Public Board Meeting

Tuesday 10 November 2026, 09:30 - 13:25

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

Somerset NHS Foundation Trust

Agenda

09:30 - 09:35
5 min

1. Welcome and Apologies for Absence

Note *Chair*

- 00 Programme for the Day - 10 November 2026 v1.1.pdf (1 pages)
- 101126 - 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 8 September 2026

Approve *Chair*

- Enclosure 02 - Minutes of the 8 September 2026 Public Board meeting v1.1.pdf (10 pages)

09:35 - 09:35
0 min

4. Action Log and Matters Arising

Review *Chair*

- Enclosure 03 - Action Log public.pdf (1 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: Richard’s experience of OASIS booking system

Receive *Caroline Walker/Richard Mayhew/Trish Acton/Carly Jackson*

- Enclosure 04 - Patient Story Summary November Board FINAL 301026.pdf (6 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:
  - Gynaecology Assessment Unit Business Case (Ratify)
  - Learning from Deaths Report – Quarter 1 2026-2027
  - Freedom to Speak Up Guardian Report
  - Constitution and Standing Orders (Approve)
  - Scheme of Delegation and Standing Financial Instructions (Approve)
  - Use of the Corporate Seal

Enclosure 05 - Chief Executive and Executive Director Board Report - 10 November.pdf (131 pages)

10:45 - 11:00
15 min

Refreshment Break

11:00 - 11:10
10 min

9. Q2 Board Assurance Framework (BAF) and Corporate Risk Register Report

Receive *Mel Iles*

Enclosure 06 - 2026-27 Q2 Board Assurance Framework and Corporate Risk Register Report.pdf (55 pages)

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 (78 pages)

11:30 - 11:45
15 min

11. Maternity & Neonatal Quarter 2 26/27 Quality & Safety Report and update on Paediatric and Maternity Services at Yeovil District Hospital

Receive *Sally Bryant/Mel Iles*

Enclosure 08 - Maternity and Neonatal Quarter 2 2026 27 Quality and Safety Report.pdf (100 pages)

11:45 - 11:55
10 min

12. Thirlwall Inquiry Report Findings and Recommendations

Receive *Deirdre Fowler/Mel Iles*

Enclosure 09 - Thirlwall - November 2026 v0.2.pdf (10 pages)

11:55 - 12:05
10 min

Comfort Break

12:05 - 12:40
35 min

13. Trust Strategy, Objectives and Engagement

Receive *David Shannon/Richard Baum*

Enclosure 10 - Trust Strategy Objectives and Engagement.pdf (61 pages)

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

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12:40 - 12:50
10 min

14. Wellbeing Guardian Report

Receive *Graham Hughes*

Enclosure 11 - Wellbeing Guardian report.pdf (23 pages)

12:50 - 13:00
10 min

15. Workforce Resilience Framework

Receive *Isobel Clements*

Enclosure 12 - Workforce Resilience Paper Trust Board November 2026.pdf (13 pages)

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

13:00 - 13:05
5 min

16. Finance Report (M6)

Receive *Pippa Moger*

Enclosure 13 - M6 Board report FINAL.doc.pdf (7 pages)

13:05 - 13:15
10 min

17. Healthset Programme

Receive *David Shannon/Stuart Hill/Luke Gompels*

Enclosure 14 - Healthset Programme - Trust Board - November 2026.pdf (5 pages)

Reports from Board Committees (for discussion by exception only)

13:15 - 13:20
5 min

18. Assurance report from the Quality and Governance Assurance Committee meeting held on 30 September 2026

Receive *Inga Kennedy*

Enclosure 15 - Assurance Report from the QGAC meeting held on 30 September 2026.pdf (5 pages)

13:20 - 13:20
0 min

19. Assurance report from the Audit Committee meeting held on 21 October 2026

Receive *Paul Mapson*

Enclosure 16 - Assurance Report from the Audit Committee meeting held on 21 October 2026.pdf (5 pages)

13:20 - 13:20
0 min

20. Assurance Report from the People Committee meeting held on 16 September 2026

Receive *Graham Hughes*

Enclosure 17 - Assurance Report from the People Committee meeting held on 16 September 2026.pdf (5 pages)

13:20 - 13:20
0 min

21. Assurance Report from the Mental Health Legislation Committee meeting held on 15 September 2026

Receive *Alexander Priest*

Enclosure 18 - Assurance Report from the Mental Health Legislation Committee meeting held on 15 September 2026.pdf (4 pages)

13:20 - 13:20
0 min

22. Assurance report from the Charity Committee meeting held on 2o October 2026

Receive *Graham Hughes*

Enclosure 19 - Assurance Report from the Charity Committee meeting held on 20 October.pdf (4 pages)

13:20 - 13:20
0 min

23. Report from the Research and Innovation Committee meeting held on 15 September 2026

Receive *Olena Doran*

Enclosure 20 - Report from the Research and Innovation Committee meeting held on 15 September 2026.pdf (4 pages)

For Information

13:20 - 13:25
5 min

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

Receive *Chair*

13:25 - 13:25
0 min

25. Any other business

All

13:25 - 13:25
0 min

26. Risks identified

All

13:25 - 13:25
0 min

27. Evaluation of the effectiveness of the Meeting

Chair

13:25 - 13:25
0 min

28. Items to be discussed at the Confidential Board Meeting

- Minutes of the Confidential Board meeting
- Notes of the Board Seminar session
- Investigation and Disciplinary Procedure Review
- Maternity and neonatal reflections and learning, including any confidential discussions relating to the findings and recommendations of the Thirlwall Inquiry
- Finance Update
- Minutes of the Finance Committee meetings

13:25 - 13:25
0 min

29. 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.

13:25 - 13:25
0 min

30. Close and Date of Next Meeting

12 January 2027

Somerset NHS Foundation Trust

PROGRAMME FOR THE DAY

Board of Directors

Tuesday 10 November 2026
John Meikle Room, Deane House, Belvedere Road, Taunton, TA1 1HE

		Timing
1	**Arrival and Coffee**	**09:15 – 09:30**
2	**Public Board of Directors**	**09:30 – 13:25**
	Refreshment Break	10:45 – 11:00
	Comfort Break	11:55 – 12:05
3	**Lunch**	13:25 – 13:55
4	**Confidential Board of Directors**	**13:55 – 15:10**
5	**Refreshment Break**	15:10 – 15:20
6	**Seminar Session**	**15:20 – 16:40**
7	**Close**	**16:40**

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 10 November 2026** at **9.30 am** in the John Meikle Room, Deane House, Belvedere Road, Taunton, TA1 1HE.

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

Yours sincerely

Dr Rima Makarem
Chair

AGENDA

		Action	Presenter	Time	Enclosure
1.	**Welcome and Apologies for Absence**	Note	Chair	09:30	Verbal
2.	**Register of Interests and Declarations of Interest relating to items on the agenda**	Note and Receive	Chair		Enclosure 01
3.	**Minutes of the Somerset NHS Foundation Trust's Public Board meeting held on 8 September 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: Richard's experience of OASIS booking system**	Receive	Caroline Walker/ Richard Mayhew/ Trish Acton/ Carly Jackson	09:55	Enclosure 04
8.	**Chief Executive and Executive Director Report** • National and Regional Developments/ Policy Updates • Reports and Assurance updates including: • Gynaecology Assessment Unit Business Case	Ratify	Peter Lewis	10:25	Enclosure 05

		Action	Presenter	Time	Enclosure
	• Learning from Deaths Report – Quarter 1 2026-2027 • Freedom to Speak Up Guardian Report • Constitution and Standing Orders • Scheme of Delegation and Standing Financial Instructions • Use of the Corporate Seal	Approve Approve			
	Refreshment Break: 10:45 – 11:00				
9.	**Q2 Board Assurance Framework and Corporate Risk Register Report**	Receive	Mel Iles	11:00	Enclosure 06
	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 2 26/27 Quality & Safety Report and update on Paediatric and Maternity Services at Yeovil District Hospital**	Receive	Sally Bryant/ Mel Iles	11:30	Enclosure 08
12.	**Thirlwall Inquiry Report Findings and Recommendations**	Receive	Deirdre Fowler/ Mel Iles/	11:45	Enclosure 09
	Comfort Break: 11:55 – 12:05				
13.	**Trust Strategy, Objectives and Engagement**	Receive	David Shannon/ Richard Baum	12:05	Enclosure 10
	Aim 5 – Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture				
14.	**Wellbeing Guardian Report**	Receive	Graham Hughes	12:40	Enclosure 11
15.	**Workforce Resilience Framework**	Receive	Isobel Clements	12:50	Enclosure 12
	Aim 6: Live within our means and use our resources wisely				
16.	**Finance Report (M6)**	Receive	Pippa Moger	13:00	Enclosure 13
17.	**Healthset Programme**	Receive	David Shannon/ Stuart Hill/ Luke Gompels	13:05	Enclosure 14
	Reports from Board Committees (for discussion by exception only)				
18.	**Assurance report from the Quality and Governance Assurance Committee meeting held on 30 September 2026**	Receive	Inga Kennedy	13:15	Enclosure 15

		Action	Presenter	Time	Enclosure
19.	**Assurance Report from the Audit Committee meeting held on 21 October 2026**	Receive	Paul Mapson		Enclosure 16
20.	**Assurance Report from the People Committee meeting held on 16 September 2026**	Receive	Graham Hughes		Enclosure 17
21.	**Assurance Report from the Mental Health Legislation Committee meeting held on 15 September 2026**	Receive	Alexander Priest		Enclosure 18
22.	**Assurance Report from the Charity Committee meeting held on 20 October 2026**	Receive	Graham Hughes		Enclosure 19
23.	**Report from the Research and Innovation Committee meeting held on 15 September 2026**	Receive	Olena Doran		Enclosure 20

For Information

24.	**Follow-up questions from Members of the Public and Governors**	Receive	Chair	13:20	Verbal
25.	**Any other business**		All		Verbal
26.	**Risks identified**		All		Verbal
27.	**Evaluation of the effectiveness of the Meeting**		Chair		Verbal

28. Items to be discussed at the Confidential Board Meeting

- Minutes of the Confidential Board meeting
- Notes of the Board Seminar session
- Investigation and Disciplinary Procedure Review
- Maternity and neonatal reflections and learning, including any confidential discussions relating to the findings and recommendations of the Thirlwall Inquiry
- Finance Update
- Minutes of the Finance Committee meetings

29. 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.

30. Close and Date of Next Meeting 13:25

12 January 2027

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:	10 November 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 3 November 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: Click or tap here to enter text.

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

Board of Directors as at 3 November 2026

NHS Somerset NHS Foundation Trust

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Rosie	Benneyworth	Trust Board Member	Loyalty Interests	Member	Royal College of GPs	01/07/2025		02/11/2026
Rosie	Benneyworth	Trust Board Member	Outside Employment	Interim CEO	Health Services Safety Investigations Body	01/08/2022		02/11/2026
Rosie	Benneyworth	Trust Board Member	Loyalty Interests	Chair	Symphony Healthcare Services Ltd	01/03/2026		02/11/2026
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			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		02/09/2026
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		02/09/2026
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	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	Trust Board Member	Nil Declaration			07/10/2026		

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

REGISTER OF INTERESTS

Board of Directors as at 3 November 2026

NHS Somerset NHS Foundation Trust

Firstname	Lastname	Role	Interest Category	Interest Description (Abbreviated)	Provider	Date Arose	Date Ended	Date Updated
Pippa	Moger	Chief Financial Officer	Outside Employment	NED SSL	Non Executive for Simply Serve Limited	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Outside Employment	SPS Board member	Member of Southwest Pathology Services (SPS) Board	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Outside Employment	Director on JV	Shepton Mallet Health Partnership	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Loyalty Interests	Step daughter employed as Ward Manager	Somerset NHS Foundation Trust	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Loyalty Interests	Son employed as Payroll lead and technical support	Somerset NHS Foundation Trust	04/04/2025		16/06/2026
Pippa	Moger	Chief Financial Officer	Outside Employment	Director of JV - SEP	Director of SEP Project Co Ltd	04/04/2025		16/06/2026
Alexander	Priest	Trust Board Member	Outside Employment	Chief Executive	Mind in Somerset	01/04/2018		24/11/2025
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

Somerset NHS Foundation Trust

PUBLIC BOARD MEETING

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

PRESENT

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

IN ATTENDANCE

Reenee Barton	Deputy Responsible Officer (Revalidation) and Lead Medical Appraiser/Consultant Psychiatrist Deaf CAMHS Regional SW team (for item 8 - virtual)
Richard Baum	Head of Strategic Planning (for item 12)
Sally Bryant	Director of Midwifery and Deputy to the Chief Nurse for Somerset (for item 11 - virtual)
Sarah Green	Somerset Health and Care Academy Director (for item 15 - virtual)
Zoe Hamilton	Clinical Transformation Advisor (for item 12)
Rachel Hembury	Operations Manager South, Defence Medical Welfare Service (for item 7 - virtual)
Julie Hutchings	Board Secretary and Corporate Services Manager
Krystle Pardon	Head of Patient Engagement and Involvement (for item 7)
Tony Rackshaw	Programme Director, Somerset Council (for item 15 - virtual)
Fiona Reid	Director of Communication
Paul Zollo	Patient (for item 7 - via recording)
Tracy Zollo	Patient's Wife (for item 7 - via recording)

APOLOGIES

Darshan Chandarana	Non-Executive Director
Alexander Priest	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, including members of the public and Governors. 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 14 JULY 2026

3.1. The minutes of the Public Board meeting held on 14 July 2026 were **approved** as a true and accurate record.

4. ACTION LOG AND MATTERS ARISING

4.1. The Board reviewed the Action Log and noted that all actions had either been completed or were progressing as planned. In relation to the action concerning the review of the Integrated Performance Report, members were advised that work remained ongoing. A survey was being finalised to gather feedback from Board members on the content, format and usefulness of the report, following which proposals would be developed regarding future reporting arrangements and presentation of performance information.

4.2. The Chair invited members to raise any matters arising not otherwise covered on the agenda. No additional matters were raised.

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

5. QUESTIONS FROM MEMBERS OF THE PUBLIC AND GOVERNORS

5.1. The Chair invited questions from members of the public and Governors.

5.2. The Board received two questions from representatives of UNISON relating to proposals concerning the expansion of services provided through Simply Serve Limited. In response, David Shannon advised that all development of proposals relating to the transfer of services or staff to subsidiaries had been paused pending publication of national guidance from NHS England. He confirmed that any future proposals would be subject to consultation with trade unions and affected colleagues. Peter Lewis thanked the representatives for attending the meeting and welcomed further discussion regarding the issues raised.

5.3. The Board also considered four questions submitted by Ray Tostevin, Public Governor for South Somerset and Chair of Quicksilver Community Group, regarding implementation of the new Hyper Acute Stroke Unit model. Peter Lewis advised that a detailed written response would be provided and explained that standard operating procedures had been developed and tested for patients presenting at Yeovil District Hospital with suspected stroke symptoms. He confirmed that implementation of the new arrangements would be subject to ongoing monitoring through the Somerset Integrated Care Board.

5.4. The Board received a statement from Gerry Smith regarding independent monitoring of stroke performance data following implementation of the new service model and noted that ongoing performance information would continue to be reviewed.

5.5. The Board **noted** the questions and responses provided.

6. CHAIR'S REMARKS

6.1. The Chair provided an update on recent visits across the Trust, including a number of visits to Yeovil District Hospital. Whilst challenges continued to be raised in relation to workforce pressures and service performance, the Chair highlighted many positive examples of innovation, leadership and staff engagement.

6.2. The Chair noted the positive impact of several newly appointed matrons at Yeovil District Hospital, including examples of innovative workforce development which were helping to improve retention and staff experience. The Chair also highlighted innovation within pharmacy services and recent visits to Symphony GP practices, where colleagues had demonstrated enthusiasm for developing services to support population health and prevention.

6.3. The Chair reflected on feedback received from staff regarding workforce vacancies and variation in performance across services. The Chair noted the importance of understanding where the Trust was performing differently from comparable organisations and ensuring that support was provided to areas requiring improvement, whilst continuing to celebrate and share examples of good practice.

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

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

7.1. Deirdre Fowler introduced the patient story and welcomed Krystle Pardon and Rachel Hembury from the Defence Medical Welfare Service (DMWS). The Board viewed a recorded account from Paul Zollo and his wife, Tracy Zollo, describing their experience following Paul Zollo's diagnosis of Motor Neurone Disease and a prolonged hospital stay whilst suitable accommodation was identified to enable a safe discharge.

7.2. The story highlighted the importance of personalised care, partnership working and effective advocacy. Paul Zollo and Tracy Zollo described the challenges they faced navigating health, housing and social care systems and the significant support provided by a DMWS Welfare Officer, who helped coordinate agencies, facilitate

discussions and ensure that the family's wishes were heard. The family reflected that without this support they may not have secured a suitable housing solution and that the prolonged uncertainty had a significant impact on their wellbeing. They emphasised the importance of remembering the human impact of delays and system complexities.

7.3. Following the video, Deirdre Fowler noted that Paul Zollo had remained in a Somerset NHS Foundation Trust bed for approximately twelve months whilst a discharge solution was identified. She highlighted the benefits of working closely with voluntary and third-sector organisations in supporting patients with complex needs.

7.4. In response to questions, Rachel Hembury explained how veterans were identified through NHS coding systems and emphasised the importance of staff routinely asking patients whether they had served in the armed forces, as coding information was not always complete. Discussion focused on the wider learning arising from the story, particularly the need for effective case management and coordinated support for patients with complex health and social care needs.

7.5. Rosie Benneyworth, Inga Kennedy, Owen Woodley, Peter Lewis and Andy Heron reflected on the challenges of discharge planning, housing availability and accountability across organisational boundaries. Members discussed the importance of integrated working across health, social care and housing services and recognised the opportunity for emerging system-wide arrangements within Somerset to strengthen collective accountability for resolving complex discharge issues.

7.6. The Chair thanked Paul Zollo and Tracy Zollo for sharing their experience and thanked Krystle Pardon, Rachel Hembury and the Defence Medical Welfare Service for their support. The Chair noted the powerful reminder the story provided of the importance of coordinated, person-centred care for patients and families with complex needs.

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

8. CHIEF EXECUTIVE AND EXECUTIVE DIRECTOR REPORT

8.1. Peter Lewis introduced the report and highlighted the opening of the new Surgical Centre at Musgrove Park Hospital and the Bridgwater Diagnostic Centre, together with recent success in the HSJ Awards. He also updated the Board on the recent Care Quality Commission report, noting the improvement in rating from Inadequate to Requires Improvement, and confirmed that all criteria had been met to enable implementation of the Hyper Acute Stroke Unit service model from 9 September 2026.

8.2. The Board considered the Designated Body Annual Report and Statement of Compliance. Reenee Barton advised that appraisal compliance had improved during the year, although recruitment of medical appraisers remained a challenge. The Board approved the report. During discussion, members welcomed the progress made within maternity services and sought assurance regarding the impact of estate challenges, resident doctor concerns and payroll issues. Assurance was provided that work was underway to strengthen out-of-hours medical staffing arrangements,

address payroll issues through improved systems and oversight, and provide additional support for resident doctors.

8.3. Members also discussed organisational learning, patient experience and research and innovation. Deirdre Fowler outlined work to strengthen the Trust's learning framework and ensure learning from patient feedback, incidents and claims was shared more effectively across the organisation. David Shannon advised that the Trust had reviewed its research portfolio and was increasingly focusing activity on areas of strategic strength.

8.4. The Board discussed the proposal to delegate final approval of the Winter Plan to the Quality and Governance Assurance Committee and highlighted the importance of understanding wider system dependencies.

8.5. Following discussion, the Board **approved** the Designated Body Annual Report and Statement of Compliance and **approved** delegation of final approval of the Winter Plan to the Quality and Governance Assurance Committee and noted the report.

9. Q1 BOARD ASSURANCE FRAMEWORK (BAF) AND CORPORATE RISK REGISTER REPORT

9.1. Mel Iles presented the Quarter 1 Board Assurance Framework and Corporate Risk Register Report and advised that the framework had been refreshed to align with the emerging Trust Strategy. Progress had been made across population health, community transformation, personalised care, digital services, research and innovation, although significant oversight remained necessary due to the scale of transformation required.

9.2. In discussion, Rosie Benneyworth sought assurance regarding neighbourhood health metrics, personalised care and governance arrangements for artificial intelligence. David Shannon and Deirdre Fowler advised that further work was underway to develop reporting arrangements and ensure appropriate oversight of emerging technologies and personalised care initiatives. Members also discussed the importance of audit and assurance processes in relation to the use of artificial intelligence.

9.3. Mel Iles reported that there were 22 risks on the Corporate Risk Register as at August 2026, compared with 20 in April 2026. New risks related to non-urgent patient transport, delivery of the national non-clinical treatment trajectory and contraction of the nursing agency market. The safe staffing risk had reduced and the risk relating to claims and inquests had been closed. David Shannon also highlighted emerging risks associated with climate adaptation, including extreme heat and flooding. Tom Frederick queried why certain maternity risks did not appear on the Corporate Risk Register and Peter Lewis agreed to review this. **ACTION:** To review the Corporate Risk Register and consider whether maternity-related risks should be escalated to the Corporate Risk Register (Lead: Mel Iles).

9.4. The Board **noted** the Quarter 1 Board Assurance Framework and Corporate Risk Register Report.

10. INTEGRATED PERFORMANCE EXCEPTION REPORT

10.1. Pippa Moger presented the report and highlighted strong performance across community waiting times, urgent community response, mental health waiting times, diagnostics, cancer pathways, maternity measures and patient satisfaction.

10.2. The Board noted ongoing challenges relating to neighbourhood caseloads, frailty services, talking therapies, urgent and emergency care performance, elective waiting times, cancer standards, dermatology services and children's therapy waiting times.

10.3. The Chair expressed concern regarding the increasing number of patients waiting more than 52 weeks for treatment and sought assurance regarding the expected timescales for improvement. Andy Heron outlined a range of actions to increase capacity and productivity, including the Bridgwater Diagnostic Centre, the Urology Investigation Unit, additional theatre capacity and Getting It Right First Time initiatives. Mel Iles noted that whilst some patients remained on waiting lists for clinically appropriate reasons or patient choice, reducing long waits remained a priority. The Chair requested that a clearer trajectory for improvement be brought back to the Board. **ACTION:** To provide the Board with a clearer trajectory and anticipated timescales for reducing 52-week waits (Lead: Andy Heron).

10.4. Members also discussed recruitment challenges, Advice and Guidance pathways and deteriorating dermatology performance. Isobel Clements advised that a detailed review of recruitment processes was underway to better understand the causes of delays and identify improvements. Rosie Benneyworth sought assurance regarding oversight of Advice and Guidance pathways and was advised that patients awaiting advice and guidance responses remained visible to the Trust and were monitored through specialty-level reporting. The Board was also advised that workforce shortages, increased demand and capacity pressures continued to affect dermatology services and that a range of mitigations were being pursued.

10.5. The Board noted the Integrated Performance Exception Report.

11. MATERNITY & NEONATAL QUARTER 1 (2026/27) QUALITY & SAFETY REPORT AND UPDATE ON PAEDIATRIC AND MATERNITY SERVICES AT YEOVIL DISTRICT HOSPITAL

11.1. Sally Bryant presented the Quarter 1 Maternity and Neonatal Quality and Safety Report and advised that significant progress had continued during the quarter, including the successful reopening of maternity and neonatal services at Yeovil District Hospital. Improvements had been made in governance, oversight and delivery of the Maternity and Neonatal Improvement Programme, whilst patient feedback continued to reflect compassionate and high-quality care. Workforce sustainability, operational flow, culture and behaviours, foetal medicine and neonatal staffing remained key areas of risk. Mel Iles highlighted ongoing challenges relating to neonatal nurse recruitment and advised that further assurance regarding maternity triage and the Trust's response to the national maternity 10-point plan would be considered during the Confidential Board meeting.

11.2. In discussion, Rosie Benneyworth welcomed the progress made and sought assurance regarding ongoing work to address culture and behaviours within

maternity services. Sally Bryant advised that work was underway to strengthen culture, improve multidisciplinary working and support staff to raise concerns. Mel Iles noted that audits undertaken since the reopening of services had provided assurance regarding clinical practice, whilst also identifying opportunities to improve documentation and consistency. Inga Kennedy highlighted the importance of ensuring that improvement activity remained focused on measurable improvements in outcomes, and the Board also noted ongoing work to understand discrepancies between local breastfeeding data and externally published reports. The Board noted the report.

11.3. The Board noted the report.

12. TRUST STRATEGY NARRATIVE 2027-32

12.1. David Shannon presented the final draft Trust Strategy Narrative and advised that engagement with colleagues and stakeholders had been positive. He noted that the next phase of work would focus on developing the detailed delivery plan, objectives and measures to support implementation.

12.2. The Chair welcomed the strategy and emphasised that the Board's focus should now move to delivery, including the development of clear milestones, measures and assurance arrangements. Future Board development sessions would focus on transformation and delivery of the strategy.

12.3. In discussion, members welcomed the progress made since earlier drafts and highlighted the importance of maintaining staff engagement, developing clear outcome measures and ensuring that the accompanying delivery plan was shared with the full Board once completed.

12.4. The Board **approved** the Trust Strategy Narrative 2027-32.

13. FINANCE REPORT (M4)

13.1. Pippa Moger presented the Month 4 Finance Report and advised that the Trust had reported an in-month deficit of £1.4 million and a year-to-date deficit of £15.4 million. Operational pressures within Children's Services, Surgery and Medicine continued to affect performance, resulting in an income shortfall against plan. Agency expenditure remained above planned levels and reductions in agency and bank expenditure had not yet been achieved.

13.2. The Board noted that delivery of the cost improvement programme remained ahead of plan year-to-date. However, it was recognised that achievement of the year-end financial position was dependent upon delivery of further efficiencies and resolution of pressures arising from the pause to elements of the estates transformation programme. Capital expenditure remained ahead of plan due to phasing, although financial pressures were emerging and could require difficult decisions regarding future schemes.

13.3. The Board also noted that workforce expenditure remained below establishment, with gaps continuing to be covered through agency and bank staffing. A bottom-up

review of the financial forecast was underway to assess the impact of these pressures on delivery of the Trust's financial plan.

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

14. HEALTHSET PROGRAMME

14.1. David Shannon presented the report and advised that the programme had moved into the implementation phase and remained on track overall. Recruitment and resource challenges identified earlier in the year had improved and work was now focused on system design and build activities. Key upcoming milestones included agreement of the third-party systems strategy and the continuation of external assurance reviews.

14.2. Members welcomed the positive update and sought assurance regarding patient and public involvement, digital inclusion and programme governance. David Shannon, Deirdre Fowler and Mel Iles outlined the engagement arrangements in place and confirmed that the Clinical and Operational Design Authority had been re-established to oversee clinical design and decision-making. The Board also noted that the planned go-live date remained April 2028.

14.3. The Board **noted** the report.

15. SOMERSET HEALTH AND CARE ACADEMY FULL BUSINESS CASE (FBC) AND COLLABORATION AGREEMENT

15.1. Sarah Green introduced the report and outlined the benefits of the proposed Somerset Health and Care Academy in supporting workforce development, training, innovation and partnership working across Somerset. Tony Rackstraw provided an overview of the property, construction and financial arrangements and advised that the revenue model had been developed on a prudent basis.

15.2. Members welcomed the proposal and discussed the opportunities for integrated training, innovation and collaboration across health and social care. Assurance was provided regarding the risks associated with the project, governance arrangements and the involvement of academic partners. Members noted that the financial risk to the Trust was limited and that robust oversight arrangements would continue throughout delivery of the programme.

15.3. The Board **approved** the Somerset Health and Care Academy Full Business Case and Collaboration Agreement.

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

16.1. Inga Kennedy presented the report and highlighted continuing workforce risks across the organisation. Members noted the importance of understanding workforce resilience more broadly than recruitment alone, including retention, sickness absence and employee feedback.

16.2. In discussion, members agreed that further work was required to triangulate the range of workforce information available to provide a clearer picture of workforce sustainability and areas of vulnerability. Deirdre Fowler advised that a detailed review was underway and that a further update would be provided later in the year.

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

17. ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETING HELD ON 22 JULY 2026

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

18. ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 23 JULY 2026

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

19. REPORT FROM THE RESEARCH AND INNOVATION COMMITTEE MEETING HELD ON 26 JUNE 2026

19.1. The Board **noted** the report.

20. FOLLOW UP QUESTIONS FROM THE PUBLIC AND GOVERNORS

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

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

21. ANY OTHER BUSINESS

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

22. RISKS IDENTIFIED

22.1. The Chair invited members to identify any new risks arising from discussions during the meeting. Members noted the workforce sustainability concerns discussed during the meeting, particularly in relation to recruitment, retention and areas of workforce fragility. It was agreed that these issues were already being monitored through existing governance arrangements, the Board Assurance Framework and Corporate Risk Register. No new risks were identified.

23. EVALUATION OF THE EFFECTIVENESS OF THE MEETING

23.1. The Board reflected positively on the quality of discussion throughout the meeting. Members welcomed the strategic discussion on the Trust Strategy and recognised the importance of maintaining focus on the supporting delivery plans, milestones and performance measures.

23.2. The Board also noted the value of the patient story and the wider learning arising from discussions regarding partnership working, personalised care and system-wide accountability.

24. ITEMS FOR DISCUSSION AT CONFIDENTIAL BOARD MEETING

24.1. 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.

25. WITHDRAWAL OF PRESS AND PUBLIC

25.1. 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.

26. CLOSE AND DATE OF NEXT MEETING

21.1. The meeting closed at 12.57 pm. The next meeting will take place on 10 November 2026.

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 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	November 2026	Survey to be sent to Board members to gain their views on the current IPR. 16/9/26: Survey sent to Board members to seek their views on the current IPR (responses due by 16/10/26). 30/10/26: Survey has now closed and responses are being viewed to assess next steps.	Ongoing
Public Board meeting held on 8 September 2026					
9.3 - Q1 Board Assurance Framework (BAF) and Corporate Risk Register Report	To review the Corporate Risk Register and consider whether maternity-related risks should be escalated to the Corporate Risk Register.	Mel Iles	November 2026	2/10/2026: Review completed. Review undertaken with the Trust Risk Manager and maternity risks reconciled against the Corporate Risk Register and associated mapped risks. Planned ongoing refinements in reporting arrangements in progress.	Complete
10.3 – Integrated Performance Exception Report	To provide the Board with a clearer trajectory and anticipated timescales for reducing 52-week waits	Andy Heron	November 2026		

NHS
Somerset
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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Patient Story: Richard's experience of OASIS booking system
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and Midwife
REPORT BY:	Caroline Walker, Head of Patient Experience
PRESENTED BY:	Caroline Walker, Head of Patient Experience Richard Mayhew- patient (in person/via recording) Trish Acton, Head of iMSK Carly Jackson, Project Manager Digital and Administration Transformation
DATE:	10 November 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	Richard Mayhew's experience of accessing the OASIS service following referral by his GP illustrates the cumulative impact of access and communication difficulties and the value of complaints in informing organisational learning and improvement. Despite following the instructions provided and using online booking, telephone, email and the Trust's digital assistant, Richard was unable to identify a clear route to arranging his appointment. The story also highlights a positive experience of the Trust's complaints process. Richard described the eventual response as comprehensive and welcomed the Trust's acknowledgement of the underlying problems and its intention to work differently in future. The OASIS service identified staffing pressures, weaknesses in booking processes and limitations in contact routes as contributing factors to Richard's negative experience. In response, staffing and booking processes have been strengthened, contact routes improved, and a target introduced to respond to 90% of contacts within 48 hours. Further pathway improvements are underway, with implementation and sustained improvement monitored through service and iMSK governance.

Recommendation	The Board is asked to discuss and reflect on the patient story, note the learning identified and seek assurance that improvements arising from the complaint are embedded, with wider learning applied to the design and review of patient access 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: Click or tap here to enter text.

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 experience, with additional information regarding improvements provided by iMSK colleagues.

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 November 2026 Public Board of Directors.

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: RICHARD'S EXPERIENCE OF OASIS BOOKING SYSTEM

1. BACKGROUND AND PURPOSE

1.1 This patient story has been selected to illustrate the cumulative impact of access and communication processes on the patient's experience and highlight the value of complaints in informing organisational learning and improvement.

1.2 This patient story describes the difficulties experienced by Richard Mayhew when attempting to access the OASIS service following referral by his GP. Despite following the instructions provided and attempting multiple routes of contact, including online booking, telephone, email and the Trust's digital assistant, he was unable to secure a clear and straightforward route to arranging his appointment.

1.3 The OASIS service identified staffing pressures, weaknesses in booking processes and limitations in contact routes as contributing factors to Richard's experience. In response, staffing and booking processes have been strengthened, contact routes improved, and a target introduced to respond to 90% of contacts within 48 hours. Further pathway improvements are underway, with implementation and sustained improvement monitored through service and iMSK governance.

2. RICHARD'S STORY

2.1 Richard Mayhew was referred to the OASIS service by his GP. Shortly afterwards, he received an automated invitation asking him to arrange an appointment through the OASIS team. He followed the instructions and initially tried to book online, but was directed to telephone the OASIS booking office instead.

2.2 Richard repeatedly tried to telephone the service but was unable to get through, with the telephone system telling him to call back later. He then tried another available route and emailed the booking team. The automated reply advised that, because of staffing pressures, there could be a delay of up to three weeks before his email was answered. For Richard, three weeks felt like a very long time simply to find out how to arrange an appointment.

2.3 He subsequently received a letter which again instructed him to telephone the same number he had already been unable to get through to. The opening hours stated in the letter were also different from those given by the automated telephone system. He tried the Trust's digital AI-assisted route too, but found that this could not book a new patient appointment.

2.4 Individually, these could have been viewed as relatively small administrative problems. For Richard, however, they became a frustrating experience. He was doing everything he had been asked to do, using each of the routes

provided to him, but was still unable to navigate successfully through the system.

2.5 This created uncertainty as well as frustration. Richard began to question whether his referral had been received, whether he was waiting for an appointment or needed to do something else, and whether he should contact his GP or the hospital again. He also questioned whether continuing to telephone, email or use the digital route would achieve anything.

2.6 It was this experience that led Richard to make a formal complaint. He was clear that he was not seeking special treatment or trying to move ahead of other patients. His concern was that the process for obtaining an appointment appeared inaccessible and that, if he had experienced these difficulties, other patients might experience them too.

2.7 Richard described his experience of the Trust's complaints process very differently. He felt that his concerns were listened to carefully, that the issues were properly understood and that the questions put to the service accurately reflected what had happened.

2.8 The Trust subsequently carried out a detailed review. Richard described the eventual response as comprehensive, acknowledging the problems he had experienced and explaining that the service intended to work differently in future. He particularly valued that the response did not simply attribute the problems to the service being busy, but acknowledged issues including the telephone system, staffing pressures, inconsistent information, delays in responding to emails and limitations of the digital booking route. This gave him confidence that his complaint had genuinely been listened to.

3. LEARNING FROM THE COMPLAINT

3.1 Learning from Richard’s complaint identified that staffing pressures, delays in responding to contacts, limited access routes and inconsistent information contributed to a poor patient experience. In response, staffing and booking processes have been strengthened, alternative contact routes improved, and a target introduced for 90% of contacts to receive a response within 48 hours. Further work is underway to streamline the referral-to-booking pathway, with delivery and sustained improvement monitored through service and iMSK governance.

4. KEY POINTS FOR BOARD

4.1 Richard’s story highlights that access to healthcare begins when a patient tries to obtain an appointment, not when they arrive at the hospital. When individual parts of a system change, it is important to step back and consider what the whole pathway now feels like for the person using it.

4.2 Richard’s experience demonstrates how compassionate complaint handling, careful consideration of concerns and a comprehensive response can support improvements for future patients, while reinforcing his confidence that raising a complaint was worthwhile and that his feedback was valued by the Trust.

5. RECOMMENDATION

5.1 The Board is asked to discuss and reflect on the patient story, note the learning identified and seek assurance that improvements arising from the complaint are embedded, with wider learning applied to the design and review of patient access pathways.

CAROLINE WALKER, HEAD OF PATIENT EXPERIENCE

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:	10 November 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 teams and/or points of note which are not covered in the standing business, assurance reporting from executive-led committees, and any key legal or statutory changes affecting the work of the Trust

Recommendation	To note the report and discuss the items within it. To ratify the Gynaecology Assessment Unit Business Case (approved by the Finance Committee on 26 October). To approve the updated Standing Orders and Scheme of Delegation.

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**: Although an EQIA is not required for the purposes of this briefing paper, an EQIA may be required for individual components.

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, assurance reporting from executive-led committees, and any key legal or statutory changes affecting the work of the Trust.

NATIONAL DEVELOPMENTS

2.1 NHS England publishes guidance to support NHS organisations in the provision of same-sex services and facilities

Following the Equality and Human Rights Commission's (EHRC's) Code of Practice for Services, Public Functions and Associations that came into force on 5 August 2026, NHS England has released guidance, including:

- Privacy, dignity and safety in hospital accommodation – revised guidance on same sex accommodation for patients.
- Guidance on NHS staff facilities – new guidance on the provision and use of NHS staff facilities.

The code of practice provides statutory guidance on the implementation of the Equality Act 2010 and has implications for NHS organisations, both as providers of services and as employers. The Trust is reviewing this guidance and the implications for local policy and practice. Boards should ensure that:

- The new guidance is reviewed by relevant board-level leads and those responsible for clinical operations, people, estates and facilities and communications.
- Local policies and practices are consistent with the law and the new guidance.
- There is a clear plan for addressing any areas where change is required.
- They have oversight of a clear plan to meet the NHS Constitution's pledge to eliminate mixed-sex accommodation.
- Staff understand what is expected of them and know where to seek advice on complex cases.
- Arrangements are in place to support consistent decision-making and escalate difficult issues when needed.

- Organisations continue to foster workplaces that are safe, respectful and inclusive, with clear expectations around dignity and protection from bullying, harassment and discrimination.

- Plans include arrangements for monitoring impact, responding to issues raised and reviewing or revising decisions where evidence or circumstances change.

2.2 Government publishes independent review and pledges earlier support to tackle mental health crisis

On 9 October the Government published an independent review into prevalence and support for mental health conditions, ADHD and autism led by Professor Peter Fonagy, and has pledged earlier support for children, young people and adults, without long waits for clinical diagnosis.

The review has found that mental distress has increased substantially among children and young people. The findings show this has been driven by several factors, including social media, financial insecurity, increased uncertainty about the future, poorer sleep, and reduced feelings of connection and belonging. While referrals and diagnoses for ADHD and autism have risen significantly, the review found that population-level prevalence of these conditions appears broadly stable.

The interim report of Alan Milburn's review of 'Young People and Work' also found that - among the 16 to 25-year-old age group not currently in education, employment or training - 24 per cent cited depression or anxiety as their main limiting condition, 22 per cent autism, and 18 per cent another mental illness.

The Government has responded by seeking to improve support at every stage of life. For children, young people and adults experiencing mental distress, greater support will be available in schools, colleges and communities with a focus on earlier intervention, reducing long waits and ensuring support is available before and without a diagnosis.

Where clinically appropriate, the system will continue to offer timely diagnosis and treatment, such as when someone may require medication. As part of this work, the Health and Social Care Secretary has asked NHS leaders to urgently examine how people can access advice, assessments and treatment more easily.

2.3 Thirwall Inquiry report findings and recommendations

On 15 September 2026, The Thirlwall Inquiry published its report into events at the Countess of Chester Hospital from 2015 to 2018.

Following publication of the report, NHS England wrote to Trusts, requesting that Boards review the report and consider its findings at the next available public Board meeting, while also progressing a number of immediate actions arising from the Inquiry.

As communicated to Board members by email, the Trust completed the immediate action requirements to communicate the application of the Sudden and Unexpected Death in Childhood (SUDIC) process within the prescribed timeframe (28 September 2026). Existing Joint Agency Response and Child Death Review arrangements are in place. Further work is underway to ensure consistent awareness and application of these arrangements.

There is further discussion on the findings of the Thirlwall Inquiry on the Board agenda.

2.4 Your Voice – building a better future for maternity and neonatal care

The national 'Your Voice' conversation has been launched across the country. More than 9,000 members of staff from across the NHS contributed their views to the independent national maternity and neonatal investigation led by Baroness Amos – and staff concerns were heard. NHS England has now launched 'Your Voice', an NHS-wide opportunity for an open conversation to determine what happens next for maternity and neonatal services.

All colleagues working within, or closely with, maternity and neonatal services are being asked to share their views. This is set to be the largest single conversation ever held about an NHS service, bringing together colleague voices from across the country to help turn the independent national maternity and neonatal investigation led by Baroness Amos into meaningful action for the women, babies and families. By sharing views, colleagues will help to build the clearest possible picture of what needs to change locally and nationally. These insights will help inform the national maternity and neonatal taskforce's action plan and provide valuable evidence for the Modern Service Framework, so that future decisions are grounded in the realities of colleagues, services and families.

REGIONAL AND LOCAL DEVELOPMENTS – SOUTHWEST

2.5 £54.8 million investment in infrastructure and building Improvements

£49 million has been awarded to improve fire safety, infrastructure and refurbishment for the ward and theatre areas within Yeovil District Hospital's (YDH) tower block and £5.8 million will go to improve fire safety infrastructure and building improvements at Crewkerne Community Hospital, Broadway Health Park in Bridgwater, and Musgrove Park Hospital in Taunton.

It is very important that we update and improve our infrastructure to support the care and services we deliver. This money will support us to improve the infrastructure at buildings that deliver important services to patients in different parts of Somerset.

2.6 Gynaecology Assessment Unit Business Case – For Ratification

To meet submission timescales, the Board agreed to delegate approval of the updated Gynaecology Assessment Unit business case, and this was considered and approved by the Finance Committee on 26 October 2026.

The Board is asked to ratify this decision with the proposed contractor award to presented to the Board in December.

The Gynaecology Assessment Unit (GAU) will deliver an integrated approach to urgent and emergency care by bringing four key pathways together in one dedicated service. A GAU acts as a direct destination for urgent gynaecological and early pregnancy issues. This coordinated model will deliver a more timely, efficient and compassionate service whilst reducing pressure on the emergency department. The investment will fit out the unused space in the King's Building ground floor and the capital costs of the scheme are entirely funded by public dividend capital.

2.7 Provider Capability Assessment

Building on last year's approach, the Board considered and approved the 2026 Provider Capability Self-Assessment by electronic resolution which was submitted to NHS England. The self-assessment provides an evidence-based review of the Trust's capability across six domains aligned to NHS England's Insightful Provider Board Guide, with ratings of Green for Strategy, Leadership and Planning and Amber-Green across Quality of Care, People and Culture, Access and Delivery of Services, Productivity and Value for Money, and Financial Performance and Oversight. The submission recognised a number of areas requiring continued focus and improvement, while acknowledging the governance, leadership and assurance arrangements that are in place.

2.8 Constitution and Standing Orders – For Approval

The annual review of the Trust's Constitution and Standing Orders is ordinarily undertaken during the autumn, ahead of Board approval in November. However, it is proposed that this year's review be deferred in light of the anticipated Health Bill in April 2027. The forthcoming legislative changes are expected to require more substantive amendments to the Trust's governance framework, and deferring the review will enable a single, comprehensive update to be undertaken. This approach will avoid introducing interim changes that may need to be revisited shortly afterwards.

In the meantime, a small number of minor amendments have been made to the Standing Orders to ensure alignment with the Trust's current governance arrangements. These include the addition of references to the Executive Committee and the Research and Innovation Committee within the governance framework and the renaming of the Mental Health Act Committee as the Mental Health Legislation Committee. The Trust's governance arrangements will continue to be kept under review, and any urgent or necessary amendments will be brought forward as required.

The revised Standing Orders are presented to the Board for approval (Appendix B).

2.9 Scheme of Delegation and Standing Financial Instructions – For Approval

A review of the Trust's Scheme of Delegation has been undertaken following the annual review of Committee Terms of Reference. The review concluded that the majority of existing delegated authorities remain appropriate and continue to support the effective discharge of the Board's responsibilities, with a small number of updated amendments, including: the incorporation of delegated authority sections for the Executive Committee and the Research and Innovation Committee, together with enhancements to existing committee responsibilities. These amendments strengthen delegated oversight in areas including risk management, strategic partnerships, estates and sustainability, workforce governance, transformation programmes, and the management of charitable funds. In addition, a small number of housekeeping updates are proposed to ensure governance terminology and committee titles remain current and consistent, including the renaming of the Mental Health Act Committee as the Mental Health Legislation Committee.

The revised Scheme of Delegation is presented to the Board for approval (Appendix C). Approval will ensure that the Trust's delegated governance arrangements remain aligned with the responsibilities set out within the updated Committee Terms of Reference and continue to provide a clear and effective framework for decision-making and accountability.

Alongside the review of the Scheme of Delegation, the Trust's Standing Financial Instructions (SFIs) have also been reviewed. No changes to the SFIs are proposed at the current time, as they remain fit for purpose and continue to provide an appropriate framework for the regulation of the Trust's financial affairs. The SFIs will continue to be kept under review, and any future amendments will be brought forward through the Trust's established governance processes as required.

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

3.1.1 Assurance Report from the Executive Committee meeting held on 5 October 2026

The Committee reviewed the Month 5 financial position, and the corresponding risks and challenges; operational pressures, activity underachievement and shortfalls in our efficiency programme. A programme of financial turnaround and mitigating actions is being established in response to these pressures.

In line with the quality and performance exception report presented to the Board, operational performance and winter resilience were discussed extensively, noting the areas of operational pressure and challenge.

The Committee reviewed the corporate risk register, noting an increase in risks relating to delivery of the financial plan and emergency department

nursing, alongside the addition of a new corporate risk associated with non-urgent patient transport services. The distinction between service-level risks registers and those escalated onto the corporate risk register was discussed as not all high-scoring service-level risks automatically escalate onto the corporate layer (they are mapped in if they meet particular criteria). Greater clarity will be provided on the escalation and categorisation of risks.

The Committee considered several strategic workforce initiatives, including the development of the executive inclusion objectives. The objectives have been designed to focus leadership attention on a smaller number of priority areas, aligned to the new NHS England staff standards, with executive directors taking ownership of specific workstreams. The Committee considered progress made by the staffing solutions service on implementing the majority of recommendations arising from an internal audit. The Committee supported proposals to establish a Trust-wide pool of trained investigating officers to improve the timeliness and quality of employee relations investigations. The Committee received the recruitment internal audit report, which highlighted a number of recommendations for improvement. It was confirmed that recruitment policies, procedures and governance arrangements are in place, and there was a presentation on the actions that have occurred to strengthen recruitment processes and standard operating procedures, with a particular focus on addressing the challenges with consistent completion of pre-employment checks.

