1	68.4	70.0	70.4	69.6	76.5	76.4	73.7	73.1	77.9	71.8	64.9	70.6

3) 31-day decision to treat to treatment performance was below the 96% June 2026 standard, at 90.7%, and below the planning trajectory of 94.7%. Thirty-nine percent of the breaches of the 31-day standard were in breast and 31% in skin. The breast breaches are related to a shortfall of capacity within the team, to cover periods of annual leave. The skin breaches are related to the very high levels of demand, possibly in part linked with the extended period of hot weather experienced in the South West in 2025, and peaks in the surgical treatments required. The dermatology service has also had a reduction in capacity following a consultant departure in December 2025. The Trust's insourcing provider is increasing the capacity it provides and artificial intelligence support for the triaging of referrals is being considered to enable patients with the highest risk of cancer to be prioritised.

SOMERSET NHS FOUNDATION TRUST

CANCER SERVICES

No.	Description	Source	Links to strategic aims	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Thresholds	Trend	Variation / Assurance
C1	Cancer: 62-day wait from referral to treatment for urgent referrals – number of patients treated on or after day 104	OPG	1,2	19	31	25	40	24	14	20	18	19	17	19	23	0= Green >0 = Red		
C2	Cancer: 62-day wait from referral to treatment for urgent referrals – Breast	OPG	1,2	74.6%	70.9%	67.3%	78.1%	73.1%	68.4%	81.5%	69.0%	87.8%	91.9%	70.0%	73.8%	At or above trajectory =Amber and below trajectory =Red		
C3	Cancer: 62-day wait from referral to treatment for urgent referrals – Colorectal	OPG	1,2	60.0%	67.8%	65.6%	37.9%	48.5%	72.5%	55.3%	51.9%	49.4%	45.5%	46.9%	57.7%	At or above trajectory =Amber and below trajectory =Red		
C4	Cancer: 62-day wait from referral to treatment for urgent referrals – Gynaecology	OPG	1,2	62.5%	75.0%	72.7%	86.4%	57.1%	94.4%	81.8%	50.0%	75.0%	83.3%	90.0%	77.5%	At or above trajectory =Amber and below trajectory =Red		
C5	Cancer: 62-day wait from referral to treatment for urgent referrals – Haematology	OPG	1,2	75.0%	78.9%	63.4%	74.4%	100.0%	82.6%	100.0%	95.8%	94.8%	92.9%	84.3%	88.7%	At or above trajectory =Amber and below trajectory =Red		
C6	Cancer: 62-day wait from referral to treatment for urgent referrals – Head and Neck	OPG	1,2	52.6%	51.4%	68.8%	67.5%	77.8%	61.3%	77.8%	66.7%	78.6%	50.0%	61.9%	55.6%	At or above trajectory =Amber and below trajectory =Red		
C7	Cancer: 62-day wait from referral to treatment for urgent referrals – Lung	OPG	1,2	57.6%	66.7%	68.1%	69.6%	100.0%	86.9%	40.0%	45.2%	79.7%	48.9%	44.4%	61.9%	At or above trajectory =Amber and below trajectory =Red		
C8	Cancer: 62-day wait from referral to treatment for urgent referrals – Other	OPG	1,2	92.3%	86.7%	77.8%	61.5%	58.8%	100.0%	87.5%	76.5%	100.0%	100.0%	80.0%	83.3%	At or above trajectory =Amber and below trajectory =Red		
C9	Cancer: 62-day wait from referral to treatment for urgent referrals – Skin	OPG	1,2	81.4%	83.1%	82.3%	76.3%	89.7%	81.1%	85.1%	89.3%	87.6%	84.4%	70.0%	79.7%	At or above trajectory =Amber and below trajectory =Red		
C10	Cancer: 62-day wait from referral to treatment for urgent referrals – Upper GI	OPG	1,2	66.7%	95.8%	63.8%	77.8%	86.2%	56.7%	76.6%	88.9%	82.3%	75.0%	73.7%	70.6%	At or above trajectory =Amber and below trajectory =Red		
C11	Cancer: 62-day wait from referral to treatment for urgent referrals – Urology	OPG	1,2	58.3%	52.7%	64.8%	55.0%	68.3%	55.2%	68.8%	67.5%	65.3%	63.9%	60.6%	63.0%	At or above trajectory =Amber and below trajectory =Red		
C12	Cancer: Percentage of all (stageable) cancers diagnosed discussed at MDT to be submitted with a complete stage (data Completeness)	PAF	1,2	82.1%	81.0%	83.0%	82.1%	82.7%	82.6%	82.4%	82.2%	80.9%	81.6%	83.8%	Data awaited	>=80%= Green >=60% to <80% = Amber <60% =Red		

NARRATIVE REPORT

MATERNITY SERVICES

The key points of note in respect of maternity services are outlined below:

The service remains fully operational across all areas. Booking and delivery activity has remained broadly consistent with the same period last year. During July 2026, there were 315 deliveries compared with 307 in July 2025, during which time Yeovil District Hospital services were suspended.

Processes for the review of, and response to, RADAR reports continue to strengthen, with the Safety and Governance team providing ongoing support across all areas.

Two incidents resulting in moderate harm or above were reported:

- one severe harm incident.
- one stillbirth.

The service continues to demonstrate a downward trend in postpartum haemorrhage greater than 1.5 litres and is no longer an outlier for obstetric anal sphincter injury. These indicators, alongside the additional maternity triggers, continue to be monitored closely.

The principal areas of concern and risk remain workforce, theatre capacity, fetal medicine, neonatal transport, triage, and safeguarding.

Maternity triage performance metrics are now included within the Integrated Performance Report and provide assurance of an improved position in waiting times over the past 12 months. Staffing levels have remained challenging during the summer period.

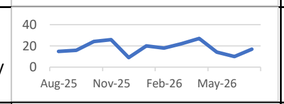
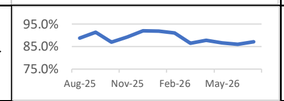
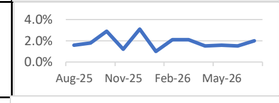
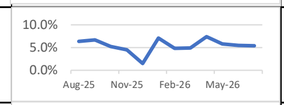
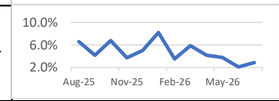
The service continues to review babies born with low APGARS, although low numbers result in inability to identify trends in the data. For measure M1: Babies readmitted to hospital who were under 30 days, the service is currently undertaking a validation exercise to understand the data and ensure accurate recording and reporting of this metric.

The service continues to progress through the improvement phase of the Maternity and Neonatal Improvement Support Team programme, with sustained focus on strengthening safety, governance, and quality improvement processes.

The service is working towards the assurance requirements arising from the Amos review and the publication of the NHS England 10-point plan, with a baseline assessment due by 25 September 2026. The team has submitted a response to the draft Care Quality Commission report for Musgrove Park Hospital and is awaiting publication of the final report.

