Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Maternity & Neonatal Quarter 2 26/27 Quality & Safety Report
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and Midwife
REPORT BY:	Sally Bryant, Director of Midwifery & Deputy to the chief Nurse & Midwife
PRESENTED BY:	Sally Bryant, Director of Midwifery & Deputy to the chief Nurse & Midwife
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	To provide assurance on the safety and quality of maternity & neonatal services

Recommendation	The Trust Board is asked to: • Review the Q2 Q&S report • Note actions being taken to address the strategic risks

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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)
MNVP provides service user feedback and work with SFT colleagues as quorate members of all quality & safety meetings within the governance framework

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

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

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

SOMERSET NHS FOUNDATION TRUST

MATERNITY & NEONATAL QUARTER 2 26/27 QUALITY & SAFETY REPORT

1. BACKGROUND AND PURPOSE

To provide the Board with assurance on the Quarter 2 position for perinatal quality, safety, workforce and leadership, drawing on the October 2026 Perinatal Governance review. The report sets out the principal achievements, current safety and experience indicators, material risks, mitigations and priorities for Quarter 3.

Quarter 2 demonstrates continued progress against the Maternity and Neonatal Improvement Plan, strengthening governance arrangements and delivery of targeted improvement work. Key achievements include:

- Enhanced executive and non-executive oversight through the MatNeo Improvement Board
- Implementation of a Perinatal Leadership Team oversight structure
- Continued achievement of 100% supernumerary labour ward coordinator compliance and 100% one-to-one care in established labour across both sites
- Positive progress within Saving Babies' Lives care bundle workstreams
- Development of a comprehensive thematic review process to triangulate learning across incidents, complaints, PMRT, MNSI and audit activity.

2. KEY LEARNING POINTS

A thematic review of 307 safety events identified three cross-cutting priorities for continued focus:

- Recognition, escalation and clinical decision-making.
- Neonatal and newborn safety.
- Positive family-centred and compassionate care.

Whilst there is significant evidence of learning activity and improvement work, assurance remains partial. Recurring themes continue to highlight challenges in demonstrating that learning has consistently translated into sustained improvements in practice. The service remains focused on strengthening action tracking, evidencing implementation and creating a robust assurance framework that demonstrates impact.

3. AREAS REQUIRING ONGOING OVERSIGHT

Key areas requiring ongoing committee oversight include:

- Workforce resilience, leadership capacity and training compliance.
- Safeguarding training and supervision compliance.
- Neonatal medical leadership arrangements at YDH.

- Reliability of learning response implementation.
- Triage performance and capacity pressures.
- Delivery of Maternal Care Bundle and MIS year 8 requirements.
- Closure of overdue complaints and demonstrable learning from patient feedback.

4. IMPROVEMENT JOURNEY

While progress continues across a number of improvement programmes, including delivery of the Maternity & Neonatal Improvement Plan and strengthened governance arrangements, assurance remains partial in some domains. Work during Quarter 3 will focus on evidencing the impact and sustainability of improvements and demonstrating that learning has translated into measurable changes in practice.

5. SUMMARY

Overall, the report provides moderate assurance that maternity and neonatal services are continuing to improve quality, safety and governance arrangements, whilst recognising that further work is required to embed and evidence sustainable improvement in a number of key areas.

6. RECCOMMENDATION

The Board is asked to:

- Note the Quarter 2 assessment of maternity and neonatal quality and safety.
- Take assurance from progress made against the Maternity & Neonatal Improvement Plan and associated governance arrangements.
- Note the findings of the Perinatal Thematic Review and associated improvement priorities.
- Endorse the Quarter 3 focus on workforce resilience, training compliance, safeguarding assurance, neonatal leadership and evidencing the impact of learning and improvement activity.
- Receive assurance that mitigating actions are in place for principal strategic risks and that these continue to be monitored through established governance arrangements

SALLY BRYANT, DIRECTOR OF MIDWIFERY & DEPUTY TO THE CHIEF NURSE & MIDWIFE

APPENDICES:

Appendix A: Perinatal Governance Meeting (PowerPoint of Q2 Q&S Data)
Appendix B: Q2 Safety events thematic review

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Perinatal Quarterly Governance Group

Kindness, Respect, Teamwork
Everyone, Every day

Wednesday 14th October 2026

Chair: Penny Booysen

Actions				Update
1	Revise and continue monitoring anaesthetic participation in PROMPT training.	Kate Beaumont	14/10/2026	ongoing
2	Present thematic review of neonatal deaths associated with congenital anomalies.	Elizabeth Strong	14/10/2026	Complete – Within slide deck
3	Develop and circulate CQC action plan.	Sally Bryant	14/10/2026	Complete
4	Share safe sleep learning with paediatric services.	Elizabeth Strong / Naomi	14/10/2026	
5	Explore mandatory safe sleep documentation within BadgerNet and investigate functionality changes with Digital Team and BadgerNet regarding safe sleep prompts.	Penny Booysen	14/10/2026	Added to Action Tracker
6	Complete review of antibiotic administration delays and identify mitigations.	Kate Beaumont	14/10/2026	
7	Review guidelines approaching expiry and escalate lack of capacity early.	Amy Dodsworth	14/10/2026	Complete – Within slide deck

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Service / Corporate Updates

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Perinatal Leadership Team: September 2026

NHS Somerset

Key achievements/overview

- PLT Team Charter shared with staff during leadership walkabouts across both sites, reinforcing team values, expectations and leadership visibility.
- Head of Midwifery and Obstetric Lead completed the first joint unit walkabout, providing opportunities for direct engagement with staff.
- In response to the publication of the Thirlwall Report, the Paediatric Lead completed a Neonatal Unit walkthrough to provide assurance on family experience and engagement within the neonatal service.