The Committee approved the histopathology workforce business case.

The Executive Committee reviewed the position regarding the Trust's aseptic pharmacy facility, which prepares injectable chemotherapy treatments for Somerset patients, following a national regulatory review relating to serious incidents elsewhere and changes to acceptable levels of microbial growth.

The Committee supported the revised Social Media Policy and approved its progression through the Trust’s policy governance process.

The Committee supported the need for a workforce plan and pipeline to be developed for occupational therapy for future consideration.

Updates were received on the electronic health record programme and associated systems replacement.

An update was provided on service-level job planning and NHS England’s 90-Day Challenge. The programme forms part of a three-year national ambition to move from individual job planning towards team-based, multi-professional workforce planning. Teams are working through this process.

These exception reports were received and discussed: Quality Assurance Group, Patient Experience and Engagement Committee, Health and Safety Committee, Service Group Governance meetings and Medicines Management.

The Committee noted reaccreditation with the Two Star Triangle of Care standard. It was noted that complaint volumes have increased significantly, placing continued pressure on services, with communication remaining the most common theme of patient concerns, with actions underway to improve complaints management, organisational learning and the consistency of responses across the Trust.

The Board has previously received an update on the Fuller Inquiry relating to the handling and oversight of deceased patients and mortuary services, which led to a series of recommendations aimed at strengthening arrangements across NHS organisations. Following Board approval of the Mortuary Assurance Statement in July 2026, the Executive Committee reviewed the associated Premises Assurance Model (PAM) assessment. The Committee considered the findings noting the assessment is based on clear compliant or non-compliant responses, resulting in a more robust evaluation of compliance across estates services. The Committee noted strengths in areas including estates competency and patient experience, but also recognised ongoing challenges relating to estate infrastructure, resource capacity, documentation management and statutory compliance requirements. The Committee noted the update and supported increased engagement between estates and service groups to strengthen understanding of risk and compliance.

Colleagues reflected on the effectiveness of the Executive Committee itself and agreed that further consideration should be given to the format and operation of future meetings to ensure sufficient opportunity for discussion, engagement and effective decision-making.

3.2 Learning from Deaths – Quarterly Summary (Q1 2026–2027)

This report is a requirement of the National Guidance on Learning from Deaths (National Quality Board, March 2017) and the Implementing the Learning from Deaths Framework, Key Requirements for Trust Boards (NHS Improvement, July 2017).

The Trust continues to identify and learn from deaths across acute, mental health, and community services through a range of mechanisms including Medical Examiner scrutiny, case record reviews, PSIRF learning responses, and feedback from bereaved families. Learning reflected recurring themes seen in previous reporting periods, including recognition and escalation of deterioration, communication with patients and families, documentation and implementation of treatment escalation plans (TEP), coordination of care across services, and continuity of care. Alongside opportunities for improvement, reviews identified examples of good practice including effective multidisciplinary working, timely recognition of deterioration, specialist clinical input, and compassionate end-of-life care. No deaths reviewed during the reporting period were considered more likely than not to have been due to problems in care.

Independent scrutiny of deaths through the Medical Examiner service remains central to the Trust's Learning from Deaths arrangements. During the quarter, 504 deaths of patients in Trust hospital settings were referred to the Medical

Examiner service, with potential concerns identified and escalated in relation to 56 deaths. Feedback from bereaved families and carers was shared in relation to 29 deaths and continues to provide valuable insight into the experiences of patients and families. Case record reviews and proportionate PSIRF learning responses are undertaken in line with Trust policy where thresholds were met.

Coronial activity remained high, with 56 new enquiries received and one Regulation 28 Report issued during the period. An internal audit of the Medical Examiner and Learning from Deaths arrangements recognised a number of areas of good practice and identified opportunities to strengthen consistency, timeliness, oversight of learning, and governance processes, with improvement work now underway.

Mortality surveillance data continue to be used as high-level signals to inform Learning from Deaths arrangements. The Trust's Summary Hospital-level Mortality Indicator (SHMI) remains within the expected range at 1.07. Whilst mortality remains within expected limits, the Mortality Surveillance Group has identified a gradual upward trend, most notably at Yeovil District Hospital. Initial scoping work has not identified any immediate concerns regarding the quality of care provided; however further patient-level clinical review has been commissioned to better understand the factors contributing to this trend and provide additional assurance.

3.3 Freedom to Speak Up Guardian Report

This report provides the six-monthly update on Freedom to Speak Up (FTSU) activity across the Trust for the period April 2026 to September 2026.

The National Guardian's Office formally closed on 30 June 2026, with functions transferring to NHS England.

175 concerns were raised during Q1/Q2, representing a 5% increase compared to the previous six-month period.

The predominant themes continue to relate to worker safety and wellbeing, inappropriate attitudes and behaviours, bullying and harassment and patient safety and quality.

Communication remained the most significant learning theme. Additional learning related to leadership behaviours, colleague wellbeing, consistency of process and timeliness of resolution.

Colleague feedback consistently described the service as safe, supportive, responsive and empowering. Anonymous reporting reduced from 11% to 5% and will continue to be monitored as an indicator of psychological safety. No formal cases of detriment were reported, reflecting known national patterns of under-reporting.

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

3.4 USE OF THE CORPORATE SEAL

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

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

JADE RENVILLE, CHIEF OF STAFF TO THE CHIEF EXECUTIVE AND JULIE HUTCHINGS, BOARD SECRETARY AND CORPORATE SERVICES MANAGER

APPENDICES:

Appendix A: Use of the Corporate Seal
Appendix B: Standing Orders
Appendix C: Scheme of Delegation

Somerset NHS Foundation Trust

Appendix A

SOMERSET NHS FOUNDATION TRUST - SEAL REGISTER

1 April 2026 – 31 October 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
09/10/2026	07	Ryalls Park Lease	Pippa Moger	Andy Heron

APPENDIX B

SOMERSET NHS FOUNDATION TRUST

STANDING ORDERS

SOMERSET NHS FOUNDATION TRUST

STANDING ORDERS

1. INTRODUCTION

1.1. The Somerset NHS Foundation Trust (the "Trust") (previously known as the Somerset Partnership NHS Foundation Trust) became a Public Benefit Corporation on 1 May 2008 following authorisation by Monitor pursuant to the National Health Service Act 2006 (the "2006 Act") and this Authorisation is of unlimited duration.

1.1. The principal place of business of the Trust is currently at Yeovil District Hospital, Higher Kingston, Yeovil, Somerset, BA21 4AT.

1.2. The Trust is governed by the 2006 Act, its Constitution and the terms of its Provider Licence granted by NHS Improvement (Monitor) (the Regulatory Framework). The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Trust Board and the Council of Governors of the Trust to adopt SOs for the regulation of its proceedings and business.

1.3. The Trust applies the principles of the NHS Foundation Trust Code of Governance, most recently revised in July 2014, which is based upon the principles of the UK Corporate Governance Code issues in 2012.

1.4. The SOs, Scheme of Delegation and SFIs provide a comprehensive business framework. All Executive Directors and Non-Executive Directors, all members of staff, and Governors should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1.5. As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.6. The Trust has a number of wholly and partially owned corporate entities. These corporate entities are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As separate, independent corporate entities, they are subject to their own governance arrangements, which are the responsibility of the relevant entity's management structure, and therefore these Standing Orders are not applicable. For avoidance of doubt, any matter reserved to the Trust in relation to such corporate entitles will be treated as an item of the Trust and will be considered in accordance with these Standing Orders.

1.7. The Chairman, Chief Executive or any other person giving information to the public on behalf of the Trust shall ensure that they follow the principles set out by the Committee on Standards in Public Life (the Wicks Committee) and that they will adhere to the principles set out within the Independent Commission's Good Governance Standard for Public Service, and the Care Quality Commission's Fit and Proper Person regulations. They will also ensure that they follow the best practice advice set out in the NHS Foundation Trust Code of Governance 2006 (the "Code") published by Monitor that sets out the overarching framework for compliance with the Regulatory Framework.

1.8. The Trust shall deal with NHS England/Improvement (Monitor) in an open and co-operative manner and shall promptly notify NHS England/Improvement (Monitor) of anything relating to the Trust of which NHS England/Improvement (Monitor) would reasonably expect prompt notice, including, without prejudice to the foregoing generality, any anticipated failure or anticipated prospect of failure on the part of the Trust to meet its obligations under its Provider Licence or any financial or performance thresholds which NHS England/Improvement (Monitor) may specify from time to time.

ANNEX 1 - STANDING ORDERS FOR THE COUNCIL OF GOVERNORS
(Ref. Paragraphs 19, 20 and 21)

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SCHEDULE A: PRESCRIBED FORM OF DECLARATION OF INTERESTS

1. DEFINITIONS

1.1. In these Standing Orders:

Annual Meeting
means a general meeting of the Council of Governors at which the annual accounts, annual report and external auditors' opinions are presented to the Council of Governors.

Clear Day
means a day of the week not including Saturday, Sunday or a public holiday.

Code of Conduct
means any code which the Trust may publish from time to time to govern or guide the conduct of the Council of Governors, Directors and Officers of the Trust.

Appointments Panel
means the Panel established in accordance with Annex 3.

Officer
means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

Returning Officer
means an employee of the Trust or any other person holding a paid appointment or office with the Trust who is administering and counting the e-mail votes for the issue(s) to be voted upon.

2. INTERPRETATION

2.1. Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SOs shall bear the same meaning as in the constitution.

2.2. For the purposes of these SOs, the "board" means the Board of Directors and the "Council" means the Council of Governors.

3. THE COUNCIL OF GOVERNORS

3.1. The roles and responsibilities of the Governors as set out in paragraph 24 of the Constitution also have effect as if incorporated into the SOs. Certain powers and decisions may only be exercised by the Council of Governors in formal session. These powers and decisions are set out in paragraphs 23, 24, 26 and 50.

3.2. The roles and responsibilities of the Council are to be carried out in accordance with the Regulatory Framework include the following:

3.2.1. to hold the Board to account for the performance of the Trust;

3.2.2. to respond as appropriate when consulted by the Board in accordance with the Constitution; and

3.2.3. to prepare and from time to time review the Trust's membership strategy.

3.3. The Council and each Governor individually shall at all times seek to comply with the Trust's Code of Governance and the Code of Conduct for the Council.

4. MEETINGS OF THE COUNCIL OF GOVERNORS

4.1. Admission of the Public

4.1.1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors except where it resolves by special resolution that members of the public and representatives of the press be excluded from all or part of a meeting on the grounds that:

4.1.1.1. any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

4.1.1.2. for other reasons stated in the resolution and arising from the nature of the business or the proceedings that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the Constitution.

4.1.2. The Chairman shall give such directions as he thinks fit (including a decision to expel or exclude any member of the public and/or press if the individual in question is interfering with or preventing the proper conduct of the meeting).

4.1.3. Nothing in these SOs shall require the Council of Governors to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Chairman.

4.1.4. Matters to be dealt with by the Board or the Council following the exclusion of the public and representatives of the press under SO 4.1.1 above shall be confidential to the Governors.

Members of the Council and others in attendance at the request of the person chairing the meeting shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chairman.

4.1.5. The Chairman (or Deputy Chairman) will decide what arrangements and terms and conditions they feel are appropriate to offer in extending an invitation to observers, advisors and others to attend and address any meeting of the Board or the Council (as relevant), and may change, alter or vary these terms and conditions as it deems fit.

4.2. Calling Meetings

4.2.1. Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine and there shall be at least 4 (four) meetings in any year including:

4.2.1.1. an annual meeting no later than the 30 September in each year, when the Council of Governors are to receive and consider the Annual Accounts, any report by the Auditor and the Annual Report; and

4.2.1.2. any other meetings required of the Governors in order to fulfil their functions in accordance with the Constitution.

4.2.2. Not less than 8 (eight) Governors may by notice in writing to the Secretary requisition an extraordinary meeting of the Council of Governors and on receipt of such notice the Secretary shall cause such a meeting to be called within 5 (five) working days of receipt of the notice.

4.2.3. The Council of Governors may invite the Chief Executive, member of the Board of Directors or a representative of the financial auditor or other advisors to attend a meeting of the Council of Governors.

4.2.4. The Council of Governors may agree that its Governors can participate in its meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to be exceptional but shall constitute presence in person at the meeting for the purposes of SO 4.16 (Quorum).

4.3. Notice of Meetings

4.3.1. Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be

transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf, shall be delivered to, or sent by post to the usual place of residence of every Governor, so as to be available to them at least four (4) Clear Days before the meeting save in the case of emergencies.

4.3.2. Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and if possible the public part of the agenda, shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least four (4) Clear Days before the meeting, save in the case of emergencies.

4.3.3. Want of service of the notice on any one Governor shall not affect the validity of a meeting but failure to serve such a notice on more than five Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of posting or in the case of a notice being sent electronically, on the date of transmission.

4.3.4. In the case of a meeting called by Governors in default of the Secretary, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the requisition.

4.4. Setting the Agenda

4.4.1. The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2. A Governor of the Council of Governors desiring a matter to be included on an agenda, including a formal proposition for discussion and voting on at a meeting, shall make their request in writing to the Chairman at least 10 (ten) Clear Days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 (ten) Clear Days before a meeting may be included on the agenda at the discretion of the Chairman.

4.5. Petitions

4.5.1. Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting of the Council of Governors.

4.6. Written Motions

4.6.1. In urgent situations and with the consent of the Chairman, business may be effected by a Governor's written motion to deal with business otherwise required to be conducted at a meeting of the Council of Governors.

4.6.2. If all Governors of the Council of Governors have been notified of the proposal and a simple majority of Governors entitled to attend and vote at a meeting of the Council of Governors confirms acceptance of the written motion either in writing or electronically to the Secretary within 5 (five) Clear Days of dispatch then the motion will be deemed to have been resolved, notwithstanding that the Governors have not gathered in one place.

4.6.3. The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date, a Governor who has previously indicated acceptance can withdraw, and the motion shall fail.

4.6.4. Once the resolution has been passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

4.6.5. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months shall bear the signature of the Governor or Director who gives it and also the signature of four (4) other Governors or Directors. When any such motion has been disposed of by the Council or the Board, it shall not be competent for any Governor or Director other than the Chairman to propose a motion to the same effect within six (6) months, however the Chairman may do so if he considers it appropriate.

4.6.6. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.6.7. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor or Director (as relevant) to move:

4.6.7.1. An amendment to the motion.

4.6.7.2. The adjournment of the discussion or the meeting.

4.6.7.3. That the meeting proceed to the next business (*).

4.6.7.4. The appointment of an ad hoc committee to deal with a specific item of business.

4.6.7.5. That the motion be now put to a vote (*).

4.6.7.6. That the public be excluded from the meeting in relation to the discussion concerning the proposition under SO 4.1.1.

4.6.8. In the case of SOs denoted by (*) above, to ensure objectivity motions may only be put by a Governor or a Director who has not previously taken part in the debate.

4.6.9. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

4.6.10. No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

4.7. Chairman of Meeting

4.7.1. At any meeting of the Council of Governors, the Chairman, if present, shall preside.

4.7.2. If the Chairman is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, the Deputy Chairman shall preside.

4.7.3. If the Deputy Chairman is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director shall preside.

4.7.4. Where it has been determined by the Chair that it is inappropriate for the Chairman or any non-executive director to chair the meeting, the Lead or Deputy Lead Governor shall preside.

4.8. Agenda

4.8.1. Where a Governor has requested inclusion of a matter on the agenda in accordance with SO 4.4.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this SO 4.8 shall apply in respect of the proposition.

4.8.2. The Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted ("Standing Items").

4.8.3. Agendas will be sent to Governors before the meeting and supporting papers, whenever possible, shall accompany the

agenda, but will certainly be despatched no later than 3 (three) Clear Days before the meeting, save in the case of emergencies. It is the responsibility of the Chairman to ensure that sufficient information is provided to Governors to ensure that rational discussion can take place.

4.8.4. In the event of an emergency giving rise to the need for an immediate meeting failure to comply with the notice periods referred to in SO 4.3 shall not prevent the calling of or invalidate such meeting provided that every effort is made to contact Governors of the Council of Governors who are not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

4.8.5. No business may be transacted at any meeting of the Council which is not specified in the notice of that meeting unless the Chairman, in his absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by the Council as a matter of urgency. A decision by the Chairman to permit consideration of the item in question and (where relevant) the supporting papers shall be recorded in the minutes of that meeting.

4.9. Report from the Board of Directors

4.9.1. Unless otherwise agreed in writing, at each meeting of the Council of Governors, the Board of Directors is required to report to the Council of Governors on the Trust's general progress and forward planning unless it is agreed in writing they will not do so.

4.10. Chairman's Ruling

4.10.1. Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.11. Voting

4.11.1. A Governor may not vote at a meeting of the Council of Governors unless, within the 12 months prior to the commencement of the meeting they have:

4.11.2. made a declaration that they are a member of the constituency which elected them; or

4.11.3. if the Governor is an Appointed Governor, they are not prevented from being a governor of the Council

of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution.

4.11.4. Such declaration will be in the form as set out in paragraph 18 of the Constitution.

4.11.5. Subject to SO 4.11.7 below, every question at a meeting shall be determined by a majority of the votes of the Chairman of the meeting and the Governors present and voting on the question.

4.11.6. Whoever is Chairman of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal have a second or casting vote.

4.11.7. A resolution for the removal of the Chairman or a Non-Executive Director shall be passed only if three quarters of the total number of Governors vote in favour of it.

4.11.8. If at least one-third of the Governors present so request, the voting (other than by paper ballot or e-mail vote) on any question may be recorded to show how each Governor present voted or abstained.

4.11.9. If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot or e-mail vote).

4.11.10. Subject to SO 4.17, a Governor may only vote if present at the time of the vote on which the question is to be decided; no Governor may vote by proxy but a Governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote. For the avoidance of doubt, SO 4.11.11 does not apply if an e-mail vote is required under SO 4.17.

4.11.11. In certain circumstances, the Chairman may specify in a notice of a meeting any matter which requires approval by a written resolution and such a matter may be approved in writing provided that at least three quarters of the Governors, and a majority of the elected Governors, approve the resolution in writing within the timescale imposed in such a notice.

4.12. Minutes

4.12.1. The minutes of the proceedings of a meeting shall be drawn up by the Secretary or a Nominated Officer and submitted for agreement at the next ensuing meeting of the

Council of Governors where they will be signed by the Chairman presiding at it.

4.12.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.12.3. Minutes of meetings shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of SO 4.1.1 above.

4.13. Suspension of Standing Orders

4.13.1. Except where this would contravene any statutory provision or any guidance or best practice advice issued by NHS England/Improvement (Monitor), any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Governors are present, there is a majority of Governors who are members of the Public Constituency of the Trust, and that a majority of those present vote in favour of suspension.

4.13.1.1. A decision to suspend the SOs shall be recorded in the minutes of the meeting.

4.13.1.2. A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Chairman and Governors.

4.13.1.3. No formal business may be transacted while the SOs are suspended.

4.13.1.4. The Audit Committee shall review every decision to suspend SOs.

4.14. Variation and Amendment of Standing Orders

4.14.1. Subject always to paragraph 54 of the Constitution, these SOs shall be amended only if:

4.14.1.1. a notice of proposal under SO 4.4.2 has been given; and

4.14.1.2. no fewer than half the total number of Governors vote in favour of amendment; and

4.14.1.3. no fewer than half of the total number of Governors is present; and

4.14.1.4. the variation proposed has been approved by the Council of Governors and does not contravene a statutory provision or guidance issued by NHS England/Improvement (Monitor) or the Constitution.

4.15. Record of Attendance

4.15.1. The names of the Chairman and Governors present at the meeting shall be recorded in the minutes.

4.16. Quorum

4.16.1. No business shall be transacted at a meeting unless at least half of the Governors are present, and of these not less than half shall be Governors elected from the Public or appointed by non Health Service Bodies.

4.16.2. If at any meeting there is no quorum present within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for a minimum period of 5 (five) Clear Days and upon reconvening, those present shall constitute a quorum.

4.16.3. If a Governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest as provided in SO 6, they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.16.4. At all times all questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined in the first instance by oral expression or by a show of hands, unless the Chairman uses their discretion under SO 4.17 to hold an e-mail vote. At all times, no Governor may vote by proxy.

4.16.5. Chairman's discretion to hold an e-mail vote may be exercised at any time, and for any reason in consultation with the Lead Governor.

4.16.6. If the Chairman exercises their discretion to hold an e-mail vote, then the Governors must vote by e-mail by sending their e-mail vote back to the Returning Officer by the Deadline Date (as prescribed under SO 4.17 and as agreed

with the Lead Governor). For the avoidance of doubt, if the Chairman exercises their discretion to hold an e-mail vote, this e-mail vote will form the only method of voting.

4.16.7. Individual Governor may only cast one vote on the issue(s) to be voted on unless a second further vote is required owing to any previous vote not being passed in accordance with SO 4.11.5. Once an e-mail vote has been cast by a Governor in accordance with SO 4.17, the vote cannot be revoked or altered in any way.

4.17. Protocol for Voting by e-mail

4.17.1. The Returning Officer is to e-mail a notice of the e-mail vote stating:

4.17.1.1. The details of the issue(s) to be voted upon.

4.17.1.2. The date and time at which the e-mail votes are required to be sent out to the Governors.

4.17.1.3. The e-mail address for return of e-mail votes including the date and time by which they must be received by the Returning Officer ("Deadline Date") and

4.17.1.4. The contact details of the Returning Officer.

4.17.2. As soon as is reasonably practicable on or after the e-mail of the notice of the e-mail vote, the Returning Officer is to e-mail to the valid e-mail address of every Governor, the following information:

4.17.2.1. A ballot paper attachment in accessible electronic format with clear instructions as to how to cast their vote by e-mail.

4.17.2.2. A Declaration of Eligibility form (if required). This form may be combined with the ballot paper.

4.17.2.3. Information about the issue(s) to be voted upon.

4.17.2.4. A covering e-mail providing:

4.17.2.4.1. The e-mail address for return of the ballot paper.

4.17.2.4.2. Clear instructions instructing the voter as to how to return their e-mail vote to the Returning Officer by the

Deadline Date ("e-mail voting information").

5. COMMITTEES

5.1. Subject to any guidance as may be issued by NHS England/Improvement (Monitor), the Council of Governors may and, if directed by NHS England/Improvement (Monitor), shall appoint committees of the Council of Governors consisting wholly or partly of its members to assist it in the proper performance of its functions under the Regulatory Framework.

5.2. The Council may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors and other persons to assist the Council in carrying out its functions. The Council may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

5.3. All decisions taken in good faith at the meeting of the Council of Governors or at any meeting of a committee shall be valid even if it is subsequently discovered that there was a defect in the calling of the meeting or the appointment of the Governors attending the meeting.

5.4. A committee appointed under SO 5 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.5. These SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms "Chairman" to be read as a reference to the Chairman of the committee, and the term "Governor" to be read as a reference to a member of the committee as the context permits.

5.6. Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the Regulatory Framework and any guidance or best practice advice issued by NHS England/Improvement (Monitor), but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.

5.7. Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.8. Any committee or sub-committee established under this SO 5 may call upon outside advisers to assist them with their tasks, subject to the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the Dispute Resolution Procedure as set out in paragraph 53 of the Constitution.

5.9. The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.10. Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with guidance issued by NHS England/Improvement (Monitor).

5.11. Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors or NHS England/Improvement (Monitor).

5.12. The Council of Governors may appoint Governors to serve on joint committees with the Board of Directors or committees of the Board of Directors.

5.13. In making any recommendations, a committee of the Council must have due regard to the established policies of the Council and shall not depart from them without due reason and consideration. Any such departure and the reason for it shall be drawn to the attention of the Council at the earliest opportunity. The Council requires its committee to refer back to them for a decision.

5.14. In consideration of any recommendation, a committee of the Council must comply with:

5.14.1. The Trust's Standing Financial Instructions, SOs and written procedures and specific reference to the relevant sections of these documents should be made.

5.14.2. Any statutory provisions or requirements.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1. Declaration of Interests

6.1.1. The Regulatory Framework requires each Governor to declare to the Secretary:

6.1.1.1. any actual or potential interest, direct or indirect, which is relevant and material to the business of the Trust, as described in SO 6.2.1; and

6.1.1.2. any actual or potential pecuniary interest, direct or indirect, in any matter concerning the Trust, as described in SOs 6.2.3 and 6.2.4; and

6.1.1.3. any actual or potential family interest, direct or indirect, of which the Governor is aware, as described in SO 6.2.6.

6.1.2. Such a declaration shall be made either at the time of the Governor's election or appointment or as soon thereafter as the interest arises, and in a form prescribed by the Secretary which shall be included as Schedule A to these SOs.

6.1.3. In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

6.1.4. If a Governor has a pecuniary interest, whether direct or indirect, or any material non-financial interest in any contract, proposed contract or other matter which is under consideration by the Council of Governors, they shall disclose that to the rest of the Council of Governors as soon as they are aware of it.

6.1.5. At the time the interests are declared, they should be recorded in the Council of Governors meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

6.1.6. Subject to SO 6.2.5, if a Governor has declared a pecuniary interest (as described in SO 6.2.3 and 6.2.4 they shall not take part in the consideration or discussion of the matter.

6.1.7. This SO 6 applies to any committee, sub-committee or joint committee of the Council of Governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not they are also a Governor).

6.1.8. The interests of Governors in companies likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

6.2. Nature of Interests

6.2.1. Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by NHS England/Improvement (Monitor):

6.2.1.1. directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies); or

6.2.1.2. ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS; or

6.2.1.3. majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS; or

6.2.1.4. a position of authority in a charity or voluntary organisation in the field of health and social care; or

6.2.1.5. any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services; or

6.2.1.6. any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

6.2.2. For the avoidance of doubt, the following shall not be considered relevant and material for the purposes of these SOs:

6.2.2.1. Shares not exceeding 2% of the total share in issue held in any company whose shares are listed on any public exchange.

6.2.2.2. An employment contract held by Staff Governors.

6.2.2.3. An employment contract with the relevant local authority held by a Local Authority Governor.

6.2.2.4. An employment contract with a Partnership Organisation held by a Partnership Governor.

6.2.3. A Governor shall be treated as having indirectly a pecuniary interest in a matter, if:

6.2.3.1. They, or a nominee of them, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

6.2.3.2. They are a partner of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

6.2.4. A Governor shall not be treated as having a pecuniary interest in any matter by reason only:

6.2.4.1. of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

6.2.4.2. of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

6.2.4.3. of any travelling or other expenses or allowances payable to a Governor in accordance with the Constitution.

6.2.5. Where a Governor:

6.2.5.1. has an indirect pecuniary interest in a matter by reason only of a beneficial interest in securities of a company or other body, and

6.2.5.2. the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

6.2.5.3. if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not

exceed one-hundredth of the total issued share capital of that class,

the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

6.2.6. A family interest is an interest of an Immediate Family Member of a Governor which if it were the interest of that Governor would be a personal interest or a pecuniary interest of them.

6.2.7. If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.3. Register of Governors

6.3.1. The register of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted which may be the Secretary.

6.4. Register of Governors' Interests

6.4.1. The Secretary shall keep a register of interests of Governors which shall contain the names of each Governor, whether he has declared any interest, and if so, the interest declared.

7. STANDARDS OF BUSINESS CONDUCT

7.1. Governors of the Council of Governors shall comply with the NHS Foundation Trust Code of Governance, the Council of Governors' Code of Conduct and any guidance or best practice advice issued by NHS England/Improvement (Monitor).

8. APPOINTMENTS AND RECOMMENDATIONS

8.1. A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment but this SO shall not preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.2. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

8.3. Candidates for any staff appointment under the Trust shall, when making such an application, disclose in writing to the Trust whether they are related to any Governor or the holder of any office within the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4. The Chairman and every Governor shall disclose to the Chief Executive or their delegated officer any relationship between themselves and a candidate of whose candidature that Governor or Officer is aware. It shall be the duty of the Chief Executive or their delegated Officer to report to the Council of Governors any such disclosure made.

8.5. On appointment, Governors of the Council of Governors should disclose to the Council of Governors whether they are related to any other Governor of the Council of Governors or holder of any office in the Trust.

8.6. Where the relationship to a Governor of the Council of Governors of the Trust is disclosed, SO 6 shall apply.

9. MISCELLANEOUS

9.1. The Secretary shall provide a copy of these SOs to each Governor and endeavour to ensure that each Governor understands their responsibilities within these SOs.

9.2. These SOs including all documents having effect as if incorporated in them shall be reviewed annually by the Board of Directors and the Council of Governors.

9.3. If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All Governors have a duty to disclose any non-compliance with these SOs to the Chairman as soon as possible.

Schedule A

Prescribed Form of Declaration of Interests

Declaration to the Secretary of Somerset NHS Foundation Trust

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Date [insert]

To the Secretary of Somerset NHS Foundation Trust Dear

[insert]

In fulfilment of the obligations imposed on me by paragraph 16 of the Constitution of the Somerset NHS Foundation Trust and the provisions of Standing Order 6 of the Standing Orders for the Council of Governors generally, I hereby give notice to the Trust of my interest in **[**insert details of the nature and extent of the relevant interest(s) (e.g. pecuniary, non pecuniary, direct, indirect, actual, potential, etc.)**]** as of the date posted above.

I require the nature and extent of my interest(s) to be recorded in the Trust's register of interests of the Governors of the Council of Governors.

Yours faithfully [name]

ANNEX 2 - BOARD OF DIRECTORS STANDING ORDERS
(Ref. Paragraph 32)

CONTENTS:

1. INTERPRETATION

2. THE TRUST BOARD

3. MEETINGS OF THE TRUST

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5. COMMITTEES

6. INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

7. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

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9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

10. SIGNATURE OF DOCUMENTS

11. MISCELLANEOUS

1 INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of SOs (on which they should be advised by the Chief Executive and Secretary).

1.2 Any expression to which a meaning is given in the 2006 Act or any regulations or orders made under the 2006 Act shall have the same meaning in these SOs and, in addition, defined terms used in these SOs have the same meaning as in the Constitution unless the context requires otherwise, or a contrary intention is evident.

1.3 Words importing the singular shall include the plural and vice-versa.

1.4 In these SOs:

"Accounting Officer"
means the Officer responsible for discharging the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For this Trust is shall be the Chief Executive.

"Board of Directors"
means the Board of Directors as constituted in accordance with the Constitution.

"Budget"
means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Chairman"
means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression "the Chairman" shall be deemed to include the Deputy Chairman or any other non-executive appointed in accordance with paragraph 26 of the Constitution if the Chairman is absent from the meeting or is otherwise unavailable.

"Chief Executive"
means the Chief Executive officer of the Trust.

"Clear Days"
means a day of the week not including a Saturday, Sunday or Public Holiday.

"Concode"
means a code of procedure for building and engineering contracts for the NHS.

“Constitution”
means the Constitution of the Trust, together with the Annexes and Appendices attached hereto as approved by NHS England/Improvement (Monitor).

“Council of Governors”
means the Council of Governors as constituted in this Constitution, which has the same meaning as the “Council of Governors” in the 2006 Act.

“Director”
means a member of the Board of Directors appointed in accordance with the Constitution and includes both executive and non-executive Directors and the phrase “member of the Board” shall be construed accordingly.

“Finance Director”
means the Director of Finance of the Trust.

"Funds held on Trust"
means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Section 14 of Part 2, Schedule 4 to the 2006 Act. Such funds may or may not be charitable.

“Member”
means a member of the Trust.

"Motion”
means a formal proposition to be discussed and voted on during the course of a meeting.

“NHS England/Improvement”
means the body corporate known as NHS England/Improvement (Monitor), the successor body of Monitor, as provided by Section 61 of the 2012 Act.

"Nominated Officer"
means an Officer charged with the responsibility for discharging specific tasks within the SOs and the SFIs.

“Officer”
means an employee or any other person holding a paid appointment or office with the Trust.

“Scheme of Delegation”
means the Reservation of Powers to the Board of Directors and Delegation of Powers.

"Secretary to the Trust"
means a person appointed by the Trust to act independently of the Board of Directors to provide advice on corporate governance issues to the Board of Directors and the Chairman and to monitor the Trust's compliance with the Regulatory Framework, the Standing Orders, and regulatory guidance.

"SFIs"
means Standing Financial Instructions.

"SOs"
means these Standing Orders.

"the 2006 Act"
means the National Health Service Act 2006.

"Trust"
means the Somerset NHS Foundation Trust.

"Trust Headquarters"
means Musgrove Park Hospital, Taunton, Somerset, TA1 5DA

"Vice Chairman"
means a non-executive Director appointed by the Council of Governors to undertake the Chairman's duties in the event that the Chairman is absent for any reason.

2 THE TRUST BOARD

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee.

2.3 In relation to Funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as the Trust.

2.4 The Trust has the functions conferred on it by its Provider Licence issued by NHS Improvement (Monitor). Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees. Accountability for charitable Funds held on Trust is to the Charity Commission. Accountability for non-charitable Funds held on Trust is only to NHS England/Improvement (Monitor).

2.5 The powers of the Trust established under statute shall be exercised by the Board of Directors meeting in public/ private session except as otherwise provided for in SO 4.

2.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Delegation and have effect as if incorporated into the SOs.

2.7 Composition of the Board of Directors

2.7.1 In accordance with the Constitution, the Board of Directors is to comprise:

2.7.1.1 The following Non-Executive Directors:

2.7.1.1.1 the Chairman, and up to a maximum of 9 (nine) other Non-Executive Directors.

2.7.1.2 the following Executive Directors:

2.7.1.2.1 the Chief Executive who shall be the Accounting Officer, the Finance Director, and up to a maximum of 6 (six) other Directors as set out in paragraph 31 of the Constitution.

2.7.2 At meetings of the Board of Directors, in the event that the number of Non-Executive Directors (including the Chairman) is equal to the number of Executive Directors, the Chairman (and in their absence, the Deputy Chairman) shall have a second or casting vote.

2.7.3 A person may only be appointed as a Non-Executive Director if:

2.7.3.1 They are a member of the Public Constituency, and

2.7.3.2 They are not eligible by virtue of paragraph 34 of the Constitution or disqualified by virtue of paragraph 35.

2.7.4 The validity of any act of the Board of Directors is not affected by any vacancy among the Directors or any defect in the appointment of a Director.

2.7.5 The Chairman (in consultation with the Council of Governors) will appoint a Non-Executive Director as the "senior independent director", for such period not exceeding the remainder of their term as a Non-Executive Director as they may specify on appointing them.

2.7.6 Any Non-Executive Director so appointed may at any time resign from the office of "senior independent director" by

giving notice in writing to the Chairman. The Chairman (in consultation with the Council of Governors) will thereupon appoint another Non-Executive Director as "senior independent director" in accordance with the provisions in SO 2.7.5.

2.7.7 The "senior independent director" shall perform the role set out in the Code of Governance.

2.8 Register of Directors

2.8.1 In accordance with paragraphs 41 and 42 of the Constitution, the Trust shall keep and maintain a register of Directors which shall list the names of the Directors, their capacity on the Board of Directors and an address through which they may be contacted which may be the Secretary.

2.9 Appointment and Removal of the Chairman and other Non-Executive Directors

2.9.1 The Chairman and other Non-Executive Directors are to be appointed by the Council of Governors following a formal, rigorous and transparent procedure. The current Chairman or a Non-Executive Director may stand for reappointment. Six months before the end of the term of office of the Chairman or a Non-Executive Director (as the case may be), the Council of Governors will adopt a procedure as set out in Annex 3 for appointing the Chairman and the Non-Executive Directors.

2.9.2 The provisions of paragraph 32 of the Constitution apply to the removal of the Chairman or other Non-Executive Directors.

2.10 Remuneration and Terms of Office of the Chairman and Non-Executive Directors

2.10.1 The Chairman and the Non-Executive Directors are to be appointed for a period of office determined by the Council of Governors at a general meeting of the Council of Governors.

2.10.2 At the general meeting of the Council of Governors referred to at SO 2.10.1 the Council of Governors shall decide the:

2.10.2.1 period of office;

2.10.2.2 remuneration and allowances; and

2.10.2.3 other terms and conditions of office, including the job description, of the Chairman and other Non-Executive Directors.

2.11 Appointment and Powers of Deputy Chairman

2.11.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairman and in accordance with paragraph 36 of the Constitution, the Council of Governors shall appoint a Non-Executive Director to be Deputy Chairman for such period, not exceeding the remainder of their term as Non-Executive Director, as the Council of Governors may specify on appointing them.

2.11.2 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Council of Governors. The Council of Governors may thereupon appoint another Non-Executive Director as Deputy Chairman in accordance with the provisions of SO 2.11.1.

2.11.3 Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Deputy Chairman will be "acting chairman" until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these SOs shall, so long as there is no Chairman able to perform their duties, be taken to include references to the Deputy Chairman. Where both the Chairman and Deputy Chairman are unable to perform their duties owing to illness, conflict of interest or any other cause, another Non-Executive Director as may be appointed by the Council of Governors shall act as Chairman.

2.12 Remuneration and Terms of Office of the Chief Executive and Executive Directors

2.12.1 The Trust shall establish a committee of Non-Executive Directors in accordance with SO 33 to decide the:

2.12.1.1 remuneration and allowances; and

2.12.1.2 the other terms and conditions of office of the Chief Executive and other Executive Directors.

2.13 Disqualification

2.13.1 Directors are subject to the disqualification criteria included at paragraphs 34 and 35 of the Constitution.

3 MEETINGS OF THE TRUST

3.1 Admission of the Public and the Press

3.1.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons, to be determined by the Board of Directors.

3.1.2 Before holding a public meeting, the Board of Directors will send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding the meeting, the Board of Directors will send a copy of the minutes of the meeting to the Council of Governors. Want of service of the agenda and minutes of the Board meeting on any Governor shall not affect the validity of a meeting.

3.1.3 The public and representatives of the press shall be afforded facilities to attend public meetings of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

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

3.1.4 The Chairman shall give such directions as they thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board of Directors resolving as follows:

"that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public.

3.1.5 Nothing in these SOs shall require the Board of Directors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board of Directors.

3.1.6 Matters to be dealt with by the Board following the exclusion of the public and representatives of the press under SO 3.1.4

above shall be confidential to the Directors. Members of the Board and others in attendance at the request of the person chairing the meeting shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chairman.

3.1.7 The Chairman (or Deputy Chairman) will decide what arrangements and terms and conditions they feel are appropriate to offer in extending an invitation to observers, advisors and others to attend and address any meeting of the Board, and may change, alter or vary these terms and conditions as they deem fit.

3.2 Calling Meetings

3.2.1 Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

3.2.2 The Chairman may call a meeting of the Board of Directors at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Board of the Directors, and this has been presented to them, or if, without so refusing, the Chairman does not call a meeting within 7 (seven) days after such requisition has been presented to them, such one third or more members of the Board of Directors may forthwith call a meeting.

3.3 Notice of Meetings

3.3.1 Before each meeting of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman, or by an Officer of the Trust authorised by the Chairman to sign on their behalf, shall be delivered to every Director, or sent by post and where possible by email to the usual place of residence of every Director, so as to be available to them at least 4 (four) Clear Days before the meeting.

3.3.2 Want of service of the notice on any member of the Board of Directors shall not affect the validity of a meeting.

3.3.3 In the case of a meeting called by the Directors in default of the Chairman, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.3.4 Failure to serve such a notice on more than 3 (three) Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.3.5 In the event of an emergency giving rise to the need for an immediate meeting, SOs 3.3.1 to 3.3.4 shall not prevent the calling of such a meeting without the requisite 4 (four) Clear Days' notice provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

3.4 Agendas

3.4.1 Agendas will be dispatched by post and by email to members of the Board of Directors 4 (four) Clear Days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than 3 (three) Clear Days before the meeting, save in emergency. Failure to serve such a notice on more than three members of the Board of Directors will invalidate the meeting. A notice shall be presumed to have been served one day after dispatch.

3.4.2 Before each meeting of the Board of Directors (where SO 3.1.2 applies), a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's Headquarters at least 3 (three) Clear Days before the meeting.

3.4.3 No business may be transacted at any meeting of the Board of Directors which is not specified in the notice of that meeting unless the Chairman, in his absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by the Board as a matter of urgency. A decision by the Chairman to permit consideration of the item in question and (where relevant) the supporting papers shall be recorded in the minutes of that meeting.

3.5 Setting the Agenda

3.5.1 The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

3.5.2 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chairman at least 10 (ten) Clear Days before the meeting, subject to SO 3.3. Requests

made less than 10 (ten) Clear Days before a meeting may be included on the agenda at the discretion of the Chairman. Agendas will be sent to Directors before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than 3 (three) Clear Days before the meeting, save in the case of emergencies. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next meeting of the Board of Directors.

3.7 Chairman of Meeting

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

3.7.2 If the Chairman is absent temporarily on the grounds of a declared conflict of interest, the Deputy-Chairman, if present, shall preside. If the Chairman and Deputy-Chairman are absent, or are disqualified from participating, such Non-Executive Director as the members of the Board of Directors present shall choose shall preside.

3.8 Chairman's Ruling

3.8.1 Statements of Directors made at meetings of the Trust shall be relevant to the matter under discussion at the material time, and subject to SO 1.1 the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.9 Notices of Motion

3.9.1 Subject to the provisions of SO 3.11 ('Motions: procedure at and during a meeting') and SO 3.12 ('Motion to rescind a resolution'), a member of the Board of Directors wishing to move or amend a motion shall send a written notice to the Chairman.

3.9.2 The notice shall be delivered at least 10 (ten) Clear Days before the meeting. The Chairman shall include in the agenda

for the meeting all notices so received that are in order and permissible under these SOs. Subject to SO 3.3.3, this SO shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meeting.

3.10 Emergency Motions and Written Motions

3.10.1 Emergency Motions

3.10.1.1 Subject to the agreement of the Chairman, and subject also to the provision of SO 3.11 ('Motions: procedure at and during a meeting'), a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.10.2 Written Motions

3.10.2.1 In urgent situations and with the consent of the Chairman, business may be effected by a Director's written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.

3.10.2.2 If all members of the Board of Directors have been notified of the proposal and a simple majority of Directors entitled to attend and vote at a meeting of the Board of Directors confirms acceptance of the written motion either in writing or electronically to the Secretary within 5 (five) Clear Days of dispatch then the motion will be deemed to have been resolved notwithstanding that the Directors have not gathered in one place.

3.10.2.3 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date a Director who has previously indicated acceptance can withdraw and the motion shall fail.

3.10.2.4 Once the resolution is passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

3.11 Motions: Procedure at and during a meeting

3.11.1 Who may propose

3.11.1.1 A motion may be proposed by the Chairman of the meeting or any member of the Board of Directors present. It must also be seconded by another member of the Board of Directors.

3.11.2 Contents of motions

3.11.2.1 The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

3.11.2.1.1 the reception of a report;

3.11.2.1.2 consideration of any item of business before the Board of Directors;

3.11.2.1.3 the accuracy of minutes;

3.11.2.1.4 that the Board of Directors proceed to next business;

3.11.2.1.5 that the Board of Directors adjourn;

3.11.2.1.6 that the question be now put.

3.11.3 Amendments to motions

3.11.3.1 A motion for amendment shall not be discussed unless it has been proposed and seconded.

3.11.3.2 Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board of Directors.

3.11.3.3 If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.11.3.4 No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

3.11.4 Rights of reply to motions

3.11.4.1 Amendments

3.11.4.1.1. The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment but may not otherwise speak on it.

3.11.4.2 Substantive/original motion

3.11.4.2.1. The Director who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.11.5 Withdrawing a motion

3.11.5.1 A motion or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

3.11.6 Motions once under debate

3.11.6.1 When a motion is under debate, no motion may be moved other than:

3.11.6.1.1. an amendment to the motion;

3.11.6.1.2. the adjournment of the discussion, or the meeting;

3.11.6.1.3. that the meeting proceed to the next business;

3.11.6.1.4. that the question should be now put;

3.11.6.1.5. the appointment of an 'ad hoc' committee to deal with a specific item of business;

3.11.6.1.6. a motion under SO 3.1.3 resolving to exclude the public (including the press); and

3.11.6.1.7. that a member be not further heard.

3.11.6.2 In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board of Directors who has not taken part in the debate and who is eligible to vote.

3.11.6.3 If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.11.6.4 The mover of a motion shall have a maximum of 5 (five) minutes to move and 5 (five) minutes to reply. Once a motion has been moved, no member of the Board of Directors shall speak more than once or for more than 5 (five) minutes.

3.12 Motion to Rescind a Resolution

3.12.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 (six) calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of 4 (four) other members of the Board of Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate committee or the Chief Executive for recommendation.

3.12.2 When any such motion has been dealt with by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chairman to propose a motion to the same effect within 6 (six) months however the Chairman may do so if he considers it appropriate. This SO shall not apply to motions moved in pursuance of a report or recommendations of a committee or the Chief Executive.

3.13 Voting

3.13.1 Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the chairman of the meeting shall have a second or casting vote. For any avoidance of doubt, for voting, there must not be more Executive Directors voting than Non-Executive Directors.

3.13.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.13.3 If at least one-third of the members of the Board of Directors present so request, the voting (other than by paper ballot), on any question may be recorded to show how each Director present voted or abstained.

3.13.4 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

3.13.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.13.6 An Officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.14 Minutes

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

3.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting. Minutes shall be retained in the Chief Executive's office.

3.14.3 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public.

3.15 Suspension of Standing Orders

3.15.1 Except where this would contravene any statutory provision or any guidance or best practice advice issued by NHS England/Improvement (Monitor), any one or more of the SOs may be suspended at any meeting, provided that at least two-thirds of the Directors are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

3.15.2 A decision to suspend the SOs shall be recorded in the minutes of the meeting.

3.15.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

3.15.4 No formal business may be transacted while the SOs are suspended.

3.15.5 The Audit Committee shall review every decision to suspend the SOs.

3.16 Variation and Amendment of Standing Orders

3.16.1 Subject always to paragraph 38 of the Constitution, these SOs shall be amended only if:

3.16.1.1 relevant notice of a meeting has been served in accordance with SO 3.3;

3.16.1.2 a notice of motion under SO 3.9 has been given;

3.16.1.3 no fewer than half the total of the Non-Executive Directors vote in favour of amendment;

3.16.1.4 at least two-thirds of the Directors are present; and

3.16.1.5 the variation proposed does not contravene the Regulatory Framework, any statutory provisions or any guidance issued by Monitor.