SOMERSET NHS FOUNDATION TRUST

MATERNITY SERVICES

No.	Description	Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
M1	Babies readmitted to hospital who were under 30 days	CQIM	2	0	0	0	0	0	0	0	0	0	1	9	9	Monitored using Statistical Process Control rules. Report by exception.		
M2	Babies who were born preterm - less than 37 weeks gestation	CQIM	2	15	16	24	26	9	20	18	22	27	14	10	17	Monitored using Statistical Process Control rules. Report by exception.		
M3	Percentage of babies where breast feeding was initiated	CQIM	1,2	88.8%	91.3%	86.9%	89.2%	92.0%	91.9%	91.1%	86.4%	87.8%	86.6%	86.0%	87.1%	>=80%= Green >=75% - <80% =Amber <75% =Red		
M4	Percentage of babies with an APGAR score between 0 and 6	CQIM	1,2	1.6%	1.8%	2.9%	1.2%	3.1%	1.0%	2.1%	2.1%	1.5%	1.6%	1.5%	2.0%	=<1%= Green >1% - =<2% =Amber >2% =Red		
M5	Women who had a 3rd or 4th degree tear at delivery	CQIM	2	4	10	9	4	4	8	6	10	5	6	10	6	To be confirmed, following benchmarking against regional performance.		
M6	Women who had a postpartum haemorrhage (PPH) of 1,500ml or more	CQIM	2	15	9	10	8	9	6	8	8	10	10	16	7	To be confirmed, following benchmarking against regional performance.		
M7	Women who were current smokers at booking appointment	CQIM	1,2	6.4%	6.7%	5.2%	4.5%	1.5%	7.1%	4.8%	4.9%	7.4%	5.8%	5.5%	5.4%	No target level.		
M8	Women who were current smokers at delivery	CQIM	1,2	6.6%	4.2%	6.8%	3.7%	5.0%	8.2%	3.5%	5.9%	4.2%	3.8%	2.1%	2.9%	=<10%= Green >10% - =<12% =Amber >12% =Red		
M9	No. of still births	CQIM	2	0	0	0	1	0	0	0	2	1	0	1	0	Monitored using Statistical Process Control rules. Report by exception.		
M10	No. of babies with Hypoxic Ischaemic Encephalopathy Diagnosis (rate per 1,000 births)	CQIM	2	0.0	0.0	0.0	0.0	7.6	0.0	0.0	0.0	0.0	3.9	0.0	0.0	Monitored using Statistical Process Control rules. Report by exception.		
M11	Babies under observation should have Newborn Early Warning Score assessment recorded as per trust clinical guidelines.	SFT	1,2,4	98.1%		96.7%			96.7%			Quarterly reporting Report awaited			Quarterly reporting	>=90%= Green >=80% - <90% =Amber <80% =Red		
M12	Babies under observation who have NEWS score alerts should be escalated to the paediatrics team for review	SFT	1,2,4	93.3%		100.0%			100.0%									
M13	Women being triaged within 15 minutes	SFT	1,2,5	85.6%	81.1%	77.5%	70.6%	68.8%	70.0%	81.3%	80.1%	86.6%	90.6%	93.2%	92.9%	From April 2026 >=90% = Green >=80% - <90% = Amber <80% =Red		
M14	Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency - Midwifery	SFT	1,2,6	75.7%	59.6%	65.8%	70.9%	72.1%	72.4%	79.9%	76.9%	84.4%	90.8%	93.9%	95.5%	From April 2026 >=80% = Green >=75% - <79% = Amber <75% =Red		
M15	Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency - Medics	SFT	1,2,6	55.0%	57.8%	53.9%	67.3%	73.0%	71.7%	66.0%	81.9%	84.3%	85.7%	85.4%	85.7%	From April 2026 >=80% = Green >=75% - <79% = Amber <75% =Red		

NARRATIVE REPORT

CHILDREN AND YOUNG PEOPLE'S SERVICES

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

Children and Young People's Eating Disorders Service
Demand for the service continues to increase, alongside growing clinical complexity. Referrals for Avoidant/Restrictive Food Intake Disorder (ARFID) have risen significantly, requiring further development of clinical pathways to meet emerging patient needs. In addition, a higher proportion of referrals are now being triaged as urgent, placing ongoing pressure on routine capacity and service flow. Despite these challenges, performance has improved significantly. As at 30 June 2026, the service achieved 100% compliance (shift from red to green) against the three-month rolling standard for urgent referrals. Routine referral compliance was 95.5%, reflecting the team's continued focus on ensuring timely access to care for children and young people requiring urgent intervention.

Children and Young People's Community Mental Health Service
Access performance was 88.6% in July 2026 (Amber against the six-week access standard). Activity in respect of children and young people seen in the 12 months to July 2026 was 6,001, being 11% above the 5,400 target and reflecting both rising demand and continued service responsiveness. Despite this sustained increase in activity, the service remains under pressure from workforce and capacity challenges. Sustained high demand, staff sickness and vacancies continue to impact on routine access and service flow, while limited additional capacity restricts opportunities for further performance improvement.

Primary Care Dental Service
Recovery across Somerset and Dorset continues, with sustained reductions in waiting lists in Somerset and early signs of improvement in Dorset. As at 31 July 2026, the number of patients waiting more than 18 weeks reduced to 1,681, from 1,793 in June 2026, while patients waiting more than 52 weeks remained at 497. Somerset continues to deliver improvements across most pathways, with paediatric General Anaesthetic (GA) services also reducing the longest waits despite ongoing operational challenges. However, overall recovery remains constrained by system pressures, most notably limited GA capacity across adult and paediatric pathways. Progress in Dorset remains slower, reflecting local operational pressures and the earlier stage of recovery. Workforce challenges, including vacancies and sickness absence, continue to affect the pace of improvement.

Acute Paediatrics
CYP Emergency Department (ED) four-hour performance remains challenged, with performance at 73.3% at Musgrove Park Hospital (MPH) and 84.0% at Yeovil District Hospital (YDH). Overall performance, including Urgent Treatment Centre (UTC) activity, was 86.3% in July 2026.

A detailed review of performance data is underway to better understand the factors contributing to delays across the patient pathway. Particular focus is being given to the distinction between admitted and non-admitted children and young people, recognising that the drivers of delay, and therefore the required interventions, differ significantly between these cohorts. This analysis will enable improvement activity to be targeted to the teams and processes with the greatest impact on performance and patient flow.