3.17 Record of Attendance

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

3.18 Quorum

3.18.1 No business shall be transacted, where a vote is required, at a meeting of the Board of Directors unless at least two Executive Directors, two Non-Executive Directors and the Chairman, or nominated Deputy Chairman for the purpose of this meeting, are present and to be properly constituted the number of Non-Executive Directors (including the Chairman) voting must exceed the number of Executive Directors. This paragraph should be read in conjunction with paragraph 3.13.1.

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

3.18.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 7)7 they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Nomination and Remuneration Committee).

3.19 Joint Directors

3.19.1 Where a post of Executive Director is shared by more than one person:

3.19.1.1 both persons shall be entitled to attend meetings of the Board;

3.19.1.2 either of those persons shall be eligible to vote in the case of an agreement between them;

3.19.1.3 in the case of disagreements between them no vote shall be cast; and

3.19.1.4 the presence of either or both of those person shall count as one person for the purposes of SO 3.13.

3.20 Meetings: Electronic Communication

3.20.1 In this SO, “communication” and “electronic communication” shall have the meanings set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

3.20.2 A Director in electronic communication with the Chairman and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.20.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chairman of the meeting is physically present.

3.20.4 Meetings held in accordance with this SO are subject to SO 3.18 (Quorum). For such a meeting to be valid, a quorum MUST be present and maintained throughout the meeting.

3.20.5 The minutes of a meeting held in this way MUST state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to SO 2.6 and such guidance as may be issued by NHS England/Improvement (Monitor), the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee appointed by virtue of SO 4.3 below or by a Director or an Officer in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

4.2 Emergency Powers

4.2.1 The powers which the Board of Directors has retained to itself within these SOs may in emergency be exercised by the Chief

Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board of Directors for ratification.

4.3 Delegation to committees

4.3.1 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or subcommittees, or joint committees, which it has formally constituted. The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

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

4.4 Delegation to Officers

4.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or subcommittee or joint-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Officers to undertake the remaining functions for which they will still retain accountability to the Board of Directors.

4.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

4.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Finance Director or other Executive Director to provide information and advise the Board of Directors in accordance with any statutory requirements. Outside these statutory requirements the Finance Director shall be accountable to the Chief Executive for operational matters.

4.4.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these SOs.

4.5 Delegation of Powers – Scheme of Delegation

4.5.1 Under the SOs relating to the Arrangements for the Exercise of Functions by Delegation (SO 4) the Board of Directors exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5.1.1 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit. Delegated Powers are covered in a separate document (the Scheme of Delegation). That document has effect as if incorporated into the SOs.

4.6 Duty to Report Non-Compliance with Standing Orders

4.6.1 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors and all Officers have a duty to disclose any non-compliance with these SOs to the Secretary as soon as possible.

5 COMMITTEES

5.1 Appointment of Committees

5.1.1 Subject to SO 2.6, the Regulatory Framework and such guidance issued by NHS England/Improvement (Monitor), the Board of Directors may and, if directed by NHS England/Improvement (Monitor), shall appoint committees of the Trust consisting wholly or partly of Directors or other Health Service Bodies or wholly of persons who are not Directors of the Trust or other Health Service Bodies.

5.1.2 A committee appointed under SO 5.1.1 may, subject to the Regulatory Framework and such guidance and/or best practice advice as may be issued by NHS England/Improvement (Monitor) or the Board of Directors or other Health Service Bodies in question, appoint sub-committees or sub-groups consisting wholly or partly of Directors or wholly of persons who are not Directors of the Trust, the committee of the Trust or the other Health Service Bodies in question.

5.1.3 The SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-groups established by the Board of Directors, in which case

the term “Chairman” is to be read as a reference to the Chairman of the committee as the context permits, and the term “member" is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Trust in public.)

5.1.4 Each such committee, sub-committee or sub-group shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide in accordance with any legislation, and/or regulations and/or such guidance or best practice advice issued by Monitor. Such terms of reference shall have effect as if incorporated into the SOs.

5.1.5 Where committees are authorised to establish sub-committees or sub-groups they may not delegate executive powers to the sub-committee/group unless expressly authorised by the Board of Directors.

5.1.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the Regulatory Framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.1.7 Where the Board of Directors is required to appoint persons to a committee and/or undertake statutory functions as required by the Secretary of State and/or NHS England/Improvement (Monitor), and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations and guidance made by NHS England/Improvement (Monitor).

5.1.8 Where the Board determines, and legislation, regulations and directions or guidance issued by NHSI permit that persons who are not Directors of the Trust shall be appointed to a committee of the Board, the terms of such appointment shall be determined by the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses.

5.1.9 The committees established by the Board of Directors are:

5.1.9.1 Audit Committee;

5.1.9.2 Nomination and Remuneration Committee;

5.1.9.3 Charity Committee;

5.1.9.4 Finance Committee;

5.1.9.5 Quality and Governance Assurance Committee;

5.1.9.6 People Committee; ~~and~~

5.1.9.7 Mental Health ~~Act~~ Legislation Committee;

5.1.9.8 Executive Committee; and

~~5.1.9.7~~5.1.9.9 Research and Innovation Committee.

5.1.10 The terms of reference of those committees and sub-groups shall be agreed by the Board of Directors.

5.1.11 Notwithstanding the provisions of SO 5.1.9 above, the Board of Directors may establish other committees and sub-groups from time to time at its discretion.

5.2 Confidentiality

5.2.1 A member of a committee, sub-committee or joint committee shall not disclose a matter dealt with, by, or brought before, the committee without its permission until the committee shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

5.2.2 A Director or a member of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

6 INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

6.1 The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters

which are set out specifically within the Constitution.

6.2 The Directors, having regard to the views of the Council of Governors, are to prepare the Forward Plan in respect of each Financial Year to be given to NHS England/Improvement (Monitor).

6.3 The Directors are to present to the Council of Governors at a general meeting the Annual Accounts, any report of the Auditor on them, and the Annual Report.

6.4 The Annual Report is to give:

6.4.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its Public Constituency is representative of those eligible for such membership;

6.4.2 information on each non-executive director determining whether each is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement, with particular reference to paragraph 40 of the Constitution; and

6.4.3 any other information which NHS England/Improvement (Monitor) requires.

6.5 In order to comply with the Regulatory Framework in all respects and in particular in relation to the matters which are set out above, the Council of Governors may request that a matter which relates to paragraphs 42 – 44 of the Constitution is included on the agenda for a meeting of the Board of Directors.

6.6 If the Council of Governors so desires such a matter as described within SO 6.5 to be included on an agenda item, they shall make their request in writing to the Chairman at least 10 (ten) Clear Days before the meeting of the Board of Directors, subject to SO 3.3. The Chairman shall decide whether the matter is appropriate to be included on the agenda. Requests made less than 10 (ten) Clear Days before a meeting may be included on the agenda at the discretion of the Chairman.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 The Regulatory Framework requires members of the Board of Directors to declare to the Secretary:

7.1.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter which is under

consideration concerning the Trust or is to be considered by the Board of Directors; and

7.1.2 any interests including but not limited to any personal or family interests which are relevant and material to the business of the Trust, irrespective of whether those interests are direct or indirect, actual or potential'

7.2 Directors should declare such interests as soon as the Director in question becomes aware of it. Any members of the Board of Directors appointed subsequently should do so on appointment.

7.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the Constitution or the SOs and delivering it to the Secretary on appointment or as soon thereafter as the interest arises, but within 7 (seven) Clear Days of becoming aware of the existence of a relevant and material interest.

7.4 If a declaration under SO 7.1 or 7.2 above provided to be, or becomes, inaccurate or incomplete, the Director must make a further declaration before the Trust enters into the transaction or arrangement. This does not require a declaration of an interest of which the Director is not aware or whether the director is not aware of the transaction or arrangement in question.

7.5 A Director need not declare an interest:

7.5.1 if, it cannot reasonably be regarded as likely to give rise to a conflict of interest;

7.5.2 if, or to the extent that, the Directors are already aware of it;

7.5.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered by:

7.5.4 a meeting of the Board of Directors, or

7.5.5 by a committee of the Directors appointed for the purpose.

7.6 In addition, if a Director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

7.7 If a Director has declared a pecuniary interest in accordance with SO 7.8 below they shall not take part in the consideration or discussion of the matter in respect of which an interest has been disclosed and

shall be excluded from the meeting whilst that proposed contract is under consideration. At the time the interests are declared, they should be recorded in the Director's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

7.8 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by NHS England/Improvement (Monitor):

7.8.1 Directorships, including Non-Executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

7.8.2 ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

7.8.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

7.8.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

7.8.5 any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services;

7.8.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

7.9 Any travelling or other expenses or allowances payable to a Director in accordance with the Constitution shall not be treated as a pecuniary interest.

7.10 Members of the Board of Directors of companies likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

7.11 A Director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.11.1 they, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

7.11.2 they are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

7.12 For the avoidance of doubt, the following shall not be considered relevant and material for the purposes of these SOs:

7.12.1.1 Shares not exceeding 2% of the total share in issue held in any company whose shares are listed on any public exchange;

7.12.1.2 An employment contract held by Staff Governors;

7.12.1.3 An employment contract with the relevant local authority held by a Local Authority Governor;

7.12.1.4 An employment contract with a Partnership Organisation held by a Partnership Governor.

7.13 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.13.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or

7.13.2 of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.14 Where a Director:

7.14.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

7.14.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

7.14.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

the Director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from

voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

7.15 In the case of Immediate Family members, the interest of one Immediate Family member shall, if known to the other, be deemed for the purposes of the Constitution and the SOs to be also an interest of the other.

7.16 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.17 Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 to Schedule 7 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this SO.

7.18 SO 7 applies to any committee, sub-committee of the Board of Directors and applies to any member of any such committee or sub-committee (whether or not they are also a Director) and will need to be read in conjunction with the applicable policy.

7.19 Register of Interests

7.19.1 The register of interests of Directors shall contain the names of each Director, whether they have declared any interests and, if so, the interests declared in accordance with the Constitution or these SOs.

7.19.2 It is the obligation of the Director to inform the Secretary in writing within 7 (seven) Clear Days of becoming aware of the existence of a relevant or material interest. The Secretary must amend the appropriate register of interests of Directors upon receipt of new or amended information as soon as is practical and, in any event, within 14 (fourteen) days.

7.19.3 The register of interests of Directors will be available to the public and the Chairman will take reasonable steps to bring the existence of the register of interests of Directors to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the register of interests of Directors must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register of Interests.

7.19.4 The details of Directors' interests recorded in the register of interests of Directors will be kept up to date by means of a

regular review as necessary of the register of interests of Directors by the Chief Executive or Secretary during which any changes of interests recently declared will be incorporated.

8 STANDARDS OF BUSINESS CONDUCT

8.1 Policy

8.1.1 Directors and Officers should comply with the NHS Foundation Trust Code of Governance, the Nolan Principles, Standards for Members of NHS Boards and Clinical Commissioning Group governing bodies in England and any guidance and best practice advice issued by NHS England/Improvement (Monitor). This section of the SOs should be read in conjunction with these documents.

8.1.2 Directors and Officers should also comply with provisions of the Trust's Fraud Response Plan and Anti Bribery Policy.

8.2 Interest of Directors and Employees in Contracts

8.2.1 If it comes to the knowledge of Director or an Officer that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or Secretary of the fact that they are interested therein. In the case of Immediate Family Members, the interest of one Immediate Family Member shall, if known to the other, be deemed to be also the interest of that Immediate Family Member.

8.2.2 A Director or Officer must also declare to the Chief Executive or Secretary any other employment or business or other relationship of their, or of an Immediate Family Member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust in accordance with SO 7. The Trust shall require such interests to be recorded in the register of interests of Directors.

8.3 Canvassing of, and Recommendations by, Directors in Relation to Appointments

8.3.1 Canvassing of Directors or members of any committee, sub-committee or joint committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these SOs shall be included in application forms or otherwise brought to the attention of candidates.

8.3.2 A Director of the Board of Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

8.4 Relatives of Directors or Officers

8.4.1 Directors and Officers shall bear in mind that candidates for any staff appointment shall when making an application disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

8.4.2 The Directors and Officers shall disclose to the Chief Executive any relationship between themself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board of Directors whether they are related to any other member of the Board of Directors or holder of any office in the Trust.

8.4.4 Where the relationship to an Officer or another Director to a Director of the Trust is disclosed, SO 7 shall apply.

8.5 External Consultants

8.5.1 SO 8 will apply equally to all external consultants or other agents acting on behalf of the Trust. The Scheme of Delegation should be adhered to at all times.

9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 Custody of Seal

9.1.1 The Common Seal of the Trust shall be kept by the Secretary to the Trust or Nominated Officer in a secure place.

9.2 Sealing of Documents

9.2.1 The Common Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee thereof or where the Board of Directors has delegated its powers.

9.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an Officer nominated by them) and authorised and countersigned by the Chief Executive (or an Officer nominated by them who shall not be within the originating directorate).

9.3 Register of Sealing

9.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

10 SIGNATURE OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or Nominated Officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.

11 MISCELLANEOUS

11.1 Standing Orders to be given to Members and Officers

11.1.1 It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within the SOs and the SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be

informed in writing and shall receive copies, where appropriate, of the SOs.

11.2 Documents having the standing of Standing Orders

11.2.1 The SFIs and the Scheme of Delegation shall have the effect as if incorporated into the SOs.

11.3 Review of Standing Orders

11.3.1 The SOs shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs. For the avoidance of doubt, any changes to the SFIs and Scheme of Delegation only requires Board of Directors' approval.

11.4 Corporate Documents

11.4.1 Any corporate documents specific to the setting up of the Trust shall be held in a secure place by the Chief Executive.

ANNEX 3 - STANDING ORDERS

TENDERING AND CONTRACT PROCEDURE

CONTENTS*:*

1. DUTY TO COMPLY WITH STANDING ORDERS

2. DISPOSALS

3. IN-HOUSE SERVICES

1 DUTY TO COMPLY WITH STANDING ORDERS

1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and the Trust's Standing Financial Instructions (SFIs) (except where SO 3.15. (Suspension of SOs) is applied).

1.2 Acts Governing Public Procurement

1.2.1 The Procurement Act 2023, The Provider Selection Regime and the Public Contracts Regulations 2015 prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SOs.

1.2.2 The Bribery Act 2010, which came into effect on 1 July 2011, makes it a criminal offence to give promise or offer a bribe, and to request, agree to receive or accept a bribe, either at home or abroad. The Bribery Act 2010 shall have effect as if incorporated in these SOs.

1.2.3 The Trust shall adopt as good practice the requirements of the NHS England Business Case Approvals Process for Capital Investment, Property, Equipment and ICT 14 August 2013 Publications Gateway Reference: 00324 and Health Building Note 00-08 Part A: Strategic framework for the efficient management of healthcare estates and facilities and associated relevant guidance issued by Monitor/NHS England/Improvement (Monitor) in respect of capital investment and estate and property transactions, including the "Capital Regime, Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts November 2016.

1.2.4 In the case of management consultancy contracts the Trust shall adopt, as far as is practicable, the NHS Executive guidance "The Procurement and Management of Consultants within the NHS". The Trust will also comply with the Guidance from NHS England/Improvement (Monitor) entitled "Best Practice in Making Investments" and the Regulatory Framework.

1.2.5 The Trust should have policies and procedures in place for the control of all tendering activity.

1.3 Formal Competitive Tendering

1.3.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health or other regulatory organisations); for the design, construction and maintenance of building and engineering works (including construction and concession contracts); and for disposals.

1.3.2 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive where:

1.3.2.1 the estimated expenditure or income does not, or is not reasonably expected to exceed thresholds stated in Appendix 1, table 3 of the Trust Standing Financial Instructions, or

1.3.2.2 the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

1.3.2.3 where the requirement is covered by an existing national, regional or local contract or framework

1.3.2.4 where provided for in regulatory guidance.

1.3.3 Formal tendering procedures may be waived by Officers to whom powers have been delegated by the Chief Executive:

1.3.3.1 in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstance are detailed in an appropriate Trust record;

1.3.3.2 where the timescale genuinely precludes competitive tendering (failure to plan the work properly is not a justification for single tender);

1.3.3.3 where it is apparent from the specification that specialist expertise is required to meet it and the expertise is only available from one source;

1.3.3.4 where the task is essential to complete the project, and arises as a consequence of a recently

completed assignment and engaging different consultants for the new task would be inappropriate; or

1.3.3.5 where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

1.3.4 The waiving of competitive tendering procedures should not be used:

1.3.4.1 to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure;

1.3.4.2 for building and engineering construction works, and maintenance (other than in accordance with Concode or other relevant regulatory guidance) without Departmental of Health and Social Care approval.

1.3.5 Where it is decided that competitive tendering is not applicable and should be waived by virtue of SO 1.3.3.1 to SO 1.3.3.4 above the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported by the Chief Executive to the Audit Committee.

1.3.6 Except where SO 1.3.2 and SO 10.3.3, or a requirement under SO 1.2, applies, the Board of Directors shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and where possible, no less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

1.3.7 Items estimated to be below the limit set in this Standing Order for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

1.3.8 The Board of Directors shall review the Tendering Procedure at least every two years.

1.4 Invitation to tender

1.4.1 All invitations to tender shall state the date and time as being

the latest time for the receipt of tenders.

1.4.2 All invitations to tender shall be by an e-tendering software package. The suppliers response shall be completed on-line and uploaded into a secure electronic mailbox until the opening time.

1.4.3 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in SO 1.4.4 and 1.4.5 below.

1.4.4 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

1.4.5 Every tender for building or engineering works (except for maintenance work, when Estatecode or other relevant regulatory guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the Department of Health and Social Care or modified and/or amplified to accord with guidance issued by NHS England and the Department of Health and Social Care and, in minor respects, to cover special features of individual projects.

1.4.6 Each significant member of Trust staff involved in the tendering process must declare any interests relating to the project they are overseeing.

1.5 Receipt and safe custody of Formal tenders

1.5.1 The tender documents will be stored in the electronic mailbox until the closing date and time. An audit log within the e-tendering system will record the data and time the offer

documents are received.

1.6 Opening Formal tenders

1.6.1 Where an electronic tendering package is used the tender documents will be opened electronically by two independent professionals from the procurement service.

1.6.2 Each significant member of staff involved in the tendering process is to declare any interests relating to the project they are overseeing. Where an electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening.

1.6.3 All actions by both procurement staff and suppliers shall be recorded within the system audit reports.

1.7 Admissibility

1.7.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

1.7.2 Where only one tender is sought and/or received, the Chief Executive and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

1.8 Late tenders

1.8.1 Tenders received after the due time and date, but before the opening of the other tenders, may be considered only if the Chief Executive or their Nominated Officer decides that there are exceptional circumstances, eg where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned.

1.8.2 The Chief Executive or Nominated Officer shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender shall be reported to the Board at its next meeting.

1.8.3 Technically late tenders (ie those despatched in good time but delayed through no fault of the tenderer) may at the discretion of the Chief Executive be regarded as having arrived in due time.

1.8.4 Incomplete tenders (ie those from which information necessary for the adjudication of the tender is missing) and amended tenders (ie those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt) will be dealt with in the same way as late tenders.

1.8.5 Where examination of tenders reveals errors or incompleteness which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their offer.

1.8.6 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, and the process of evaluation shall not be started.

1.9 Acceptance of formal tenders

1.9.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

1.9.2 A tender other than the lowest whole life cost (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless for good and sufficient reason and the decision and reason recorded as a written record using the appropriate Tender Acceptance Authorisation Form.

1.9.3 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

1.9.4 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive.

1.9.5 The use of these procedures must demonstrate that the award of the contract was:

1.9.5.1 not in excess of the going market rate/price current at the time the contract was awarded, and

1.9.5.2 achieved best value for money.

1.9.6 In considering which tender to recommend, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. This will take the form of an official evaluation process involving a consideration of both commercial and technical aspects, any key stakeholders involved in the tender process. In cases of doubt they shall consult the Chief Executive via the completion of a Recommendation Report. The Chief Executive or Chief Finance Officer, see SO 1.16.1.1 for authorisation levels, shall approve acceptance of the tender in writing to the responsible officer. (Larger tenders ie those exceeding a total value of £1,000,000 (inc Vat) shall be referred to the Trust Board for approval).

1.9.7 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.

1.9.8 All tenders shall be treated as confidential and shall be retained for inspection.

1.10 Tender reports to the Trust Board

1.10.1 Reports to the Board of Directors will be made on an exceptional circumstance basis only.

1.11 List of approved firms

1.11.1 Building and Engineering Construction Works

1.11.1.1 Invitations to tender shall be made only to firms included on either an approved list of tenderers compiled by the Trust or by neighbouring Trusts or on the Construction Line, NHS Supply Chain or other national or regional purchasing framework list.

1.11.1.2 Firms included on approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person and shall act in accordance with all relevant employment legislation and guidance.

1.11.1.3 Firms shall conform at least with the requirements of the Health and Safety at Work Act 1974 (as

amended) and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British standard code of practice issued by the British Standard Institution. Firms must provide to the appropriate Officer a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

1.11.2 Financial Standing and Technical Competence of Contractors

1.11.2.1 The Chief Finance Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

1.12 Exceptions to using approved contractors

1.12.1 If in the opinion of the Chief Executive and the Chief Finance Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from a list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on a list), or where a list for whatever reason has not been prepared, the Chief Executive shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

1.12.2 An appropriate record in the contract file shall be made of the reasons for inviting a tender or quote other than from an approved list.

1.13 Competitive Quotations

1.13.1 Quotations are required to be obtained where formal tendering procedures have been waived under SOs 1.3.2 or 1.3.3 and where the intended expenditure or income exceeds, or is reasonably expected to exceed the limits defined in the Scheme of Delegation and/or the SFIs.

1.13.2 Where quotations are obtained under SO 1.14 they shall be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board of Directors.

1.13.3 Quotations shall be in writing.

1.13.4 All quotations shall be treated as confidential and shall be retained for inspection.

1.13.5 The Chief Executive or their Nominated Officer shall evaluate the quotations and select the one which gives value for money. If this is not the lowest quotation then this fact and the reasons why the lowest quotation was not chosen shall be recorded in a permanent record and a Quotation Acceptance Authorisation Form completed.

1.14 Non-Competitive Quotations

1.14.1 Formal quotation procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive where:

1.14.2 the estimated expenditure or income does not, or is not reasonably expected to, exceed £10,000 excl VAT (this figure to be reviewed annually); Or

1.14.3 the supply is proposed under special arrangements negotiated by the Department of Health and Social Care in which event the said special arrangements must be complied with;

1.14.4 where the requirement is covered by an existing national, regional or local contract or framework

1.14.5 where provided for in regulatory guidance.

1.14.6 Formal quotation procedures may be waived by Officers to whom powers have been delegated by the Chief Executive:

1.14.7 in very exceptional circumstances where the Chief Executive decides that formal quotation procedures would not be practicable or the estimated expenditure or income would not warrant formal competitive procedures, and the circumstance are detailed in an appropriate Trust record;

1.14.8 where the timescale genuinely precludes competitive quotations (failure to plan the work properly is not a justification for single quotation);

1.14.9 where it is apparent from the specification that specialist expertise is required to meet it and the expertise is only available from one source;

1.14.10 where the task is essential to complete the project, and arises as a consequence of a recently completed

assignment and engaging different consultants for the new task would be inappropriate; or

1.14.11 where there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competition.

1.14.12 The waiving of competitive quotation procedures should not be used:

1.14.13 to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure;

1.14.14 for building and engineering construction works, and maintenance (other than in accordance with Concode or other relevant regulatory guidance) without Departmental of Health and Social Care approval.

1.14.15 Where it is decided that competitive quotations are not required and should be waived by virtue of SO 1.14.2.1 to SO 1.14.2.5 above the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported by the Chief Executive to the Audit Committee.

1.15 Quotations to be within Financial Limits

1.15.1 No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these SOs except with the authorisation of either the Chief Executive or Chief Finance Officer.

1.16 Authorisation of Tenders and Competitive Quotations

1.16.1 Providing all the conditions and circumstances set out in these SOs have been fully complied with, formal authorisation and awarding of a contract may be decided in accordance with the Financial Limits set out in Tables 4 and 5 of Appendix 1 'Financial Limits' of the Trust Standing Financial Instructions.

1.16.2 These levels of authorisation may be varied or changed from time to time by the Board of Directors and need to be read in conjunction with the Scheme of Delegation and/or SFIs.

1.16.3 Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

1.17 Instances where formal competitive tendering or competitive quotation is not required

1.17.1 Where competitive tendering or a competitive quotation is not required, the Trust should adopt one of the following alternatives:

1.17.1.1 the Trust shall use the NHS supply chain for procurement of all goods and services unless the Chief Executive or their Nominated Officer deem it inappropriate. The decision to use alternative sources must be documented;

1.17.1.2 if the Trust does not use the NHS supply chain (where tenders or quotations are not required, because expenditure is below £10,000 excluding VAT), the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

1.18 Private Partnership

1.18.1 The Trust should normally market-test for "Private Partnership" funding when considering a capital procurement. When the Board of Directors proposes, or is required, to use finance provided by the private sector the following shall apply:

1.18.1.1 The Chief Executive and Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

1.18.1.2 Where the sum exceeds delegated limits, a business case must be referred to NHS England and/or Department of Health and Social Care for approval or treated as per current guidelines.

1.18.1.3 The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

1.18.1.4 The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

1.19 Compliance Requirements for all Contracts (including lease contracts)

1.19.1 The Board of Directors may only enter into contracts on behalf of the Trust within its statutory powers and within the Regulatory Framework and shall comply with:

1.19.1.1 these SOs;

1.19.1.2 the SFIs;

1.19.1.3 the Trust's Provider Licence;

1.19.1.4 statutory provisions;

1.19.1.5 such of the NHS Standard Contract Conditions as are applicable;

1.19.1.6 appropriate NHS guidance;

1.19.2 Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

1.19.3 Contracts shall include lease and hire purchase agreements.

1.19.4 In all contracts made by the Trust, the Board of Directors shall endeavour to obtain value for money by use of all systems in place. The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.

1.20 Personnel and Agency or Temporary Staff Contracts

1.20.1 The Chief Executive shall nominate Officers with delegated authority to enter into contracts for the employment of other Officers and to enter into contracts for the employment of agency staff or temporary staff service contracts.

1.21 Healthcare Services Agreements

1.21.1 Healthcare Services contracts made between two Health Service Bodies for the supply of healthcare services, will be legally binding contracts and are subject to the provisions of the 2006 Act and any other relevant legislation.

1.21.2 The Chief Executive shall nominate Officers with power to negotiate for the provision of healthcare services from providers of healthcare services.

1.22 Cancellation of Contracts

1.22.1 Except where specific provision is made in model forms of contracts or standard schedules of conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if:

1.22.1.1 the contractor has offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust; or

1.22.1.2 the contractor has shown or foreborne favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by them or acting on their behalf (whether with or without the knowledge of the contractor); or

1.22.1.3 in relation to any contract with the Trust the contractor or any person employed by them or acting on their behalf shall have committed any offence under the Prevention of Corruption Acts 1989 and 1916,the Prevention of Corruption (Amendment) Act 2018, Bribery Act 2010, and other appropriate legislation.

1.23 Determination of Contracts for Failure to Deliver Goods or Material

1.23.1 There shall be inserted in every written contract for the supply of goods or materials entered into by the Trust a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may (without prejudice) determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good such default.

1.23.2 The clause referred to at SO 1.23.1 shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

1.24 Contracts Involving Funds held on Trust

1.24.1 Contracts involving Funds held on Trust shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

1.24.2 SO 1.24.1 shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

2 DISPOSALS

2.1 **Competitive** Tendering or Quotation procedures shall not apply to the disposal of:

2.1.1 any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their Nominated Officer;

2.1.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

2.1.3 items to be disposed of with an estimated sale value as set out in the Scheme of Delegation;

2.1.4 items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; or

2.1.5 land or buildings concerning which Department of Health and Social Care guidance has been issued but subject to compliance with such guidance; or

2.1.6 any matter which NHS England has issued alternate specific guidance and/or best practice advice in relation to.

3 IN-HOUSE SERVICES

3.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

3.2 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

3.2.1 "specification group", comprising the Chief Executive or Nominated Officer(s) and specialist(s).

3.2.2 "in-house tender group", comprising representatives of the in-house team, a nominee of the Chief Executive and appropriate technical support.

3.2.3 "evaluation group", comprising normally a specialist Officer, a supplies Officer and Chief Finance Officer representative. For services having a likely annual expenditure exceeding £500,000 a non-Officer member should be a member of the evaluation team.

3.3 All groups referred to in SO 3.2.1 to 3.2.3 should work independently of each other but individual Officers may be a member of more than one group. No member of the "in-house tender group" may, however, participate in the evaluation of tenders.

3.4 The "evaluation group" shall make recommendations to the Board of Directors.

4. REVIEW OF THE TENDERING AND CONTRACT PROCEDURE

4.1 For the avoidance of doubt, the Tendering and Contracting Procedure form part of the Standing Orders but any changes to the procedure only require Board of Directors' approval.

ANNEX 4 - FURTHER PROVISIONS

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1. REPRESENTATIVE MEMBERSHIP

1.1. The Trust shall at all times strive to ensure that, taken as a whole, its actual membership is representative of those eligible for membership. To this end:

1.1.1. The Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors and shall be reviewed by them from time to time at least every three years.

1.1.2. The Council of Governors shall present to each Annual Meeting:

1.1.2.1. a report on steps taken to secure that, taken as a whole, the actual membership of its constituencies and the classes of constituencies is representative of those eligible for such membership;

1.1.2.2. the progress of the membership strategy; and

1.1.2.3. any changes to the membership strategy.

2. CO-OPERATION WITH HEALTH SERVICE AND OTHER BODIES

2.1. In exercising its functions, the Trust shall co-operate with Health Service Bodies and any local authority with which the Trust has a Local Authority Partnership Agreement.

2.2. Notwithstanding the provisions of paragraph 2.1 above, the Trust shall co-operate with any specific third party body that it has a duty (statutory, contractual, or otherwise) to co-operate with.

3. RESPECTS FOR RIGHTS OF PEOPLE

3.1. In conducting its affairs, the Trust shall respect the rights of the members of the community it serves, its employees and people dealing with the Trust as set out in the Human Rights Act 1998.

4. APPOINTMENT OF CHAIRMAN AND NON-EXECUTIVE DIRECTORS

4.1. Decisions and processes regarding the appointment and reappointment of the Chairman and Non-Executive Directors of the

Trust are solely within the purview of the Council of Governors.

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4.2. The Nominations and Remuneration Committee has delegated powers from the Council of Governors to consider the Non-Executive Director or Chairman vacancies due in the next 12 months and make recommendations to the Council of Governors.

4.3. The Nominations and Remuneration Committee shall:

4.3.1. recommend the re-appointment of an existing Non-Executive Director/Chairman or if applicable the recruitment process for the Chairman and Non-Executive Directors (as may be the case).

4.3.2. take advice, as necessary, from the Director of People and Organisational Development and the Trust Secretary or other internal or external sources

4.3.3. report its recommendations regarding the re-appointment of the Non-Executive Director or Chairman as an agenda item in a timely manner at a Council of Governors meeting for decision, or:

4.3.4. report its recommendations regarding the recruitment process for the Non-Executive Director or Chairman post as an agenda item in a timely manner to the Council of Governors meeting for decision.

4.3.5. make recommendations to the Council of Governors meeting in relation to pay and tenure of Non-Executive Directors/Chairman for the Council of Governors' decision. Each period of appointment (or re-appointment) will be to a maximum of three years, and any re-appointment over six years will be subject to particularly rigorous review. Any re-appointment over six years will be subject to annual re-appointment to provide assurance that the Non-Executive Director seeking re-appointment retains their independence of character and judgement.

4.3.6. ensure that a formal, rigorous and transparent procedure is followed, which takes into account the needs of the organisation, the balance of expertise and experience on the Board, eligibility of existing Non-Executive Directors or Chairman to stand for a further term, and any other relevant factors. This is not an exhaustive list of the matters which may need to be considered by the Nominations and Remuneration Committee, but is merely intended to act as a guide.

4.4. Subject to the provisions of paragraph 4.3.1 above, the process for

appointing new Non-Executive Directors and the Chairman, including the potential re-appointment of the Chairman and Non-Executive Directors, will be as follows:

4.4.1. No later than six months before the end of the term of office of the Chairman or a Non-Executive Director (as the case may be), the Nominations and Remuneration Committee will consider, paying due regard to the provisions set out in paragraph 4.3.1, the formal performance evaluation for the Non-Executive Director or Chairman for the previous two years, skills and experience and eligibility of existing Non-Executive Directors prepared to stand for re-appointment. The reason for considering the performance of existing Non-Executive Directors will be to inform the decisions made regarding the re-appointment of the Non-Executive Director or Chairman, or the recruitment process to be followed. However, nothing within this paragraph will preclude the Nominations and Remuneration Committee from considering other relevant circumstances when deciding on the recruitment process as outlined in paragraph 4.3.1 above. Having due regard to the needs of the composition of the Board, the Nominations and Remuneration Committee may either 1) recommend to the Council of Governors that 1) an external recruitment process is followed or 2) recommend the re-appointment, pay, length of term of an existing Non-Executive Director. For the avoidance of doubt, if the recommendation to re-appoint a Non-Executive Director or Chairman is approved by the Council of Governors, there is no requirement to set up an Appointments Panel, unless this is specifically requested by the Council of Governors.

4.4.2. Following a recommendation to follow an external recruitment process, and subject to the Council of Governors' agreement, the Council of Governors will appoint an Appointments Panel to undertake the recruitment process. The Appointments Panel will be constituted in accordance with paragraphs 4.4.4 and 4.4.5 below.

4.4.3. The current Chairman or a Non-Executive Director may stand for reappointment, subject to the conditions at paragraph 4.4 above.

4.4.4. The Appointments Panel for the Chairman will consist of the Senior Independent Director, or if the Senior Independent Director is standing for appointment a Non-Executive Director who is not standing for appointment, two Elected Governors, and one Appointed Governor. If the number of Elected/Appointed Governors prepared to serve on the Appointments Panel is greater than the number of places available, the Panel members will be selected by election by

the Elected/Appointed Governors respectively. A Public Governor will chair the Appointments Panel. Each member of the Appointments Panel will have one vote. The chairman of another NHS foundation trust will be invited to act as an independent assessor to the Appointments Panel.

4.4.5. The Appointments Panel for Non-Executive Directors will consist of the Chairman, two Elected Governors, and one Appointed Governor. If the number of Elected/Appointed Governors prepared to serve on the Appointments Panel is greater than the number of places available, the Panel members will be selected by election by the Elected/Appointed Governors respectively. The Chairman will chair the Appointments Panel. Each member of the Appointments Panel will have one vote.

4.4.6. Appropriate candidates (not more than 5 (five) for each vacancy) will be identified by an Appointments Panel.

4.4.7. The Appointments Panel constituted under paragraphs 4.4.4 and 4.4.5 above will be supported by appropriate advice from the Trust's Director of People and Organisational Development on the qualifications, skills and experience required for each position. They may also work with an external organisation recognised as expert at appointments to identify the qualifications, skills and experience required for Non-Executive Directors.

4.4.8. The Council of Governors will not consider nominations for the Chairman and other Non-Executive Directors other than those made by the appropriate Appointments Panel.

4.4.9. The Appointments Panel will make recommendations to the Council of Governors meeting about the preferred candidate to be appointed to the Non-Executive Director or Chairman post for the Council of Governors' decision.

APPENDIX C

SOMERSET NHS FOUNDATION TRUST

SCHEME OF RESERVATION AND DELEGATION

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Approve a scheme of delegation of powers from the Board to committees, Officers or other bodies. 5. Ratify any urgent decisions taken by the ~~Chairman~~Chair and Chief Executive in accordance with the SOs. 6. Approve and delegate authority from the Board to committees. 7. Require and receive the declaration of Board members' and Governors' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 8. Require and receive the declaration of Executive and Non-Executive Directors' interests that may conflict with those of the Trust. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. For clarity this would comprise details of the structure of the Board and its sub-committees and the Directorate structure of the Trust. Organisational structures below Executive and Clinical Director are the responsibility of the Chief Executive. 10. Receive reports and/or minutes from committees including those that the Trust is required by regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

(Please read this document in conjunction with the Constitution, Standing Orders and Standing Financial Instructions)

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REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Receive quarterly reports on the use of the Corporate Seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention. 17. Discipline Executive Directors, consultants and those individuals, where a non-executive director formed part of the interview panel, or employees who are in breach of statutory requirements or SOs 18. Ensure compliance with the Code of Governance, the Risk Assessment Framework and the NHS Provider Licence. 19. Approve the "Going Concern" statement as part of the annual accounts approval process. 20. Non-Executive Directors shall appoint or remove the Chief Executive. 21. Subject to the provisions in the constitution, the appointment of the Chief Executive shall require the approval of the Council of Governors. 22. A committee, consisting of the ~~Chairman~~Chair, the Chief Executive and the other Non-Executive Directors shall appoint, discipline or remove the other Executive Directors. 23. Approve the incorporation of new subsidiaries, to include the terms of articles of association and standing financial instructions; maintain oversight and review regular reports by the wholly owned subsidiaries. 24. Approve the dissolution of existing subsidiaries.
NA	THE BOARD	**Appointments/Dismissal/Redundancy** 1. Recommend the appointment of the Deputy ~~Chairman~~Chair and the Senior Independent Director to the Council of Governors. 2. Appoint Chairs of Committees and dismiss committees (and individual members) that are directly accountable to the Board. 3. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 4. Approve staff redundancies.

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REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**Strategy, Plans and Budgets** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing governance in services provided by the Trust, having regard to any guidance issued by NHS England, the Care Quality Commission and the Secretary of State 3. Approve the Trust's strategy for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment in line with the investment policy and Standing Financial Instructions. 5. Approve the Trust's proposed organisational development proposals. 6. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 7. Approve PFI proposals. 8. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to ***over the defined limits within the SFIs and the investment policy*.** 9. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board. 10. Approve individual compensation payments ***above limits of delegation to Executive Directors.*** 11. Approve such business plans, budgets and capital programmes submitted by the Chief Executive on at least an annual basis, including the approval of Cost Improvement Programmes. 12. Approve business cases (requiring additional revenue resources) ***above limits of delegation to Executive Directors***.
	THE BOARD	**Policy Determination** 1. Overall responsibility for policy, procedural documents such responsibility to be delegated by a specific policy for developing and approval of policies and other procedural documents as appropriate, which shall be approved and monitored by the Policy Review Group.
	THE BOARD	**Audit**

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REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		1. Review of the annual audit letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receive and approve the Trust's Annual Report and Annual Accounts prior to the submission to NHS England and Parliament and presentation to the Council of Governors and, subsequently, members of the Trust.. 2. Receive and approve the Annual Report and Accounts for funds held on trust.
NA	THE BOARD	**Monitoring** 1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated or from Directors and Officers of the Trust. 2. Continuously appraise the affairs of the Trust by means of the provision of such reports to the Board as the Board may require from directors, committees, and officers of the Trust. All monitoring returns required by NHS England as outlined in the NHS Provider Licence shall be reported, at least in summary, to the Board. 3. Make such monitoring returns required by the Department of Health and/or NHS England (NHSE) and the Charity Commission where Board certification is required. 4. Receive reports from the Chief Finance Officer on financial performance against budget including how income contracts are performing.

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DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 4.1	AUDIT COMMITTEE	The Committee will: 1. Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives, including approval of the Trust's policies and procedures for the management of risk, to gain assurance about the robustness of the system and controls. 2. Ensure the adequacy of the Risk Management Strategy in relation to the effective identification, assessment, mitigation and monitoring of risk within the Trust and ensure the implementation of the Strategy. 3. Review the adequacy of: • all statutory risk and control related disclosure statements (in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board/governing body. • the underlying assurance processes (including the Board Assurance Framework and Corporate Risk Register) that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, including risk appetite and maturity, and the appropriateness of the above disclosure statements; • the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications. • the policies and procedures for all work related to counter fraud, bribery and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (NHSCFA). 4. Review the Annual Report, Financial Statements, and external audit opinion on the Financial Statements and Quality Accounts (if required) and make recommendations on the approval of the Annual Accounts and Annual Report to the Board

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		5. Monitor and review the internal audit function to ensure that there is an effective internal audit function established by management that meets the mandatory NHS Internal Audit Standards, the Public Sector Internal Audit Standards, and provides appropriate independent assurance to the Audit Committee, to the Chief Executive as Accountable Officer, and to the ~~Board of Directors~~Trust Board ~~6. Develop and implement a policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethnical guidance regarding the provision of non-audit services by the External Audit firm~~ ~~7.~~6. Make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approval of the terms of engagement of the external auditor ~~8.~~7. Review the work and findings of the External Auditor and consider the implications and management's responses to their work. The Committee shall also monitor and review the External Auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements ~~9.~~8. Review the work and findings of the Counter Fraud Service and consider the implications and management's responses to their work ~~10.~~9. Review the findings of other significant assurance functions external to the organisation, and consider the implications to the integrated governance of the organisation. ~~11.~~10. Review the work of other committees and groups within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This includes the work of other Board Assurance Committees. ~~12.~~11. Review reports and positive and negative assurances from directors and managers on the overall arrangements for governance, risk management and internal control. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it. ~~13.~~12. Ensure that the systems for financial reporting to the Board, including those of budgetary control, and formal announcements relating to the Trust's financial performance are subject to review as to completeness and accuracy of the information provided to the Board. ~~14.~~13. Review and approve write offs/losses and special payments in line with the limit set out in the Standing Financial Instructions.

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		~~15.~~14. Scrutinise the trust's cyber security arrangements and ensure the trust has robust and rapid responses in place, in line with national guidance, ~~16.~~15. Approve the National Cost Collection process. 16. Manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation. 17. Oversee proposed changes to Standing Orders, Standing Financial Instructions and the Scheme of Delegation. ~~17.~~
SO 5	QUALITY AND GOVERNANCE ASSURANCE COMMITTEE	The Committee will: 1. Enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: - promote safety and excellence in patient care - identify, prioritise and manage risks within the Trust - ensure the effective and efficient use of resources through evidence-based clinical practice - protect the health and safety and wellbeing of Trust employees 2. Enable the Board to obtain assurance that the Trust has systems in place to ensure it is compliant with and delivers: - legal and statutory requirements - agreed clinical standards and quality objectives - quality standards required by NHS ~~Improvement~~ England and the Care Quality Commission 3. Review the annual reports on the implementation of strategies for: – Safeguarding Adults and Children: – Health and Safety;

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		– Emergency Preparedness, Resilience and Response; – Infection Control; – Organ Donation; – Information Governance; – Complaints and Patient Experience. 4. Ensure effective arrangements are in place to assure high standards of clinical governance, including clinical effectiveness, management of clinical risk, practice standards and patient safety; 5. Ensure effective arrangements are in place to deliver Care Quality Commission registration, requirements and outcomes in response to any CQC inspections and reports; 6. Enable the Board to obtain assurance that the Trust has systems and procedures in plan to identify learning from deaths, Serious Incidents and other incidents, complaints, claims and ensuring they are shared across the Trust and implemented to improve patient safety, patient experience and colleague health and wellbeing; 7. Ensure the Trust has in place procedures to monitor and review the operational effectiveness of policies and procedures. 8. Manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation. 9. Seek assurance on the robustness of the governance arrangements for the Trust's joint ventures, strategic partnerships and subsidiary organisations. 10. Seek assurance on the governance arrangements and effective implementation of the Trust's estates, facilities and sustainability strategies. 11. Receive assurance in respect of significant programme risks within the Committee's remit, including the Healthset programme, with specific focus on clinical safety, people impact and inclusion, information governance, oversight of clinical pathways, quantitative quality and outcome benefits, and associated quality-related risks and mitigations. ~~8.~~

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SO5	FINANCE COMMITTEE	The Committee will: 1. Consider and keep under review the Trust's medium term financial sustainability plan, in relation to both revenue and capital and risk. 2. Review capital and revenue business cases above the Committee's authority limits as set out within the Trust's Standing Financial Instructions and Scheme of Delegation and make recommendation to the Board for approval. 3. Examine the key principles and assumptions for the Trust's business planning and budget setting processes. 4. Receive and monitor reports on financial performance including forecasts, cost improvement programmes and use of resources, noting any trends, exceptions and variances against plans on a Trust-wide and ~~directorate~~ service group basis and reviewing in detail any major performance variations. 5. Review and make submissions to NHS ~~Improvement~~ England as necessary on behalf of the Board. 6. Review major procurements and tenders. 7. Recommend to the Board approval of the Trust's annual operational plan, capital investment plan and revenue budgets. 8. Keep under review key strategic, commercial contracts and seek assurance that appropriate due diligence is undertaken on any new contracts and/or renewals. 9. Monitor performance of commercial activities as necessary and ensure that such activities deliver improved patient care and/or experience and that the Trust's principal purpose is not jeopardised by over-development of commercial activity. 10. Approve and review the Trust's treasury management and working capital policy ~~annually or~~ as required;

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		11. Review and monitor the strategic five-year capital programme and the annual capital budgets and recommend actions or mitigations to the Trust Board. 12. Consider proposals for investment in the estate and technology to ensure alignment with Trust strategy. 13. Manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation. 14. Review the benefits realisation of business cases and post-implementation reviews to ensure that the standard of business case preparation is consistently high. 15. Receive assurance in respect of significant programme risks associated with major transformation programmes within the Committee's remit, including the Healthset programme, with a focus on financial exposure, commercial and contractual risks, affordability, benefits realisation and the financial implications of delivery decisions or delays, and escalate material concerns to the Board as appropriate. ~~13.~~
SO 2.12 and 6	NOMINATION AND REMUNERATION COMMITTEE	The Committee will: 1. Review regularly the remuneration and terms of service of the Chief Executive and other Executive Directors (and other Very Senior Officers) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements where appropriate; 2. Decide the appropriate remuneration of the Chief Executive and other Executive Directors. Any decisions made by the Nomination and Remuneration Committee shall be recorded in the minutes of the Nomination and Remuneration Committee meetings; 3. Monitor and evaluate the performance of individual Executive Directors; 4. Advise on and oversee appropriate contractual arrangements for such staff including scrutiny of termination payments taking account of such national guidance as is appropriate.

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SO 5~~6~~	MENTAL HEALTH ~~ACT~~ LEGISLATION COMMITTEE	The Committee will: 1. Monitor the Trust's implementation of, and compliance with, current mental health legislation and proposed changes to such legislation, in particular the Mental Health Act 1983, within the Trust taking into account best practice; 2. Consider the implications of any changes to legislation and regulations within the policies, practices, procedures and resource requirements of the Trust and its partner organisations. 3. Monitor the processes relating to and outcomes of First Tier Tribunals (Mental Health) and of hearings held by the hospital managers' panels. 4. Ensure there is an appropriate number of Hospital Managers' panel members in place with the appropriate skills and experience to fulfil their role. 5. Monitor trends in compliance with and the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary. 6. Receive reports following Care Quality Commission Mental Health Act compliance visits for information and comment and ensure appropriate action is agreed and implemented within the organisation. 7. To receive reports on the application of the Mental Capacity Act 2005 within the Trust and make recommendations where necessary. 8. Monitor delivery against the Trust's action plan developed as a result of the Care Quality Commission's Annual Report as instructed by Trust Board. 9. Approve policies in relation to the Mental Health Act and Mental Capacity Act across the Trust and scrutinise the application of these policies throughout the Trust in relation to both Acts.~~.~~ 10. Identify and address training issues in terms of delegation of responsibilities under the Mental Health Act 1983. 11. Identify and address quality issues in terms of delegation of responsibilities under the Mental Health Act 1983.

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		12. Manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation.
SO 5	PEOPLE COMMITTEE	1. Oversee the development and delivery of the People ~~Strategy~~Plan, Promise and Staff Standards ~~,~~ and provid~~e~~~~ing~~ strategic direction to the Board in respect of the elements contained within it. 2. Identify and monitor key performance indicators relating to the delivery of the People ~~Strategy~~Plan, undertaking detailed review against these indicators and aspects of the People ~~Strategy~~Plan, as required, or as directed by the Board or another Committee of the Board. ~~3.~~ Ensure that the Trust has effective Freedom to Speak Up processes, including reporting, monitoring and support arrangements, in place.~~Review arrangements by which staff may raise in confidence, concerns about possible improprieties of financial reporting and control, clinical quality, patient safety or other matters~~ 3. Ensure the implementation of strategies for shared direction and culture, organisational development and workforce equality, diversity and inclusion. ~~4. Review and implement strategies for:~~ ~~– Organisational Development;~~ ~~– Equality and Diversity;~~ ~~–~~ ~~5.~~4. Ensure that effective arrangements are in place to secure the availability of a competent and appropriately qualified workforce to deliver healthcare for the Trust. 5. Manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation. 6. Oversee the development and implementation of an inclusive culture, including assurances relating to capable, compassionate and inclusive leadership arrangements.

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		7. Ensure that robust processes are in place to monitor and improve Guardian of Safe Working Hours arrangements. 8. Ensure that robust processes are in place to monitor and improve colleague wellbeing and that the Guardian of Health and Wellbeing function is well resourced. 9. Seek assurance on the workforce implications of Healthset, including organisational readiness, people resourcing, workforce implications and training risks. ~~6.~~
SO 5	CHARITY COMMITTEE	1. Ensure Funds Held on Trust (charitable funds) are managed in accordance with the Trust's SOs and SFIs, as approved by the Board. 2. Receive regular reports from the Chief Finance Officer covering: Number and value of funds Purpose of funds Income and expenditure analysis 3. Decide upon expenditure criteria. 4. Ensure that the requirements of the Charities Acts and the Charities Commission are met. 5. Provide reports to the ~~Board of Directors~~Trust Board (acting as the Corporate Trustee) as appropriate. 6. Review the Annual Accounts prior to submission to the Corporate Trustee for formal approval. 7. Ensure that all expenditure and contractual commitments funded from charitable funds are allocated to the appropriate charitable fund and are applied solely for the charitable purposes for which those funds were established. 8. Ensure that appropriate procurement and contracting arrangements are in place for activities funded through charitable funds and that such arrangements comply with the Trust's Standing Financial Instructions and applicable legal requirements.

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		9. Receive assurance regarding the investment management of charitable funds, including compliance with the approved investment strategy and review of investment performance. ~~6.~~
SO 5	EXECUTIVE COMMITTEE	The Committee will: 1. Make management decisions on issues within the remit of the Executive Directors and support individual Executive Directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information and resolution of issues. 2. Ensure timely operational decision-making and risk mitigation processes in delivering the Trust's strategic objectives and priorities. 3. Act as the primary forum for operational oversight of the Healthset programme, including monitoring delivery progress, readiness across service groups, performance and data impacts, programme-level risks and delivery assurance.
SO 5	RESEARCH AND INNOVATION COMMITTEE	The Committee will: 1. Make recommendations to the Trust Trust Board on research-related matters. 2. Seek assurance that the regulatory requirements related to research and development are being met, including research governance and research ethics. 3. Provide oversight of research activity and performance. 4. Ensure active consideration of equality, diversity and inclusion in the conduct of Committee business and the provision of research activities. 5. Ensure that risks arising from research and innovation activities are being managed and escalated appropriately in line with the Trust's policies and procedures.

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SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

REF	DELEGATED TO	DUTIES DELEGATED
3	CHIEF EXECUTIVE	Duty to prepare the accounts in accordance with the NHS Act 2006. Duty to personally sign the accounts. Witness before the Committee of Public Accounts to deal with questions arising from the accounts or from any report made to Parliament by the Comptroller and Auditor General under the National Audit Act 1983.
5	CHIEF EXECUTIVE	Responsible to Parliament for resources under his control.
7	CHIEF EXECUTIVE	Responsible for overall organisation, management and staffing of the Foundation Trust and for its procedures in financial and other matters. Ensure that: a) there is a high standard of financial management in the Foundation Trust as a whole; b) financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Foundation Trust; and c) financial considerations are fully taken into account in decisions on Foundation Trust policy proposals.
8	CHIEF EXECUTIVE	Personal responsibility for:

(Please read this document in conjunction with the Constitution, Standing Orders and Standing Financial Instructions)

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REF	DELEGATED TO	DUTIES DELEGATED
		a) the propriety and regularity of the public finances for which the Chief Executive is answerable; b) the keeping of proper accounts; c) prudent and economical administration in line with the principles set out in "*managing public money*". d) avoidance of waste and extravagance; e) the efficient and effective use of all the resources in their charge.
9	CHIEF EXECUTIVE	Required to: a) personally sign the accounts and accept personal responsibility for their proper form and content as prescribed by NHS England in accordance with the Act; b) comply with the financial requirements of the NHS Provider Licence; c) ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts; d) ensure that the resources for which he is responsible are properly well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official; e) ensure that assets for which he is responsible are controlled and safeguarded with similar care, and with checks as appropriate; f) ensure that protected property (or interest in) is not disposed of without the consent of NHS ~~Improvement~~England; g) ensure that conflicts of interest are avoided, whether in the proceedings of the ~~Board of Directors~~Trust Board, the Council of Governors or the actions of advice of Foundation Trust staff; and h) ensure that, in the consideration of policy proposals relating to the expenditure for which he is responsible, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account and brought to the attention of the ~~Board of Directors~~Trust Board.

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REF	DELEGATED TO	DUTIES DELEGATED
10	CHIEF EXECUTIVE	Ensure that effective management systems appropriate for the achievement of the Foundation Trust's objectives, including financial monitoring and control systems, have been put in place. Ensure that managers at all levels: a) have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives; b) are assigned well-defined responsibilities for making the best use of resources, including a clinical scrutiny of output and value for money; and c) have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.
11	CHIEF EXECUTIVE	Ensure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills.
12	CHIEF EXECUTIVE	Responsibility to see that appropriate advice is tendered to the ~~Board of Directors~~Trust Board and the Council of Governors on all matters of financial propriety and regulation, and more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Determine how and on what terms such advice should be tendered, and whether in a particular case to make reference to their own duty, as Accounting Officer, to justify to the Public Accounts Committee, transactions for which they are accountable.
13	BOARD	Act in accordance with the requirements of propriety or regularity; including the Fit and Proper Persons Test requirements.
13	CHIEF EXECUTIVE	Make written objections to proposals by the ~~Board of Directors~~Trust Board, Council of Governors or Chair which he considers to infringe the requirement to act with the requirements of propriety or regularity. If the ~~Board of Directors~~Trust Board, Council of Governors or Chair decides to proceed, seek a written instruction to take the action in question, and inform ~~Monitor~~ NHS England of the position (if possible, before the decision is implemented)
14 and 15	CHIEF EXECUTIVE	If a course of action is contemplated which raises an issue relating to his wider responsibilities for economy, efficiency and effectiveness, draw the relevant factors to the attention of the ~~Board of Directors~~Trust Board or Council of Governors and advise them in whatever way he deems appropriate. If his decision is overruled, and the proposal is one which he would not feel able to defend to the Public

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REF	DELEGATED TO	DUTIES DELEGATED
		Accounts Committee as representing value for money, seek a written instruction before proceeding. Inform NHS ~~Improvement~~ England of such an instruction, if possible, before the decision is implemented. If there is no time to submit advice in writing due to extreme urgency, ensure that if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards.
16	CHIEF EXECUTIVE	Appear before the Public Account Committee from time to time to give evidence on the reports arising from examinations undertaken by the Comptroller and Auditor General, and answer questions concerning expenditure and receipts for which he is Accounting Officer.
17	CHIEF EXECUTIVE	Furnish the Public Accounts Committee with explanations of any weaknesses in the matters covered in paragraphs 8-15 of the NHS Foundation Trust Accounting Officer Memorandum, to which his attention has been drawn by the Comptroller and Auditor General or about which they may wish to question to Accounting Officer.
19	CHIEF EXECUTIVE	Ensure that he is adequately and accurately briefed on matters which are likely to arise at any hearing of the Public Accounts Committee.
21	CHIEF EXECUTIVE	Ensure that he is generally available for consultation, and that in any temporary period of unavailability, there will be a senior officer in the Foundation Trust who can act on his behalf if required.
22	BOARD	Where it becomes clear that the Accounting Officer is so incapacitated that he or she will be unable to discharge his responsibilities over a period of four weeks or more, appoint an acting Accounting Officer (~~usually the Finance Director~~Deputy Chief Executive)~~,~~ until his return.
23	ACTING ACCOUNTING OFFICER	Sign accounts where the Accounting Officer is unable to sign in time for printing.

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SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	~~CHAIRMAN~~CHAIR	Final authority in interpretation of Standing Orders (SOs).
2.7.5	~~CHAIRMAN~~CHAIR	Recommend the appointment of the Deputy ~~Chairman~~Chair and the Senior Independent Director to the Council of Governors.
2.10.1 2.10.2	COUNCIL OF GOVERNORS	To appoint the ~~Chairman~~Chair and Non-Executive Directors at a general meeting of the Council of Governors. To decide the period of office, remuneration and allowances, and other terms and conditions of office of the ~~Chairman~~Chair and other Non-Executive Directors.
3.2	~~CHAIRMAN~~CHAIR	Call meetings of the Board.
3.7	~~CHAIRMAN~~CHAIR	Chair all Board meetings and associated responsibilities.
3.8	~~CHAIRMAN~~CHAIR	Give final ruling in questions of order, relevancy and regularity of meetings.
3.13	~~CHAIRMAN~~CHAIR	Having a casting vote in the event of a tie.
3.15	BOARD	Suspension of Standing Orders
3.15.5	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.16	BOARD	Variation or amendment of Standing Orders
4.1	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference (terms of reference of sub committees may be approved by the Chief Executive.)
4.2.1	~~CHAIRMAN~~CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.

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SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
4.4.2	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
4.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	BOARD	Declare relevant and material interests.
7.19	CHIEF EXECUTIVE OR SECRETARY TO THE TRUST	Maintain Register(s) of Interests.
8.	ALL STAFF	Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff". Comply with Trust's Ethical Standards Policy. Comply with Nolan principles. Fit and Proper Person requirements.
8.2	ALL	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board.)
Annex 3 SO	CHIEF EXECUTIVE	Tendering and contract procedure.
Annex 3 1.3.3	CHIEF EXECUTIVE	Waive formal tendering procedures.
Annex 3 1.3.5	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Audit Committee.
Annex 3 – 1.12	CHIEF FINANCE OFFICER	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
	~~CHIEF EXECUTIVE~~	~~Shall maintain a register to show each set of competitive tender invitations dispatched.~~ (now an electronic system)

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SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Annex 3 – 1.7.2	CHIEF EXECUTIVE AND CHIEF FINANCE OFFICER	Where one tender is received will assess for value for money and fair price.
Annex 3 – 1.9.4	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
Annex 3 – 1.15	CHIEF EXECUTIVE OR CHIEF FINANCE OFFICER	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
Annex 3 – 1.18.1.1	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
Annex 3 – 1.18	BOARD	All PFI proposals must be agreed by the Board.
Annex 3 – 1.19.4	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
Annex 3 – 1.20	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
Annex 3 – 3.1	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
Annex 3 – 1.21	CHIEF EXECUTIVE	Must ensure the Trust enters into contracts with service commissioners for the provision of NHS services.
N/A	CHIEF EXECUTIVE	Approve the legally binding contract with the Integrated Care Board or successor body.
Annex 3 - 9	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.

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SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
Annex 3 – 10.1	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents that will be necessary in legal proceedings.

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SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS (SFIs)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.6	CHIEF FINANCE OFFICER	Approval of all financial procedures.
1.7	CHIEF FINANCE OFFICER	Advice on interpretation or application of Standing Financial Instructions.
1.9	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.
3.2.1	CHIEF EXECUTIVE	Responsible as the Accounting Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
3.2.2	CHIEF EXECUTIVE & CHIEF FINANCE OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
3.2.3	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions and that they understand the responsibilities.
3.3	CHIEF FINANCE OFFICER	Responsible for: a) implementing the Trust's financial policies and coordinating corrective action; b) maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) providing financial advice to members of Board and staff; e) maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
3.4.1	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
3.5.1	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
4.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
4.1.2	CHAIR OF AUDIT COMMITTEE	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
4.1.3	CHIEF FINANCE OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
4.2.1	CHIEF FINANCE OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
4.3.1	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with ~~NHS Internal Audit Manual~~Global Internal Audit Standards and best practice.
4.6.2	AUDIT COMMITTEE	Ensure cost-effective External Audit.
4.4.1	CHIEF EXECUTIVE & CHIEF FINANCE OFFICER	Monitor and ensure compliance with the NHS Standard Contract, Service Condition 24 on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
4.5.1	CHIEF EXECUTIVE	Ensure the safety and security of officers, patients and visitors of the Trust, as part of the Trust's role as an employer and healthcare provider; safeguard Trust's premises and keep them secure. This includes the appointment of the Local Security Management Specialist.
5.1.1	CHIEF EXECUTIVE	Compile and submit to the Board an Annual Plan. The content of the Annual Plan to comply with the NHS ~~Improvement~~ England Planning Guidance.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
5.1.2 and 5.1.3	CHIEF FINANCE OFFICER	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
5.1.5	CHIEF FINANCE OFFICER	Ensure adequate training is delivered on an ongoing basis to budget holders.
5.2.1	CHIEF EXECUTIVE	Delegate budgets to budget holders.
5.4.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
5.3.1	CHIEF FINANCE OFFICER	Devise and maintain systems of budgetary control.
5.4.1 5.4.2 5.4.3	BUDGET HOLDERS	Ensure that: a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment
5.4.4	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Integrated Business Plan, the three year financial plan and the Annual Plan for NHS ~~Improvement~~England.
5.6.1	CHIEF EXECUTIVE	Submit monitoring returns to requisite monitoring organisations.
6.1	CHIEF FINANCE OFFICER	Preparation of annual accounts and reports ensuring that a copy of the annual accounts and any reports of the external auditor are laid before Parliament and then sent to NHS ~~Improvement~~ England and that the annual report is presented to the Council of Governors. Prepare a report for approval by the Board on "Going Concern".

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
7.	CHIEF FINANCE OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.
7.2.1	CHIEF FINANCE OFFICER	Develop and maintain income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
8.2.2	ALL EMPLOYEES	Duty to inform Chief Finance Officer of money due from transactions which they initiate/deal with.
11.1.1	BOARD	Establish a Nomination and Remuneration Committee, in accordance with the constitution.
11.1.2	NOMINATION AND REMUNERATION COMMITTEE	The Committee will: • decide the appropriate remuneration and terms of office for the Chief Executive and other Executive Directors (and Very Senior Officers) including all aspects of salary; provision for other benefits including pensions and cars and arrangements for termination of employment and other contractual terms and to advise the ~~Board of Directors~~Trust Board of any decisions made. • regularly review, discuss and if necessary approve changes to the remuneration and terms of service of the Chief Executive and other Executive Directors (and other Very Senior Officers) to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements where appropriate and to advise the ~~Board of Directors~~Trust Board of any decisions made. • monitor and evaluate the performance of individual senior employees, including Executive Directors. • advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
5.4.2	EXECUTIVE TEAM	Approval of variation to funded establishment of any ~~directorate~~service group.
11.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
11.4.1	CHIEF FINANCE OFFICER	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications;

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 11.4.2).
11.4.3	NOMINATED MANAGERS*	Submit time records in line with timetable. Complete time records and other notifications in required form. Submit termination forms in prescribed form and on time.
11.4.4	CHIEF FINANCE OFFICER	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
11.5.1	CHIEF OF PEOPLE AND ORGANISATIONAL DEVELOPMENT	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
12.1.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
12.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
12.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
12.2.2	CHIEF FINANCE OFFICER	Shall be responsible for the prompt payment of accounts and claims.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
12.3.1	CHIEF FINANCE OFFICER	• advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; • prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; • be responsible for the prompt payment of all properly authorised accounts and claims; • be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; • a timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; • instructions to employees regarding the handling and payment of accounts within the Finance Department; • be responsible for ensuring that payment for goods and services is only made once the goods and services are received
12.4.1	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
12.4.1	CHIEF FINANCE OFFICER	Approve proposed prepayment arrangements.
12.4.1	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform CFO if problems are encountered).
12.5.1	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
12.6.1	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
12.6.2	CHIEF EXECUTIVE CHIEF FINANCE OFFICER	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE or other relevant guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.
13.1	CHIEF FINANCE OFFICER	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
14.2.1	CHIEF FINANCE OFFICER	The CFO will advise the Board on the Trust's ability to pay dividend on Public Dividend Capital (PDC) and report, periodically, concerning the PDC debt and all loans and overdrafts.
14.2.2	BOARD	Approve a list of employees authorised to make short-term borrowings on behalf of the Trust. (This must include the Chief Executive and Chief Finance Officer .)
14.2.3	CHIEF FINANCE OFFICER	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
14.2.5	CHIEF EXECUTIVE OR CHIEF FINANCE OFFICER	Be on an authorising panel comprising one other member for short term borrowing approval.
14.3.2	CHIEF FINANCE OFFICER	Will advise the Board on investments and report, periodically, on performance of same.
15.1	CHIEF EXECUTIVE	Capital investment programme: • ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans • responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; • ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; • ensure that a business case is produced and presented to the Finance Committee.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
15.1	CHIEF FINANCE OFFICER	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
15.1	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
15.1	CHIEF FINANCE OFFICER	Assess the requirement for the operation of the construction industry taxation deduction scheme.
15.1	CHIEF FINANCE OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
15.1.5	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
15.1.7	CHIEF FINANCE OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
15.2.1	CHIEF FINANCE OFFICER	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
15.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
15.3	CHIEF FINANCE OFFICER	Maintenance of asset registers.
15.3	CHIEF FINANCE OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
15.3	CHIEF FINANCE OFFICER	Calculate capital charges in accordance with International Financial Reporting Standards and accepted accounting policies.
15.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
15.4.2	CHIEF FINANCE OFFICER	Approval of fixed asset control procedures.
15.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to CFO, and reporting losses in accordance with Trust procedure.
16.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to CFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
16.4	CHIEF FINANCE OFFICER	Responsibility for systems of control over stores and receipt of goods.
16.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsibility for controls of pharmaceutical stocks
16.2	DESIGNATED ESTATES OFFICER	Responsibility for control of stocks of fuel oil and coal.
16.3	NOMINATED OFFICERS*	Security arrangements and custody of keys
16.4	CHIEF FINANCE OFFICER	Set out procedures and systems to regulate the stores.
16.5	CHIEF FINANCE OFFICER	Agree stocktaking arrangements.
16.6	CHIEF FINANCE OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
16.7	CHIEF FINANCE OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
16.7	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to CFO evidence of significant overstocking.
16.8	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supply Chain (NHS Shared Business Agency) stores.
17.1.1	CHIEF FINANCE OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
17.2.1	CHIEF FINANCE OFFICER	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
15.5.5	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and CFO.
17.2.2	BOARD	Approve write off of losses above the level delegated to nominated Executive Directors or other senior officers contained in the Financial Limits.
17.2.4	CHIEF FINANCE OFFICER	Consider whether any insurance claim can be made.
17.2.5	CHIEF FINANCE OFFICER	Maintain losses and special payments register.
18.1.1	CHIEF FINANCE OFFICER	Responsibility for accuracy and security of computerised financial data.
18.1.5	CHIEF FINANCE OFFICER	Satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.
23.1	DIRECTOR OF CORPORATE SERVICES	Shall publish and maintain a Freedom of Information Scheme.
18.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to CFO.

(Please read this document in conjunction with the Constitution, Standing Orders and Standing Financial Instructions)

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
18.3.1	DIRECTOR OF STRATEGY AND DIGITAL DEVELOPMENT	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
18.4.1	DIRECTOR OF STRATEGY AND DIGITAL DEVELOPMENT	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
18.5.1	DIRECTOR OF STRATEGY AND DIGITAL DEVELOPMENT	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c) the Director of Strategy and Digital Development and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
19.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
19.3	CHIEF FINANCE OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
19.6	MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
20.1	CHIEF FINANCE OFFICER	Shall ensure that each trust fund that the Trust is responsible for managing is managed appropriately.
21.1	CHIEF FINANCE OFFICER	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
22.1	CHIEF EXECUTIVE	Retention of documents procedures in accordance with Records Management: NHS Code of Practice part 1 and part 2 (2006).
24.1	CHIEF EXECUTIVE	Risk management programme.
	AUDIT COMMITTEE	Approve and monitor risk management programme.
24.4	BOARD	Decide whether the Trust Board decides to use the risk pooling schemes administered by NHS Resolution if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the ~~Board of Directors~~Trust Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.
24.8	BOARD OF DIRECTORS	Where the Board decides not to use the risk pooling schemes administered by NHS Resilience for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
24.9	CHIEF FINANCE OFFICER	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

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DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES	DUTIES DELEGATED BY THE BOARD TO COMMITTEES
Audit Committee	See Terms of Reference
Nomination and Remuneration Committee	See Terms of Reference
Charity Committee	See Terms of Reference
~~Governance and Quality Assurance Committee~~Quality and Governance Assurance Committee	See Terms of Reference
Finance Committee	See Terms of Reference
People Committee	See Terms of Reference
Mental Health Legislation Committee	See Terms of Reference
Executive Committee	See Terms of Reference
Research and Innovation Committee	See Terms of Reference

The Overview of Financial Limits will be attached to the final version of the Scheme of Delegation.

(Please read this document in conjunction with the Constitution, Standing Orders and Standing Financial Instructions)

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Appendix 1:

FINANCIAL LIMITS

Paragraph 2 on page 5 under the heading Interpretation of these SFIs states that "wherever a financial limit is stipulated but no value is given, reference should be made to the Trust's decision on Financial Limits". The approved limits are set out below. The Board periodically reviews these Financial Limits:

1) Overall Financial Limits for sign off of invoices (subject to observance of the provisions of the SFIs relating to procurement	**Up to Authorisation Level £ (excluding VAT)**
Authorised Secondary List Signatory (e.g. ward sisters)	1,000
Budget holders / other authorised main list signatories (e.g. Clinical Service Manager)	5,000
Service Group Managers or equivalent (including Pharmacy) and their nominated deputies	50,000
Board Director	100,000
Assistant Director - Financial Services/Financial Management	100,000
Deputy Chief Finance Officer	750,000
Chief Finance Officer/Chief Executive	Over 750,000

2) Authorisation Limits For ordering (iProcurement)	Authorisation Level £ (excluding VAT)
Requisitioner	0
Authorised Secondary List Signatory (e.g. ward sisters)	1,000
Budget holders/other authorised main list signatories (e.g. Clinical Service Manager)	5,000
Service Group Managers or equivalent (including Pharmacy)	50,000
Board Director	100,000
Assistant Director - Financial Services/Financial Management	100,000
Deputy Chief Finance Officer	750,000
Chief Finance Officer/Chief Executive	Over 750,000

3) Procurement thresholds for competition

Type of Expenditure	Process	Procurement threshold for competition excluding VAT
Goods and Services	Request for Quotation (minimum 3 quotations sought)	£10,000
	Procurement Act 2023 above threshold tender or competition against compliant framework agreement	£112,515*
Works	Request for Quotation (minimum 3 quotations sought)	£10,000
	Below Threshold Tender (minimum 4 tenders sought) or competition against compliant framework agreement	£250,000
	Procurement Act 2023 above threshold tender or competition against compliant framework agreement	£4,327,500*
Healthcare Services	Process in accordance with Provider Selection Regime	No threshold

*The levels are amended at a national level. Advice should be sought from the Procurement Department as to the correct limit to apply in each situation

3A) Procurement Department Limits ***(note: These amounts set out the limits applicable to Procurement staff in executing orders that have been approved in accordance with sections 1,2,3&4 of appendix 1 and Appendix 3)***	**Authorisation Level £ (excluding VAT)**
Buyer	10,000
Senior Buyer	50,000
Contracts Manager	100,000
Senior Contracts Manager	250,000
Head of Procurement	Unlimited

Note: In the exceptional circumstances in which an authorised signatory wishes to delegate this responsibility to a more junior member of staff, this must be authorised by the Assistant Director-Financial Services/Financial Management (or above) for levels up to £200,000 (ex VAT) or by the Chief Finance Officer/Chief Executive if this is above £200,000.

4) Limits for entering of new contracts including products/services, maintenance, leases and managed services		
Level excluding VAT	**a) If contract awarded to the lowest cost bidder**	**b) If contract is not awarded to the lowest cost bidder**
£50,000 or below	Main List signatory	Chief Finance Officer* or Chief Executive
Above £50,000	Main List signatory and an Executive Director	Chief Executive and Chief Finance Officer*
Above £1m	Approval by the Board	Approval by the Board

*or in their absence Deputy Chief Finance Officer

5) Limits for entering of existing contracts and covered by delegated budgets or within and managed services for financial plan. Include products, services, maintenance, leases which the Trust already has had a contract in place		
Level excluding VAT	**c) If contract awarded to the lowest cost bidder**	**d) If contract is not awarded to the lowest cost bidder**
£50,000 or below	Main List signatory	Chief Finance Officer* or Chief Executive
Above £50,000	Main List signatory and an Executive Director	Chief Finance Officer* or Chief Executive
Above £1m	Main list signatory and Chief Finance Officer*	Chief Finance Officer* and Chief Executive

*or in their absence Deputy Chief Finance Officer

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	2026/27 Q2 Board Assurance Framework
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Ben Edgar-Attwell, Director of Governance
PRESENTED BY:	Mel Iles, Chief Medical Officer
DATE:	10 November 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 2 2026/27 Board Assurance Framework (BAF), providing the Board with an updated assessment of delivery against the Trust's seven strategic aims and the principal strategic risks, controls and sources of assurance. Overall, the Quarter 2 position shows progress across the majority of strategic objectives. Areas requiring continued attention include dementia, children and young people with complex needs and SEND, research capability, financial sustainability, estate development and decarbonisation. Most strategic risks remain rated Amber for assurance, with the highest-scoring risks relating to rising demand complexity, workforce sustainability, financial sustainability and capital investment, each scored 20. Aim 1 (population health and health inequalities) and Aim 7 (innovation, research and digital transformation) remain reserved for direct Board oversight. The remaining aims are overseen through the relevant Board assurance committees.
Recommendation	The Board is asked to: • Review and consider the Q2 2026/27 Board Assurance Framework. • Note that the strategic aims and objectives. • 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. Equality and health inequalities considerations are embedded within the strategic aims and programmes described in the BAF, particularly Aim 1 and the work focused on children and young people, people with complex needs, neurodevelopmental services and access to care.

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 2026/27 Board Assurance Framework have been developed from the Trust Strategy 2026-2031.

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 reviewed quarterly through the Trust's assurance committee structure. The Quarter 2 position for Aims 2, 3 and 4 was considered by the Quality and Governance Assurance Committee on 28 October 2026. Aims 5 and 6 are overseen through the People Committee and Finance Committee respectively. Aim 1 and Aim 7 remain reserved for direct oversight by the Board of Directors.

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 Q2 BOARD ASSURANCE FRAMEWORK

1. PURPOSE OF THE REPORT

1.1. This report presents the Quarter 2 2026/27 Board Assurance Framework (BAF) and provides the Board of Directors with an updated assessment of delivery against the Trust's seven strategic aims, together with the principal strategic risks, controls and sources of assurance.

1.2. The report supports the Board in fulfilling its responsibilities for strategic oversight, risk management and assurance. It highlights areas of progress, delivery exceptions, risks above appetite and areas requiring continued Board or committee attention.

1.3. The Quarter 2 BAF reflects the Trust Strategy 2026-2031. It reports the current delivery status for each objective, the position against risk appetite, strategic risk scores, controls, sources of assurance and key areas of focus.

2. OVERALL POSITION

2.1. The Quarter 2 position demonstrates progress across all seven strategic aims, with most objectives reported as on plan. Key areas of progress include:

- establishment of the Population Health Programme's five priority workstreams;
- continued development of cancer early-diagnosis and self-referral pathways;
- primary care and neighbourhood integration through Symphony;
- development of Integrated Neighbourhood Teams and care closer to home;
- delivery of frailty front-door services at both acute hospital sites;
- workforce supply, learning, leadership and retention initiatives;
- continued implementation of personalised care;
- mobilisation of the Healthset Electronic Health Record programme; and
- development of artificial intelligence, automation, data and analytics capability.

2.2. The principal exceptions relate to dementia, research capability, financial sustainability, estate development and decarbonisation. Further programme definition is also required for the objective concerning children and young people with complex needs and SEND.

2.3. Most strategic risks continue to carry an Amber assurance rating, indicating that some key controls and assurances are in place but do not yet cover all elements of the respective risks or strategic aims. The Healthset digital transformation risk is the only risk currently rated Green for assurance.

2.4. The highest-scoring strategic risks are rising demand complexity, workforce supply and sustainability, financial sustainability, and capital investment and funding, each scoring 20.

3. OVERVIEW OF STRATEGIC AIMS AND OBJECTIVES

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

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

3.2. All three objectives are reported as on plan. Progress includes establishment of five priority workstreams, launch of the Health Inequalities Dashboard, creation of the Population Health Forum and development of prevention-focused programmes relating to cardiovascular disease, tobacco dependency and obesity. Work is continuing to develop the Population Health Delivery Plan, outcome measures and trajectories.

Aim 2: Provide the Best Care and Support to People

3.3. Three of the four objectives are reported as on plan. Progress includes continued development of cancer self-referral and targeted case-finding pathways, together with improved primary care access and neighbourhood integration through Symphony. The dementia objective remains behind schedule pending development of a more detailed delivery plan.

Aim 3: Strengthen Care and Support in Local Communities

3.4. All three objectives are reported as on plan. Delivery is focused on the development of Integrated Neighbourhood Teams, more joined-up care for people with multiple long-term conditions and increased use of digital technology and remote monitoring.

Aim 4: Respond Well to Complex Needs

3.5. Five of the six objectives are reported as on plan, with further work required to define the programme for children and young people with complex needs and SEND. Progress includes delivery of frailty front-door services at both acute sites; development of the Complex Emotional Needs Strategy; appointment of a Transitional Care Lead; co-produced learning disability, autism and ADHD services; and implementation of the Personalised Care Improvement Plan. The aim remains above its Seek risk appetite.

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

3.6. All three objectives are reported as on plan. Delivery includes strengthening local and international workforce supply, expanding apprenticeships and development pathways, implementing compassionate leadership programmes and improving management capability. The aim remains within its Significant risk appetite.

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

Financial sustainability is significantly behind schedule, with the forecast percentage of recurrent efficiency savings below the aspiration in the

2026/27 financial plan. Estate development and decarbonisation are both behind schedule. Although several capital developments have been completed or are progressing, risks remain in relation to backlog maintenance, major capital funding, the New Hospital Programme, neighbourhood infrastructure and the investment required to improve estate resilience and reduce carbon emissions.

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

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

3.8. Three of the four objectives are reported as on plan. The Healthset programme remains on track against agreed milestones, while work continues on artificial intelligence and automation, the Trust's data-reporting portal and the Somerset Decision Support Unit. The research objective is behind schedule because the need to prioritise delivery of the existing research portfolio has reduced capacity for longer-term strategic development.

4. CONCLUSION

4.1. Overall, the Quarter 2 BAF demonstrates progress across the majority of the Trust's strategic objectives. The framework also identifies several areas where delivery remains behind schedule, where programmes require further definition, or where controls and assurance require continued development.

4.2. Particular attention is required in relation to:

- development of the dementia delivery plan;
- definition of the programme for children and young people with complex needs and SEND;
- risks arising from increasing complexity of demand;
- financial sustainability and delivery of recurrent efficiencies;
- capital funding, estate resilience and decarbonisation;
- continued development of research capability; and
- the adequacy of controls and assurance for risks above appetite.

4.3. Aim 1 and Aim 7 remain reserved for direct Board scrutiny. The Board is invited to consider whether the controls and sources of assurance described within the BAF are sufficient to support delivery of the Trust Strategy and whether any further action or assurance is required.

DIRECTOR OF GOVERNANCE

NHS Somerset NHS Foundation Trust

Q2 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 will stay healthier, and report greater satisfaction with our services. 3. More people with Serious Mental illness will live longer and healthier.	Board	⇔
2	DF	**Provide the best care and support to people** 1. There will be a reduction in the use of secondary care services, as a result of more joined-up support available in neighbourhoods. 2. Fewer people will die of cancer, because more cancers will be detected earlier and cancer patients will receive better care. 3. Patients with dementia will have the chance to be as independent as possible. 4. Symphony will be integral to the continued integration of neighbourhood teams, to reduce demand on the hospital and improve patient outcomes and satisfaction.	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 the majority of appropriate outpatient care will be delivered outside of acute hospitals, and more people will have their health monitored remotely thanks to expanded digital technology.	QGAC	⇔
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 admissions to Mental Health hospitals, and fewer deaths caused by intentional self-harm.	QGAC	⇔

Ref	Exec Owner	Aim & Objectives	Overseeing Committee	Risk Appetite
		3. Children and young people with complex needs and SEND will receive the right support, at the right time, in the right place, through close system partnerships, to achieve positive lifelong outcomes. 4. Children and young people transferring from CYP to adult services will be satisfied with their experience of the transfer. 5. 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. 6. People who frequently use our services will use them less frequently due to more personalised, coordinated care planning.		
5	IC	**Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture**	**People**	⇔
		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. Services will be more sustainable, and provide higher quality care, because we will be better able to retain colleagues.		
6	PM	**Live within our means and use our resources wisely**	**Finance**	⇔
		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 effects of climate change, so as to guarantee the resilience of our clinical services.		
7	DS	**Transform our services through innovation, research and digital transformation**	**Board**	⇔
		1. 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 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, reducing health inequalities and addressing the wider determinants of health. Delivery is supported through five priority workstreams and by embedding population health principles within strategic planning, service improvement and operational decision-making across the Trust.	

	A dedicated Cardiometabolic Health and Preventable Vascular Disease Workstream is now in place and is progressing development of a prevention-focused programme aimed at reducing the burden of cardiovascular disease and other preventable long-term conditions. Since the previous update, workstream leadership has been established and development has commenced on a secondary prevention service model for people at high cardiovascular risk, in partnership with Health Innovation South West. The Trust's Obesity Steering Group continues to progress work focused on prevention, education and addressing gaps in support for children and young people, whilst a new Tobacco Reduction Steering Group has been established to strengthen tobacco dependency treatment and support wider smokefree ambitions. Together, these initiatives reflect the programme's emphasis on prevention, early intervention and reducing inequalities in the conditions that contribute most significantly to reduced healthy life expectancy. An Anchor Institution Workstream has now been established to maximise Somerset FT's contribution to population health through its role as a major employer, purchaser, landowner and community partner. The workstream has established membership from across key organisational functions, completed initial benchmarking using the UCLP Anchor Measurement Framework and begun development of priorities to maximise the Trust's social, economic and environmental impact across Somerset. Development of a wider Somerset Anchor Network remains an ambition, with ongoing engagement with system partners. The Enabling Population Health Workstream continues to strengthen the systems, tools and organisational capability required to support population health improvement across SFT. Key developments this quarter include launch of the Health Inequalities Dashboard, a successful first session of SFT's new Population Health forum, and Exec approval of a revised Equality and Quality Impact Assessment policy and process. The workstream is also supporting stronger organisational governance and accountability for health inequalities, helping to strengthen assurance and improve the Trust's ability to identify, understand and address variation in outcomes and experience.	
2	**Children and young-people will stay healthier, and report greater satisfaction with our services**	**On Plan**
	A dedicated Children, Young People and Life-course Inequalities Workstream has been established within the Population Health Programme to support improved outcomes for children and young people across Somerset. The workstream aligns closely with the CYPF Pathways Transformation Programme and wider system partners, supporting a life-course approach from pregnancy through childhood and into adulthood. Planned areas to be considered include development and education, healthy weight, SEND, looked after children, injury prevention and transitions to adult services. Since the previous update, leadership arrangements, governance structures and programme documentation have been established. Following initial system engagement, the first priority improvement project has been agreed, focusing on children and young people who are persistently absent from school. The workstream is exploring school absence as an indicator of unmet health, social and developmental need and will work with education, health, social care and community partners to better understand opportunities for earlier identification and support. Co-production with children, young people and families will be a core component of programme development. The workstream is also embedded within the developing CYP Neighbourhoods model, ensuring a population health and inequalities lens is applied consistently across children and young people's service development, pathway transformation and neighbourhood delivery.	

	The workstream is also developing a broader children and young people population health approach which will provide oversight and coordination across a range of priority areas, including healthy weight and other emerging children and young people's health inequalities priorities.	
3	**More people with Serious Mental illness will live longer and healthier**	**On Plan**
	A dedicated Mental Health, Substance Misuse and Inclusion Health Workstream is being developed within the Population Health Programme to support improved physical health, wellbeing and life expectancy for people experiencing serious mental illness and other inclusion health needs. The workstream will provide oversight and coordination of related initiatives including substance misuse, tobacco dependency, inclusion health and the Patient and Carer Race Equality Framework, helping to ensure these areas contribute to wider population health and health inequalities objectives. In developing the workstream, consideration has been given to the emerging Serious Mental Illness Modern Service Framework. Early review suggests strong alignment between the framework and the aims of the Population Health Programme, particularly its focus on prevention, wider determinants of health and reducing inequalities experienced by people living with serious mental illness. Consideration is being given to how the framework can help shape priorities, measures and future delivery plans. Since the previous update, work has focused on mapping related activity across the Trust, strengthening links with existing programmes and refining the proposed scope of the workstream. Substance misuse improvement activity continues to progress and will form part of the workstream's future programme of work. Permanent leadership arrangements remain under development; however, interim arrangements have enabled the first workstream meeting to be scheduled for late October, bringing together key stakeholders to agree priorities and next steps. Establishing workstream leadership, confirming key priorities and agreeing outcome measures will be the next steps in strengthening oversight and assurance against this objective.	

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 Exec Committee and Board (final arrangements for this in progress) • 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 healthy 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	**There will be a reduction in the use of secondary care services, as a result of more joined-up support available in neighbourhoods**	**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	**Fewer people will die of cancer, because more cancers will be detected earlier and cancer patients will receive better care**	**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. • 4686 self-referrals for suspected cancer received to date, with 186 cancers detected. • 77% of patients diagnosed via a self-referral are stage 1 or 2, demonstrating a high rate of early detection. • 30% of colorectal patients have gone onto a surveillance programme at the point of coloscopy following their self-referral and a positive FIT test. • 56% of patients accessing self-referral live in the most deprived areas of Somerset. • Capsule sponge for the early identification of oesophageal cancer, case-finding now live in 3 PCNs, 1545 high risk individuals invited to take part, 375 have opted to proceed; 20% of those proceeding have been found to have a positive Barrett's Oesophagus marker, which is a condition that can be a pre-cursor to cancer; one early cancer has been identified to date. • Bladder cancer self-referral service has gone live.	

	• Liver cancer (hepatocellular carcinoma) case finding to launch in October, finding patients with abnormal liver function tests.	
3	**Patients with dementia will have the chance to be as independent as possible**	**Behind Schedule**
	Further work required to develop the plan which will provide more detail on future focus.	
4	**Symphony will be integral to the continued integration of neighbourhood teams, to reduce demand on the hospital and improve patient outcomes and satisfaction**	**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.

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.	
3	**Outpatients will need to go to hospital less, and will find it easier to manage their health at home, because the majority of appropriate 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.	

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. By definition, the development of Integrated Neighbourhood Teams is a partnership process and therefore not fully under the control of the Trust.	**4x4** **16**
	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.

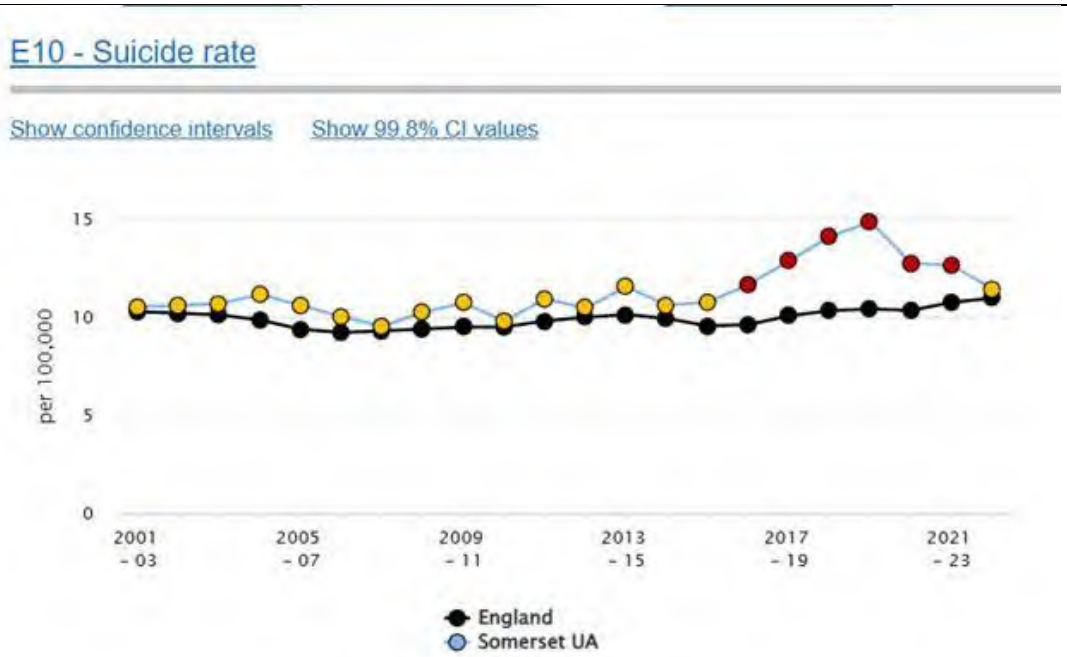
SFT Objectives / Programmes

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 YDH Frailty front door program in ED has now been running for 6 months. The experience for patients and staff is under constant review. Modifications to working practices and improved communications are in place as a result, and the team will continue to look for further improvements.

	All relevant information from YDH was shared with the team at MPH ahead of their Frailty front door service which went live on 12 October. It's still early days but weekly reviews are in place. The SFT Acute Frailty Programme Board has been re-established and met last week, chaired by Sophie Sennett, Deputy Director for Medicines Service Group. A weekly Frailty working party, led by the GPSU, supported by the ICB, has been focusing on the system wide activity to support the top 1% of people over 65, most likely to need a hospital admission in the next year. We're seeing great engagement from Neighbourhoods, Primary Care, Adult Social Care, ICB, the GPSU and the Acutes and our work continues ahead of winter. A clear governance structure is now in place for the county, led by Peter Lewis, and our Steering Group feeds into this. Somerset has also just been accepted into the second year of the National Frailty Improvement Collaborative. Sophie Sennett is attending a meeting in London on 22 October with representatives from the Somerset System and Trusts countrywide. We've been given £25,000 to support our activity.	
2	**There will be fewer admissions to Mental Health hospitals, and fewer deaths, caused by intentional self-harm.**	**On Plan**
	The update in August 2026 suggested suicides may have reduced since the last available data in 2023 but did not have evidence of this. Public Health data provides some support for this suggestion and confirms there is a long lag for available data because of the time it takes of inquest conclusions following a death. The latest (2022-24) suicide rate data from ONS (and reused by OHID) for death registrations shows the Somerset suicide rate has dropped and is now in line with the England average but probably more accurately reflects about half a year earlier in terms of when the majority of deaths occurred.	



This information, along with data from partner agencies, supports our belief that suicides have not escalated or remained at a high level.

A plan is now in place for 12-month focus on community provision in our Complex Emotional Needs (roughly analogous to Personality Disorder) Strategy and extended last year's focus on urgent care which includes transitions on discharge. This will be discussed and ratified at the next CEN Steering Group but involves work to clarify the community intervention offer for patients with CEN and ensure standardisation across all parts of the trust. This includes an expectation of in-reach onto wards when people with CEN are admitted to mental health wards, as well as a mechanism for reviewing ongoing need (i.e. decisions whether should people continue their community intervention while admitted, pause and restart, or need for review pathway and alternative offer). In addition, a proposal for a pilot project where Relational Recovery Team (specialist CEN clinicians) and Home Treatment Team staff work together to enhance care over the transition of discharge based on a model in Oxford Health.