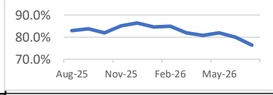
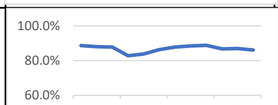
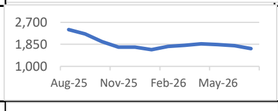
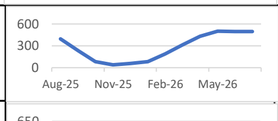
Alongside this work, pathway development continues across the service. In the absence of a Paediatric Assessment Unit (PAU) at YDH, work has commenced to develop more streamlined clinical pathways. A review of activity within the MPH PAU also identified significant levels of non-acute utilisation, leading to the development of alternative outpatient and neonatal follow-up pathways, strengthened escalation processes and improved demand management arrangements. This is being supported through ongoing engagement with GPs, Minor Injury Units (MIUs) and UTCs to ensure children are directed to the most appropriate care setting first time. Recognising the need for a system-wide approach, a multidisciplinary working group bringing together Paediatrics and Acute Medicine has been established to review performance, understand the causes of delay and develop a more effective and sustainable approach to managing patient flow across both specialties.

Paediatric Early Warning Score (PEWS)
Performance against the current PEWS KPI remains challenging to demonstrate clearly, as compliance is measured through completion of the escalation field rather than the clinical rationale recorded by staff. While compliance in July 2026 was 73.9% at MPH and 57.1% at YDH, there has been no evidence of failures to recognise or respond appropriately to clinical deterioration in children and young people. Clinical teams have raised concerns that the current electronic measure does not adequately reflect professional judgement where clinically appropriate decisions not to escalate have been made and documented. Work is therefore underway with the Trust's Head of Resuscitation and the Deteriorating Patient & Sepsis Committee to review the KPI and develop a more meaningful measure of the recognition and escalation of deterioration in children and young people.

Community Waiting Lists
The percentage of patients waiting less than 18 weeks from referral to first appointment has reduced to 76.4%, reflecting a deterioration in performance compared with previous months. This decline is primarily driven by pressures within the Children and Young People’s Therapies (CYPTs) and Paediatric Continence services, where workforce challenges, including vacancies and delays in recruitment, have reduced available capacity and increased waiting times. Recruitment activity has been successful, with several new staff due to commence in September 2026. While a period of induction and competency development will be required before these staff are able to contribute fully to service delivery, the additional resource is expected to increase capacity over the coming months, supporting a reduction in waiting times and gradual recovery of performance.

SOMERSET NHS FOUNDATION TRUST

CHILDREN AND YOUNG PEOPLE'S SERVICES

No.	Description		Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
CYP1	CAMHS Eating Disorders - Urgent referrals to be seen within 1 week - (rolling 3 months)		NHSC	1,2,3,4	100.0%	100.0%	100.0%	100.0%	80.0%	85.7%	85.7%	83.3%	87.5%	83.3%	100.0%	Data not yet due	>=95%= Green >=85% - <95% =Amber <85% =Red		
CYP2	CAMHS Eating Disorders - Routine referrals to be seen within 4 weeks - (rolling 3 months)			1,2,3,4	98.2%	89.8%	90.9%	90.8%	90.8%	91.8%	91.0%	97.1%	96.9%	98.3%	95.5%	Data not yet due	>=95%= Green >=85% - <95% =Amber <85% =Red		
CYP3	Increase the number of CYP accessing mental health services to achieve the national ambition for 345,000 additional CYP aged 0–25 compared to 2019		NOF, OPG	1,2	5,451	5,610	5,676	5,691	5,751	5,822	5,896	5,945	5,998	6,013	6,024	6,001	From April 2025 >=5,400 = Green <5,400 = Red		
CYP4	Mental health referrals offered first appointments within 6 weeks	Children and young people's mental health services	ICB	1,2,3	96.7%	97.1%	96.6%	94.9%	100.0%	90.0%	97.0%	90.9%	90.1%	89.6%	91.8%	88.6%	>=90%= Green >=80% - <90% =Amber <80% =Red		
CYP5	Community Waiters Percentage waiting under 18 weeks from referral to first appointment (excludes dental)		NOF	1,2,3	82.9%	83.7%	81.9%	85.1%	86.4%	84.6%	85.0%	82.0%	80.8%	82.0%	80.0%	76.4%	From April 2025 >=78% = Green <78% = Red		
CYP6	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours from March 2026, rising to 95% by September 2026: Trust-wide performance - Under 16 years old		PAF	2	88.6%	88.0%	87.8%	82.8%	83.7%	86.3%	87.8%	88.4%	88.8%	86.7%	87.0%	86.2%	From April 2026 >=trajectory = Green <trajectory = Red		
CYP7	Community dental services - General, Domiciliary or Minor Oral surgery waiting 18 weeks or more		SFT	1,2,3	2,420	2,252	1,956	1,747	1,747	1,645	1,766	1,815	1,866	1,840	1,793	1,681	From April 2024 <1,979 = Green >=1,979 = Red		
CYP8	Community dental services - General, Domiciliary or Minor Oral surgery waiting 52 weeks or more				393	234	84	39	55	81	189	316	431	501	497	497	From April 2024 <574 = Green >=574 = Red		
CYP9	Community dental services - Child GA waiters waiting 18 weeks or more		SFT	1,2,3	522	491	454	395	405	397	380	316	187	315	327	344	From April 2023 <463 = Green >=463 = Red		
CYP10	National paediatric early warning system (PEWS) - Medium risk: percentage reviewed by the nurse in charge	MPH	SFT	1,2,4	57.1% (4/7)	66.7% (6/9)	73.3% (11/15)	58.3% (7/12)	81.0% (17/21)	76.9% (10/13)	91.7% (11/12)	80.0% (4/5)	50.0% (3/6)	0.0% (0/3)	33.3% (2/6)	73.9% (17/23)	>=90%= Green >=80% - <90% =Amber <80% =Red		
CYP11		YDH	SFT	1,2,4	71.4% (5/7)	88.9% (8/9)	66.7% (2/3)	100% (2/2)	93.3% (14/15)	100% (1/1)	100% (5/5)	50.0% (2/4)	66.7% (4/6)	80.0% (4/5)	66.7% (4/6)	57.1% (4/7)			

NARRATIVE REPORT

PEOPLE

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

Areas of Success / Celebration

- **Retention** – Retention remains strong at 90.3% for the month, exceeding the Trust target and providing positive assurance regarding the overall stability and resilience of the workforce. This continues to reflect the organisation's ability to retain colleagues and maintain a stable staffing position. However, assurance around the drivers of employee turnover is currently limited by the quality of exit data. The category "Unknown" now represents the most frequently recorded reason for leaving, reducing our ability to identify themes accurately, understand emerging workforce risks, and target retention initiatives where they will have the greatest impact. While overall retention performance remains positive, improving the quality and completeness of this data is essential to strengthen workforce intelligence and support evidence-based decision-making. The implementation of ESR Manager Self Service is expected to provide greater assurance in this area by enabling managers to record leaving reasons directly at source, improving both the accuracy and completeness of workforce data. Strengthening exit data quality will therefore be a key priority during 2026/27, supporting more informed workforce planning, enhanced retention strategies, and greater confidence in the insights used to shape future workforce interventions.
- **Mandatory Training** – Mandatory training compliance has continued to strengthen, at 93.9%, and remains comfortably above the Trust target of 90%. This sustained improvement provides positive assurance that colleagues are completing essential training requirements and that the Trust is maintaining a strong focus on workforce capability, safety, and regulatory compliance. Improvements have been achieved across all service groups, demonstrating a collective commitment to compliance and learning. In particular, notable progress has been seen in Safeguarding Adults and Children Level 3 training, areas which have historically presented greater challenges and are critical to ensuring the Trust meets its statutory and professional responsibilities. Whilst overall performance is strong and provides assurance that mandatory training risks are being effectively managed, some variation remains between service groups. Surgical Services continue to report the lowest levels of compliance relative to other areas; however, targeted support, performance monitoring, and local improvement actions remain in place to drive further progress and reduce variation across the organisation. The continued improvement in compliance rates, coupled with focused support in lower-performing areas, provides assurance that the Trust is maintaining a proactive approach to workforce development and is well-positioned to sustain high levels of compliance whilst reducing organisational risk.