3	**Children and young people with complex needs and SEND will receive the right support, at the right time, in the right place, through close system partnerships, to achieve positive lifelong outcomes**	**Update to be provided**
	Further work is required to define this programme.	
4	**Children and young people transferring from CYP to adult services will be satisfied with their experience of the transfer**	**On Plan**

	A Transitional Care Lead has been appointed and is expected to take up the role on 1 January 2027. Induction and implementation planning are under way, with the post intended to provide dedicated leadership and coordination across children's and adult services. Current work includes scoping anticipated transition needs over the next five years, supporting young people with complex needs who are actively transitioning, incorporating transition requirements into the Epic programme, and digitising the national care plan for children and young people. The Trust is also taking forward the transition group previously supported by the ICB, and joint transition clinics with paediatric and adult colleagues have been arranged for 2027. These developments provide a stronger foundation for improving transition pathways. However, the governance and reporting arrangements will be developed once the Transitional Care Lead is in post, and there is not yet an agreed measure or baseline demonstrating whether children and young people are satisfied with their experience. The immediate priorities are therefore to establish the governance structure, define the transition pathway and cohort, and introduce systematic feedback and outcome measures for young people and families.	
5	**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.	
6	**People who frequently use our services will use them less frequently due to more personalised, coordinated care planning**	**On Plan**
	The Personalised Care Programme continues to support the Trust's aim to put people, their families and carers at the centre of care decisions. The Trust has agreed its strategy and developed the improvement plan for 2026 to 2029. The Personalised Care Improvement Group now reports regularly to the Patient Experience and Engagement Committee, with its first report presented on 24 September 2026. BDO confirmed in August 2026 that the recommendations from its January 2024 audit were complete. The digital Somerset personalised care and support plan has launched on SiDer with 83 plans developed from June to August and 26 in September. Nearly 100 colleagues have completed the online introduction to personalised care this year. Work with the Every Minute Matters programme is also supporting teams to make "what matters to you" conversations part of everyday care. Since June, 2 additional questions have been included in the monthly inpatient surveys to track whether people feel involved in care decisions and whether teams ask what matters to them, this will be helpful to track progress more regularly. The early results show progress with patient involvement in care, but a deterioration in being asked about what matters to them post the 100 day sprint work. The 2025 inpatient survey found that 77% of respondents always felt included in conversations with doctors and 77% with nurses. However, only 38% felt involved "a great deal" in decisions about their care and treatment. Involving families and carers in discharge planning remains an area for improvement. Training capacity remains a barrier. The part-time trainer role ended following organisational changes, and the Trust has been unable to recruit a replacement. Teams also face challenges in releasing colleagues for training. The personalised care improvement group is exploring other ways to support training and shared learning. The next priorities are to further increase use of personalised care plans, support training, extend patient feedback beyond inpatient wards and focus on actions to support colleagues routinely asking patients what matters to them. These steps will help the Trust to test changes and assess whether changes improve people's involvement, experience and outcomes. Oversight and delivery have progressed, but further evidence is needed to show that personalised care forms a consistent part of care across all 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 colleague experience, 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 and talent management 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**	**Signficantly 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 in reducing the underlying deficit if it is not improved. The position has deteriorated from Q1 due to the pause of the subsidiary expansion plans until further guidance is received from NHSE. 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**	**Behind Schedule**
	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 and therefore the delivery of this objective is at risk. The identification of potential neighbourhood health centres has been undertaken, however long term funding has not yet been identified.	
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.	

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**	**5x4**

	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.	**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**	**3x4 12**

	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	
	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 unified Electronic Health Record, due to go live in 2028. When in place, we will be able to provide seamless, integrated care using with a unified digital patient record.

This is part of a broader transformation of services with digital, data and technology over the next five years.

Using 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. Good progress has been made on recruitment to the programme team including technical, clinical and operational subject matter experts to commence the initial system build. Technical deliverables are progressing to plan, with a key milestone to baseline the replaced and retained clinical systems achieved. 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. The NHSE organisational readiness assessment has recently been undertaken, and the external NHSE assurance gateway commences mid-October.	
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 an 8-week diagnostic review of use cases across digital, data and technology services, people services and other corporate	

	areas. Recommendations will inform the short to medium term AI developments, building on the learning from early AI agent development. Work continues to establish the AI lab, 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. The Somerset Decision Support Unit has launched, enabling data professionals from across the Trust to collaborate, supporting support better, well-informed, timely decisions. The DSU is part of the evolving operating model for our data services ahead of the Epic implementation. 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) • Partnership Board reporting in place and receiving regular assurance reports • Programme assurance reporting quarterly to Board / committees • 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
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Corporate Risk Register Report
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Mark Roughan, Trust Risk Manager
PRESENTED BY:	Mel Iles, Chief Medical Officer
DATE:	10 November 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	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: • Financial position • Insufficient capacity to meet demand, deliver against referral to treatment times and reduce waiting lists • Workforce recruitment and retention • 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: • Financial sustainability and strategic delivery • 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 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

Recommendation	The report covers those risks detailed on the Somerset NHS Foundation Trust CRR on 19th October 2026. The report focuses on the defined corporate risks. The Committee is asked to note the report and the risks identified.

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: Click or tap here to enter text.

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 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

COPORATE RISK REGISTER REPORT

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.

1.2 The risks recorded within this report 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 Somerset Foundation Trust (SFT) has been included within Appendix 2.

1.4 The management of corporate risks also includes those 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 Public Board

2.2 This risk report aims to provide details of the key risks detailed on the Trust's Corporate Risk Register on 19th October see Risk Circle, Appendix 0.

3. CORPORATE RISK REGISTER OVERVIEW

3.1 There are currently twenty-three risks on the Corporate Risk Register (and 150 service group risks that score 15 or more) see Risk Circle Appendix 0

Risks Added in October

3.2 Three new risks have been identified since the August report:

- RSK-003754 – Delivery of the 2026/27 efficiency programme (score 25).
- RSK-003752 – Delivery of the 2026/27 financial plan (score 25).
- RSK-003882 – Risk of failure to deliver timely, high-quality patient safety incident investigations due to workforce constraints (score 16)

3.3 The most notable additions are the emergence of financial sustainability as the Trust's highest-rated risk theme. In August there were no risks scored 25. By October, two new financial risks had entered the register at the maximum score of 25:

- RSK-003752- Delivery of the 2026/27 Financial Plan
- RSK-003754- Delivery of the 2026/27 Efficiency Programme

3.4 These became the highest-ranked corporate risks and replaced the former SHS financial sustainability risk (RSK-002192), which was removed from the register.

Risk Score Changes

3.5 Only one existing risk changed score in the current reporting period:

- RSK-001815- Workforce metrics such as vacancies, retention and sickness affecting delivery of care which scored 16 in August and scores 15 in October.

Risk Management Thematic Narrative of the 150 15+ Risks

3.6 A clear theme emerging from the risks this month is the growing pressure on workforce capacity, recruitment and retention across a wide range of services. Significant risks are evident in Radiology, Oncology, Maternity, Paediatrics, Rheumatology, District Nursing and Emergency Care, where vacancies, specialist skill shortages, sickness absence and reliance on temporary staffing are affecting resilience. Many risks describe single points of failure, limited succession planning and difficulties recruiting to highly specialised roles. These workforce challenges are creating operational fragility, increasing pressure on existing staff and raising concerns regarding staff wellbeing, burnout and the sustainability of services over the longer term

3.7 A second prominent theme is capacity and flow across the Trust. Numerous risks highlight increasing demand, insufficient bed capacity, delays in discharge pathways, Emergency Department overcrowding and prolonged waiting times for diagnostics, treatment and specialist services. These pressures are interconnected, with delayed patient flow affecting emergency care performance, elective recovery and overall organisational efficiency. Several risks also reference external dependencies, including community capacity, social care provision and availability of onward care placements, demonstrating the system-wide nature of these challenges.

3.8 There is also a strong theme concerning patient safety, quality of care and clinical governance. Risks relating to diagnostics, cancer pathways, transfusion services, safeguarding, infection prevention, clinical investigations and compliance with national standards suggest ongoing concerns about maintaining consistent quality in a high-pressure environment. Several risks identify potential delays in diagnosis or treatment, limitations in governance processes, and challenges in ensuring staff maintain competencies and training compliance.

3.9 Finally, there are significant concerns regarding estate infrastructure, facilities and digital systems. A substantial number of risks relate to fire safety, evacuation challenges, ageing buildings, backlog maintenance, ventilation, water safety, electrical resilience and unsuitable clinical environments. Alongside this, several risks reference fragmented IT systems, digital transformation challenges and technology dependencies that could impact patient care and operational continuity. Together these risks indicate that

maintaining safe, modern and resilient infrastructure remains a critical operational challenge.

4. RISK APPETITE & RISK TOLERANCE

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 3.

5. SERVICE GROUP & CORPORATE FUNCTION RISKS

Excluding the twenty-three corporate risks there are 150 risks scoring 15 or more identified at Service Group and departmental levels. These are managed locally within the Service Groups.

6. COMPOUND RISKS

6.1 Compound risks occur when multiple risks happen at the same time, or in sequence, and amplify one another's impact. For example, a surge in demand alongside workforce shortages and system failures can create significantly greater disruption than any single issue alone. Understanding how risks interact helps the organisation take a more joined-up approach to planning, strengthening resilience and reducing the potential impact on services, staff and patient care.

6.2 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

6.3 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

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

7. RISK MANAGEMENT ARRANGEMENTS UPDATE

7.1 The Trust has also appointed a new Head of Risk, Lisa Bartlett, who commenced on 26 October 2026. Lisa brings a wealth of experience across both public and private sectors within risk management and compliance.

7.2 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.

7.3 Overall compliance with Level 1 Risk Management mandatory training shows marked progress, with the latest data showing Trust-wide compliance rising to 94.7% as of 5th October 2026 up from 86.9% in the previous report.

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

8. CONCLUSION

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.

9. RECOMMENDATION

The Board are asked to review the Corporate Risk Register.

RISK MANAGER

APPENDICES:
Appendix 0: Risk Circle
Appendix 1: Board Assurance Framework
Appendix 2: Validation of Risks
Appendix 3: Risk Appetite and Risk Tolerance

Corporate Risk Register 19th October 2026

NHS Somerset NHS Foundation Trust

People Committee

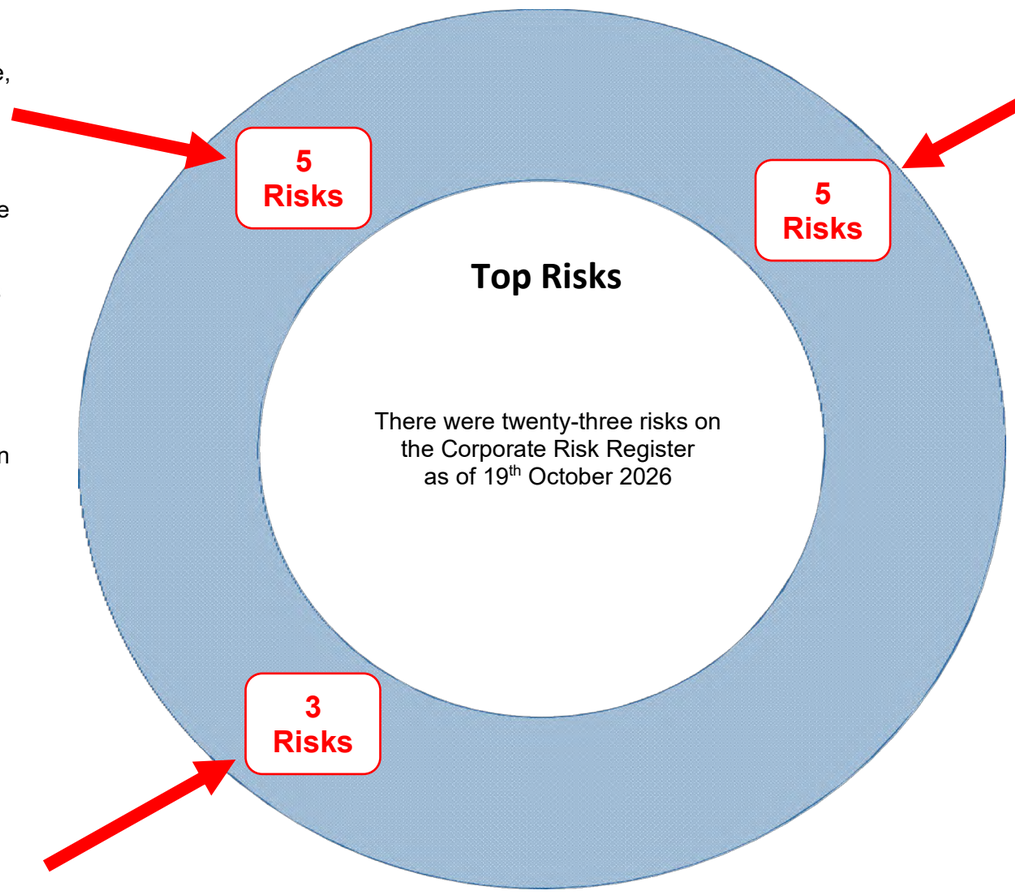
16 RSK-003775 If safer staffing standards are not maintained, risk of degradation of the safety of patient and service user care, for example increased likelihood of clinical errors, delayed interventions, or unsafe skills mix.

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

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



Financial Committee

25 RSK-003754 Delivery of the 2026/27 efficiency programme
25 RSK-003752 Delivery of the 2026/27 financial plan
20 RSK-001611 Failure to secure necessary infrastructure due to the assurance of availability of capital funding either locally or through national programmes

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-003882 Risk of failure to deliver timely, high-quality patient safety incident investigations Due to workforce constraints,

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*

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 the central repository for the Trust's most significant operational risks. It includes risks scoring 15 or above that cannot be managed adequately within a Service Group or corporate service, together with risks that have a significant organisation-wide impact and require Executive oversight and assurance.

7.7 These risks represent the most significant risks affecting the Trust's 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 Assurance 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's consideration of the Annual Report,

including the Annual Governance Statement, which describes the effectiveness of the Trust's systems of governance, risk management and internal control.

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 Assurance Committees, the Board will receive assurance that the BAF and Corporate Risk Register have 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 Group 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 Performance Oversight Meetings (POM). 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 POM 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 POM 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 Executive Committee meetings.

9. RISK APPETITE AND RISK TOLERANCE

9.1 Risk appetite is defined as '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 is 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 aid 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 that 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)**

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
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:	10 November 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 62-day cancer 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 against the A&E delivery standard in respect of patients being admitted, discharged or transferred within twelve hours. • inappropriate Out of Area Placements for non-specialist mental health inpatient care. National priority areas in respect of which the contributory causes of, and actions to address, underperformance are set out in greater detail in this report include: • Talking Therapies: percentage of patients completing a course of treatment for anxiety and depression achieving Reliable Recovery. • compliance against the A&E delivery standard in respect of patients being admitted, discharged or transferred within four hours • compliance in respect of the diagnostic six week waiting times standard remained above the operational plan. • compliance in respect of the 28-day Faster Diagnosis cancer standard. • cancer 31 day wait from a Decision To Treat / Earliest Clinically Appropriate Date to First or Subsequent Treatment. • the percentage of patients waiting no longer than 18 weeks for acute treatment was above the planned level.
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: SEPTEMBER 2026

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



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

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

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

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

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

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

- NOF NHS Oversight Framework for 2025/26
- NSG Measures derived from a range of guidance documents for Stroke services
- OPG NHS England Priorities and Operational Planning Guidance
- PAF NHS England Performance Assessment Framework for 2025/26
- SFT Somerset NHS Foundation Trust internal target / monitoring
- SHS Symphony Healthcare Services internal target / monitoring
- 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.
- Patients attending A&E admitted, discharged or transferred from ED within 12 hours across achieved the 94.7% standard.
- inappropriate Out of Area Placements for non-specialist mental health inpatient care.
- maintain performance against the 62-day cancer standard at 75%.

For these measures, our performance in September 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.
- improve A&E waiting times, with a minimum of 82% of patients admitted, discharged and transferred from ED within 4 hours in March 2027.
- deliver a minimum 3% improvement in respect of the diagnostic six week waiting time standard.
- improve performance against the headline 28-day cancer Faster Diagnosis 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.
- Improve the percentage of clinical trials set up within 90 days.
- 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 September 2026 compliance of 44.9% was achieved. Utilising current underspend to outsource 200 treatments at Step 3 will help to reduce waiting times which is shown to lead to better recovery rates.

Compliance in respect of the A&E and UTC four-hour reporting standard decreased from 73.0% in August 2026 to 71.7% in September 2026b, below the Recovery Trajectory level for September 2026 of 73.4%. A range of actions and developments are in progress to improve the position at both sites, including a dedicated push on paediatric patients having a plan and being admitted, transferred or discharged within four hours, and reviewing data on diagnostic delays across CT, X-ray, MRI and ultrasound pathways, to understand better where scope for improvement lies.

The percentage of patients waiting under six weeks for their diagnostic test was 79.5% in September 2026, the lowest rate reported since April 2026 and below the planning trajectory of 82.6%. Waiting list initiatives are being undertaken in ultrasound; additional locums and insourcing are also being sought to support the ultrasound service. Weekend insourcing of endoscopy continues.

Compliance reported during August 2026, the latest validated data available, in respect of the 28-day Faster Diagnosis cancer standard was 74.7%, below the current national standard of 80%, and below our Operational Plan trajectory of 78.6%. The highest numbers of breaches were in skin (36% of breaches; performance of 61%), colorectal (24%; 63%) and urology (10%; 69%), together making up 70% of breaches. Colorectal has commenced a weekly Improvement Programme; pathway analysis is under way, supported by Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance (SWAG) and a project manager from the Trust is in place to provide support. Work also continues to try to reduce colonoscopy waiting times.

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 August 2026 was 91.3%, below the national reporting standard of 96% and below the Operational Plan of 92.4%. There were 60 breaches of the standard, 24 (40% of breaches) of which were for skin, 18 (30%) of which were for urology and 10 (17%) of which were for breast. There were smaller volumes of breaches across a range of tumour sites. Increase in breaches of the 31-day standard for skin patients have occurred due to an early and prolonged seasonal 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 dermatologist retired from the skin service in December

2025, and there has also been an unexpected extended absence, which represent service gaps. An insourcing provider is being used to provide additional capacity within the dermatology service, and a further insourcing contract has been awarded; 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 63.9% in September 2026, 3.8% below plan. Actions to improve the position include expanding service capacity for treating patients awaiting surgery, through 15 additional theatre sessions running each week, which started to increase in September 2026 through the opening of the King's building.

For the percentage of clinical trials set up within 90 days our performance in September 2026 sits within the middle to upper tier nationally. The main challenge remains in respect of recruiting the first patient within 30 days of site opening. Actions agreed to improve compliance are tracked through to completion, with escalation of significant risks through the appropriate governance routes.

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.

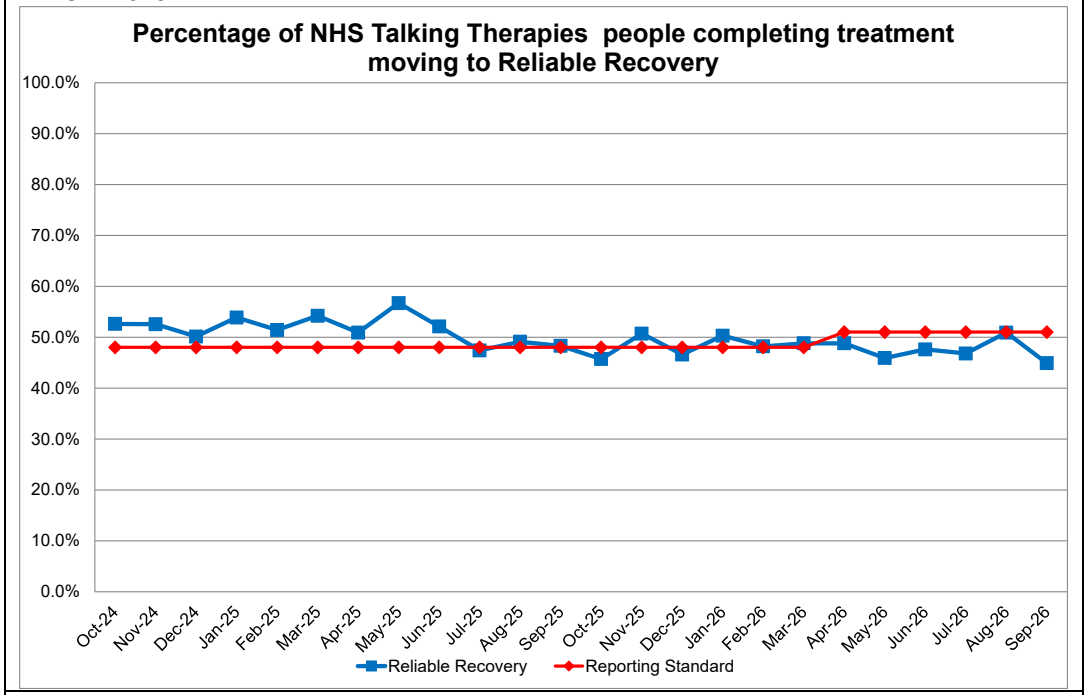
Current performance (including factors affecting this)

- During September 2026, of a total of 434 patients discharged, 195 were recorded as moving to Reliable Recovery, a rate of 44.9%.
- From 1 April 2026 the national reporting standard increased from 48% to 51%.

Focus of improvement work

- Utilising the underspend to outsource 200 treatments at Step 3. Reduced waiting times are shown to lead to better recovery rates.
- Health inequalities need to be addressed in order to improve referral rates in respect of people aged over 65.
- Communications are issued in the GP newsletter on a rolling basis, particularly targeting the over 65 population. Six-weekly meetings to be held with the ICB / GP Support Unit to monitor progress/impact.
- Recovery-focused supervision for all staff, with bespoke training completed for supervisors on the importance of outcome measures.
- There is a focus on productivity and recovery, in line management supervision, with clear guidance set in the service update regarding what counts as patient-facing activity.
- A request has been submitted to our Data Analytics team for individual therapist-level dashboards.

Line Chart



How do we compare

National average performance for providers was 47.5% in August 2026, the latest data available. Our performance was 50.9%.

Performance over the last six months

Area	Apr	May	Jun	Jul	Aug	Sep
Compliance	48.8%	45.9%	47.6%	46.8%	50.9%	44.9%

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 52.4% during September 2026, down from 55.0% in August 2026. With Urgent Treatment Centres (UTCs) compliance included at 96.6%, the overall compliance was 71.7%, below the Operational Plan standard for September 2026 of 78.5%, and below the recovery plan of 73.4%.
- Compliance in respect of our two A&E departments was:
  - Musgrove Park Hospital (MPH): 49.8%.
  - Yeovil District Hospital (YDH): 56.7%.
- In September 2026 a total of 1,362 out of 1,419 patients (96.0%) were discharged, admitted or transferred with four hours at the YDH UTC.
- Between 1 and 30 September 2026, 94.8% of patients spent less than 12 hours in the EDs, better than the Operational Plan target of 94.7%.

Focus of improvement work

Both

- Scrutiny of daily performance, weekly operational reviews and analysis of reasons for breaches.
- Nurse in Charge challenging delays where an ED doctor's plan remains pending when EPIC is otherwise busy.
- Review of ambulance arrival batching and offloading plans

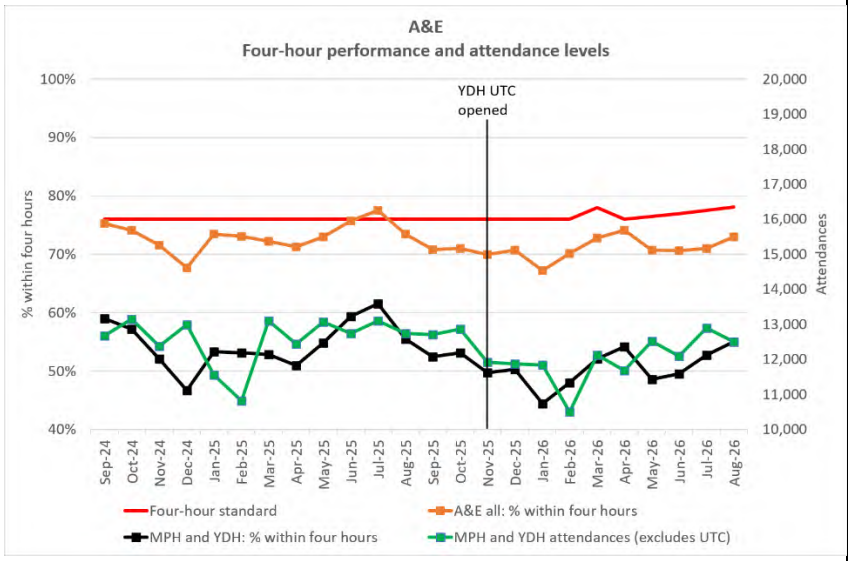
MPH:

- Trial of a progress chaser in ambulatory majors to chase radiology, bloods etc.
- Improving data collection for non-admitted patients waiting over 12 hours to identify learning and improve patient care.
- Requesting data on diagnostic delays across CT, X-ray, MRI and ultrasound pathway, to understand better where scope for improvement lies.
- QI improvement programme under way focussing on improving our non-admitted performance for paediatrics

YDH:

- Resetting the administration progress chaser role to work more closely with doctors and follow up potential delays in the patient pathway more effectively.
- New administration recruits have now started, allowing better cover at all urgent front door services.
- Return appointments have gone live for when the UTC closes while patients are still waiting to be seen. Where clinically safe, patients will be discharged home with an appointment for the following morning. This approach will later be extended to overnight ED patients, focusing on minor injuries and ailments.

Line Chart



How do we compare

In September 2026, the national average performance for Trusts with a major Emergency Department was 60.6%. Our performance was 52.4%. We were ranked 87 out of 121 trusts. With Urgent Treatment Centre attendances included, we were ranked 66 with performance of 71.7%. National average performance was 72.3%.

Recent performance

Area	Apr	May	Jun	Jul	Aug	Sep
A&E only	54.1%	48.6%	49.5%	52.7%	55.0%	52.4%
Including UTC	74.1%	70.7%	70.6%	71.0%	73.0%	71.7%

Responsive

The Diagnostic six-week wait is a measure of the length of wait from referral through to diagnostic testing being carried out. This standard is applied to the top 15 national high-volume tests. The target is to achieve, by March 2027, at least 93.7% of patients to have been waiting less than six weeks for a test at the month-end.

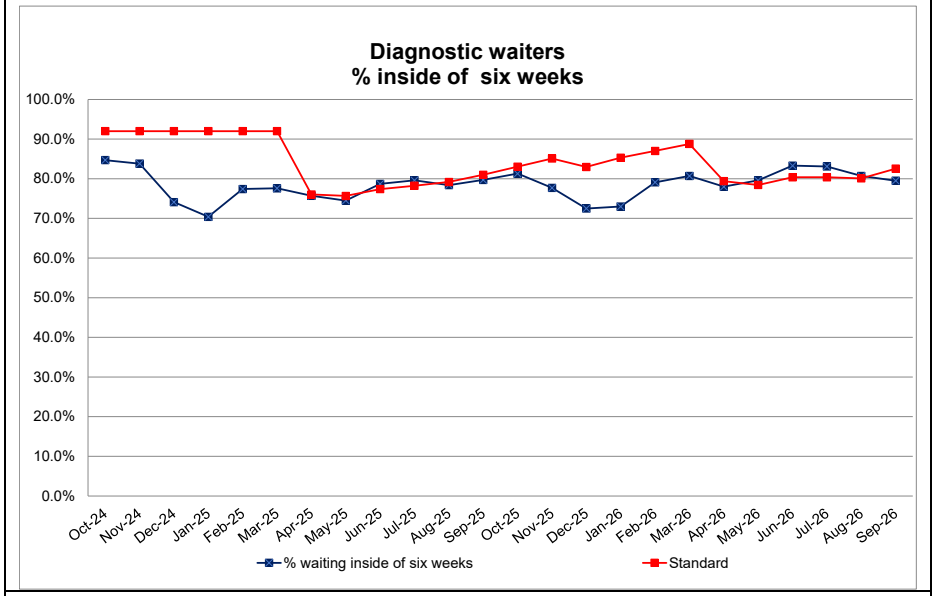
Current performance (including factors affecting this)

- The percentage of patients waiting under six weeks for their diagnostic test was 79.5% in September 2026, below the planning trajectory of 82.6%.
- The number of patients waiting over six weeks in September 2026 increased by 219 patients in the month; the highest numbers of patients were waiting for the following diagnostic tests:
  - Ultrasound (up from 668 to 947; 35% of over six-week waiters).
  - Endoscopy (up from 810 to 903; 33% of over six-week waiters).
  - MRI (up from 280 to 326; 12% of over six-week waiters).
- The total waiting list size increased by just over 2% (302 patients); most of this increase was in ultrasound.
- The deterioration in performance largely reflects this increase in the ultrasound waiting list due to a shortfall in capacity related to high demand, staff vacancies and sickness absence.

Focus of improvement work

- Waiting list initiatives in ultrasound; additional locums and insourcing are also being sought to support the ultrasound service; a longer-term plan is being developed.
- Continued weekend insourcing of endoscopy.
- Reviewing the utilisation of endoscopy capacity within the Yeovil Community Diagnostic Centre, and how we can make use of any spare capacity to scope patients from the west of the county where the waiting times are longer.
- Opening of the Bridgwater Diagnostic Centre scanners (complete), which provides additional complex scanning capacity away from Musgrove and Yeovil, which will particularly help to reduce MRI waiting times.

Line Chart



How do we compare

National average performance for NHS providers (i.e. excluding Independent Sector providers) was 74.7% in August 2026, the latest data available. Our performance was 80.7%. We were ranked 73 out of 153 trusts for the 15 high-volume diagnostic tests.

Recent performance

Area	Apr	May	Jun	Jul	Aug	Sep
% compliance	78.0%	79.6%	83.3%	83.1%	80.7%	79.5%
Trajectory	79.4%	78.4%	80.4%	80.4%	80.1%	82.6%

Responsive

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

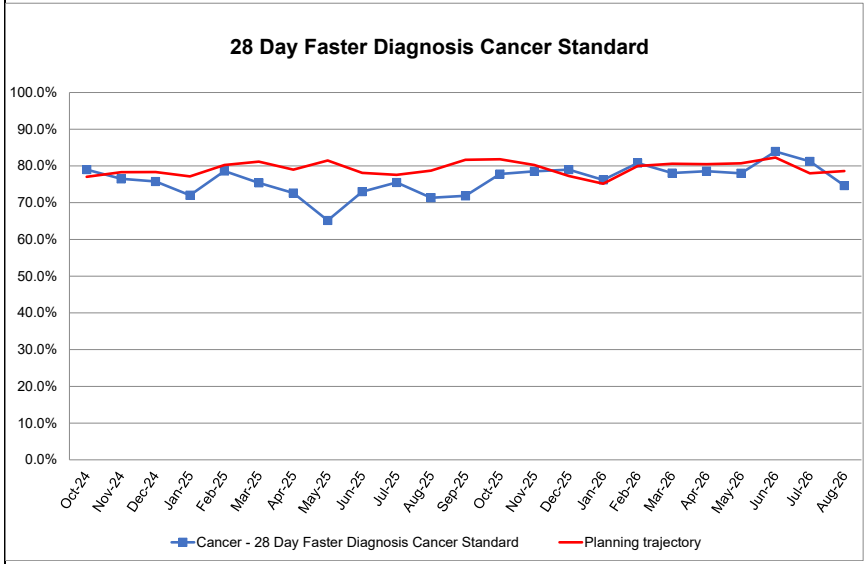
Current performance (including factors affecting this)

- The percentage of patients diagnosed with a cancer or given a benign diagnosis within 28 days of referral was 74.7% in August 2026, below our planning trajectory of 78% and also below the new March 2026 target of 80%.
- The highest numbers of breaches were in skin (36% of breaches; performance of 61%), colorectal (24%; 63%) and urology (10%; 69%), together making up 70% of breaches.
- We have had an early and prolonged seasonal surge in suspected skin cancer referrals in the last few months, which may be 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 dermatologist retired from the skin service in December 2025, and there has also been an unexpected extended absence.
- Colorectal waiting times have been affected by waiting times for colonoscopies, which have increased due to reduced service capacity; the causes for longer colonoscopy waits are multifactorial but include extended leave of a locum and nurse endoscopist sickness. Waiting times for CT colons have also been longer than optimal.

Focus of improvement work

- Please see the 31-day cancer report for actions related to the skin cancer service.
- Colorectal has commenced a weekly Improvement Programme; pathway analysis is under way, supported by Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance (SWAG) and a project manager from the Trust is in place to provide support.
- Work continues to try to reduce colonoscopy waiting times, including additional sessions being established, nurse endoscopist recruitment and ongoing insourcing; Additional CT colon capacity is being provided at Taunton and Yeovil Community Diagnostic Centres.
- Please also see the Cancer report.

Line Chart



How do we compare

National average performance for providers was 78.6% in August 2026, the latest data available. Our performance was 74.7%. We ranked 108 out of 141 providers.

Recent performance

Performance in recent months was as follows:

28-day GP cancer performance

Area	Mar	Apr	May	Jun	Jul	Aug
Trajectory	80.6%	80.2%	80.5%	80.7%	82.3%	78.0%
Compliance	78.1%	78.6%	78.0%	83.9%	81.2%	74.7%

Responsive

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

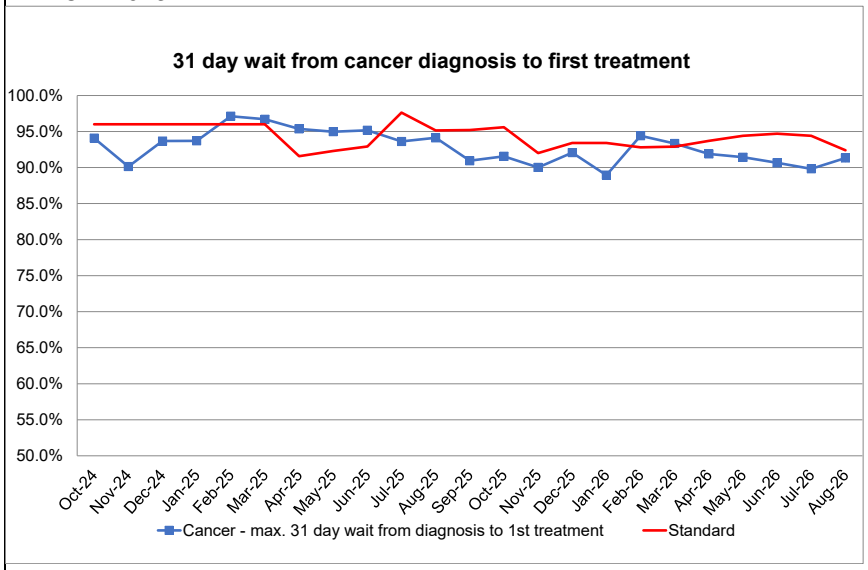
Current performance (including factors affecting this)

- Performance against the 31-day first combined treatment standard was 91.3% in August 2026, below the 96% standard to be achieved by March 2027 and also below the planning trajectory of 92.4%.
- There were 60 breaches of the standard, 24 (40% of breaches) of which were for skin, 18 (30%) of which were for urology and 10 (17%) of which were for breast. There were smaller volumes of breaches across a range of tumour sites.
- There has been an increase in breaches of the 31-day standard for skin patients due to an early and prolonged seasonal 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 dermatologist retired from the skin service in December 2025, and there has also been an unexpected extended absence, which represent service gaps.
- Urology has gaps in its capacity as a result of retirements and resignations.

Focus of improvement work

- An insourcing provider is being used to provide additional capacity within the dermatology service, and a further insourcing contract has been awarded; a locum was appointed and started in June 2026 but has since left; a replacement locum is being sought.
- A business case is being developed for the procurement of an Artificial Intelligence based system to support the triage of referrals for suspected skin cancer. This should enable patients with the highest suspicion of cancer to be prioritised.
- Additional theatre capacity came 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, including urology.

Line Chart



How do we compare

National average performance for providers was 92.1% in August 2026, the latest data available. Our performance was 91.3%. We ranked 109 out of 140 providers.

Recent performance

Performance in recent months was as follows:

31-day GP cancer performance

Area	Mar	Apr	May	Jun	Jul	Aug
Trajectory	92.9%	93.7%	94.4%	94.7%	94.4%	92.4%
Compliance	93.3%	91.9%	91.4%	90.7%	89.8%	91.3%

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.

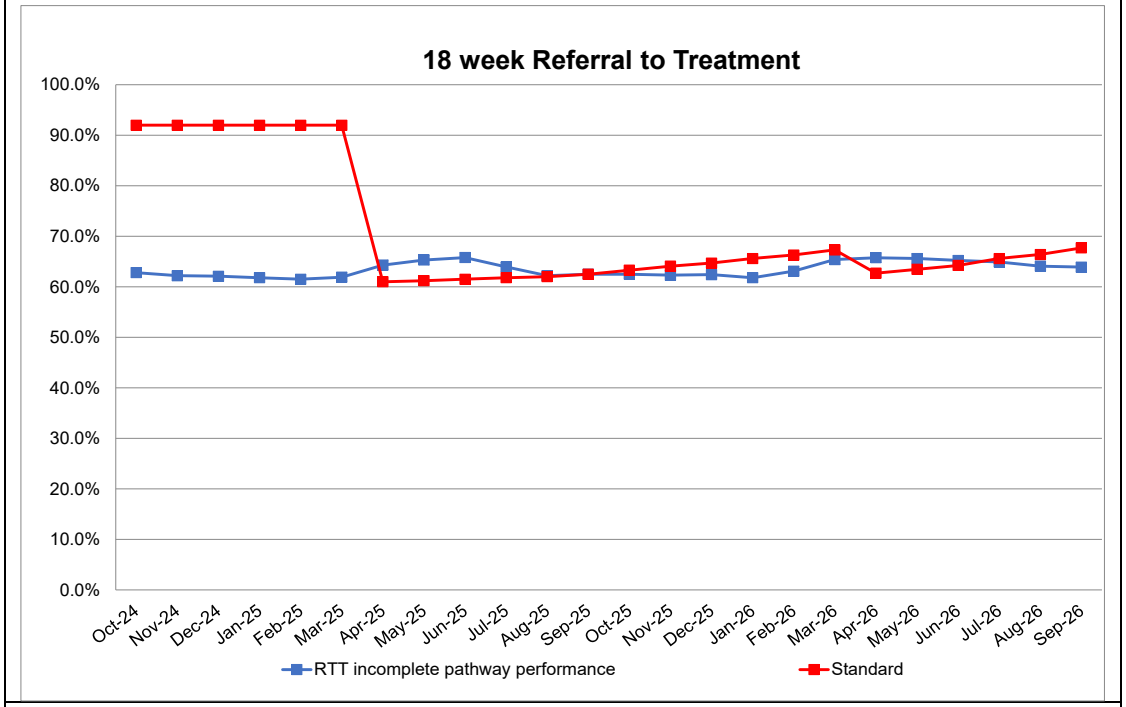
Current performance (including factors affecting this)

- The percentage of patients waiting under 18 weeks RTT reduced to 63.9% in September 2026. This is 3.8% below (i.e. worse than) plan. The percentage of patients waiting under 18 weeks for a first appointment decreased to 71.6% and was also below the plan level of 74.2%.
- Total waiting list size increased by 458 pathways (55,859 actual vs. 47,845 plan). The variance from plan is in part due to the plan being set when the impacts of Advice & Refer were still emerging. Clock stops (i.e. treatments) remain on plan, but clock starts (i.e. referrals) are significantly above plan.
- The number of patients waiting over 52 weeks increased to 1,764 against an original plan of 485. This represents 3.2% of the waiting list against the plan of no more than 0.8%. This in part represents an increase in the maxillofacial waiting list due to gaps in service capacity.
- The number of patients waiting over 65 weeks decreased to 58 at the end of September 2026 against a national expectation of zero; three patients 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, started to ramp up in September 2026 through the opening of the King's building.
- Using the machine-learning RTT missed stops App, to prioritise pathways for validation on both hospital sites, to make sure the RTT waiting list is update to date and as 'clean' as it can be.
- 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 65.2% in August 2026, the latest data available; our performance was 64.1%. National performance deteriorated by 0.1% between July and August 2026; our performance deteriorated by 0.8%. The number of patients waiting over 52 weeks across the country increased by 1,960 to 113,339 (1.5% of the national waiting list compared with 3.1% for the Trust). The number of patients waiting over 78 weeks nationally increased by 143 to 1,637.

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

Area	Apr	May	Jun	Jul	Aug	Sep
18-week trajectory	62.7%	63.5%	64.2%	65.6%	66.4%	67.7%
18-week actual	65.8%	65.6%	65.2%	64.9%	64.1%	63.9%
First OPA 18 weeks trajct.	71.8%	72.0%	72.3%	73.2%	73.4%	74.2%
First OPA 18 weeks actual	76.2%	73.9%	73.4%	73.4%	73.5%	71.6%
52-week trajectory	1.5%	1.4%	1.2%	1.1%	1.0%	0.8%
52-week actual	2.1%	2.4%	2.4%	2.7%	3.1%	3.2%

Research and Development

Percentage of clinical trials set up within 90 days: this measures the percentage of NIHR portfolio studies at each organisation that recruited their first participant within 90 days of regulatory approval or date site selected, whichever comes later. Our aim is to achieve a compliance level of 80%

Current performance (including factors affecting this)

For an organisation of the size and research portfolio of Somerset NHS Foundation Trust:

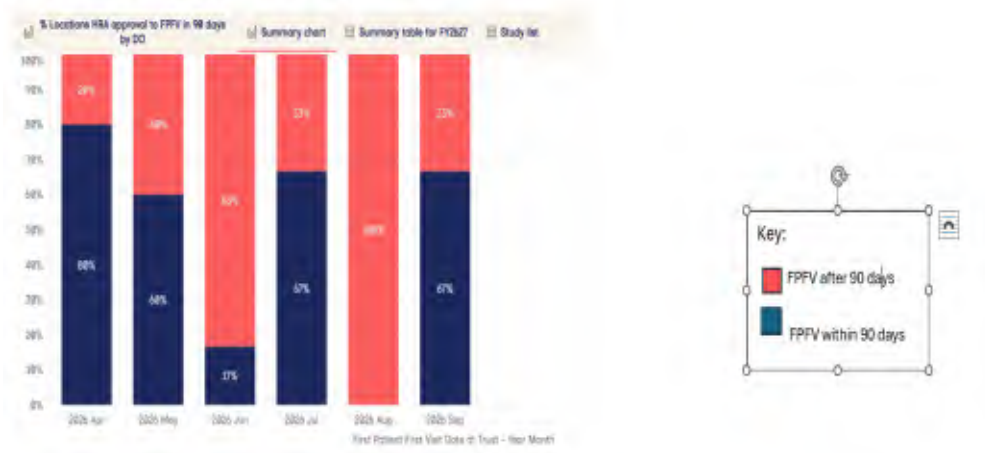
- Performance for September 2026 sits in the middle-to-upper tier nationally.
- The most encouraging metric is the 35-day median set-up time, which suggests study set up processes are efficient.
- The main challenge remains recruiting the first patient within 30 days of site opening. A new portfolio management system will support better-informed decisions about which studies the Trust has capacity to deliver.

Focus of improvement work

- **Portfolio Management:** The Lead Research Nurse has established a structured portfolio review process with Band 7 Team Leaders to provide oversight of study performance and delivery. First Participant First Visit (FPFV) metrics are routinely reviewed to identify operational constraints, monitor risks, and ensure timely intervention where performance issues are identified. Agreed actions are tracked through to completion, with escalation of significant risks through the appropriate governance routes.
- **Study set up workflow:** The Research and Development Manager is leading on a project that will unify study set-up approaches across Musgrove Park and Yeovil hospitals, irrespective of whether a study is based at one or both sites. A fully revised set of templates, Standard Operating Procedures (SOPs) and guidance documents are currently being prepared. This is underpinned by some strategic changes to organisational structure to further support an efficient and streamlined approach whilst maintaining effective governance.

Line Chart

First Patient First Visit (FPFV) within 90 days, by month:



How do we compare

In September 2026, Somerset NHS Foundation Trust achieved the UKCRD 90-day recruitment target in 67% of eligible commercial studies, placing the Trust broadly in the upper-middle range of NHS providers and comparable with other South West organisations.

Performance over the last six months

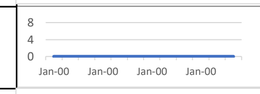
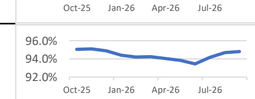
Nine commercial studies needed to achieve FPFV this FY. Three did not meet target.



FPFV was not met for three studies because: MAESTRA 2 – sponsor closed study early. Seven patients were screened, six were ineligible, one had to be withdrawn due to sponsor decision. C4551002 study - complex eligibility criteria reducing the number of eligible patients for the study. HF Polaris - National shortages of investigational medicinal product (IMP) required screening slots to be centrally allocated by the sponsor. The earliest available screening opportunity was in October 2026.

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	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-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	94.3%	93.9%	93.9%	95.8%	90.8%	89.1%	88.2%	91.4%	91.9%	92.5%	92.8%	92.6%	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	70.9%	74.1%	69.6%	76.5%	72.2%	69.9%	71.5%	71.5%	72.7%	71.5%	75.5%	69.1%	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	45.7%	50.7%	46.6%	50.3%	48.2%	48.8%	48.8%	45.9%	47.6%	46.8%	50.9%	44.9%	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	Change to reporting criteria with effect from 1 April 2026						0	0	0	0	0	0	=<1= Green >1 = Red		P
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	71.0%	70.0%	70.7%	67.2%	70.1%	72.8%	74.1%	70.7%	70.6%	71.0%	73.0%	71.7%	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	95.0%	95.1%	94.9%	94.4%	94.2%	94.2%	94.0%	93.8%	93.4%	94.2%	94.7%	94.8%	>=94.7% = Green <94.7% = Red		P
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	81.3%	77.7%	72.5%	73.0%	79.1%	80.7%	78.0%	79.6%	83.3%	83.1%	80.7%	79.5%	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	69.6%	76.5%	76.4%	73.7%	73.1%	77.9%	71.8%	64.9%	70.4%	73.5%	77.8%	Data not yet due	Above trajectory >=75% = Green Above trajectory but <75% = Amber Below trajectory = Red		?
NP9		Maintain performance against the 28-day cancer Faster Diagnosis Standard at 80%	1,2	77.8%	78.5%	79.0%	76.2%	80.8%	78.1%	78.6%	78.0%	83.9%	81.2%	74.7%	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	91.6%	90.0%	92.1%	89.2%	94.4%	93.3%	91.9%	91.4%	90.7%	89.8%	91.3%	Data not yet due	Above 96% = Green Above trajectory but < 96% = 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	62.5%	62.3%	62.4%	61.8%	63.1%	65.4%	65.8%	65.6%	65.2%	64.9%	64.1%	63.9%	From April 2026 >=trajectory = Green <trajectory = Red		F
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	-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)	-11.6% (£7,292K)	-8.7% (£8.883K)	>=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	50.7% higher than plan	51.7% 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 access performance remained strong in September 2026: 92.6% of people waited under 18 weeks from referral to first appointment.
- Mental health access improved, with 97.4% of patients across all services, 95.6% in Older People's Community Mental Health Teams and 94.3% in Memory Assessment Teams waiting under six weeks for a first appointment.
- MSK physiotherapy improved from 72.3% to 77.1% of patients waiting under ten weeks, although performance remains below the 90% standard. Rapid Response admission avoidance also improved, with only 7.2% of referrals resulting in acute admission, compared with 11.0% in August 2026 and better than the target of 20% or less.
- Workforce indicators were positive overall: mandatory training increased to 95.9%, retention reached 90.0%, vacancies improved to 8.2%, and agency spend remained within plan. Career conversation compliance is addressed under challenges.
- Ready-to-discharge date recording improved to 96.3%.
- There were no MRSA, MSSA or E. coli bloodstream infections reported in September 2026; one C. difficile case was reported.
- Symphony is now providing the Minor Injury Unit service in Burnham-on-Sea three days per week, with progression to seven days per week from 5 October 2026.
- Engagement has also commenced to bring Hospital at Home and Rapid Response together as one urgent care service.
- The number of people waiting for Pathway 2 beds was 14 as at 25 September 2026, a 50% reduction from 28 at the same point last year.