Areas of Concern

- **Vacancy Levels** – Vacancy levels remain a significant workforce risk and continue to require close monitoring. The vacancy rate has increased slightly to 9.8%, exceeding the Trust's target range and representing the highest position reported during the current financial year. This level of vacancy creates ongoing risks to service delivery, places additional pressure on existing colleagues, and can increase reliance on temporary

staffing solutions, with associated financial implications. Whilst retention continues to perform better than target, increasing vacancy levels indicate ongoing recruitment and workforce supply challenges rather than a deterioration in colleague turnover, with focused work continuing to improve appointment timelines and candidate conversion rates. Despite these challenges, there is positive assurance that recruitment activity remains strong, reflecting the busiest period of the annual recruitment cycle and a healthy pipeline of candidates progressing through the recruitment process. Focused work continues to improve recruitment performance through the streamlining of processes, increased oversight of recruitment timelines, and the reduction of avoidable delays across the employment journey, delays that can be attributed to the individual appointed, the line manager or the recruitment team. Particular attention is being given to areas experiencing the greatest recruitment challenges, including hard-to-fill roles and Healthcare Assistant vacancies. Targeted initiatives are being explored to accelerate appointment times, improve candidate conversion rates, and reduce time-to-hire. While vacancy levels remain above the desired threshold, the sustained focus on recruitment improvement and pipeline management provides assurance that appropriate actions are in place to address workforce gaps and support a reduction in vacancy levels over time

- **Sickness absence** – Sickness absence remains unchanged from the position previously reported, with the rolling 12-month average remaining at 5.2%. This indicates that sustained improvement has yet to be achieved and provides assurance that absence levels continue to require focused management attention. Current absence rates present ongoing workforce and operational challenges, including increased pressure on teams and the need for short-notice bank and agency staffing to maintain safe service delivery. Analysis continues to identify stress, anxiety and depression as a significant contributor to overall absence levels. This highlights the importance of maintaining a strong focus on colleague wellbeing and ensuring appropriate support mechanisms are in place to help colleagues remain in, or return to, work safely and sustainably. To strengthen organisational understanding and enable more targeted interventions, work is underway to explore the experiences of disabled colleagues within this absence category. This will provide valuable insight into the factors influencing attendance, recognising both the wellbeing impact on individuals and the links to employment-related casework. The findings will help inform future support arrangements, workplace adjustments, and attendance improvement initiatives, providing greater assurance that interventions are evidence-based and responsive to colleague needs. The planned review of the Trust's Supporting Attendance Policy has been temporarily paused to align with emerging national policy developments relating to sickness absence management. This approach provides assurance that any future revisions will be informed by national direction and best practice, ensuring the Trust's attendance management framework remains compliant, effective, and consistent with wider NHS workforce policy.

Focus Areas

- **Job Planning** – Implementation of the 2026/27 service-level job planning approach continues, supported by the introduction of a new data pack that is now available to all services to inform workforce, capacity and job planning discussions. Additional drop-in sessions are being established to provide practical support to teams as they progress through the planning cycle. Development of the supporting quality assurance framework is also progressing, with the format for consistency panels currently being finalised. In parallel, work is underway to standardise the application of the SPA tariff across the organisation, with completion expected by late autumn. Internal compliance remains below the desired level as services focus on developing comprehensive service plans prior to finalising individual job plans. However, NHSE-reportable compliance remains high, reflecting the national measure of managerial and clinician sign-off within the previous 12 months. This provides assurance that the majority of medical staff continue to have a recent, agreed job plan in place while the new service-level approach is embedded.

- **Appraisal** – Appraisal compliance has continued to improve, increasing to 81.0%. Whilst performance remains below the Trust target of 90%, the upward trajectory reflects ongoing management focus and increased oversight across services. Compliance continues to be closely monitored through Performance Oversight Meetings, with Mental Health and Learning Disabilities maintaining the strongest levels of completion. Whilst Operational Management remains the lowest-performing area, targeted support and challenge are in place to drive further improvement and reduce variation across the organisation. However, assurance extends beyond completion rates alone. Staff Survey findings indicate that the quality and value of appraisal conversations remain a greater area of focus than compliance itself. As a result, improvement activity is increasingly centred on enhancing the effectiveness of career and development conversations, ensuring appraisals provide meaningful opportunities to support colleague development, engagement, wellbeing, and performance. Analysis of focus group feedback and Staff Survey insights is informing a test-and-learn approach that will be implemented later this year. Pilot interventions will be introduced and evaluated prior to wider rollout, providing assurance that future improvements are evidence-based and focused on delivering a consistently high-quality appraisal experience for colleagues across the Trust.
- **Formal HR Cases** – Formal HR casework remains elevated, which continue to require close oversight due to the impact on management capacity, workforce experience, and organisational risk. While overall case volumes remain above expected control limits, there is assurance that robust governance arrangements are in place to monitor activity, support timely case progression, and ensure consistency of approach. Disciplinary case volumes remain broadly consistent with previous months; however, grievance activity has increased and will continue to be closely monitored to identify emerging themes and inform any required organisational responses. Neighbourhoods, Medicine and Surgery continue to account for the highest levels of disciplinary activity, reflecting areas where ongoing management support and oversight remain important. During the month, 16 sickness final review processes were concluded, demonstrating continued progress in managing long-running attendance cases. Suspensions and exclusions have increased to 14 active cases, although it is positive to note that the longest-running exclusion has now been successfully resolved, reducing the number of extended cases within the portfolio. Sexual misconduct and information governance breaches continue to represent the most common reasons for suspension and disciplinary action. In response, joint work with the Information Governance team is underway to strengthen awareness, education, and preventative measures aimed at reducing the risk of future data breaches. Sexual misconduct cases continue to be reviewed through the Decision Oversight Panel, providing assurance that investigations are managed consistently, proportionately, and progressed in a timely manner. Whilst the overall level of casework remains higher than anticipated and continues to indicate elevated employee relations activity, active management of the caseload, strengthened governance arrangements, and targeted preventative interventions provide assurance that appropriate measures are in place to address risk, support managers, and monitor organisational culture and workforce trends.
- **Inclusion** – As this is a quarterly measure, there has been no significant change since the previous reporting period. Progress continues against the Trust's workforce inclusion objectives, with positive indicators across key areas of representation. Representation of colleagues from ethnic minority backgrounds in senior roles has increased to 25.6%, while female representation within senior leadership remains strong at 59.2%. In addition, the proportion of senior leaders declaring a disability has increased to 5.1%. These measures provide positive assurance that sustained progress is being made towards developing a more diverse and representative leadership population. The continued improvement in representation across senior roles demonstrates the Trust's ongoing commitment to inclusion and supports the ambition of ensuring leadership increasingly reflects the diversity of the communities it serves. While this remains a long-term priority, current performance indicates that the actions being taken are contributing to positive and measurable change.

SOMERSET NHS FOUNDATION TRUST

PEOPLE

No.	Description		Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
P1	Mandatory training: percentage completed	Combined	SFT	5	93.5%	93.9%	94.0%	94.0%	94.1%	94.2%	91.9%	92.6%	93.3%	93.5%	93.9%	93.9%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber	95.0% 92.5% 90.0% Aug-25 Nov-25 Feb-26 May-26	P
P2	Monthly percentage of days lost due to sickness absence		NOF	5	5.1%	5.2%	5.6%	5.4%	5.7%	5.6%	5.4%	5.1%	4.9%	4.9%	5.0%	5.2%	SPC (Upper Control Limit 5.4%)	6.0% 5.2% 4.4% Aug-25 Nov-25 Feb-26 May-26	
P3	Sickness absence levels - rolling 12 month average (Trust-wide)		NOF	5	5.2%	5.2%	5.2%	5.1%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	SPC (Upper Control Limit 5.2%)	5.4% 5.2% 5.0% Aug-25 Nov-25 Feb-26 May-26	
P4	Career conversations (12 months)		SFT	5	78.7%	77.7%	79.8%	81.1%	82.4%	81.4%	80.1%	80.2%	80.1%	79.9%	80.6%	81.0%	>=90%= Green >=80% - <90% =Amber <80% =Red	84.0% 80.0% 76.0% Aug-25 Nov-25 Feb-26 May-26	F
P5	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		SFT	5	6.7%	7.8%	7.8%	7.4%	7.9%	8.2%	8.3%	8.6%	9.3%	9.7%	9.7%	9.8%	<=8.5%= Green >8.5% to <=9.0% =Amber >9.0% =Red	10.0% 8.0% 6.0% Aug-25 Nov-25 Feb-26 May-26	F
P6	Retention rate – rolling 12 months percentage of colleagues in post		SFT	5	89.4%	89.7%	89.8%	89.8%	89.9%	90.0%	89.9%	90.0%	90.1%	90.0%	90.2%	90.3%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red	91.0% 90.0% 89.0% Aug-25 Nov-25 Feb-26 May-26	P
P7	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	SFT	1,5	24.4%		24.7%			25.3%			25.6%				>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red	26.0% 23.0% 20.0% Apr-Jun 24 Jan-Mar 25 Oct-Dec 25	P
P8		Who are female	SFT	1,5	58.7%		59.0%			59.1%			59.2%			Quarterly reporting		60.0% 58.5% 57.0% Apr-Jun 24 Jan-Mar 25 Oct-Dec 25	F
P9		With a recorded disability	SFT	1,5	4.8%		4.8%			5.0%			5.1%					6.0% 4.0% 2.0% Apr-Jun 24 Jan-Mar 25 Oct-Dec 25	P
P10	Job planning: Percentage of Consultant and SAS doctor job plans signed off		SFT	5	31.6%	60.4%	76.4%	80.6%	83.7%	84.1%	84.1%	91.0%	37.3%	39.1%	38.4%	30.8%	>=95%= Green >=85% to <95% =Amber <85% =Red	100.0% 50.0% 0.0% Aug-25 Nov-25 Feb-26 May-26	F
P11	Percentage of patient-facing staff receiving a 'flu vaccination		PAF	1,5	Reporting to run from October 2025 to January 2026.		35.4%	45.3%	50.7%	50.2%	56.5%	56.4%	Programme finished until Otober 2026				By February 2025 >=33.1% = Green <33.1% = Red	70.0% 50.0% 30.0% Dec-25 Mar-26	P
P12	Number of formal HR case works (disciplinary, grievance and capability).		SFT	5	86	88	128	105	95	124	111	123	190	148	142	150	SPC (Upper Control Limit 78	200 120 40 Aug-25 Nov-25 Feb-26 May-26	H

NARRATIVE REPORT

PATIENT EXPERIENCE AND INVOLVEMENT

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

What is going well

The number of Care Opinion stories received increased by 84% in July 2026, from 25 to 46. Initial implementation of the service tree within the platform has enabled feedback to be assigned more accurately to relevant departments and services. This is helping teams to identify and respond to stories more effectively and is strengthening the consistency of thematic analysis across the organisation.

Kindness, compassion and reassurance were the most prominent themes in July's feedback, with patients and families frequently recognising the caring, supportive and empathetic approach of staff. Approximately 17% of feedback related to maternity services, all of which was positive. Patients and families particularly highlighted the kindness of staff, feeling safe throughout their care and the support received during pregnancy, labour and the postnatal period.

A similar proportion related to urgent and emergency care, with feedback recognising rapid identification of deterioration, prompt triage, timely assessment and compassionate care during stressful circumstances. Children and Young People's Services also received a similar proportion of feedback, with families recognising how staff adapted their communication and care for anxious children, supported parents and took additional time to reduce distress.

During July 2026, the Trust received five requests for second letters. Second letters accounted for 8.5% of open formal complaints which is below the Trust target of 10%, suggesting that the majority of complaints are being resolved without the need for further correspondence. The reduction in second letters may reflect improved effectiveness of first responses, with concerns being addressed more clearly and comprehensively at the outset. It may also demonstrate the positive effect of continued work to strengthen response quality and support early resolution.

What is going less well

Care Opinion feedback was overwhelmingly positive; however, a small number of improvement opportunities were identified. The most common area related to access, transport and the care environment, featuring in five comments (12.2%). Specific issues included transport information following discharge, travel distances for treatment, maternity unit access arrangements, and concerns regarding air conditioning on children's wards. A single comment (2.4%) highlighted concerns around communication and clinical assessment within Same Day Emergency Care, while two comments (4.9%) suggested opportunities to improve local access to services and reduce travel requirements for patients and families.