Challenges

- Urgent Treatment Centre (UTC) four-hour performance reduced from 98.0% in August 2026 to 96.6% in September 2026, with under-16 performance reducing to 97.2%. Hours lost through early closure remained substantial, but reduced from 813.5 hours in

August 2026 to 482.5 hours in September 2026. UTC sickness absence was running at around 8% and had reduced during September 2026. Unit closures had also reduced following the significant pressures experienced during August 2026; Burnham-on-Sea MIU had transferred to Symphony and was operating five days per week with some continuing HCA support from UTC. However, a significant ENP vacancy remained, with limited response to the current advert, resulting in staffing gaps and short-notice staff movement between units, including during shifts. Developing practitioner posts have been over-established as a longer-term mitigation.

- Overdue follow-ups increased from 1,206 in August 2026 to 1,300 in September 2026. The backlog was concentrated in Elderly Medicine (455), Physiotherapy (301), Pain Management (296) and Dietetics (201). The deterioration was driven principally by Pain Management (+73), Physiotherapy (+32) and Elderly Medicine (+31), and was partly offset by improvement in Dietetics (-37).
- Hospital at Home remained materially below planned utilisation: the average caseload reduced from 78 to 76, admissions increased slightly from 202 to 210 but remained below the Red threshold of 377, and bed occupancy was 45.5% against an 80% target.
- Community hospital flow remained pressured. Overall occupancy was 95.1%, average length of stay was 37.2 days for non-stroke patients and 34.8 days for stroke patients, and 47.7% of bed days were lost to patients with no reason to reside.
- The community hospital falls rate was 7.06 per 1,000 occupied bed days in September 2026, slightly improved from 7.32 in August 2026, but still above the Statistical Process Control upper limit of 6.95. A previous review identified a small number of high-risk patients during mobilisation; risk assessments and care plans were in place and bay nursing was re-implemented on one ward where supervision could have been improved.
- Elective and community access delivery remained variable. Podiatry deteriorated slightly to 34.7% of patients waiting for six weeks or less, dietetics reduced to 80.2% and Community Rehabilitation Service reduced to 85.2%. Pain performance and the overdue follow-up backlog remain significant concerns, while MSK physiotherapy is improving but remains below the standard.
- Career conversation compliance reduced to 79.7%, below the 90% standard. Nursing roster non-effective time increased to 30.4% against the 22% expectation, and consultant and SAS doctor job-plan sign-off reduced to 55.3%.
- Only 50% of complaints were responded to within the agreed timescale in September 2026, with eight open complaints awaiting response.
- Long waits for initial dementia assessment remain an operational concern. Current waits are five months in South Somerset, seven months in Taunton and West Somerset (TAWS), two months in Mendip and five months in Sedgemoor. Wellbeing support is in

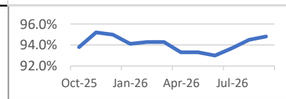
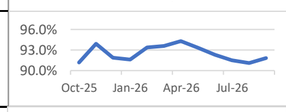
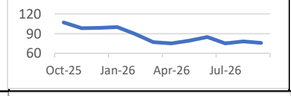
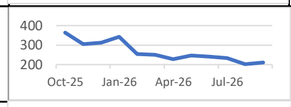
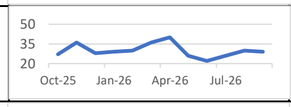
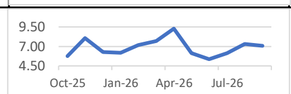
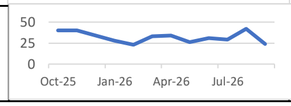
place for people waiting, and new diagnosis pathways being tested with South Somerset Complex Care GPs are now also being rolled out in Taunton.

Actions to Address Underperformance:

- A UTC workforce plan and Quality and Equality Impact Assessment are being developed alongside ICB discussions and wider same-day urgent care engagement. Additional payment arrangements are under review to support recruitment and retention in difficult-to-staff areas, with regular executive oversight. The current vacancy, sickness and closure position should be confirmed through the latest operational update.
- Targeted recovery action is under way across Elderly Medicine, Physiotherapy and Pain Management, focusing on pathway redesign, recruitment and additional capacity, while Dietetics continues to monitor mixed RTT performance and workforce pressures.
- Discharge pathways are being strengthened, including a Pathway 2 test-and-learn, to accelerate transfers and reduce community hospital length of stay and bed days lost where patients do not meet the criteria to reside.
- All neighbourhoods and community hospitals have implemented monthly pressure-ulcer huddles to review cases, leading to bespoke training and equipment reviews. Falls-reduction actions include strengthened supervision and bay nursing where indicated.
- Workforce and recovery actions are under way in MSK physiotherapy, podiatry and pain services. Improvement plans should also address career conversations, nursing roster non-effective time, job-plan sign-off and timely complaint responses.
- Hospital at Home remodelling continues, supported by the integration work with Rapid Response and a transformational lead is now in post. Lead Advanced Clinical Practitioner interviews were rescheduled for October 2026 following an unsuccessful appointment round in September 2026, and recruitment is in progress for band 6 and 7 posts.

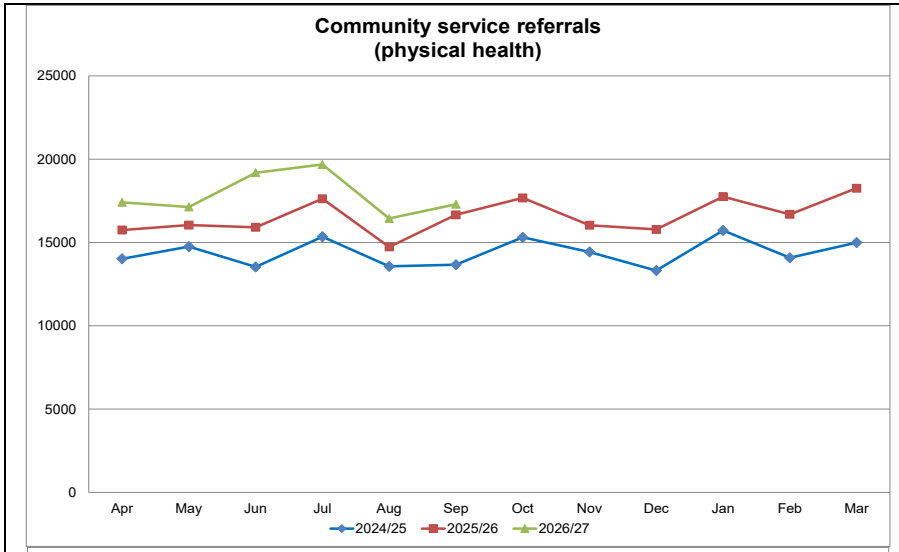
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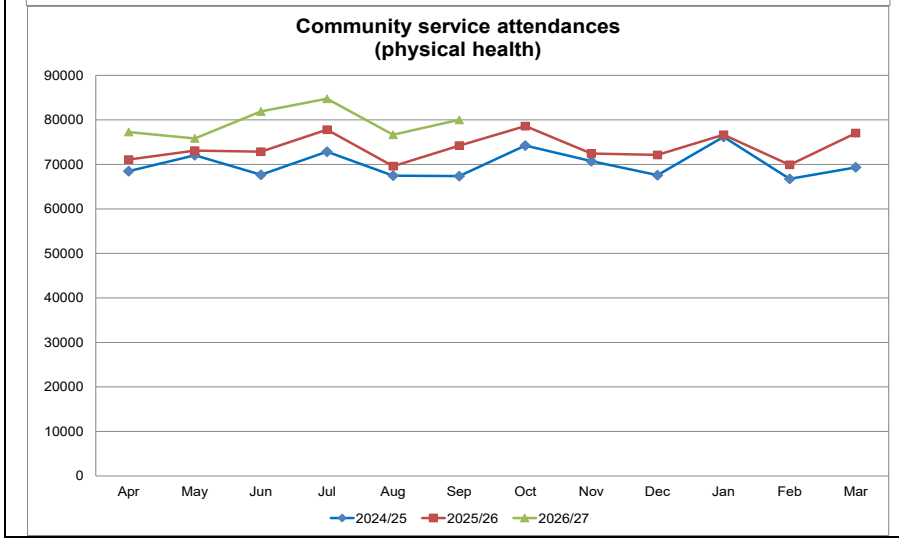
NEIGHBOURHOODS AND COMMUNITY SERVICES

No.	Description		Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
NC1	Mental health referrals offered first appointments within 6 weeks	Older Persons mental health services	ICB	1,2,3	97.9%	95.8%	97.1%	95.7%	94.5%	90.7%	92.6%	94.9%	96.9%	95.4%	94.0%	97.4%	>=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	93.8%	95.2%	95.0%	94.1%	94.3%	94.3%	93.3%	93.3%	93.0%	93.7%	94.5%	94.8%	>=95%= Green >=85% - <95% =Amber <85% =Red		
NC3	Urgent Community Response: percentage of patients seen within two hours		NHSC	1,2,3	91.2%	93.9%	91.9%	91.6%	93.4%	93.6%	94.3%	93.3%	92.3%	91.5%	91.1%	91.8%	>=70%= Green >=60% - <70% =Amber <60% =Red		
NC4	Hospital at Home - Caseload Size		VWOF	1,2,3	107	98	99	100	89	77	75	79	85	75	78	76	>167 = Green >134 - <167 =Amber <134 =Red		
NC5	Hospital at Home - Admissions		VWOF	1,2,3	364	304	313	342	254	251	227	247	241	234	202	210	>419 = Green >377 - <419 =Amber <377 =Red		
NC6	Community hospitals % of bed days lost in respect of patients not meeting the Criteria to Reside		NHSC	2	33.6%	35.8%	31.1%	29.9%	31.5%	33.9%	48.4%	46.1%	45.1%	52.6%	44.2%	47.7%	<=20% = Green >20% = Red		
NC7	Total number of patient falls - community hospitals		NHSC	2	27	36	28	29	30	36	40	26	22	26	30	29	Monitored using Statistical Process Control rules >57 = Red		
NC8	Rate of falls per 1,000 occupied bed days - community hospitals		NHSC	2	5.78	8.06	6.29	6.16	7.16	7.71	9.28	6.14	5.36	6.14	7.32	7.06	Monitored using Statistical Process Control rules >6.95 = Red		
NC9	Community hospitals - number of pressure ulcers		NHSC	2	5	5	11	12	3	7	8	3	6	3	3	Data not yet due	From April 2026 <=5 = Green >5 = Red		
NC10	Community hospitals - rate of pressure ulcer damage per 1,000 occupied bed days		NHSC	2	1.07	1.12	2.47	2.55	0.72	1.50	1.86	0.07	1.46	0.71	0.73	Data not yet due	Monitored using Statistical Process Control rules >2.90 = Red		
NC11	District nursing - number of pressure ulcers		NHSC	2	77	74	64	99	92	90	118	100	112	116	105	Data not yet due	Monitored using Statistical Process Control rules >104 = Red		
NC12	Rate of pressure ulcer damage per 1,000 district nursing contacts		NHSC	2	2.37	2.40	2.00	3.05	3.02	2.95	3.75	3.14	3.52	3.38	3.25	Data not yet due	Monitored using Statistical Process Control rules >3.15 = Red		
NC13	Total number of medication incidents in a community setting		NHSC	2	40	40	34	28	23	33	34	26	31	29	42	24	From April 2026 <=55 = Green >55 = Red		

Operational context

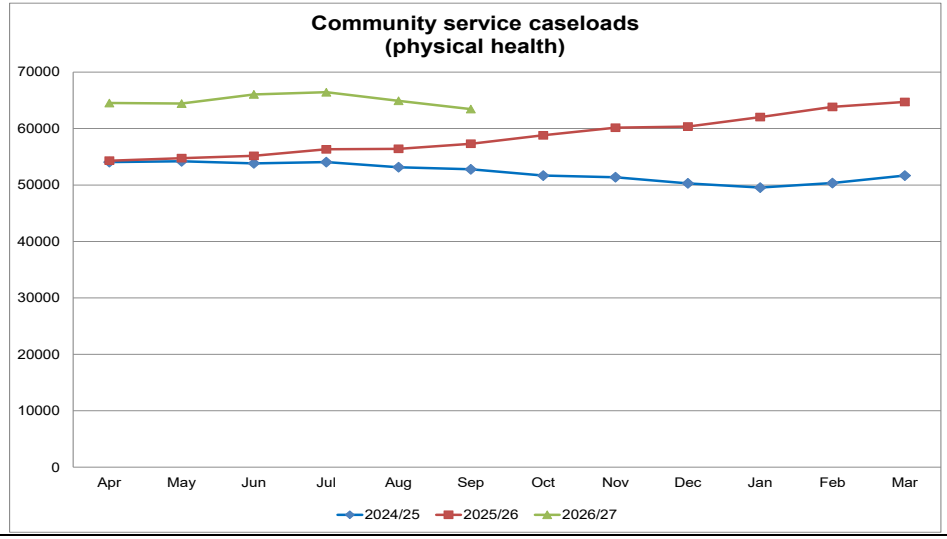
Community Physical Health: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





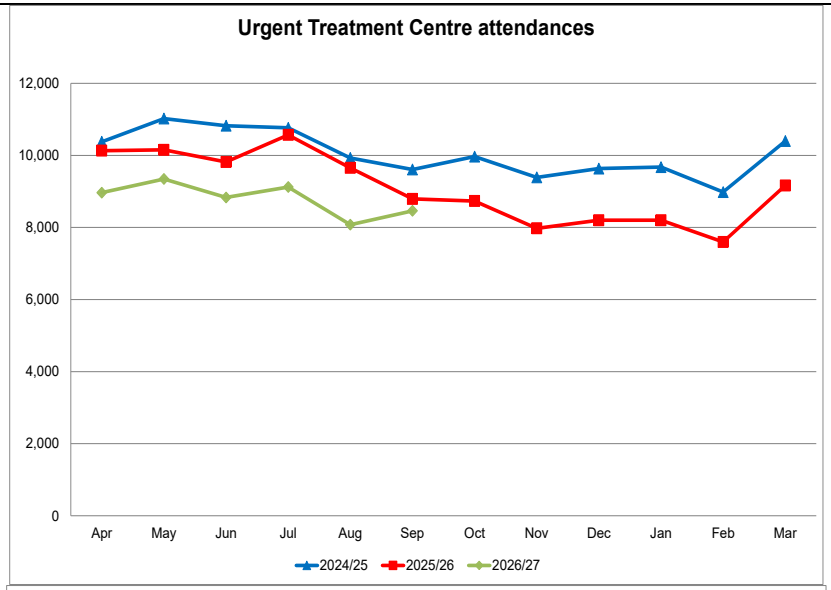
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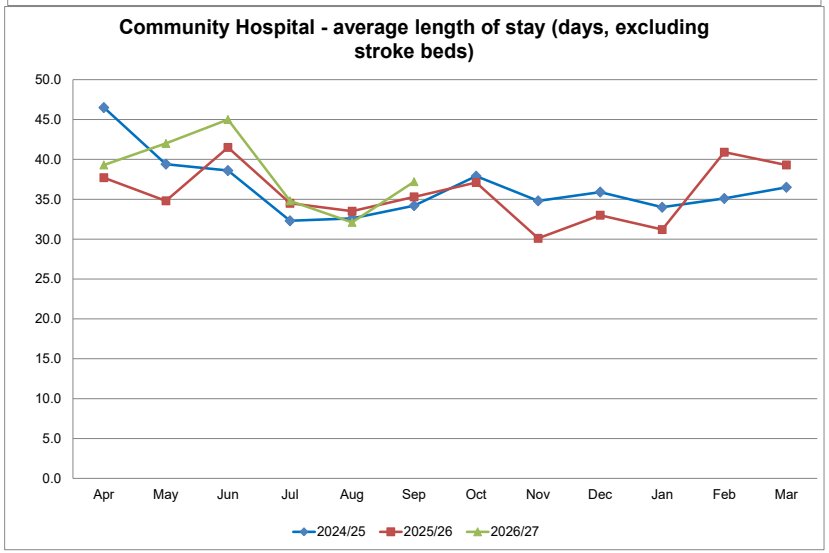
- Direct referrals to our community physical health services between 1 April and 30 September 2026 were 10.8% higher than the same months of 2025 and 26.2% higher than the same months of 2024.
- Attendances between 1 April and 30 September 2026 were 8.6% higher than the same months of 2025 and 14.6% higher than the same months of 2024.
- Community service caseload levels as at 30 September 2026 were 10.7% higher than as at 30 September 2025, and 20.2% higher than as at 30 September 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

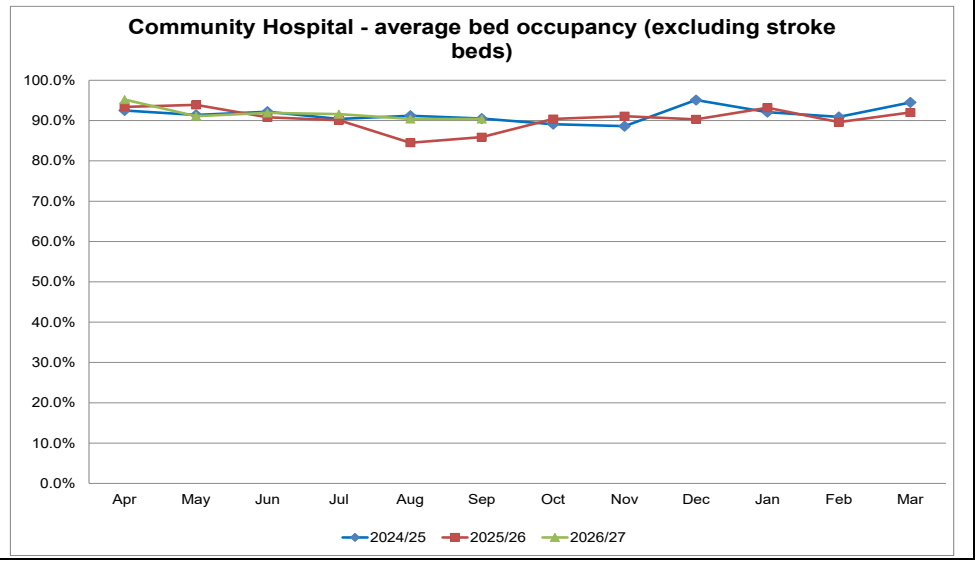
Community Physical Health: This section of the report provides a high-level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





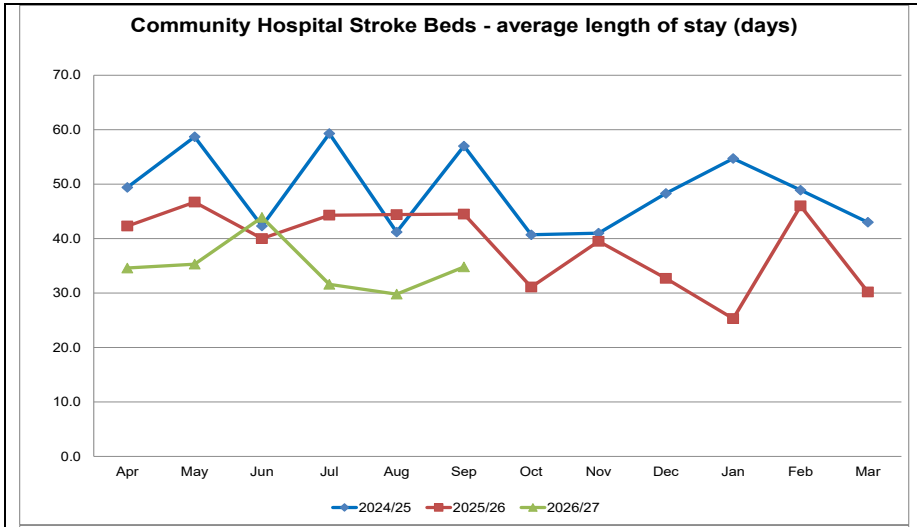
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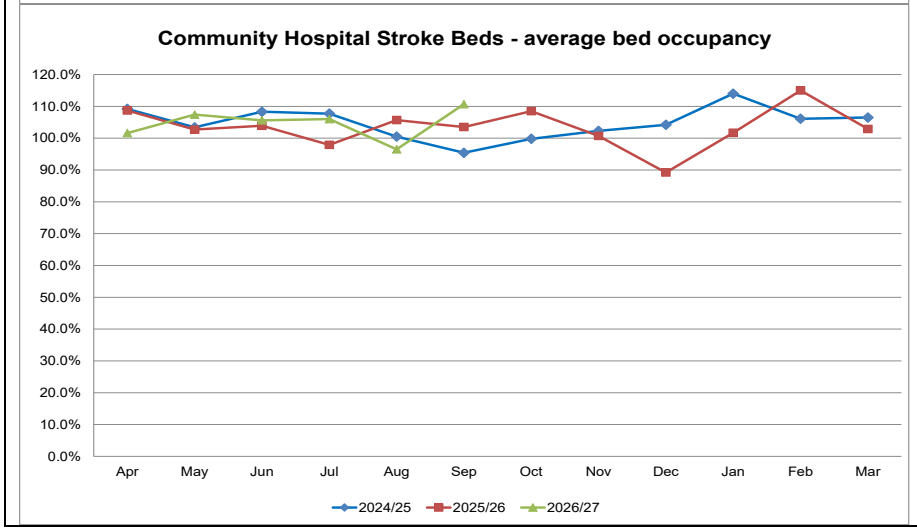
- Between 1 April and 30 September 2026, the number of Urgent Treatment Centre (UTC) attendances (excluding the YDH UTC) was 10.7% lower than the same months of 2025 and 15.5% lower than the same months of 2024. During September 2026, 96.7% of patients were discharged, admitted, or transferred within four hours of attendance, against the national standard of 78%.
- The average length of stay for non-stroke patients in our community hospitals in September 2026 was 37.2 days; an increase compared to August 2026. During September 2026, of 87 discharged non-stroke patients, three 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 30 September 2026 was 36.6 days, compared to 35.8 days for the 12-month period ending 30 September 2025.
- The community hospital bed occupancy rate for non-stroke patients in September 2026 was 90.4%, the same as during August 2026.



Operational context

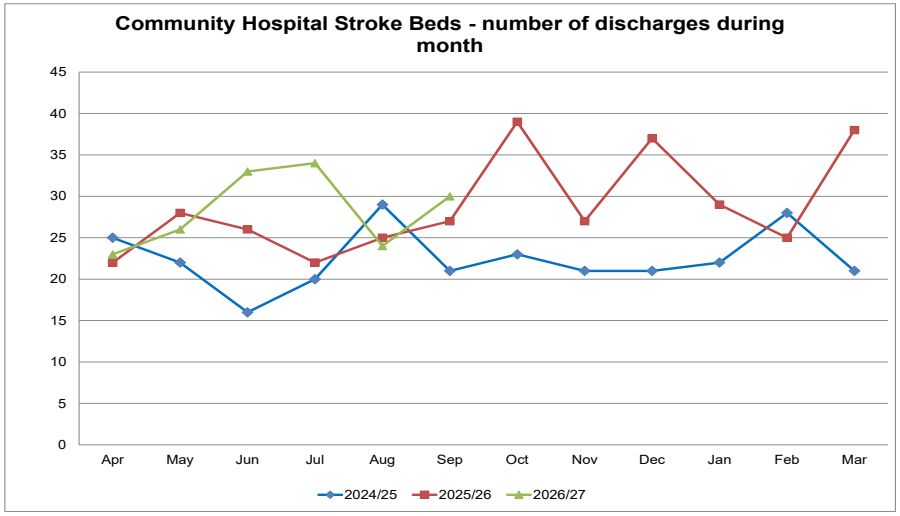
This section of the report looks at a set of key community hospital indicators relating to stroke patients, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay for stroke patients in our community hospitals in September 2026 increased to 34.8 days, from 29.8 days in August 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 30 September 2026 was 34.3 days, compared to 44.9 days for the 12-month period ending 30 September 2025.
- Stroke bed occupancy in September 2026 increased to 110.7% from 96.5% during August 2026.
- During September 2026 there were 30 discharges of stroke patients, up from 24 in August 2026.



NARRATIVE REPORT

SYMPHONY HEALTHCARE SERVICES

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

What is Going Well

- Dementia diagnosis rates continue to improve and remain on a positive upward trajectory.
- Operational performance across the organisation remains strong despite the ongoing demands associated with service transformation and organisational change.
- Delivery of the 2026/27 financial plan remains on track.

What Requires Improvement and Planned Actions

GP Vacancy Rate (S4)

- The GP vacancy rate has continued to reduce. The only remaining vacancies are within Symphony South following the merger completed on 7 July 2026.
- Recruitment activity continues, alongside targeted actions to support workforce stability and the continued development of the newly merged practice.

Call Queue Waiting Times (S7)

- Average call waiting times have increased, largely due to a significant number of call handler vacancies within Symphony South. This is likely to have impacted on patient experience and satisfaction.
- Recruitment and workforce planning initiatives are under way to improve resilience and reduce waiting times.
- In addition, work is progressing to explore the use of AI-supported receptionist technology to support call handling. A preferred supplier has been identified, and the business case is being finalised.

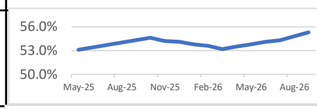
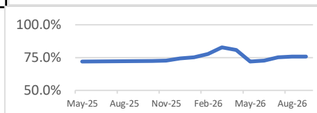
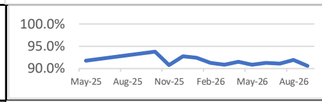
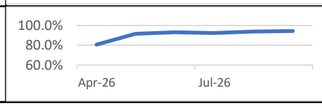
Other updates

- The management review has now been completed and contributes to delivery of the Cost Improvement Programme (CIP).
- Work continues to support the development of neighbourhood working arrangements and strengthen collaborative leadership across practices.
- The 2026/27 financial plan remains on track. However, Symphony's longer term financial sustainability remains a key risk due to the anticipated withdrawal of all ICB resilience funding from 2027/28. Discussions with the ICB are ongoing to explore future funding arrangements. A going concern for Symphony will be presented to the Board by the end of 2026.

Year	2023/24	2024/25	2025/26	2026/27	2027/28
ICB resilience support £m	7.1	5.8	4.2	2.5	0

SOMERSET NHS FOUNDATION TRUST

SYMPHONY HEALTHCARE SERVICES

No.	Description	Source	Links to strategic aims	May-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
S1	Dementia diagnosis rates for patients aged 65 years plus	OPG	1,3,4	53.1%	54.6%	54.2%	54.1%	53.8%	53.6%	53.2%	53.5%	53.8%	54.1%	54.3%	54.8%	55.3%	>=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%	72.3%	72.7%	74.4%	75.2%	77.8%	82.8%	80.8%	72.0%	72.8%	75.2%	75.9%	75.8%	Profiled target: 85% by year end		
S3	Increase the % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance	OPG	1,2,3	65.0%	62.3%	63.1%	63.9%	65.0%	67.0%	68.1%	67.0%	66.0%	66.8%	68.8%	69.9%	70.1%	>=50%= Green >=40% - <50% =Amber <40% =Red. Target to be achieved by year end		
S4	GP Vacancy rate	SHS	6	6.8%	5.0%	6.0%	7.5%	9.4%	9.5%	5.6%	5.4%	17.4%	12.1%	14.6%	10.7%	8.0%	=<5%= Green >5% - <10% =Amber >10% =Red		
S5	Percentage of total Quality and Outcomes Framework (QOF) points	SHS	1,2,3	75.0%	78.9%	81.5%	83.7%	86.8%	90.6%	93.9%	76.0%	77.0%	77.7%	77.7%	79.0%	80.9%	Profiled target: 95% by year end		
S6	Patient satisfaction rate	SHS	2,3	91.8%	93.8%	90.8%	92.7%	92.4%	91.3%	90.9%	91.5%	90.9%	91.3%	91.1%	92.0%	90.6%	>=85%= Green >=75% - <85% =Amber <75% =Red		
S7	Average time for calls in the queue	SHS	2,3	05:52	07:36	07:30	07:15	07:27	06:57	05:23	04:49	04:38	04:54	04:21	04:29	06:05	=<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%	53.6%	53.2%	52.6%	52.8%	52.1%	51.2%	52.3%	51.8%	51.9%	52.8%	54.2%	55.0%	>=50%= Green >=40% - <50% =Amber <40% =Red		
S9	Percentage of requests deemend "clinically urgent" seen on same day	SHS			New reporting					65.1%	80.6%	91.5%	93.1%	92.2%	94.0%	94.4%	>=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 learning disability services continue to exceed their targets for access to services, reporting 100% of people waiting under six weeks to be seen, and 90% of patients under crisis services received a face-to-face contact within 24 hours. The number of women accessing our specialist community Perinatal mental health service continues to increase and is significantly exceeding the planned level. The Employment Support Service, based on the reported August 2026 position, is also now meeting the target of 580 patients accessing the service, following targeted work over the last few months.

The Early Intervention in Psychosis starting treatment target reporting criteria are currently being reviewed nationally, but local data shows that we continue to exceed the expected target.

Talking Therapies Reliable Improvement continues to meet the required standard.

Inpatient follow-up within 72 hours of discharge remains above the compliance standard. The number of restrictive practices has seen a slight increase on the August 2026 position, but remains within usual reported parameters, and the majority of these continue to be to support the safe administration of nasogastric feeds to one patient.

Workforce metrics continue to demonstrate good performance, with appraisal rates further increasing in September 2026 to 91.1%. Heads of Service continue to focus on those significantly out of date, and on ensuring that the quality of these discussions are beneficial to colleagues. Similar focused work on mandatory training, is also showing a positive improvement, with Safeguarding Children Level 3 now compliant at 90.0%. Basic Life Support has shown further improvement to 83.8%, however is still below the required compliance level, with 123 colleagues currently out of date. Adult Life Support is the only other course not meeting the required standard, currently at 79.5% with 23 staff outstanding, but an improvement of 3.8% on the August 2026 position.

Finances remain in a good position for the service group, continuing to manage within budget at Month 6, with strong Cost Improvement Programme (CIP) actual delivery and projected for the year. The proportion of CIP delivery that is recurrent has slightly increased to 63%, but with the full target still projected to be met. Work is ongoing regarding a further CIP scheme with roster reviews, which will result in further recurrent CIP savings.

What is going less well
There were two out of area admissions at the end of September 2026; however these were both for PICU, which are now excluded from the NHSE national reporting definition. Against the updated criteria, the Trust is reporting zero inappropriate out of area admissions in the year to date. Both current patients are males who required a single sex environment, due to their potential risk to females. One continues to await a date to move to an agreed funded placement, and the other has now had the Ministry of Justice decline a request to move to Holford ward, as this is not a single sex environment.

Bed demand and flow continue to be challenging, and both service lines are exceeding the trajectory for Length of Stay (LoS). For the adult/ Psychiatric Intensive Care Unit (PICU) wards, this significantly increased due to the discharge of a PICU patient who had been 'nominally recalled' by the Ministry of Justice in September 2019, but continued to reside in the community on section 17 leave for the majority of this period, and only had the leave rescinded in October 2025. The LoS slightly reduced in August 2026 to 99.5 days, and the rolling three months calculation will continue to affect this metric for a further month. Of the discharges in month, 75% were for shorter than the target duration.

For the older adult wards, the LoS in August 2026 increased further to 119.8 days against the target of 77.6 days. Although the Clinically Ready for Discharge (CRFD) Standard Operating Procedure (SOP) has now been approved and enacted, there remain significant challenges with Somerset Council and the sufficiency of placement options for older adults.

The number of violent incidents against colleagues from patients on our wards, has further reduced again in September 2026 to 13; all incidents are reported as no or low physical harm, with three reported as moderate psychological harm and the remainder no or low harm. All colleagues 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 Reliable Recovery has dropped in-month to 44.9% (against a target of 51%) due to some focused work on the waiting list, and discharges of patients who have completed Step 2, but dropped out whilst waiting for Step 3. It is expected this will positively impact on waiting time and recovery targets over the next two months.

Focus of improvement work

Equality and Diversity
The service group is working with the Trust's Inclusion Leads to support all colleagues with protected characteristics, and specifically to support all colleagues from the global majority who are experiencing racism and micro-aggressions from colleagues, and will support the Trust work on delivering the NHS Staff Standards.

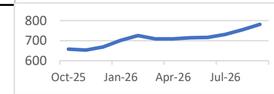
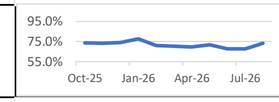
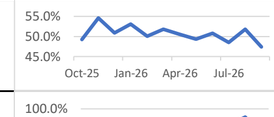
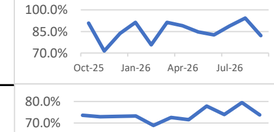
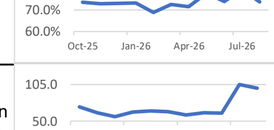
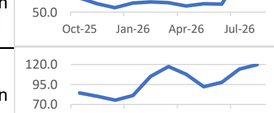
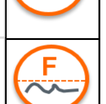
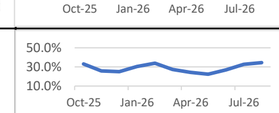
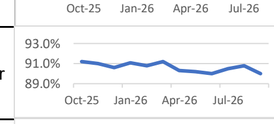
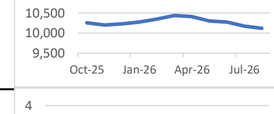
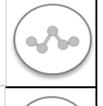
Inpatient
Targeted work is taking place to address multidisciplinary decision-making on the wards, to support bed flow and length of stay. Issues are compounded by non-substantive consultant psychiatrists and international medic recruits completing their training requirements.

Community Services
A final staff and Lived Experience Partner (LEP) engagement event took place for crisis services, as part of the access/re-access workstream, following feedback from LEPs of the importance of this area. Workstream leads are now developing their individual project plans and timescales for the three core areas:

- What happens when I am in Community Mental Health Services? Offer & processes; Clinical decision making; Data & staffing.
- How do I access or re-access services?
- How is information about me recorded and shared?

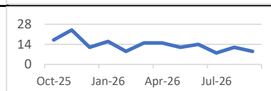
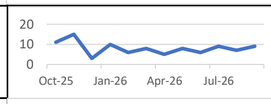
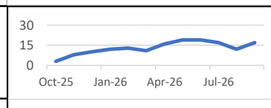
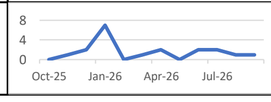
SOMERSET NHS FOUNDATION TRUST

MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description		Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
MH1	Mental health referrals offered first appointments within 6 weeks	Adult mental health services	ICB	1,2,3	92.2%	93.8%	92.0%	90.7%	97.4%	94.6%	94.4%	97.6%	100.0%	90.0%	100.0%	100.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
MH2		Learning disabilities service	ICB		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%			
MH3	Percentage of women accessing specialist community Perinatal Mental Health service - 12 month rolling reporting		LTP	1,2	658	653	668	702	726	709	709	714	716	731	755	781	>=640 = Green <640 = Red		
MH4	Early Intervention In Psychosis: people to begin treatment with a NICE-recommended care package within 2 weeks of referral (rolling three month rate)		NHSC	1,2,3	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Reporting criteria being reviewed			>=60%= Green <60% =Red		
MH5	Talking Therapies RTT : percentage of people waiting under 6 weeks		NHSC	1,2,3	73.7%	73.1%	74.1%	77.7%	71.2%	70.5%	69.7%	71.9%	67.9%	67.7%	73.4%	Data not yet due	>=75%= Green <75% =Red		
MH6	Talking Therapies RTT: percentage of people waiting under 18 weeks		NHSC	1,2,3	99.3%	99.1%	99.2%	100.0%	99.3%	99.2%	98.7%	98.5%	99.6%	98.9%	99.8%	Data not yet due	>=95%= Green <95% =Red		
MH7	Talking Therapies Recovery Rates		NHSC	1,2,3	49.2%	54.6%	50.9%	53.1%	50.1%	51.8%	50.5%	49.3%	50.8%	48.5%	51.8%	47.4%	>=50%= Green <50% =Red		
MH8	Adult mental health inpatients receiving a follow up within 72 hours of discharge		NHSC	1,2	90.9%	71.4%	83.7%	91.2%	75.7%	91.2%	88.9%	84.6%	82.5%	88.6%	94.3%	82.2%	>=80%= Green <80% =Red		
MH9	Percentage of urgent crisis response patients to receive face to face care within 24 hours		NHSC	1,2	73.7%	72.9%	73.1%	73.2%	68.9%	72.6%	71.5%	77.8%	74.0%	79.5%	73.7%	Data not yet due	>=70% = Green <70% = Red		
MH10	Overall Length of stay - Reduce average LOS by March 2027 - Adult awards and PICU only		PAF	2,6	71.2	62.5	56.7	63.9	65.4	64.1	59.5	62.5	62.3	105.0	99.5	Data not yet due	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	84.2	80.3	75.4	81.0	104.8	117.5	107.8	92.3	97.6	114.3	119.8	Data not yet due	From April 2026 at or below trajectory = Green above trajectory = Red		
MH12	Percentage of adult inpatients discharged with a length of stay exceeding 60 days		NOF, PAF	2,3	33.3%	25.8%	25.0%	30.6%	33.7%	27.3%	24.4%	22.4%	27.1%	32.6%	34.5%	Data not yet due	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	91.2%	91.0%	90.6%	91.1%	90.8%	91.2%	90.3%	90.2%	90.0%	90.5%	90.8%	90.0%	>=90%= Green >=80% - <90% =Amber <80% =Red		
MH14	Number of people accessing community mental health services with serious mental illness - rolling 12 month number.		NOF, PAF	1,2,3,4	10,255	10,202	10,227	10,276	10,349	10,439	10,415	10,305	10,277	10,178	10,119	Data not yet due	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	0	1	0	0	2	0	0	0	0	0	0	No stated target		

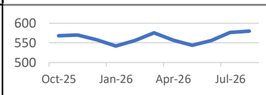
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MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-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	97.6%	97.1%	97.0%	97.7%	97.4%	97.7%	96.6%	96.5%	97.3%	97.1%	93.3%	94.5%	No stated target		
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	41.4%	39.3%	28.0%	21.4%	54.5%	66.7%	65.2%	53.8%	56.7%	57.7%	52.0%	Data not yet due	SPC <=60.9% = Green >60.9% = Red		
MH18	Total number of patient falls - mental health inpatient wards	NHSC	2	17	24	12	16	9	15	15	12	14	8	12	9	Monitored using Statistical Process Control rules >30 = Red		
MH19	Rate of falls per 1,000 occupied bed days	NHSC	2	5.10	7.26	3.73	4.88	3.02	4.53	4.72	3.60	4.39	2.37	3.42	2.58	Monitored using Statistical Process Control rules >9.07 = Red		
MH20	Restrictive Interventions - total number of incidents	NOF, NHSC	2	48	58	25	32	44	34	20	62	47	73	34	44	Monitored using Statistical Process Control rules >61 = Red		
MH21	Restrictive Interventions per 1,000 occupied bed days	NHSC	2	14.4	17.6	7.8	9.0	14.8	10.3	6.3	18.6	14.4	21.7	9.7	12.6	Monitored using Statistical Process Control rules >17.95 = Red		
MH22	Number of prone restraints	NHSC	2	11	15	3	10	6	8	5	8	6	9	7	9	Monitored using Statistical Process Control rules >22 = Red		
MH23	Prone restraints per 1,000 occupied bed days	NHSC	2	3.30	4.54	0.93	2.80	2.02	2.41	1.57	2.40	1.84	2.67	1.99	2.58	Monitored using Statistical Process Control rules >6.31 = Red		
MH24	Total number of medication incidents in a mental health setting	NHSC	2	3	8	10	12	13	11	16	19	19	17	12	17	Monitored using Statistical Process Control rules >23 = Red		
MH25	Ligatures: Total number of incidents	NHSC	2	15	10	15	7	15	5	9	17	27	59	53	60	Monitored using Statistical Process Control rules >80 = Red		
MH26	Number of ligature point incidents	NHSC	2	0	0	0	0	2	0	0	1	0	3	1	0	Monitored using Statistical Process Control rules >4 = Red		
MH27	Violence and Aggression: Number of incidents patient on patient (inpatients only)	NHSC	2	3	0	6	5	1	4	3	4	4	4	2	2	Monitored using Statistical Process Control rules >5 = Red		
MH28	Violence and Aggression: Number of incidents patient on staff	NHSC	2	13	19	15	13	14	11	17	15	18	27	21	13	Monitored using Statistical Process Control rules >25 = Red		
MH29	Number of Type 1 -Traditional Seclusion	NHSC	2	22	24	20	21	19	14	16	14	17	29	12	16	Monitored using Statistical Process Control rules >29 = Red		
MH30	Number of Type 2 -Short term Segregation	NHSC	2	0	1	2	7	0	1	2	0	2	2	1	1	Monitored using Statistical Process Control rules >5 = Red		

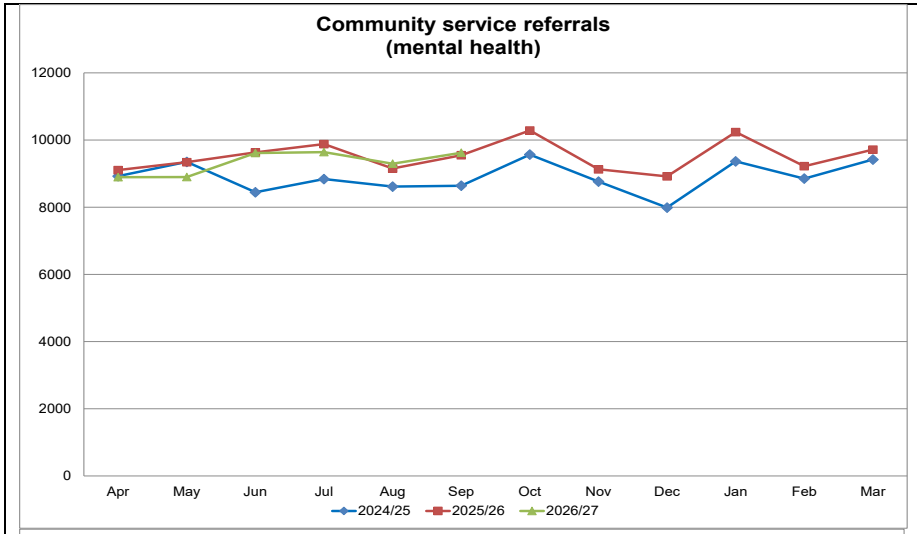
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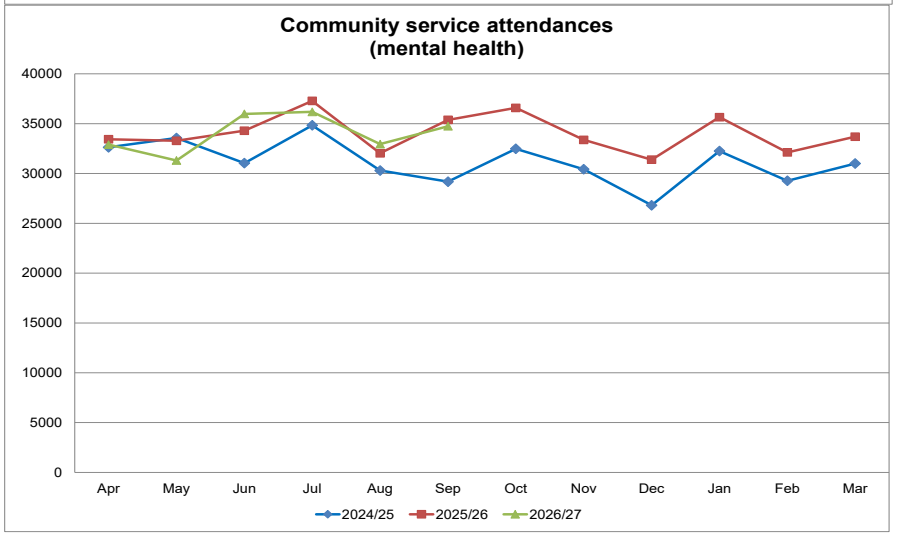
MENTAL HEALTH AND LEARNING DISABILITIES SERVICES

No.	Description	Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
MH31	Employment Support Service: 12-month rolling number of patients accessing the service against the NHSE plan	NHSC	2	568	570	558	542	556	576	557	544	556	577	580	Data not yet due	From April 2026 >=580 = Green <580 = Red		

Operational context

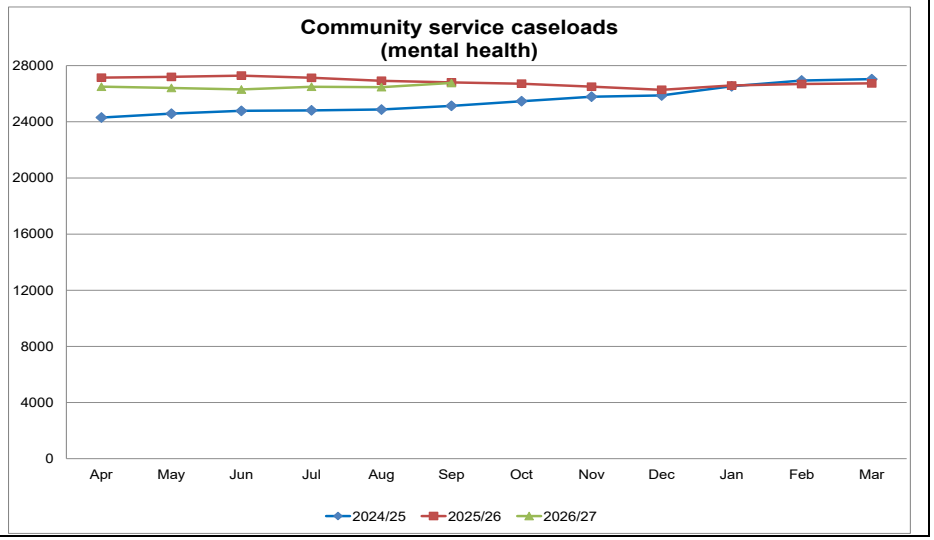
Community Mental Health services: This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, compared to the previous months and prior year.