For June and July 2026, PALS activity data is not currently available due to a backlog in the processing and recording of PALS contacts. As a result, the most recent complete dataset, covering May 2026, has been used for reporting purposes. Work is underway to resolve the

backlog and restore timely data reporting. The thematic review of complaints continues to identify recurring concerns relating to dismissive communication and patients, families and carers not feeling listened to, heard or understood. Other repeated themes include a delay or failure to diagnose, a lack of personalised care and concerns about fundamental aspects of nursing care, particularly nutrition and hydration, end-of-life care and pressure area care. July 2026 saw an increase in the number of formal complaints logged, with 67 new complaints logged on Radar. This is the highest number logged in any month over the past year. The increasing use of artificial intelligence (AI) by those raising concerns to draft correspondence continues to influence the complexity of complaints received and has now been recorded on the Trust Risk Register. To improve understanding of the impact of this emerging issue, plans have been developed to undertake a six-month pilot review of AI-enabled complaints. The review will assess any effects on complaint complexity, response times and resource requirements, enabling appropriate mitigations to be identified and implemented where necessary. This will include early engagement with individuals using AI-generated correspondence to ensure that the personal experience, concerns and impact remain clearly articulated and central to the complaint. In July 2026, the response rate for formal complaints responded to within agreed time frame increased slightly, to 61% This figure represents an aggregated Trust-wide position and reflects variation in performance across service groups. The neighbourhoods service group closed 100% of their complaints within the agreed timeframe.

Delays were attributable to the following factors:

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

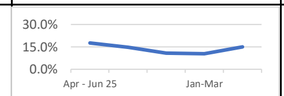
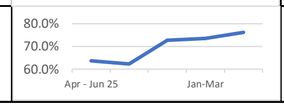
Focus of improvement work

- Secure the future sustainability of Care Opinion by progressing the subscription renewal and exploring available funding options. This will include developing an application to Love Musgrove and, where appropriate, preparing a supporting business case.
- The initial implementation of the Care Opinion service tree has enabled stories to be assigned more accurately to relevant departments and services. Further work is underway to complete and fully embed the service tree across all areas of the Trust.

- Introduce and implement KO41 tags, informed by the Royal Devon approach, to enable feedback to be categorised and searched more consistently. This will strengthen thematic analysis, support identification of recurring issues and enable services to locate relevant feedback more easily.
- Develop a structured Care Opinion relaunch plan to increase awareness and engagement across the Trust. This will include targeted communication, education and support for services, alongside updated information boards and promotional materials for patients, carers and families. The existing report confirms that a relaunch planning framework is being developed and that promotional materials will continue to be updated.
- Strengthen service-level ownership and responsiveness by providing clearer guidance on how stories should be reviewed, assigned and responded to. This will support a more consistent approach and help ensure that feedback is acknowledged and used locally.
- Improve the use of Care Opinion insight for learning and improvement by routinely reporting on story volumes, response rates, key themes, service-level patterns and improvement opportunities. Findings will be used to recognise good practice, identify areas requiring action and demonstrate how patient and family feedback is contributing to service improvement.
- A PALS survey has been developed for both patients and staff across the organisation. Using Quality Improvement (QI) methodology, the survey seeks to assess awareness of PALS and the complaints process, including understanding of how to access information and contact the relevant teams. The survey also prompts local action to ensure PALS posters and leaflets are readily available within ward and service areas. In addition, a feedback survey for patients, carers and relatives has been introduced to capture experiences of the PALS process following case closure.
- Trust-wide complaints training has commenced, with delivery dates scheduled across multiple sites, including West Mendip Community Hospital. Uptake has been high, and additional training dates have been added to meet ongoing demand.
- A weekly sit rep outlining each service group's position on formal complaints is submitted to the Director of Patient Experience and Engagement. Its purpose is to provide senior leaders with clear oversight - particularly of complaints that are approaching risk status (30 to 40 days) - to support timely and effective escalation.
- Tailored escalation pathways have been established for each service group (Families, Neighbourhoods, and Surgical), including escalation to Associate Medical Directors and Associate Directors of Patient Care before complaints reach the breach point.
- Regular tracker meetings are held between complaints co-ordinators and service groups to identify emerging delays and raise any concerns promptly.
- Development of a set of principles to assist in the categorisation of complaints (i.e. fully upheld, partially upheld, not upheld).
- A review of performance targets has been undertaken to ensure they remain aligned with national standards.
- The NHS Complaint Standards action plan has been developed and is subject to ongoing review.
- Work is in progress to develop an interactive dashboard designed to improve visibility of complaint timelines and overall performance.

SOMERSET NHS FOUNDATION TRUST

PATIENT EXPERIENCE AND INVOLVEMENT

No.	Description	Source	Links to strategic aims	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Thresholds	Trend	Variation / Assurance
PE1	Care Opinion: Number of stories per month	SFT	2	35	34	25	37	30	36	34	16	36	30	25	46	Increase from 2024/25 baseline		
PE2	Care Opinion: Percentage of stories with responses	SFT	2	100.0%	91.2%	92.0%	81.0%	100.0%	97.2%	100.0%	100.0%	91.7%	93.3%	84.0%	89.1%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE3	Monthly number of complaints received	SFT	2	29	47	36	38	50	47	35	47	48	36	52	67	TBC		
PE4	Number of complaints open at end of the month	SFT	2	96	98	92	95	109	110	116	111	120	137	122	119	TBC		
PE5	Monthly number of PALS enquiries	SFT	2	412	479	557	388	386	408	397	426	383	342	-	-	TBC		
PE6	Percentage of complaints responded to within the timescale agreed with the complainant	SFT	2	56.8%	62.0%	52.8%	73.0%	50.0%	55.8%	51.5%	49.0%	54.1%	54.2%	58.5%	61.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE7	Percentage of open complaints that are second letters	SFT	2	New reporting								11.4%	12.2%	7.3%	8.5%	<=10%= Green >10% - <=15% =Amber >15% =Red		
PE8	Percentage of formal complaints fully upheld	SFT	2	14.8%		10.7%		10.4%			15.1%				1.7%	Compare to national average		
PE9	Percentage of formal complaints partially upheld	SFT	2	62.3%		72.8%		73.6%			76.2%				84.7%	Compare to national average		

Appendix 1 – Specialty and tumour-site level performance

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

RTT specialty	Over 18-week waiters	Over 52-week waiters	Incomplete pathways	Incomplete pathways performance
General Surgery	1072	52	2764	61.2%
Urology	1394	166	2935	52.5%
Trauma & Orthopaedics	3317	353	9225	64.0%
Ear, Nose & Throat (ENT)	2162	195	5004	56.8%
Ophthalmology	715	17	3213	77.7%
Oral Surgery	2115	287	3551	40.4%
Plastic Surgery	24		218	89.0%
Cardiothoracic Surgery	1		21	95.2%
General Medicine	27		63	57.1%
Gastroenterology	629	11	2033	69.1%
Cardiology	634	11	2529	74.9%
Dermatology	781	47	3641	78.5%
Thoracic Medicine	202	1	1428	85.9%
Neurology	398	6	1505	73.6%
Rheumatology	380	10	921	58.7%
Geriatric Medicine	186	1	706	73.7%
Gynaecology	1733	82	4008	56.8%
Other - Medical Services	930	21	3858	75.9%
Other - Paediatric Services	283	15	1182	76.1%
Other - Surgical Services	2252	199	5829	61.4%
Other – Other Services	3		220	98.6%
Total	**19238**	**1474**	**54854**	**64.9%**

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

Tumour site	No of breaches	Trust performance
Brain	0.0	100.0%
Breast	15.0	75.0%
Colorectal	15.5	58.7%
Gynaecology	6.0	66.7%
Haematology	2.0	91.1%
Head & Neck	4.0	55.6%
Lung	8.0	61.9%
Other	1.0	80.0%
Skin	16.0	79.7%
Upper GI	8.0	65.2%
Urology	33.5	64.6%
Total	**109.0**	**70.6%**

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

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

Appendix 2 – Infection Control and Prevention – July 2026

MRSA bloodstream infections	Commentary on MRSA /MSSA BSIs
Musgrove Park Hospital = 1 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Total to date = 1**	There are no national thresholds assigned to MRSA or MSSA bloodstream infections (BSI). However, there is a zero tolerance of MRSA BSIs and as a Trust we assign an internal threshold for MSSA. **MSSA** – A Quality Improvement project is in place for the MPH Site in Cardiology focusing on right site, right device, removal when no longer needed. This will be monitored through the Infection Control Operational Group.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 5 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Internal Threshold = 64** **Total to date = 25**	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 3 Yeovil District Hospital = 7 Community Hospitals / Mental Health = 0 **Threshold = 100** **Total to date = 29**	The annual thresholds for 2026/27 for Gram-negative BSIs have now been published and all remain the same as last year. As a Trust we are under trajectory for E.coli and pseudomonas but are over trajectory for Klebsiella
Klebsiella bloodstream infections	
Musgrove Park Hospital = 1 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0 **Threshold = 36** **Total to date = 15**	
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 2 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Threshold = 12 (2025/26)** **Total to date = 3**	

C. difficile	Commentary on C. difficile
Musgrove Park Hospital = 7 Yeovil District Hospital = 3 GP = 2 **Threshold = 74** **Total to date = 28**	The annual thresholds for 2026/27 have now been published, and the threshold has reduced from 90 to 74 cases. As a trust we are over trajectory.
Respiratory Viral Infections - inpatients	**Commentary on Respiratory Viral Infections**
COVID (Trust Cases) = 2 Musgrove Park Hospital = 0 Yeovil District Hospital = 2 Community / Mental Health = 0 **Influenza = 8 (Inpatients)** Musgrove Park Hospital = 7 Yeovil District Hospital = 1 **Respiratory Syncytial Virus (RSV) = 0 (Inpatients)**	**Respiratory Viruses** All respiratory virus case numbers remain relatively low.
Outbreaks	**Commentary on outbreaks**
• **COVID = 0** • **Influenza = 1 (MPH)** • **Norovirus = 0** **Carbapenemase Producing Organism (CPO)** Yeovil District Hospital	**Carbapenemase Producing Organism (CPO)** On the Yeovil district hospital site work continues to manage the CPO outbreak which has spanned two key time periods, January 2022 to August 2023 and December 2023 to the current time. There are two different resistance mechanisms involved. The genes that encode for these resistance mechanisms can move between different species of bacteria which makes the linking of cases in the outbreak more challenging. Further input has been received from UKHSA and an Incident Control Group will be set up in August. Since February 2026 15 cases linked to a single ward on the YDH site have been identified. A separate outbreak management group has been established to investigate and manage this cluster. There are two possible routes of transmission, direct patient to patient and environmental. Interventions are focusing on both transmission routes. Some targeted patient testing is in place to identify unknown cases and monitor further cases. This will be monitored by the Quarterly Infection Control Committee.

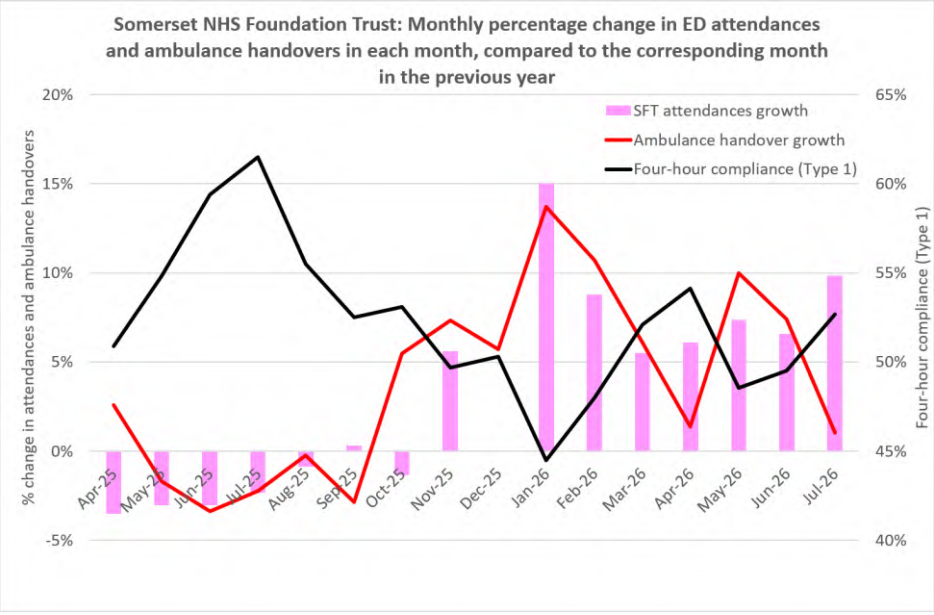
Surgical Site Infections	Commentary on Surgical Site Infections
Surgical Site Infection Surveillance enables early recognition of infections to inform remedial and improvement actions. **Musgrove Park Hospital Site** Continuous surveillance for Total Hip Replacement (THR), Total Knee Replacement (TKR) and Spinal Surgery has been in place on the MPH site since 2009. **Caesarean Section** Continuous surveillance for Caesarean Section on the MPH site started in December 2025. There is no national benchmark for C-sections against which we can compare. However, in 2022/2023, an initiative run by Health Innovation, West of England launched PreCiSSIon: Preventing Caesarean Birth Surgical Site Infection. This project reduced infection rate from 18.5% to 13.3%. Therefore, the lower rate of 13.3% will be used as a benchmark to monitor our rates against. **Yeovil District Hospital Site** Continuous surveillance on total hip replacement surgery has been in place on the YDH site since April 2022 and continuous surveillance was commenced on total knee replacement surgery from January 2024.	**Musgrove Park Hospital Site** • **Hip Replacement** Within the last year (July 2025 to June 2026) a total of 353 operations were undertaken with one infection identified giving an infection rate of 0.28%. This is inline with the national benchmark of 0.5%. • **Knee Replacement** Within the last year (July 2025 to June 2026) a total of 198 operations were undertaken and two infections identified giving an infection rate of 1,01%. This above the national benchmark of 0.4% • **Spinal Surgery** Within the last year (July 2025 to June 2026) a total of 347 operations were undertaken and 5 infections identified giving an infection rate of 1.44%. The infection rate is above the national benchmark of 1%. A review of the cases reveals that they had high risk factors for infection however, further work is required with theatres. • **Caesarean Section** Between December 2025 to May 2026 a total of 762 C-sections were undertaken and 30 infections identified (10 readmissions and 20 patient-reported) giving an infection rate of 3.94% which is below the adopted benchmark of 13.3%. **Yeovil District Hospital Site** • **Hip Replacement** Within the last year (July 2025 to June 2026) a total of 371 operations were undertaken with no infections identified. • **Knee Replacement** Within the last year (July 2025 to June 2026) a total of 445 operations were undertaken with no infections identified. The national rate is calculated over the period April 2020 to March 2025 and therefore not directly comparable to trust infection rates. However, as a trust the national benchmark is always used as a guide.