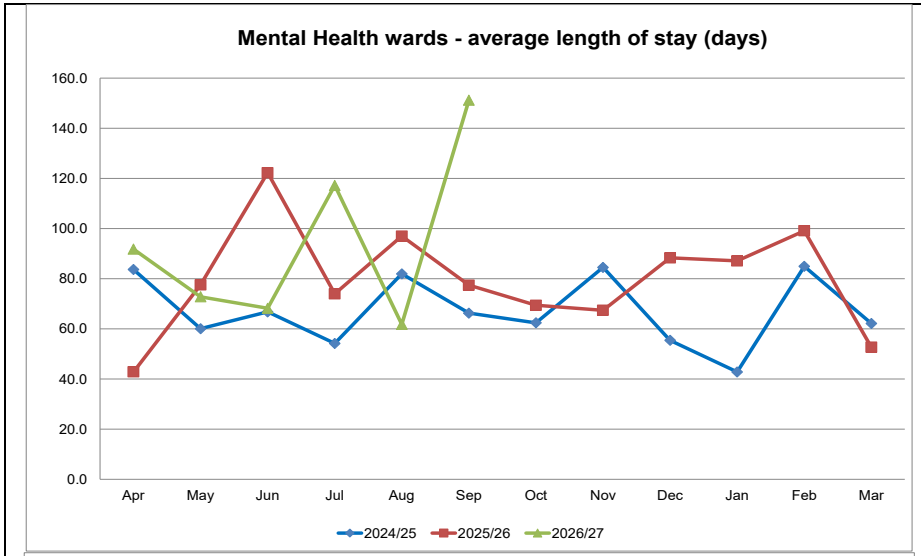
Summary:

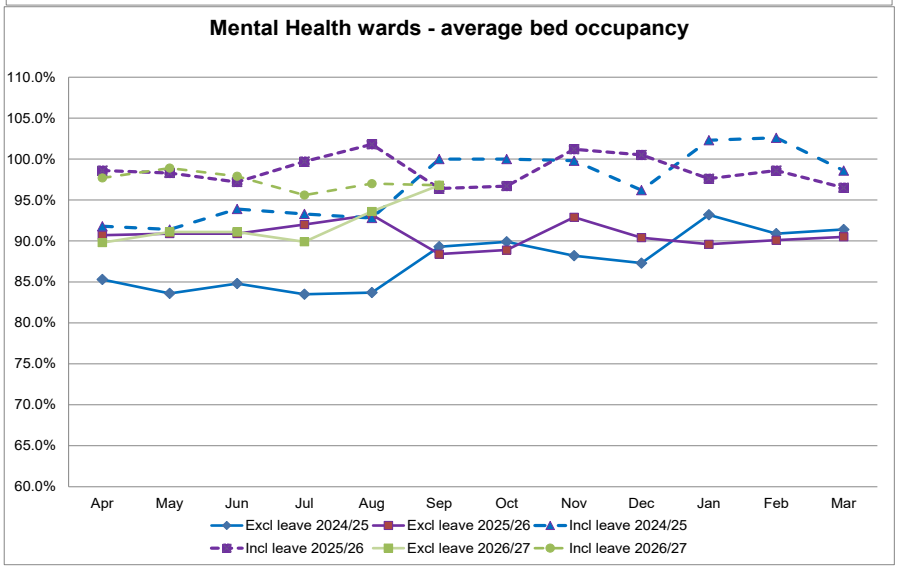
- Direct referrals to our community mental health services between 1 April and 30 September 2026 were 1.2% lower than the same months of 2025 but 6.0% higher than the same months of 2024.
- Attendances between 1 April and 30 September 2026 were 0.8% lower than the same months of 2025 but 6.5% higher than the same months of 2024.
- Community mental health service caseloads as at 30 September 2026 were 0.2% lower than as at 30 September 2025 but were 6.5% higher than as at 30 September 2024.



Assurance and Leading Indicators

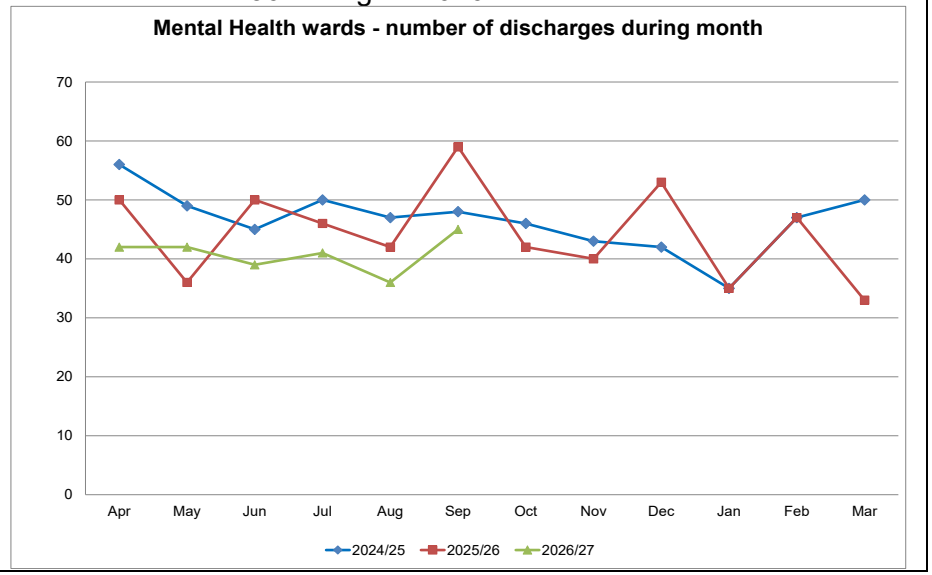
This section of the report looks at a set of leading metal health ward indicators, which helps to identify future or current risks and threats to achievement of mandated standards.





Summary:

- The average length of stay across all of our mental health wards in September 2026 significantly increased to 151.2 days, up from 61.8 days in August 2026. During September 2026, one patient discharged from Willow ward our rehabilitation unit who had a length of stay of 4,011 days. The rolling 12-month average length of stay for the period ending 30 September 2026 was 85.3 days, compared to 65.8 days for the 12-month period ending 30 September 2025. The reported length of stay within the Mental Health and Learning Disabilities scorecard includes patients on leave, thus different reporting criteria.
- The mental health bed occupancy rates excluding leave increased but including leave decreased when compared to August 2026.
- A total of 45 patients were discharged in September 2026, an increase from 36 in August 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 September 2026, performance for ambulance handovers taking more than 15 minutes deteriorated overall with compliance of 71.2%, against a recovery trajectory of no more than 60.2%. The Trustwide average ambulance handover time in September 2026 was 22.6 minutes, (21.0 minutes at MPH and 25.7 minutes at YDH).

Front Door
In September 2026, both Emergency Departments (EDs) continued to see exceptional increases in attendances, compared to 2025. Trustwide growth in ED attendances in January to September 2026 was 8.4% compared to the prior year, with the Trust-wide number of admissions increasing only by 2.3%.

1 January to 30 September 2025 and 2026: total ED attendances, Admissions, and Community UTC attendances

Measure	Jan - Sept 2025	Jan - Sept 2026	Increase / (Decrease)
ED	112,381	121,801	8.4%
Admissions	27,040	27,674	2.3%
Community UTC attendances	84,371	75,608	(11.8%)

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 September 2026 this represents a 13.0% increase compared to September 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)
Sept 2026 to Sept 2025 difference: increase / (reduction)	285	(48)	21	702	31	(161)	(293)	195
% increase / (reduction)	3.9%	(2.6%)	0.6%	13.0%	2.7%	(7.2%)	(3.5%)	264%

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 September 2026, the percentage of occupied bed days lost due to patients not meeting the criteria to reside was 21.7% at MPH and 29.2% at YDH. This remains significantly above the system plan ambition for NCTR. The average Length of Stay (LoS) at MPH increased to 6.4 days but reduced at YDH to 8.1 days, the lowest level in 12 months, despite the growth in NCTR.

Despite the challenges; SFT continues to perform well against the target of discharging 85% of our patients on a Pathway 0; in September 2026, this was 88% at MPH and 87% at YDH.

As part of the Urgent and Emergency Care transformation works, encompassing Every Minute Matters, Model Discharge and acute pathways, there is a revised focus on metrics including ensuring that 30% of patients are discharged or transferred to the discharge lounge by midday. During September 2026 38.5% of patients at YDH and 34.7% of patients on the MPH site were transferred to the discharge lounge or discharged by midday.

We also need to work towards ensuring that at least 80% of all discharges occur before 5pm. In September 2026, 71.0% of all discharges at MPH, and 68.2% of all discharges at YDH occurred before 5pm; the work that is ongoing in relation to Every Minute Matters will focus on improving this further.

Focus of improvement work

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

Stroke

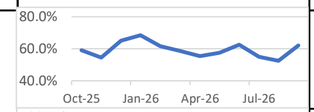
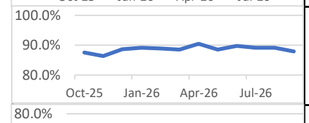
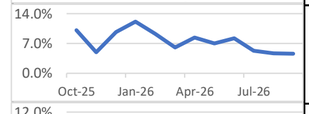
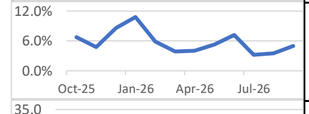
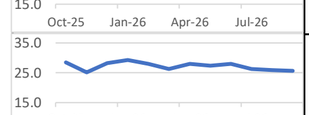
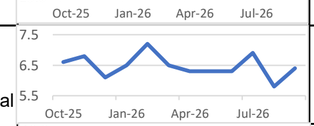
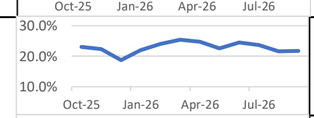
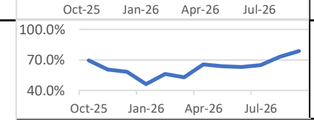
The percentage of patients admitted to a stroke ward within four hours increased at the MPH site, from 73.2% during August 2026 to 78.7% during September 2026, but reduced at YDH from 42.9% to 30.4%. MPH continues to be rated green for assessment by a stroke specialist within 14 hours, at 74%.0. Performance at YDH also increased, to 66.7%.

Focus of improvement work

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

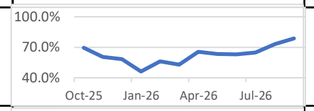
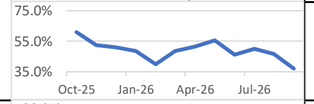
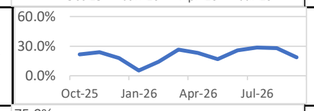
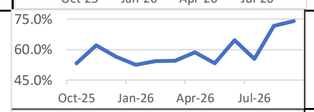
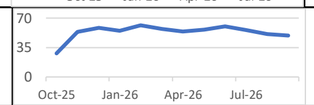
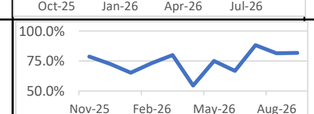
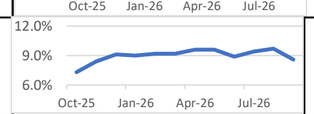
SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
UEC1	Percentage of ambulance handovers over 15 minutes	MPH	NHSC	2	59.1%	54.5%	65.1%	68.5%	61.6%	58.8%	55.4%	57.4%	62.5%	54.9%	52.5%	62.0%	From April 2026 >=trajectory = Green <trajectory = Red		P
UEC2		YDH			87.5%	86.4%	88.6%	89.2%	88.9%	88.5%	90.5%	88.6%	89.8%	89.2%	89.1%	87.9%			F
UEC3		Overall			69.1%	65.8%	73.9%	76.1%	72.2%	69.5%	67.9%	69.1%	72.3%	67.2%	66.0%	71.2%			?
UEC4	Percentage of ambulance handovers over 45 minutes	MPH	NHSC	2	4.9%	4.7%	8.0%	10.0%	3.8%	2.6%	1.7%	4.2%	6.6%	1.9%	2.8%	5.2%			P
UEC5		YDH			10.1%	4.9%	9.7%	12.1%	9.2%	6.1%	8.4%	7.0%	8.2%	5.3%	4.7%	4.6%			?
UEC6		Overall			6.7%	4.8%	8.6%	10.8%	5.9%	3.8%	4.0%	5.2%	7.2%	3.2%	3.5%	5.0%			P
UEC7	Ambulance - Average handover times (minutes)	MPH	NHSC	2	20.4	19.2	22.7	24.3	19.9	19.1	18.1	19.6	21.7	18.2	18.4	21.0			P
UEC8		YDH			28.5	25.1	28.3	29.3	28.0	26.2	28.0	27.4	28.0	26.2	25.9	25.7			F
UEC9		Overall			23.3	21.3	24.8	26.1	23.0	21.7	21.6	22.5	23.9	21.1	21.1	22.6			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	6.8	6.1	6.5	7.2	6.5	6.3	6.3	6.3	6.9	5.8	6.4	Monitored using Statistical Process Control rules. Report by exception.		
UEC11		YDH			9.6	8.5	9.3	9.2	9.0	9.5	9.6	9.4	9.6	8.9	8.8	8.1			
UEC12	Patients not meeting the criteria to reside: percentage of occupied bed days lost	MPH	SFT	2,6	23.0%	22.3%	18.7%	21.9%	24.0%	25.4%	24.7%	22.5%	24.5%	23.7%	21.6%	21.7%	<=9.8%= Green >15% =Red		F
UEC13		YDH			16.5%	16.8%	19.5%	20.4%	26.2%	22.8%	24.4%	24.5%	22.8%	22.8%	23.0%	29.2%			F
UEC14	Percentage of Stroke Patients directly admitted to a stroke ward within four hours	MPH	NSG	1,2,4	69.6%	60.7%	58.3%	46.2%	56.2%	52.9%	65.5%	63.6%	62.9%	64.7%	73.2%	78.7%	>=90%= Green >=75% - <90% =Amber <75% =Red		F

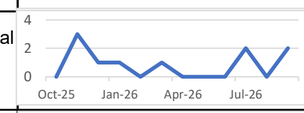
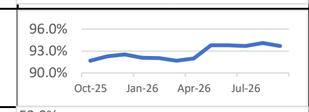
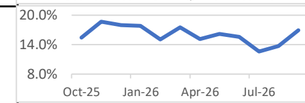
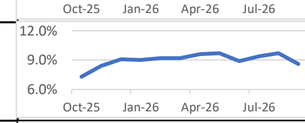
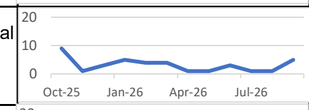
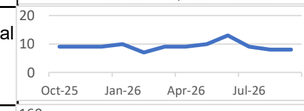
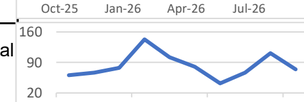
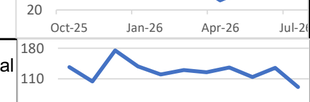
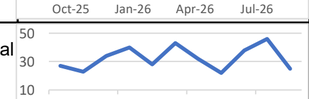
SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
UEC15	Percentage of Stroke Patients directly admitted to a stroke ward within four hours	YDH	NSG	1,2,4	27.8%	20.8%	24.3%	32.3%	34.6%	25.0%	28.9%	40.5%	29.4%	32.5%	42.9%	30.4%	>=90%= Green >=75% - <90% =Amber <75% =Red		F
UEC16	Percentage of patients spending >90% of time in stroke unit - acute services	MPH	NSG	1,2,4	62.5%	70.7%	60.3%	63.3%	63.8%	63.3%	75.0%	79.3%	79.3%	61.6%	76.7%	78.3%	>=80%= Green >=70% - <80% =Amber <70% =Red		F
UEC17		YDH			61.0%	52.4%	50.9%	48.6%	40.0%	48.6%	51.4%	55.6%	46.3%	50.0%	46.7%	37.1%			F
UEC18	Percentage of patients scanned within 20 minutes of clock start	MPH	NSG	1,2,4	44.7%	5.4%	60.9%	62.7%	50.9%	49.1%	56.9%	56.7%	61.5%	48.2%	54.3%	70.0%	>=32%= Green >=27% - <32% =Amber <27% =Red		P
UEC19	Percentage of patients scanned within 20 minutes of clock start	YDH	NSG	1,2,4	21.6%	24.0%	17.8%	5.3%	14.3%	26.3%	23.3%	16.7%	25.6%	28.6%	28.0%	18.5%	>=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	53.2%	62.1%	56.5%	52.5%	54.4%	54.5%	58.6%	53.3%	64.6%	55.4%	71.7%	74.0%	>=70%= Green >=60% - <70% =Amber <60% =Red		F
UEC21		YDH			51.4%	60.0%	57.4%	68.4%	71.4%	63.2%	60.5%	66.7%	64.1%	66.7%	56.0%	66.7%			F
UEC22	Stroke: Median number of minutes of total therapy received per inpatient day	MPH	NSG	1,2,4	28	54	59	55	61	57	54	56	60	56	51	49	>=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	32	29	31	36	40	50	39	41	28	35	36	30	>=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 Hospit	NHSC	1,2,4	80.0%	78.6%	72.7%	65.2%	73.3%	80.0%	54.5%	75.0%	66.7%	88.2%	81.3%	81.8%	>=90%= Green >=80% - <90% =Amber <80% =Red		F
UEC25	Neutropenic Sepsis: Antibiotics received within 60 minutes - acute services	MPH	NHSC	1,2,4	100.0%	97.1%	79.4%	90.0%	90.3%	88.2%	88.9%	96.6%	96.9%	95.0%	93.1%	84.8%			?
UEC26	Percentage of emergency patients who present with a NEWs score of 5 and above screened for sepsis within 60 minutes - Emergency Departments				55.3%	74.2%	68.2%	84.0%	65.6%	74.5%	60.0%	76.1%	82.4%	90.2%	74.4%	79.3%			F
UEC27	Percentage of patients admitted as an emergency within 30 days of discharge		NOF, PAF	2,3	7.3%	8.4%	9.1%	9.0%	9.2%	9.2%	9.6%	9.6%	8.9%	9.4%	9.7%	8.6%	To be confirmed.		
UEC28	Average number of days between planned and actual discharge date		NOF, PAF	2,3	2.4	2.2	2.2	1.7	1.5	1.7	1.2	1.6	1.4	1.6	1.4	1.3	To be confirmed.		

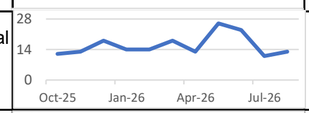
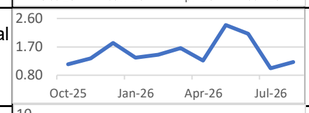
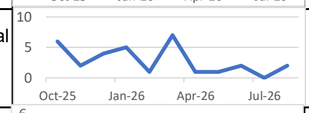
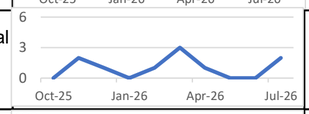
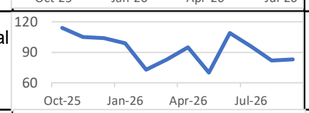
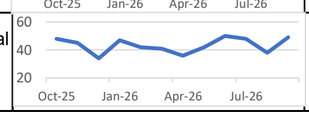
SOMERSET NHS FOUNDATION TRUST

URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
UEC29	Monthly number of inpatients to suffer a new hip fracture		PAF	2	0	3	1	1	0	1	0	0	0	2	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	91.7%	92.3%	92.6%	92.1%	92.0%	91.7%	92.0%	93.8%	93.8%	93.7%	94.1%	93.7%	From April 2026 >=trajectory = Green <trajectory = Red		
UEC31	Percentage of over 65s attending emergency departments to be admitted		PAF	2,3	44.6%	47.4%	49.4%	47.8%	47.4%	48.5%	46.1%	45.3%	44.2%	43.1%	43.9%	43.3%	To be confirmed.		
UEC32	Percentage of under 18s attending emergency departments to be admitted		PAF	2,3	15.4%	18.7%	18.0%	17.8%	15.0%	17.5%	15.1%	16.2%	15.6%	12.6%	13.7%	16.9%	To be confirmed.		
UEC34	Percentage of patients readmitted within 30 days of discharge		PAF	2,3	7.3%	8.4%	9.1%	9.0%	9.2%	9.2%	9.6%	9.7%	8.9%	9.4%	9.7%	8.6%	<10% = Green >=10% = Red		
UEC35	Average daily number of medical and surgical outliers in acute wards during the month	MPH	NHSC	2	9	1	3	5	4	4	1	1	3	1	1	5	Monitored using Statistical Process Control rules. Report by exception.		
UEC36		YDH	NHSC	2	9	9	9	10	7	9	9	10	13	9	8	8	Monitored using Statistical Process Control rules. Report by exception.		
UEC37	Number of patients transferred between acute wards after 10pm	MPH	NHSC	2	61	67	78	143	102	80	42	67	111	74	Data awaited	Data awaited	Monitored using Statistical Process Control rules. Report by exception.		
UEC38		YDH	NHSC	2	137	104	175	138	120	130	125	136	114	135	91	Data awaited	Monitored using Statistical Process Control rules. Report by exception.		
UEC39	Summary Hospital-level Mortality Indicator (SHMI)		NOF, NHSC	2	1.0516	1.0508	1.0575	1.0692	1.0689	1.0542	1.0848	1.0697	Data not yet due - June 2026 to be reported after September 2026				Monitored using Statistical Process Control rules. Report by exception.		
UEC40	Total number of patient falls - acute services		NHSC	2	181	137	179	213	198	188	179	186	185	194	167	136	Monitored using Statistical Process Control rules >206 = Red		
UEC41	Rate of falls per 1,000 occupied bed days - acute services		NHSC	2	6.10	4.85	6.33	6.96	7.34	6.46	6.39	6.48	6.38	6.87	5.93	5.09	Monitored using Statistical Process Control rules >6.99 = Red		
UEC42	Number of pressure ulcers	MPH	NOF, NHSC	2	27	23	34	40	28	43	32	22	38	46	25	Data not yet due	Monitored using Statistical Process Control rules >44 = Red		
UEC43	Rate of pressure ulcer damage per 1,000 occupied bed days	MPH	NOF, NHSC	2	1.40	1.27	1.89	2.01	1.62	2.35	1.81	1.23	2.09	2.64	1.43	Data not yet due	Monitored using Statistical Process Control rules >2.27 = Red		

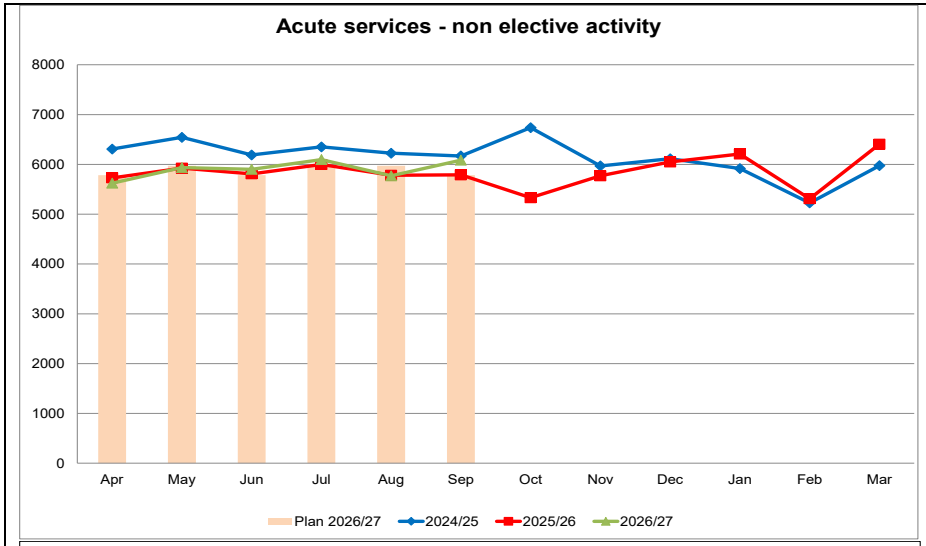
SOMERSET NHS FOUNDATION TRUST

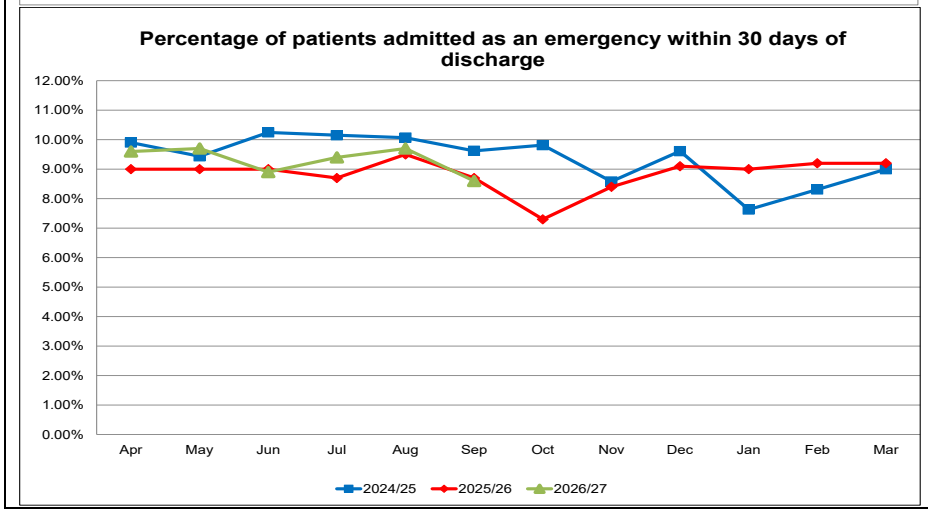
URGENT AND EMERGENCY CARE

No.	Description		Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
UEC44	Number of pressure ulcers	YDH	NOF, NHSC	2	12	13	18	14	14	18	13	26	23	11	13	Data not yet due	Monitored using Statistical Process Control rules >29 = Red		
UEC45	Rate of pressure ulcer damage per 1,000 occupied bed days	YDH	NOF, NHSC	2	1.15	1.33	1.82	1.35	1.45	1.66	1.26	2.39	2.12	1.02	1.22	Data not yet due	Monitored using Statistical Process Control rules >2.67 = Red		
UEC46	No. ward-based cardiac arrests - acute wards	MPH	NHSC	2	6	2	4	5	1	7	1	1	2	0	2	Data awaited	Monitored using Statistical Process Control rules. Report by exception.		
UEC47	No. ward-based cardiac arrests - acute wards	YDH	NHSC	2	5	0	2	1	0	1	3	1	0	0	2	Data awaited	Monitored using Statistical Process Control rules. Report by exception.		
UEC48	Total number of medication incidents	MPH	NHSC	2	114	105	104	99	73	83	95	70	109	96	82	83	Monitored using Statistical Process Control rules >119 = Red		
UEC49	Total number of medication incidents	YDH	NHSC	2	48	45	34	47	42	41	36	42	50	48	38	49	Monitored using Statistical Process Control rules >63 = Red		

Operational context

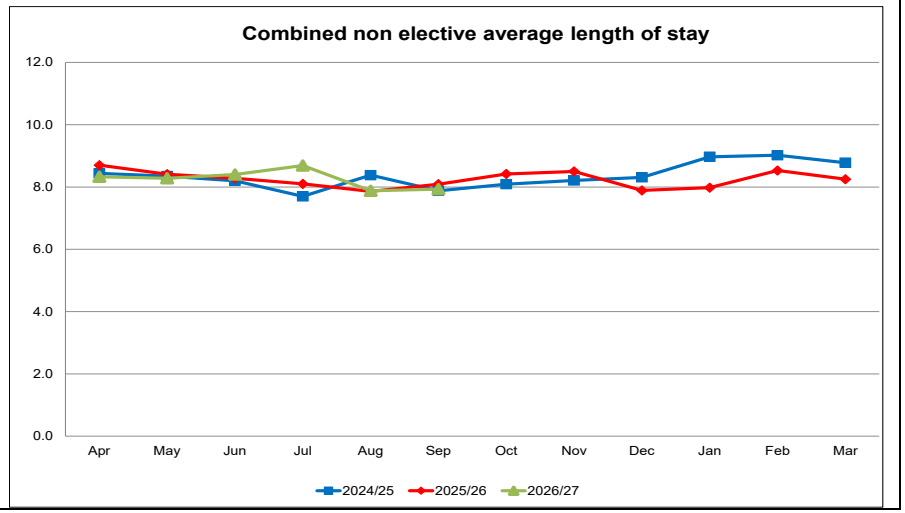
Acute services: This section of the report provides a summary of the levels of non-elective activity, emergency readmissions within 30 days, and non-elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- Between 1 April and 30 September 2026, non-elective admissions increased by 1.1% compared to the same months of 2025 but decreased by 6.3% compared to the same months of 2024. Activity for 1 April and 30 September 2026 was 0.4% above the planned level.
- Between 1 April and 30 September 2026, emergency readmissions totalled 7,141, 1.9% higher than the same period in 2025, when there were 7,007 readmissions, but decreased by 10.8% compared to the same period in 2024, when there were 8,010 readmissions.
- The trust-wide monthly non-elective average length of stay decreased in September 2026 to 7.9 days the same as during August 2026.



NARRATIVE REPORT

ELECTIVE CARE SERVICES

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

1) The percentage of patients receiving the diagnostic test they need within six weeks of the request being made was 79.5% at the end of September 2026, compared with 80.7% at the end of August 2026. The number of patients waiting over six weeks for a diagnostic test increased from 2,492 for the end of August 2026 to 2,711 at the end of September 2026 and was worse than plan (1,441). The total waiting list size was also higher than plan (13,200 versus a plan of 11,011). The variance from plan is mainly due to the ultrasound and endoscopy waiting lists having increased substantially due to a shortfall in capacity. This is mainly due to sickness absence and vacancies, although demand is also high.

Additional actions being taken in the coming months include:

- King's Building opened at Musgrove (September 2026), which has the capacity to provide an additional endoscopy room and reduce the impact of the scope decontamination capacity limit at Bridgwater.
- A review of endoscopy nursing in the new King's Building endoscopy unit is being carried out, to try to maximise patient throughput.
- Additional locum sonographer and ultrasound insourcing being sought, to increase ultrasound scanning capacity.
- Continued endoscopy insourcing at weekends.
- Additional trainee nurse endoscopists recently recruited, to be trained (around six months).

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

	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26
MRI	88	105	143	262	206	221	320	252	290	278	280	326
CT	252	212	239	167	79	40	20	16	38	45	53	60
Ultrasound	61	91	70	91	71	121	372	337	363	371	668	947
Barium Enema	12	19	10	4	4	18	18	15	6	3	2	5
DEXA	337	355	387	360	234	150	148	145	201	240	272	180
Audiology	79	117	239	161	148	92	166	277	119	87	101	83
Echo	130	296	564	757	639	766	654	427	73	13	20	8
Neurophysiology	26	35	50	33	16	37	75	74	87	104	154	73
Sleep studies	8	20	6	22	15	19	4	8	13	19	58	47
Urodynamics	30	25	58	65	68	68	58	52	70	101	67	59
Colonoscopy	465	520	618	628	501	460	322	251	271	310	334	339
Flexi sigmoid.	224	225	247	263	181	163	189	205	197	172	167	187
Cystoscopy	19	27	27	22	26	16	14	4	12	7	7	20
Gastroscopy	398	538	523	409	291	348	428	459	312	283	309	377

- Two gastroenterology consultants who were appointed a few months ago, come into post in quarter 4 of this financial year.

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 63.9%; plan 67.7%).

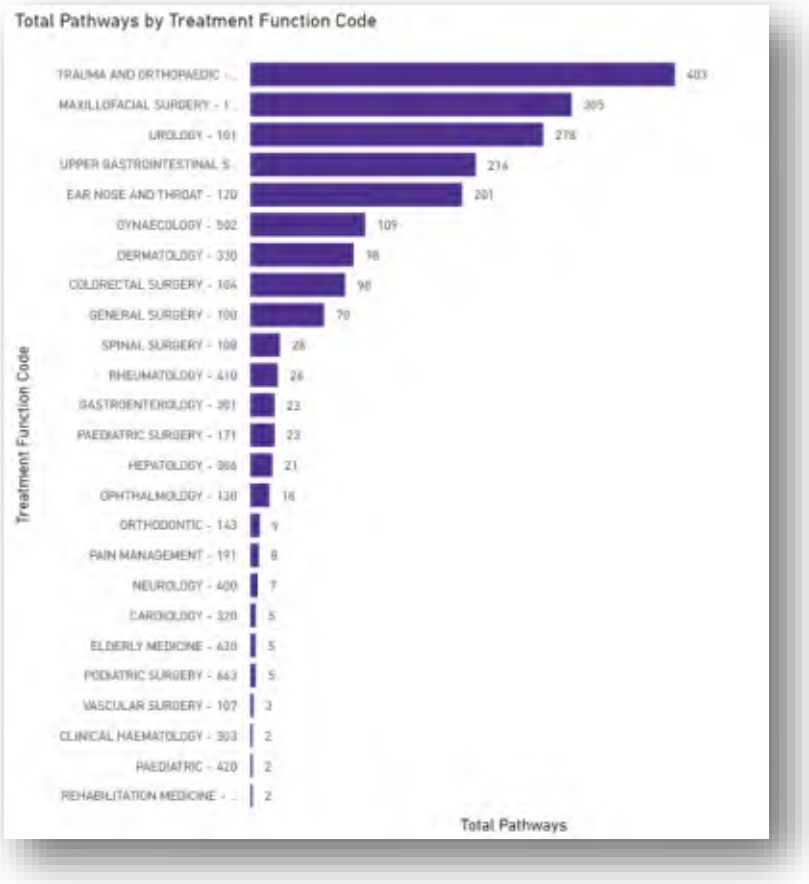
Alongside this headline target, there are several supporting metrics which the Trust continues to monitor. These are as follows:

- First OPA within 18 weeks (actual 71.6%; plan 74.2%)
- 52-week waits (actual 3.2% of total waiting list; plan 0.8% or less).
- 65-week waits (58 against a national requirement of zero).

The number of over 52-week waiters has increased slightly (from 1,702 at the end of August 2026 to 1,764 at the end of September 2026). A quarter of the increase is explained by a shortfall in maxillo facial service capacity due to clinician vacancies.

The current breakdown of the 52-week waiters by specialties is shown on the right-hand side. Since March 2026, the number of 52-week waiters has increased by 842. The growth in the waiting list is primarily in the following specialties:

- Maxillo facial (25% of the growth)
- Urology (22%)
- T&O (16%)
- Dermatology (11%)
- Colorectal surgery (8%)



The main causes of the growing waiting list of patients waiting over 52 weeks are:

- Consultant vacancies and gaps across a range of specialties, including maxillo facial (now filled) and urology, anaesthetic and theatre staff shortage and unplanned absences.
- Demand growth above plan.
- Strikes earlier in the year.

Actions to reduce these 52-week waiters, targeting the highest volume specialties, include:

- appointment to a maxillo facial consultant vacancy (starts in November 2026), with an SAS grade clinician started in September 2026; Saturday clinics have been run across August, September and October 2026.
- insourcing of capacity for maxillo facial and dermatology (starting in November 2026); continued weekend orthopaedic surgery insourcing.
- dermatology locum continuing to be sought; we remain out to advert for consultants; additional insourcing commences in November 2026.
- tier 2 oral surgery / maxillo facial community-based service being planned (in 6-9 months' time), which will allow patients to be triaged off the waiting list to a community service, and for the acute service to work to a new, higher threshold for specialist referral.

- fifteen additional theatre sessions being established each week commenced in September 2026 (five lists above plan), covering orthopaedics, ENT, upper GI and urology. However, anaesthetic and theatre staffing shortages are impacting on our ability to sustain all this additional activity.
- T&O rota changes delivering additional activity together with productivity gains through outpatient clinics, working towards full compliance with GIRFT recommendations.
- smoothing demand across the county, especially for ENT, maxillo facial and dermatology.
- clinical vacancies being appointed to.

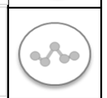
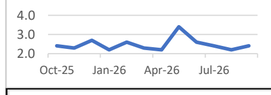
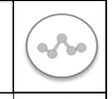
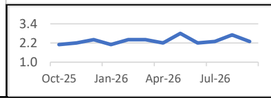
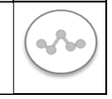
The scale of the 52-week wait cohort we need to clear by year-end is 65% greater than the cohort of 65-week waiters we had to treat over an equivalent timescale. Our best forecast at present is that we will reduce our current 52-week wait backlog down to 750 by the end of March 2027, but that is contingent upon the scale of activity delivered through some of the above actions, such as insourcing. This would represent around 1.5% of the total waiting list size compared with the current 3.2%.

The total waiting list size is significantly above plan (55,859 actual vs. 47,845 plan). We remain better than plan for treatments (clock stops), but demand (clock starts) are significantly above plan. There are a range of actions in place in the second half of the year to increase activity, through both capacity expansion but also productivity. We also continue to make use of ways in which we can optimise waiting list validation.

Senior oversight for RTT delivery includes 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 Challenged Services performance and productivity review meeting has been established, which is being chaired by the Chief Operating Officer.

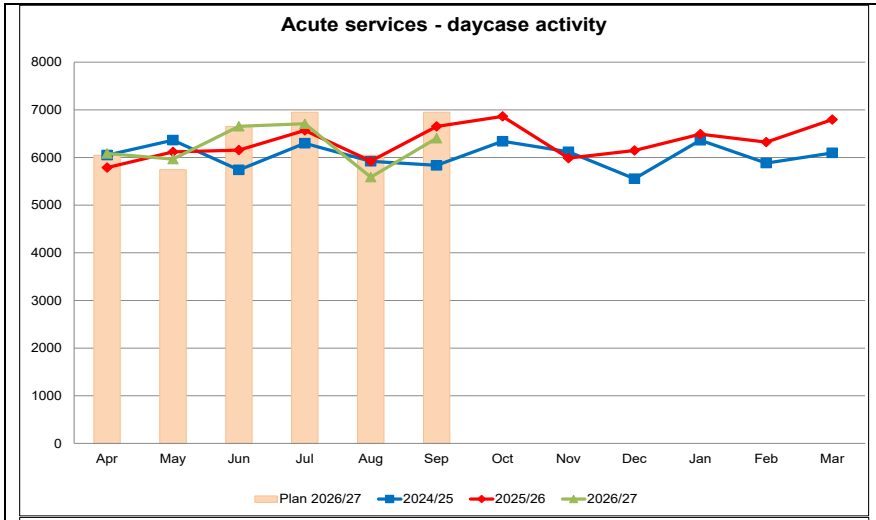
SOMERSET NHS FOUNDATION TRUST

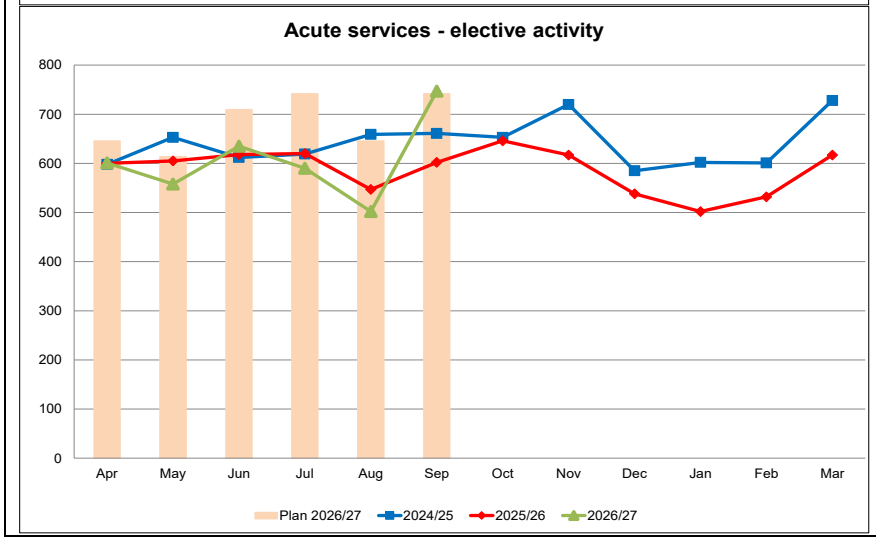
ELECTIVE CARE

No.	Description		Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
EC1	Reduce the proportion of people waiting over 52 weeks for treatment to zero March 2027		OPG	1,2	2.7%	2.3%	2.4%	2.2%	2.1%	2.0%	2.1%	2.4%	2.4%	2.7%	3.1%	3.2%	From April 2026 <=trajectory = Green >trajectory = Red		
EC2	52 week RTT breaches - Patients of all ages		OPG		1,575	1,313	1,290	1,195	1,111	1,028	1,135	1,304	1,310	1,474	1,702	1,764	From April 2023 At or below trajectory = Green Above trajectory = Red		
EC3	52 week RTT breaches - Patients aged under 18		OPG		106	81	81	84	96	120	142	138	127	148	158	136			
EC4	65 week RTT breaches - Patients of all ages		NHSC		141	79	18	11	26	17	23	37	32	29	67	58			
EC5	Referral to Treatment (RTT) incomplete pathway waiting list size - all ages		NHSC	1,2	58,068	56,659	53,781	53,143	52,985	52,302	53,891	54,011	53,524	54,854	55,401	55,859			
EC6	Referral to Treatment (RTT) incomplete pathway waiting list size - under 18		NHSC		4,005	3,918	3,820	3,762	3,803	3,868	4,098	4,013	4,039	4,079	4,012	4,063	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		-6.1%	-5.1%	-6.3%	-14.1%	-9.3%	-7.6%	-6.7%	-8.4%	-7.5%	-10.0%	-7.5%	-5.1%	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				70.3%	70.7%	70.3%	70.2%	72.4%	73.9%	76.2%	73.9%	73.4%	73.4%	73.5%	71.6%	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	2.3	2.7	2.2	2.6	2.3	2.2	3.4	2.6	2.4	2.2	2.4	Monitored using Statistical Process Control rules. Report by exception.		
EC10		YDH			2.1	2.2	2.4	2.1	2.4	2.4	2.2	2.8	2.2	2.3	2.7	2.3			

Operational context

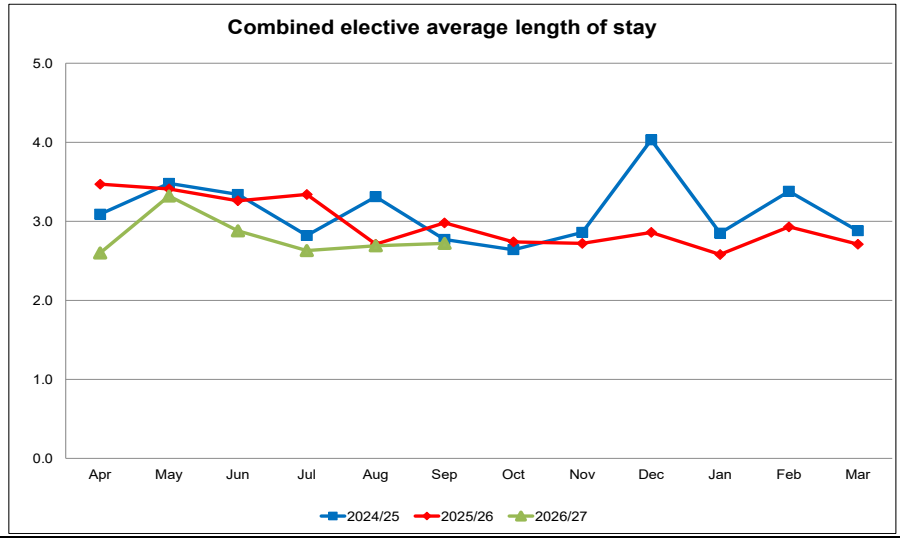
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





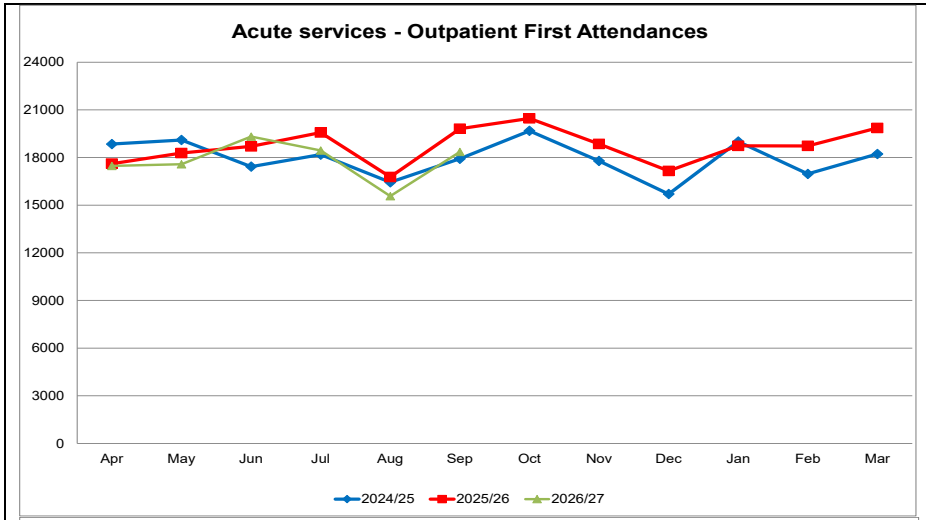
Summary:

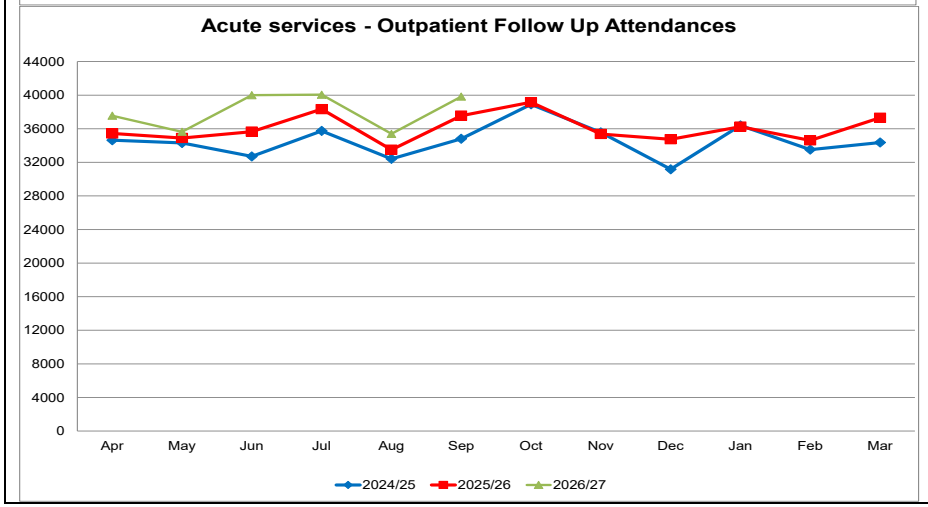
- The number of day cases undertaken by our acute services between 1 April and 30 September 2026 increased by 0.5% compared to the same months of 2025 and increased by 3.3% compared to the same months of 2024. Activity for the year to date was 2.6% below the current year plan.
- Between 1 April and 30 September 2026, elective admissions were 1.1% higher than the corresponding months of 2025 but 4.4% lower compared to the same months of 2024. Activity for the year to date was 11.4% below the current year plan.
- The trust-wide monthly elective average length of stay was 2.7 days September 2026, the same as during August 2026.