Appendix 3 – Operational Plan recovery trajectories

Recovery trajectories for the measures currently not meeting the Operational Plan trajectories are set out below.

ED four-hour standard

Performance against the ED four-hour standard was 71.0% in June 2026, against an Operational Plan recovery standard for July 2026 of 71.5%. Both Musgrove Park Hospital and Yeovil District Hospital (including the Urgent Treatment Centre) have seen significant levels of growth in attendances in 2026, compared to 2025. Attendances at MPH during the period 1 January to 31 July 2026 were 2.9% higher than during the corresponding period in 2025, and attendances at YDH during the period 1 January to 31 July 2026 were 15.7% higher than during the corresponding period in 2025, giving an overall Trust-wide increase of 8.4%. The Operational Plan assumption was growth of 1%, in line with the Office of National Statistics population growth forecast. The monthly percentage changes in attendances are shown as bars in the chart below, measured against the left-hand vertical axis. Monthly performance against the Type 1 four-hour standard is shown as the black line, measured against the right-hand vertical axis. The monthly Trust-wide level of growth in ambulance handover levels is shown as the red line, measured against the left-hand vertical axis:



Please see the ED exception template for key actions relating to the improvement of ED four-hour performance.

ED four-hour standard trajectory

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	74.1%	70.7%	70.6%	71.0%								
Planned trajectory	76.0%	76.5%	77.0%	77.5%	78.1%	78.5%	79.0%	79.5%	80.0%	80.5%	81.0%	82.0%
Recovery trajectory			70.5%	71.5%	72.4%	73.4%	74.3%	75.3%	76.3%	78.2%	80.1%	82.0%

ED four-hour standard: patients aged under 16 years

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	88.8%	86.7%	87.0%	86.3%								
Planned trajectory	85%	87%	89%	91%	93%	95%	95%	95%	95%	95%	95%	95%
Recovery trajectory			86.7%	89%	92%	95%	95%	95%	95%	95%	95%	95%

Ambulance handovers

The table below sets out the growth in ambulance conveyances to MPH and YDH in 2026, compared to 2025.

Site	1 January to 31 July 2025	1 January to 31 July 2026	Increase	Percentage increase
MPH	17,035	17,466	431	2.5%
YDH	8,696	10,085	1,389	16.0%
Total	**25,731**	**27,551**	**1,820**	**7.1%**

This shows a growth in conveyances to MPH of 2.5%, and a growth in conveyances to YDH of 16.0%, with an overall Trust-wide growth level of 7.1%. The Operational Plan assumption was that any projected growth would be negated by work being undertaken with SWAST to reduce conveyance levels to SFT to a level no higher than the regional average.

Work being undertaken to eliminate corridor care will reduce the availability of space for handovers and potentially provide a further challenge to handover performance. Actions include:

- The ED reconfiguration programme at MPH includes increased dedicated RAAT cubicles.
- Capture evidence on clustered arrivals for a review of patterns for a potential service Quality Improvement project.
- SWAST plans are currently still awaited, outlining the actions to be taken to normalise the rate of ambulance conveyances in Somerset, down to the regional average.

Percentage of ambulance handovers over 15 minutes

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	67.8%	68.1%	72.3%	67.2%								
Planned trajectory	66.0%	63.1%	60.4%	57.7%	55.0%	52.3%	49.7%	47.0%	44.2%	41.2%	38.5%	35.7%
Recovery trajectory			72.5%	68.4%	64.3%	60.2%	56.1%	52.1%	48.0%	43.9%	39.8%	35.7%

Percentage of ambulance handovers over 45 minutes

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	4.0%	5.2%	7.2%	3.2%								
Planned trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Recovery trajectory			7.5%	6.7%	5.8%	5.0%	4.2%	3.3%	2.5%	1.7%	0.8%	0.0%

The Elective Care trajectories are shown below. For further information on the reasons for the variances from plan and the actions being taken to recover performance, please refer to the Elective Care and Cancer reports, and the individual exception reports.

RTT Total Waiting list size

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	53,891	54,011	53,524	54,854								
Planned trajectory	51,346	50,653	49,981	49,170	48,544	47,845	47,489	47,147	46,738	46,425	46,124	45,835
Recovery trajectory			54,071	52,298	51,412	49,048	47,489	47,147	46,738	46,425	46,124	45,835

RTT 52-week waiters

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	1,135	1,304	1,310	1,474								
Planned trajectory	770	709	600	541	485	383	261	141	93	65	23	0
Recovery trajectory			1,357	1,332	1,282	1,157	972	787	662	437	212	65

Cancer 28-day Faster Diagnosis Standard (FDS)

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	78.6%	78.0%	83.9%									
Planned trajectory	80.2%	80.5%	80.7%	82.3%	78.0%	78.6%	80.1%	80.3%	80.0%	77.1%	81.8%	81.4%
Recovery trajectory		79.0%	80.7%	78.3%	78.0%	78.6%	80.1%	80.3%	80.0%	77.1%	81.8%	81.4%

Cancer 62-day Referral to Treatment

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	71.8%	64.9%	70.6%									
Planned trajectory	74.7%	68.4%	75.8%	75.1%	72.5%	70.7%	74.8%	78.1%	79.7%	77.5%	78.6%	82.0%
Recovery trajectory		65.0%	68.5%	72.1%	72.5%	70.7%	74.8%	78.1%	79.7%	77.5%	78.6%	82.0%

Cancer 31-day decision to treat to treatment

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	91.9%	91.4%	90.7%									
Planned trajectory	93.7%	94.4%	94.7%	94.4%	92.4%	92.9%	93.7%	93.5%	94.1%	94.1%	95.3%	94.6%
Recovery trajectory		90.0%	89.5%	91.0%	92.4%	92.9%	93.7%	93.5%	94.1%	94.1%	95.3%	94.6%