Operational context

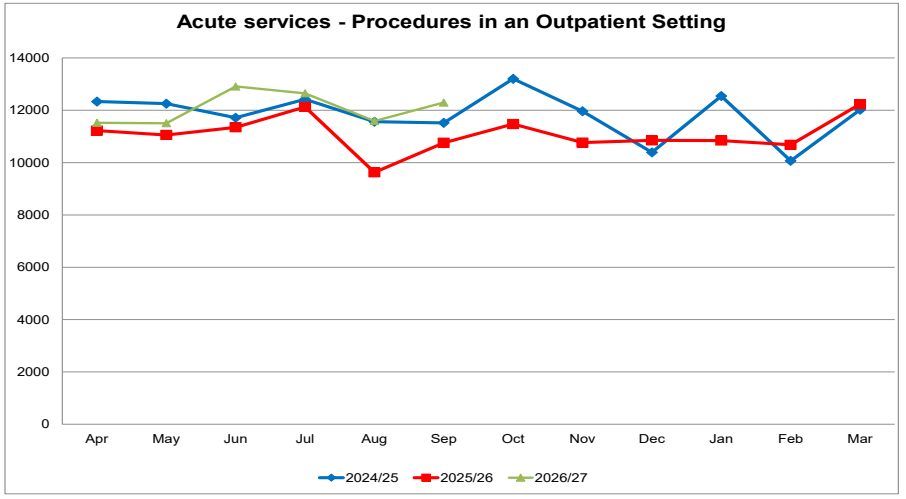
Acute services: This section of the report provides a summary of the levels of day case, and elective activity, plus elective length of stay during the reporting period, compared to the previous months and prior years.





Summary:

- The number of first outpatient attendances undertaken by our acute services between 1 April and 30 September 2026 decreased by 3.6% compared to the same months of 2025 andt was 1.1% lower than the same months of 2024.
- Between 1 April and 30 September 2026, follow up outpatient attendances were 6.1 higher than the corresponding months of 2025 and 11.7% higher than the same months of 2024.
- Between 1 April and 30 September 2026, the reported number of procedures undertaken within an outpatient setting increased by 9.6% compared to the same months of 2025 and were 0.9% higher 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 74.7% in August 2026, below both the national standard (80.0%), and our planning trajectory of 78.0%. Skin made-up 36% of all the breaches of the standard in August 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 (July 26)	Performance (July 26)	% of breaches (July 26)	Breaches (Aug 26)	Performance (Aug 26)	% of breaches (Aug 26)
Skin	81	91%	15%	244	61%	36%
Colorectal	141	69%	27%	162	69%	24%
Head & Neck	102	77%	19%	83	70%	19%
Urology	69	74%	13%	66	69%	13%
Breast	49	92%	8%	31	93%	5%

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. Had the FDS performance for skin been the more typical over 90%, the national standard and our planning trajectory would have been achieved. We are expecting a further deterioration in performance in September 2026. Longer than optimal endoscopy waiting times have also been a factor, which is impacting on colorectal pathway waits. The main actions being taken are:

Skin:

- A locum was appointed tin late spring, to support the dermatology service, although they have since left due to a bereavement; a further locum continues to be sought.

- Insourcing is continuing to be used to run additional weekend clinics, with a further insourcing contract having been awarded with an additional provider. This capacity comes into effect in November. It will largely support a reduction in long waiters for benign medical dermatology patients but will allow some additional capacity to be freed-up to support the skin cancer service.
- A pilot is being run with GPs with Extended Roles (GPwERs) running clinics under the supervision of a consultant. If successful, this will significantly increase capacity.
- Options are being reviewed to increase support for the triage of benign tele-dermatology requests being received via the Advice & Refer system, through the training-up of GPwERs; 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.

Colorectal:

- A dedicated project manager is in post to support pathway improvement work.
- A weekly Colorectal Improvement Programme has been established to re-visit and continue the 100-Day Challenge work.
- Pathway analysis has been undertaken, supported by SWAG Cancer Alliance; the analysis of the pathways is helping to identify bottlenecks and issues which will then be used by the Improvement Group.
- Delays associated with best interests meeting are being investigated, and improvements have been made.
- Review and refinement of the general anaesthetic colonoscopy pathway at YDH to reduce delays.
- Additional general anaesthetic endoscopy capacity has been established through the opening of the King's building; the new endoscopy unit in King's will also provide more flexibility in the physical space to undertake colonoscopy lists.
- Further endoscopy booking team vacancies are being filled.
- A locum has returned after a period of planned extended leave.

2) 62-day referral to cancer treatment performance was 77.7% in August 2026, above the current national standard of 75% and our planning trajectory of 72.5%. Urology, skin and colorectal are the main tumour sites contributing to breaches.
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 which started in September 2026, facilitated by the King's Building opening; a specialty doctor is being considered, to fill some of the team gaps from the resignation and retirement of two consultants in the team, although maternity leave and other departures have meant there is still a net capacity shortfall which is being reviewed.

- Four additional theatre sessions per week going into Head & Neck (ENT) which started in 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 theatre sessions have been allocated, and further plastics capacity has been secured.
- Colorectal - demand and capacity review for theatre sessions; additional theatre lists to be identified.
- Weekend operating sessions continue – mainly for benign pathways but again alleviates pressure; the King's Surgical Centre which is now open also provides increased opportunities for the team to pick-up colorectal operating lists when possible.
- Pathology – an additional consultant has been appointed, with expertise in dermatology, which should reduce delays.

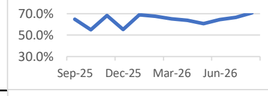
Table 2. 62-Day Cancer performance November 2024 to August 2026.

	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	Jul 26	Aug 26
Trajectory (%)	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	75.1	72.5
Actual (%)	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	73.8	77.7

3) 31-day decision to treat to treatment performance was below the 96% August 2026 standard, at 91.3%, and below the planning trajectory of 92.4%. Forty percent of the breaches of the 31-day standard were in skin, 30% in urology and 17% breast. 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 and loss of a locum. Additional plastics capacity is being established, and further theatre lists have been allocated on a regular basis. The urology breaches largely relate to the pre-radiotherapy planning requirements, and in part patient's ability to do what they need to do, such as have an empty bladder during the radiotherapy. This element of the radiotherapy pathway is being reviewed to explore options to facilitate patients being ready for the planning scan, such as being able to self-catheterise. The breast breaches are related to a shortfall of capacity within the team to cover periods of annual leave, following the departure of a colleague from the clinical team. The other actions set-out above for the 62-day standard will also help to reduce the breaches of the 31-day standard.

SOMERSET NHS FOUNDATION TRUST

CANCER SERVICES

No.	Description	Source	Links to strategic aims	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-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	25	40	24	14	20	18	19	17	19	23	22	14	0= Green >0 = Red		
C2	Cancer: 62-day wait from referral to treatment for urgent referrals – Breast	OPG	1,2	67.3%	78.1%	73.1%	68.4%	81.5%	69.0%	87.8%	91.9%	70.0%	73.8%	82.8%	87.3%	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	65.6%	37.9%	48.5%	72.5%	55.3%	51.9%	49.4%	45.5%	46.9%	58.7%	58.9%	54.2%	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	72.7%	86.4%	57.1%	94.4%	81.8%	50.0%	75.0%	83.3%	90.0%	66.7%	66.7%	70.6%	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	63.4%	74.4%	100.0%	82.6%	100.0%	95.8%	94.8%	92.9%	84.3%	91.1%	94.9%	86.7%	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	68.8%	67.5%	77.8%	61.3%	77.8%	66.7%	78.6%	50.0%	61.9%	55.6%	76.0%	42.9%	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	68.1%	69.6%	100.0%	86.9%	40.0%	45.2%	79.7%	48.9%	44.4%	61.9%	69.4%	82.1%	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	77.8%	61.5%	58.8%	100.0%	87.5%	76.5%	100.0%	100.0%	80.0%	83.3%	92.3%	75.0%	At or above trajectory =Amber and below trajectory =Red		
C9	Cancer: 62-day wait from referral to treatment for urgent referrals – Skin	OPG	1,2	82.3%	76.3%	89.7%	81.1%	85.1%	89.3%	87.6%	84.4%	70.0%	79.7%	76.1%	85.0%	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	63.8%	77.8%	86.2%	56.7%	76.6%	88.9%	82.3%	75.0%	73.7%	65.2%	77.8%	83.0%	At or above trajectory =Amber and below trajectory =Red		
C11	Cancer: 62-day wait from referral to treatment for urgent referrals – Urology	OPG	1,2	64.8%	55.0%	68.3%	55.2%	68.8%	67.5%	65.3%	63.9%	60.6%	64.6%	66.4%	70.8%	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	83.0%	82.1%	82.7%	82.6%	82.4%	82.2%	80.9%	81.6%	83.8%	Data awaited	Data awaited	Data awaited	>=80%= Green >=60% to <80% = Amber <60% =Red		

MATERNITY SERVICES

Narrative report | September 2026

Purpose — The Trust Board is asked to note the following key assurance, performance and risk matters for maternity services:

BOARD SNAPSHOT				
364 **BOOKINGS** **Somerset**	**314** **BIRTHS**	**−16.8%** **YDH ACTIVITY** 94 vs 113 (MPH -6.1%)	**2** **MODERATE HARM** incidents	**2** **DEATHS** reported

Operational position: Services remain stable, with challenges around staffing over the summer improving and a recent reduction in the in-month sickness rate. During September 2026 there were 364 maternity bookings across Somerset and 314 births. YDH activity reduced by 16.8%, from the equivalent 2024 period, with MPH also seeing a slight reduction during the same period. Activity is compared to 2024 due to the YDH unit being temporarily closed during the corresponding period in 2025.

Quality and safety: The reporting culture remains positive. Two moderate-harm incidents and one neonatal death were reported, along with one stillbirth. We commissioned learning an Multi-Disciplinary Team and After Action Review and have completed three swarm huddles.

Clinical outcomes: We have seen a continued trend in the rates of postpartum haemorrhage (PPH) of 1,500ml or more (per 1000 births) with a reduction since the introduction of a merged guideline in 2025, where we once had an outlier status against national standards. Conversely, we are seeing an upward trend in our obstetric anal sphincter injury (OASI), and QI work is continuing to address this, along with reviewing our audit standards. Babies born with low Apgars continue to be above national rates, but reviews evidence appropriate recognition and escalation for foetal compromise during labour.

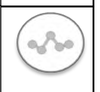
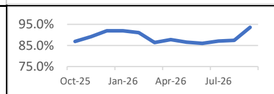
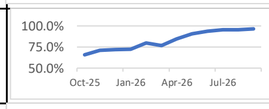
Principal risks: Workforce, theatre capacity, foetal medicine, neonatal transport, culture and safeguarding remain the key concerns. Triage metrics within the Integrated Performance Report show improved waiting times over the past 12 months, although in September 2026 there was a slight reduction in women being triaged within 15 minutes. Triage activity and compliance with the Birmingham Symptom-Specific Obstetric Triage System (BSOTS) continues to be closely monitored and is reported into the Perinatal Governance Group monthly.

Breast feeding initiation rates are now above 90%, which reflects the continued work across the service with an infant feeding drop in being introduced on Bracken Birth Centre.

External assurance and action: A team has been established in response to the Thirwell Enquiry, to establish key stakeholders and begin working towards the actions set out for services within the report.

SOMERSET NHS FOUNDATION TRUST

MATERNITY SERVICES

No.	Description	Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
M1	Babies readmitted to hospital who were under 30 days	CQIM	2	0	0	0	0	0	0	0	1	9	9	7	8	Monitored using Statistical Process Control rules >7 = Red		
M2	Babies who were born preterm - less than 37 weeks gestation	CQIM	2	24	26	9	20	18	22	27	14	10	17	27	14	Monitored using Statistical Process Control rules >39 = Red		
M3	Percentage of babies where breast feeding was initiated	CQIM	1,2	86.9%	89.2%	92.0%	91.9%	91.1%	86.4%	87.8%	86.6%	86.0%	87.1%	87.5%	93.6%	>=80%= Green >=75% - <80% =Amber <75% =Red		
M4	Percentage of babies with an APGAR score between 0 and 6	CQIM	1,2	2.9%	1.2%	3.1%	1.0%	2.1%	2.1%	1.5%	1.6%	1.5%	2.0%	3.0%	1.3%	=<1%= Green >1% - =<2% =Amber >2% =Red		
M5	Women who had a 3rd or 4th degree tear at delivery	CQIM	2	9	4	4	8	6	10	5	6	10	6	1	7	Monitored using Statistical Process Control rules >15 = Red		
M6	Women who had a postpartum haemorrhage (PPH) of 1,500ml or more	CQIM	2	10	8	9	6	8	8	10	10	16	7	7	17	Monitored using Statistical Process Control rules >21 = Red		
M7	Women who were current smokers at booking appointment	CQIM	1,2	5.2%	4.5%	1.5%	7.1%	4.8%	4.9%	7.4%	5.8%	5.5%	5.4%	5.1%	5.8%	No target level.		
M8	Women who were current smokers at delivery	CQIM	1,2	6.8%	3.7%	5.0%	8.2%	3.5%	5.9%	4.2%	3.8%	2.1%	2.9%	3.7%	4.5%	=<10%= Green >10% - =<12% =Amber >12% =Red		
M9	No. of still births	CQIM	2	0	1	0	0	0	2	1	0	1	0	1	1	Monitored using Statistical Process Control rules >3 = Red		
M10	No. of babies with Hypoxic Ischaemic Encephalopathy Diagnosis (rate per 1,000 births)	CQIM	2	0.0	0.0	7.6	0.0	0.0	0.0	0.0	3.9	0.0	0.0	3.0	0.0	Monitored using Statistical Process Control rules <=4 = Red		
M11	Babies under observation should have Newborn Early Warning Score assessment recorded as per trust clinical guidelines.	SFT	1,2,4	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	100.0%			100.0%											
M13	Women being triaged within 15 minutes	SFT	1,2,5	77.5%	70.6%	68.8%	70.0%	81.3%	80.1%	86.6%	90.6%	93.2%	92.9%	90.0%	87.1%	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	65.8%	70.9%	72.1%	72.4%	79.9%	76.9%	84.4%	90.8%	93.9%	95.5%	95.6%	96.5%	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	53.9%	67.3%	73.0%	71.7%	66.0%	81.9%	84.3%	85.7%	85.4%	85.7%	88.7%	85.3%	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, and as a result of pathway development, urgent referral performance has improved since December 2025. In August 2026, the service achieved 90% compliance against the 95% standard for urgent referrals to be seen within one week. For routine referrals to be seen within four weeks, compliance was 91.3% against the 95% standard. September 2026 data was not available at the time of writing this report.

Children and Young People's Community Mental Health Service: Access performance improved to 88.6% in September 2026. Referrals into the Single Point of Access have increased by 14% in 2026 compared with 2025, with particularly notable increases during the summer months, indicating increased pressure on core teams. The cause for this increase is not understood at this time. Workforce pressures have also affected capacity, including sickness absence, insufficient cover for maternity leave, vacancies, and new staff who are not yet working at full capacity, particularly within the West medical team. Most issues relating to leave, sickness absence and vacancies are expected to be resolved by the end of October 2026, although medical recruitment challenges in the West are likely to persist for longer pending a current recruitment process, requiring support from an additional locum psychiatrist. Continued monitoring of referral trends and workforce capacity is underway to plan for any further increases in demand.

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 of September 2026, 1,586 patients were waiting more than 18 weeks, compared with 1,956 in October 2025. A total of 464 patients have waited more than 52 weeks for treatment, continuing the sustained decrease since May 2026. 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 general anaesthetic 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 challenging, with performance in September 2026 of 72.7% at Musgrove Park Hospital (MPH) and 83.2% at Yeovil District Hospital (YDH), although overall Trust performance, including

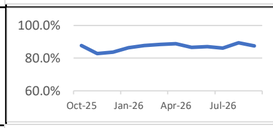
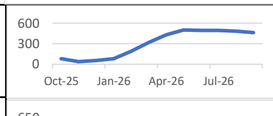
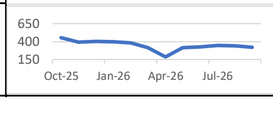
Urgent Treatment Centre (UTC) activity, reached 87.4%. A joint review by Paediatric and ED leaders has concluded that the causes are likely to be multifactorial, with further analysis required to understand the significant variation between sites and the distinct challenges within admitted and non-admitted pathways. A Quality Improvement (QI) approach is now underway, combining detailed pathway mapping with analysis of attendance patterns, referral and transfer times, points of delay, and admission and coding arrangements. Ahead of winter, the greatest immediate opportunity for improvement is within the non-admitted pathway, particularly addressing the higher proportion of four-hour breaches at MPH. Existing good practice, including proactive Paediatric Assessment Unit (PAU) nursing review, direct ambulance-to-PAU pathways, patient deflection routes and aligning senior clinical decision-making with peak demand, will be considered for wider adoption. Estate and paediatric assessment capacity remain contributory factors, with rapid-cycle QI and learning from high-performing organisations supporting further improvement.

Community Waiting Lists: Performance deteriorated in September 2026, with 70.9% of patients waiting less than 18 weeks from referral to first appointment, compared with 74% in August 2026. The position reflects capacity pressures within Paediatric Continence service; a comprehensive review of this service is under way, considering capacity and demand, efficiency, performance, workforce and contractual arrangements with the ICB to inform future service requirements and optimise pathways and workforce utilisation. Early findings demonstrate average monthly referrals increasing from an average of 58 in the 12 months to April 2020 to 90 in the 12 months to August 2026, without a corresponding staffing review, compounded by vacancies and recruitment delays. This measure also includes the Children and Young People's Therapy Service (CYPTS), which is experiencing similar pressures. Recruitment within both teams has been successful, with additional staff joining from September 2026. Following induction and competency development, this is expected to increase capacity and support performance recovery.

CAMHS Long Waiters: CAMHS is currently reporting approximately 1,165 CYP waiting over 104 weeks. A detailed review has identified that the majority of these are not children and young people who have waited without receiving care; patients may have been seen on multiple occasions but continue to be reported as waiting because the required combination of an attended appointment, appropriate SNOMED coding and a Routine Outcome Measure (ROM) has not been recorded, in order to stop the waiting time clock. An improvement plan is being developed with two immediate priorities: preventing further growth through improved coding and outcome-measure recording, and detailed validation and prioritisation of the historic backlog. Digital solutions are being explored to simplify and automate data capture, and additional resource is being sought to support historic backlog clearance. A data-led recovery trajectory will be developed, supported by ongoing engagement with NHS England.

SOMERSET NHS FOUNDATION TRUST

CHILDREN AND YOUNG PEOPLE'S SERVICES

No.	Description	Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
CYP1	CAMHS Eating Disorders - Urgent referrals to be seen within one week - (rolling three months)	NHSC	1,2,3,4	100.0%	100.0%	80.0%	85.7%	85.7%	83.3%	87.5%	83.3%	100.0%	87.5%	90.0%	Data not yet due	>=95%= Green >=85% - <95% =Amber <85% =Red		
CYP2	CAMHS Eating Disorders - Routine referrals to be seen within four weeks - (rolling three months)		1,2,3,4	90.9%	90.8%	90.8%	91.8%	91.0%	97.1%	96.9%	98.3%	95.5%	93.0%	91.3%	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	5,676	5,691	5,751	5,822	5,896	5,945	5,998	6,013	6,024	6,001	5,987	Data not yet due	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	96.6%	94.9%	100.0%	90.0%	97.0%	90.9%	90.1%	89.6%	91.8%	88.6%	79.4%	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	81.9%	85.1%	86.4%	84.6%	85.0%	82.0%	80.8%	82.0%	80.0%	76.4%	74.0%	70.9%	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	87.8%	82.8%	83.7%	86.3%	87.8%	88.4%	88.8%	86.7%	87.0%	86.2%	89.4%	87.4%	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	1,956	1,747	1,747	1,645	1,766	1,815	1,866	1,840	1,793	1,681	1,574	1,586	From April 2024 <1,979 = Green >=1,979 = Red		
CYP8	Community dental services - General, Domiciliary or Minor Oral surgery waiting 52 weeks or more			84	39	55	81	189	316	431	501	497	497	485	464	From April 2024 <574 = Green >=574 = Red		
CYP9	Community dental services - Child GA waiters waiting 18 weeks or more	SFT	1,2,3	454	395	405	397	380	316	187	315	327	344	340	322	From April 2023 <463 = Green >=463 = Red		

NARRATIVE REPORT

PEOPLE

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

Areas of Success / Celebration

- **Retention** – Although overall retention remains stable and continues to improve, the largest proportion of leavers are colleagues with less than one year of service, reversing the positive trend seen earlier in the year. Early attrition remains a concern, as it may indicate challenges relating to recruitment, induction, onboarding or integration into teams. To understand better the experiences of new starters and identify opportunities for improvement, a survey of colleagues who have joined the Trust within the last 12 months will be launched in November 2026. Work-life balance continues to feature within the top three reasons cited for leaving the organisation. The introduction of the NHS Staff Standards presents an opportunity to strengthen the Trust's focus on flexible working, supported by the implementation of ESR self-service flexible working applications. This will improve both colleague access to flexible working arrangements and organisational oversight of requests and outcomes. Positively, turnover reduced across all Service Groups and Staff Groups during the month, indicating continued progress in workforce stability.

- **Mandatory Training** – Mandatory training compliance continues to exceed the 90% benchmark at 94.5% for September 2026. There have been improvements in six service groups, and seven service groups have seen increases in the number of colleagues in date with all their mandatory training. Areas of concern continue to be resuscitation courses with six of the ten courses sitting in non-compliance. However, two of these courses have achieved an 11.1% increase (Medical Emergencies Dental) and a 5.7% increase (European Paediatric Advanced Life Support) in compliance, with small increases in two other resuscitation topics. Across the service groups, two are compliant for their resuscitation courses, six are amber, and Surgical Services remains in the red at 77.4% with 687 requiring training. Of the 687, 168 have training booked, 355 have training that has expired, and 164 have yet to access their required course. Anaesthetics Resuscitation and Emergency Simulation Training is being resumed after the move into the Kings Building; under booked courses (mainly Immediate Life Support) are being cancelled to allow trainers to concentrate their efforts on other courses; the Resuscitation Team are discussing a ‘BLS Week’ as these have been successful in the past. The Basic Life Support (BLS) Week is an opportunity for colleagues to demonstrate their skills in a drop-in session lasting 15-20 minutes that marks them as competent for adult basic life support, preventing the need to attend a 90-minute session. The number of colleagues not attending their booked BLS session decreased in September 2026 to 131 (164 in August 2026) with the message to service groups to request that colleagues do not book more than one space

Areas of Concern

- **Formal HR Cases** – Data continues to show sustained high levels of formal HR casework, increasing suspension activity and a growing Employment Tribunal caseload. Disciplinary matters remain the most significant area of activity, with a notable increase in cases relating to information governance and data breaches. This reflects both heightened national scrutiny across the NHS and the Trust's commitment to maintaining the highest standards of patient confidentiality and professional conduct. The Trust continues to take a firm and proportionate approach to allegations of data breaches; this is reflected in the increasing levels of suspension related to data breaches. To strengthen the management of formal casework, the Trust has approved the introduction of a dedicated pool of trained Investigating Officers. This new approach will improve consistency, enhance the quality of investigations and support a reduction in investigation timescales, leading to more timely outcomes for colleagues and managers.

- **Vacancy Levels** – the increased in the vacancy rate follows the significant improvement reported in August 2026, which was partly influenced by the annual resident doctor rotation. Recruitment activity remained positive during September 2026, with 132.45 FTE starters compared with 108.92 FTE leavers. Recruitment continues to be targeted towards areas with high temporary staffing usage to support workforce stability, operational resilience, and delivery of the Trust's financial objectives. Service groups are reviewing all long-term vacancies (over six months) to ensure core roles have an active recruitment plan, and where possible roles can be removed from establishment.

- **Sickness absence** – The rolling 12-month sickness absence rate remains relatively stable; however, an increase was seen during the month, rising from 5.0% to 5.4%. This was driven by an increase in short-term sickness absence, which rose from 1.7% to 2.3%, while long-term absence reduced from 3.3% to 3.1%. Service Groups continue to be supported through a programme of targeted interventions, including manager capability assessments, attendance management training, wellbeing workshops and focused audits in areas experiencing higher levels of short-term absence. Anxiety, stress and depression remain the leading causes of absence across the Trust. In addition, a seasonal increase in flu-related absence has been observed across a number of service areas. Colleagues are therefore being encouraged to take up the offer of ‘flu vaccination ahead of the winter period to help protect both workforce wellbeing and service resilience.

Focus Areas

- **Job Planning** – The Trust continues to embed the service-level approach to job planning and has recently been nominated by regional job planning leads for an award at the forthcoming NHS England National Job Planning Festival, recognising the innovative work undertaken to improve the quality of job planning.

Compliance continues to reduce as services progress through the new planning cycle. This is an anticipated consequence of the shift in focus towards developing comprehensive service-level plans before finalising individual job plans, ensuring workforce requirements, activity, and service priorities are considered collectively. While this approach has extended timelines in some areas, it is expected to support higher-quality and more sustainable job planning outcomes.

Medical leaders were further engaged through a recent leadership away day, where the NHS England 90-Day Challenge was presented and discussed, reinforcing the strategic direction of travel and the role of service-level planning in supporting productivity, workforce optimisation and service delivery.

The continued rollout of Patchwork Roster is also supporting progress by strengthening the link between job planning and rostering. The ability to generate rosters directly from agreed job plans is providing an additional incentive for timely completion and helping to improve alignment between planned and delivered activity.

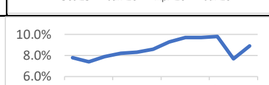
- Appraisal – Appraisal compliance decreased September 2026 compared to August 2026; and remains below the expected standard. Improvement is being driven by Mental Health & Learning Disabilities (the only service group above the compliance threshold, achieving 91%). For the last 10 months mental health appraisal compliance has continued to increase. The Service Director has set a trajectory and actively follows up with teams to ensure they are in date. SSL are at 88.9% which is an improvement of 4% on August 2026, Medical Services is at 85% a 1.8% increase on August 2026 and Corporate Services are at 86.4%, the same as August 2026.

  Operational Management is the poorest performing service group at 68.5% and compliance for Surgical services is at 76%. Clinical Support & Cancer Services (CSCS) and Children, Young People & Families (CYP&F) continue to perform below 80% and have experienced month-on-month deterioration. For CSCS, Radiology and Cancer nursing are where we have low compliance. However, demand and capacity work is underway in these areas, so we have reported compliance is unlikely to change until we complete this work. Within a number of services (e.g. Medicine, CYP&F) there are regular email reminders to improve appraisal compliance. People Business Partners are actively reminding colleagues to complete.

  The overall direction of travel is still positive with the Trust wide position improving, however where compliance remains substantially below the level expected, targeted oversight in Performance Oversight Meetings is required to deliver the greatest improvement in overall Trust compliance.

SOMERSET NHS FOUNDATION TRUST

PEOPLE

No.	Description		Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
P1	Mandatory training: percentage completed	Combined	SFT	5	94.0%	94.0%	94.1%	94.2%	91.9%	92.6%	93.3%	93.5%	93.9%	93.9%	94.3%	94.5%	All courses >=90%= Green Overall rate <80% =Red Any other position = Amber		
P2	Monthly percentage of days lost due to sickness absence		NOF	5	5.6%	5.4%	5.7%	5.6%	5.4%	5.1%	4.9%	4.9%	5.0%	5.2%	5.0%	5.4%	SPC (Upper Control Limit 5.4%)		
P3	Sickness absence levels - rolling 12 month average (Trust-wide)		NOF	5	5.2%	5.1%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	SPC (Upper Control Limit 5.2%)		
P4	Career conversations (12 months)		SFT	5	79.8%	81.1%	82.4%	81.4%	80.1%	80.2%	80.1%	79.9%	80.6%	81.0%	82.1%	81.5%	>=90%= Green >=80% - <90% =Amber <80% =Red		
P5	Vacancy levels - percentage difference between contracted full time equivalents (FTE) in post and budgeted establishment (Trust-wide)		SFT	5	7.8%	7.4%	7.9%	8.2%	8.3%	8.6%	9.3%	9.7%	9.7%	9.8%	7.7%	8.9%	<=8.5%= Green >8.5% to <=9.0% =Amber >9.0% =Red		
P6	Retention rate – rolling 12 months percentage of colleagues in post		SFT	5	89.8%	89.8%	89.9%	90.0%	89.9%	90.0%	90.1%	90.0%	90.2%	90.3%	90.8%	91.0%	>=88.3%= Green >=80% to <88.3% =Amber <80% =Red		
P7	Percentage of colleagues in a senior role (band 8a and above and consultant roles):	Who are of an ethnic minority	SFT	1,5	24.7%			25.3%			25.6%			24.4%			>=Trajectory = Green <=10% below trajectory = Amber >10% below trajectory = Red		
P8		Who are female	SFT	1,5	59.0%			59.1%			59.2%			59.2%					
P9		With a recorded disability	SFT	1,5	4.8%			5.0%			5.1%			5.1%					
P10	Job planning: Percentage of Consultant and SAS doctor job plans signed off		SFT	5	76.4%	80.6%	83.7%	84.1%	84.1%	91.0%	37.3%	39.1%	38.4%	30.8%	30.8%	31.5%	>=95%= Green >=85% to <95% =Amber <85% =Red		
P11	Percentage of patient-facing staff receiving a 'flu vaccination		PAF	1,5	35.4%	45.3%	50.7%	50.2%	56.5%	56.4%	Programme finished until October 2026						By February 2025 >=33.1% = Green <33.1% = Red		
P12	Number of formal HR case works (disciplinary, grievance and capability).		SFT	5	128	105	95	124	111	123	190	148	142	150	145	176	SPC (Upper Control Limit 78		

NARRATIVE REPORT

PATIENT EXPERIENCE AND INVOLVEMENT

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

What is going well

Care Opinion activity remains substantially higher than at the start of the year. Feedback was overwhelmingly positive, with 81% of stories containing positive comments about staff or the care provided. Patients frequently praised colleagues for their kindness, compassion, professionalism and support. Particularly positive feedback was received for maternity services, physiotherapy, ophthalmology, speech and language therapy, paediatric pre-operative assessment, emergency care and frailty services.

Communication featured in 59% of stories, demonstrating that it is both a significant organisational strength and, when inconsistent, a recurring source of poorer patient experience. Positive feedback highlighted staff who took time to explain care, involve patients in decisions and provide reassurance, while concerns related primarily to delays, lack of information and inconsistent communication.

Response rates increased from the previous month, with 94.7% of Care Opinion stories receiving a response. This reflects the collective effort of clinical teams and the Patient Engagement Team to ensure feedback is acknowledged, learning is captured and patients, relatives and carers feel heard and valued.

In September 2026, only 8.7% of open formal complaints progressed to a second letter, remaining better than the Trust target of less than 10%. This indicates that most complaints are being addressed satisfactorily through the initial response process, reducing the need for further correspondence. The lower proportion of second letters may suggest that initial responses are becoming more effective, with concerns addressed more clearly and fully at the first stage. It may also reflect the benefit of ongoing work to improve response quality and promote earlier resolution.

What is going less well

There was a slight decrease in the number of Care Opinion stories received in September 2026. Whilst the majority of Care Opinion feedback remains positive, several recurring themes highlight areas where improvement is required.

Communication continues to be a significant determinant of patient experience; although many patients reported receiving clear and timely information, others described delays in receiving updates, difficulties contacting services, inconsistent information, and feeling insufficiently involved in decisions regarding their care and discharge planning.

A smaller number of stories raised concerns regarding waiting times, appointment management, administrative processes and accessibility. These included delays in being seen despite scheduled appointment times, unanswered messages, difficulties navigating services, and concerns regarding the suitability of some facilities for people with disabilities. There were also isolated but important concerns relating to discharge planning, consent and coordination of care across organisational boundaries. Although these issues were raised infrequently, they have the potential to impact significantly on patient confidence, safety and overall experience and therefore warrant continued monitoring and targeted improvement activity.

The themes identified through Care Opinion remain broadly consistent with those reported through other patient feedback channels, particularly in relation to communication, access to services and care transitions. This provides assurance that the Trust is identifying common areas for improvement across multiple sources of patient feedback and can target action accordingly.

The business case seeking funding for a four-year Care Opinion contract from September 2027 was not supported by the Trust's charities, as the service had previously been funded by the Trust. Alternative funding options are now being explored, including the League of Friends, alongside other opportunities to retain a comparable patient feedback service.

The PALS recovery plan, implemented in September 2026 to address the backlog of enquiries accumulated during June, July and August 2026, has been successful in prioritising those individuals who continue to require support from the service. Progress continues to be made in clearing the remaining backlog and re-establishing timely reporting of PALS activity.

In September 2026, 59 new complaints were recorded on Radar, consistent with the number reported in August 2026. Whilst activity remained stable, the overall trend in complaints received continues to demonstrate an upward trajectory.

The increasing use of artificial intelligence (AI) by individuals raising concerns to support the drafting of correspondence continues to add to the complexity of complaints received and is now recorded on the Trust Risk Register. A six-month pilot review of AI-enabled complaints continues, to strengthen understanding of this emerging issue.

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.

In September 2026, the proportion of formal complaints responded to within the agreed timeframe decreased to 57.1%. This represents the aggregated Trust-wide position and reflects variation in performance across service groups, with performance varying from 37.5% to 69.2%. No service groups individually met the Trust target of 90% responded to 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.
- Changes to the complaints sign-off process have contributed to some delays, reflecting short-term capacity challenges during the implementation period.

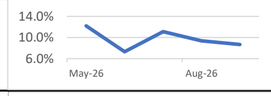
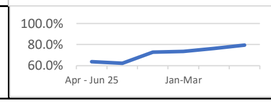
Focus of improvement work

- Continue to develop patient experience dashboards in partnership with the Data Team, bringing together Care Opinion, Friends and Family Test, PALS, complaints and compliments data. This will support services to identify emerging themes, understand local issues, monitor trends over time and evidence improvements resulting from patient feedback.
- Share learning from patient stories relating to coordination between services, identifying opportunities to improve the flow of information between hospital teams, community services and primary care.
- Work with maternity, emergency care and therapy services to understand and share the factors contributing to consistently positive patient feedback, enabling good practice to be adopted more widely across the organisation.
- 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 feedback overwhelmingly positive. 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 Deputy Chief Nurse. 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.
- Targeted escalation pathways are being used to support timely resolution within Families, Neighbourhoods and Surgical service groups, with escalation to Associate Medical Directors and Associate Directors of Patient Care taking place ahead of the breach point where required.
- 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.
- An interactive dashboard has been implemented to improve visibility of complaint timelines and overall performance.

SOMERSET NHS FOUNDATION TRUST

PATIENT EXPERIENCE AND INVOLVEMENT

No.	Description	Source	Links to strategic aims	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Thresholds	Trend	Variation / Assurance
PE1	Care Opinion: Number of stories per month	SFT	2	25	37	30	36	34	16	36	30	25	46	42	38	Increase from 2024/25 baseline		
PE2	Care Opinion: Percentage of stories with responses	SFT	2	92.0%	81.0%	100.0%	97.2%	100.0%	100.0%	91.7%	93.3%	84.0%	89.1%	78.6%	94.7%	>=90%= Green >=80% - <90% =Amber <80% =Red		
PE3	Monthly number of complaints received	SFT	2	36	38	50	47	35	47	48	36	52	67	59	59	TBC		
PE4	Number of complaints open at end of the month	SFT	2	92	95	109	110	116	111	120	137	122	119	153	178	TBC		
PE5	Monthly number of PALS enquiries	SFT	2	557	388	386	408	397	426	383	342	363	425	358	Data awaited	TBC		
PE6	Percentage of complaints responded to within the timescale agreed with the complainant	SFT	2	52.8%	73.0%	50.0%	55.8%	51.5%	49.0%	54.1%	54.2%	58.5%	61.0%	65.8%	57.1%	>=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%	11.1%	9.4%	8.7%	<=10%= Green >10% - <=15% =Amber >15% =Red		
PE8	Percentage of formal complaints fully upheld	SFT	2	10.7%		10.4%		15.1%			5.3%					Compare to national average		
PE9	Percentage of formal complaints partially upheld	SFT	2	72.8%		73.6%		76.2%			79.5%					Compare to national average		

Appendix 1 – Specialty and tumour-site level performance

Table 1 – Performance against the RTT performance standard in September 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	817	70	2539	67.8%
Urology	1514	269	3257	53.5%
Trauma & Orthopaedics	3549	372	9217	61.5%
Ear, Nose & Throat (ENT)	2234	189	4725	52.7%
Ophthalmology	756	15	3244	76.7%
Oral Surgery	2215	316	3389	34.6%
Plastic Surgery	37		214	82.7%
Cardiothoracic Surgery			18	100.0%
General Medicine	17		57	70.2%
Gastroenterology	653	16	2195	70.3%
Cardiology	494	7	2414	79.5%
Dermatology	927	83	3838	75.8%
Thoracic Medicine	252		1605	84.3%
Neurology	431	8	1956	78.0%
Rheumatology	428	16	967	55.7%
Geriatric Medicine	206	4	715	71.2%
Gynaecology	1921	88	4169	53.9%
Other – Medical Services	1060	26	3931	73.0%
Other - Paediatric Services	368	19	1206	69.5%
Other - Surgical Services	2285	266	5937	61.5%
Other – Other Services	5		266	98.1%
Total	**20169**	**1764**	**55859**	**63.9%**

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

Tumour site	No of breaches	Trust performance
Brain	0.0	100.0%
Breast	7.0	87.3%
Colorectal	13.5	54.2%
Gynaecology	5.0	70.6%
Haematology	2.0	86.7%
Head & Neck	4.0	42.9%
Lung	5.0	50.0%
Other	2.0	66.7%
Skin	14.0	85.0%
Upper GI	4.5	83.0%
Urology	21.0	70.8%
Total	78.0	77.7%

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

- Seven 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.
- Three 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 pathway was delayed due to the need to treat another medical condition first.
- One patient chose to delay their pathway.

Appendix 2 – Infection Control and Prevention – September 2026

MRSA bloodstream infections	Commentary on MRSA /MSSA BSIs
Musgrove Park Hospital = 0 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Total to date = 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** – We are slightly above our internal trajectory for MSSA BSIs. Half of cases are linked to peripheral vascular cannulae. The Quality Improvement project that has been in place on Fielding will widen into a task and finish group covering inpatient wards across Medicine and Surgery to spread improvements across the key areas of risk in the Trust. This will be monitored through the Infection Control Operational Group. The group starts 2/11/26.
MSSA Bloodstream Infections	
Musgrove Park Hospital = 4 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Internal Threshold = 64** **Total to date = 38**	
E. coli bloodstream infections	**Commentary on Gram-negative bloodstream infections**
Musgrove Park Hospital = 5 Yeovil District Hospital = 3 Community Hospitals / Mental Health = 0 **Threshold = 100** **Total to date = 48**	E. coli - as a trust our case numbers remain on trajectory, and we have the second lowest rates in the Southwest. Pseudomonas aeruginosa – as a trust our case numbers remain on trajectory, and we have the second lowest rates in the Southwest. Klebsiella – as a trust our case numbers are over trajectory but remain below the National and Southwest rates. The two most common sources are urine (35% of cases) and biliary (37% of cases).
Klebsiella bloodstream infections	
Musgrove Park Hospital = 4 Yeovil District Hospital = 1 Community Hospitals / Mental Health = 0 **Threshold = 36** **Total to date = 27**	
Pseudomonas bloodstream infections	
Musgrove Park Hospital = 1 Yeovil District Hospital = 0 Community Hospitals / Mental Health = 0 **Threshold = 12** **Total to date = 5**	

C. difficile	Commentary on C. difficile
Musgrove Park Hospital = 10 Yeovil District Hospital = 1 GP = 2 **Threshold = 74** **Total to date = 47**	Although as a Trust we are over trajectory, we have the second lowest rates of C diff in the southwest and remain below the national rate.
Respiratory Viral Infections - inpatients	**Commentary on Respiratory Viral Infections**
COVID (Trust Cases) = 60 Musgrove Park Hospital = 18 Yeovil District Hospital = 33 Community Hospitals = 8 Hospital @ Home = 1 **Influenza = 11 (Inpatients)** Musgrove Park Hospital = 7 Yeovil District Hospital = 4 **Respiratory Syncytial Virus (RSV) = 0 (Inpatients)**	**Respiratory Viruses** Case numbers of COVID have significant risen during September and Flu cases have dropped. Nationally, there remains a concern that there could be an early start to the Flu season based on the current rising trend of cases. The Trust vaccination programme for colleagues continues and is recommending colleagues get vaccinated early to protect themselves for a potential early start to the season.
Outbreaks	**Commentary on outbreaks**
COVID = 3 Musgrove Park Hospital = 1 Yeovil District Hospital = 1 Community Hospitals = 1 **Carbapenemase Producing Organism (CPO)** Yeovil District Hospital	Outbreaks due to respiratory viruses remain low currently. **Carbapenemase Producing Organism (CPO)** On the Yeovil district hospital site work continues to manage the CPO outbreak which has spanned two key time periods, January 2022 to August 2023 and December 2023 to the current time. There are two different resistance mechanisms involved. The genes that encode for these resistance mechanisms can move between different species of bacteria which makes the linking of cases in the outbreak more challenging. Since February 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

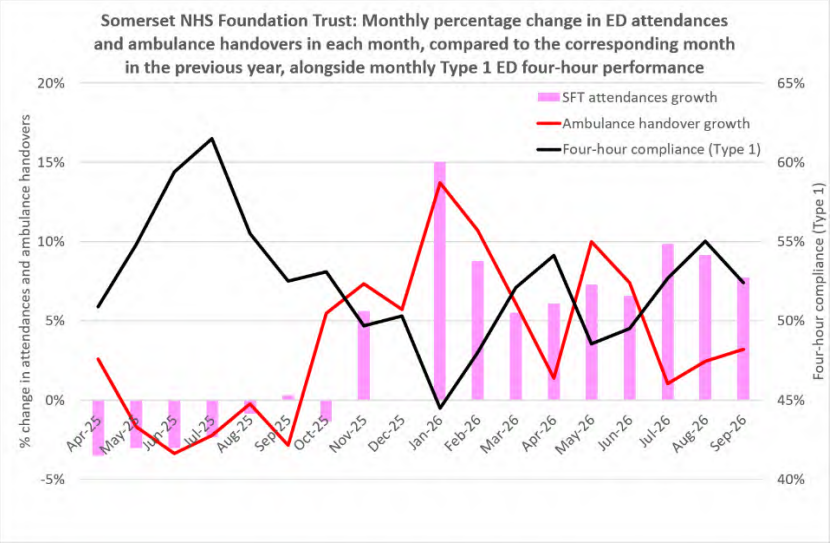
	patient testing is in place to identify unknown cases and monitor further cases. This is being monitored by the Quarterly Infection Control Committee.
Surgical Site Infections	**Commentary on Surgical Site Infections**
Surgical Site Infection Surveillance enables early recognition of infections to inform 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. **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 (September 2025 to August 2026) a total of 360 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 (September 2025 to August 2026) a total of 205 operations were undertaken and one infection identified giving an infection rate of 0.49%. This is in line with the national benchmark of 0.4% • **Spinal Surgery** Within the last year (September 2025 to August 2026) a total of 349 operations were undertaken and 7 infections identified giving an infection rate of 2.01%. 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 in progress with the Service Group to understand the reason for this rise in cases. **Yeovil District Hospital Site** • **Hip Replacement** Within the last year (September 2025 to August 2026) a total of 361 operations were undertaken with no infections identified. • **Knee Replacement** Within the last year (September 2025 to August 2026) a total of 429 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 71.7% in September 2026, below the Operational Plan standard for September 2026 of 78.5%, and also below the recovery plan of 73.4%. Both Musgrove Park Hospital and Yeovil District Hospital (including the Urgent Treatment Centre) have seen significant levels of growth in attendances in 2026, compared to 2025. Attendances at MPH during the period 1 January to 30 September 2026 were 3.2% higher than during the corresponding period in 2025, and attendances at YDH during the period 1 January to 30 September 2026 were 15.3% 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%	73.0%	71.7%						
Planned trajectory	76.0%	76.5%	77.0%	77.5%	78.1%	78.5%	79.0%	79.5%	80.0%	80.5%	81.0%	82.0%
Recovery trajectory			70.5%	71.5%	72.4%	73.4%	74.3%	75.3%	76.3%	78.2%	80.1%	82.0%

ED four-hour standard: patients aged under 16 years

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Actual	88.8%	86.7%	87.0%	86.3%	89.4%	87.4%						
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 30 September 2025	1 January to 30 September 2026	Increase	Percentage increase
MPH	21,896	22,347	451	2.1%
YDH	11,225	12,803	1,578	14.1%
Total	**33,121**	**35,150**	**2,029**	**6.1%**

This shows a growth in conveyances to MPH of 2.1%, and a growth in conveyances to YDH of 14.1%, with an overall Trust-wide growth level of 6.1%. 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%	66.0%	71.2%						
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%	3.5%	5.0%						
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	55,401	55,859						
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	1,702	1,764						
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%	81.2%	74.7%							
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%	70.4%	73.5%	77.7%							
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%	89.9%	91.3%							
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%