Planned Focus:

- Establish a cross-site meeting to undertake review of EM LSCS

Area of concern/slippage:

- No named Neonatal CSL post YDH

Mitigations:

Items requiring escalation:

Items for decision:

Monthly Update Report

Trust name:	Somerset Foundation Trust
MIA(s):	Christine Harding (Midwifery) Amanda Pearson (Midwifery) Gemma Wright (Obstetrics) Avideah Nejad (Obstetrics) Liz Langham (Neonatal) Liz Pilling (NIA)
Site visits in past month:	2 days Midwifery, 1 Day Obstetric, Neonatal- virtual support weekly

Report date:	September 2026		
Level of support:	Intensive		
Support start date:	January 2026	**Support end date:**	December 2026

Achievements and progress of milestones

42 MNIST actions to be completed in Quarter 1&2 According to MNIP 18 are signed off and evidenced and a further 2 are ready to be signed off, 6 are in progress. Review of MNIP underway with MIA involvement to ensure it reflects the progress and priorities. Progress continues to be monitored through the MatNeo Improvement board which is chaired by the Non Executive Director and has Executive representation. A review of the MNIP oversight process has taken place and the plan is being refined to enable prioritisation and meaningful reporting. The PLT Oversight Group will support traction on challenging areas by giving key leaders an opportunity to collaborate in a safe space. New midwifery MIA to support further review of MNIP to ensure up to date.
Estates- Work to secure suitable theatre space is ongoing with business case being worked up by estates and facilities. Associated workforce is also being mapped to ensure the business case is comprehensive. No current time line on progress with this as yet.
Neonatal improvement- Neonatal Milestones have been agreed and presented at this meeting. Priority areas are securing Medical Neonatal Leadership at YDH, supporting stabilisation of safe staffing in both nursing and medical across both sites, creation of Neonatal governance strategy to be incorporated as a Perinatal governance framework and ensuring the transitional care at MPH site is appropriately resourced to meet BAPM requirements and maintain safe service. Neonatal improvement advisors on site early October to support neonatal case review.
Clinical Pathways- The first meeting with consultant obstetricians regarding the case review has taken place with some actions proposed. A further meeting with the rest of the consultant body is planned for later in October and is supported by the Chief Medical Officer, Associate Medical Director and MIA team
Leadership- Ten Point Plan response has been submitted for regional review.

Escalations

Clinical Leadership YDH- Further meeting with consultant body to take place in October. Next steps will need to be confirmed following both of these meetings. There remains a need to identify clinical leadership within the Neonatal service at YDH as a priority
Financial pressures- The executive team and service are asked to mindful of removing resource from perinatal services at this critical point in the improvement journey. Quality and Safety, Practice Development and operational resource have all been designed based upon recommendation from MNIST and are all essential to the services ability to continue to improve. Removal at this point will have a negative impact on meeting both the MNIST milestones, MIS and wider improvement related to national reports.
Governance- Trust wide PSIRF and learning responses- lack of ability to oversee and track improvements and actions identified following incidents, risks etc at corporate level. Delays in commissioning appropriate learning Reponses if these are AAR or PSII. Local and corporate capacity appears to be driving this. – the meeting to consider creation of a Maternity PSIRF is still to take place which is a positive move and will align the service with other high performing organisations in this area.
Estates- Ongoing challenges with estates and facilities capacity to progress focussed work. EG.Birthing pool on labour ward no longer in use, and room not fit for purpose as a birthing room which is impacting on patient experience and potentially on flow. Pool purchased but work needed on the room before it can be installed. Awaiting time line

Monthly Executive Meeting Action Tracker

Meeting date and time:	21/9/26
Attendees:	Peter Lewis (CEO) Sally Bryant (DOM) Rachael Glasson (Deputy Chief Midwife South West) Leanne Ashmead (Service Group Director) Inga Kennedy (Mat Neo Safety Champion NED) Donna Butland (MNVP) Deirdre Fowler (CNO) Christine Harding (MIA) Avideah Nejad (MIA) Robyn Smart (Deputy Director Midwifery and Neonates)

Area of focus / summary	Action	Action owner	Target date	Update
Culture and Leadership	• Implementation of safety oversight framework at MPH and cross site safety huddle • Development of a rebranded culture strategy which will describe the process the service gathers, triangulates and acts upon all cultural intelligence. This will be described within the governance framework including the process for monitoring continual improvement in this area.	PLT Perinatal QUINT	May 2026 April 2026	• Quad have developed a PLT oversight group to provide direction to this work and other pieces of work being undertaken by the PLT.. The oversight framework is in place and needs to be rolled out on MPH site. There has been a delay to the implementation of a cross site safety huddle which is anticipated to be started within the next month • There has been good progress with the development of the Culture Strategy with positive collaboration to understand the metrics and measures. It is anticipated that this framework will be socialised by the end of October. The trust improvement team has dedicated capacity to support this work.
Quality and Safety Framework	• Alignment of Maternity Systems and processes with wider Trust PSIRF plan within the framework • Understanding of how Radar system can be developed to track learning and improvement and the timescale for this	CNO/CMO PLT	March 2026 October 2026	• Further meetings planned in the coming weeks to which MIAs have been invited • Decision made to develop existing system capabilities rather than invest in new system. Need to understanding the timeline and resources to support this given the significant digital plans for the next 18 months

Area of focus / summary	Action	Action owner	Target date	Update
Culture and Leadership Response to recommendations within the Clinical Case Review	• Second meeting with YDH consultant body planned for the 23/10/2026 to discuss next steps • Actions agreed following this meeting to be monitored and tracked through the improvement plan • To ensure that the wider recommendations within the review including the MDT are also enacted to ensure sustainable response • Strategic solution needed to address potential clinical skills gaps • Implementation of the weekly review of Emergency LSCS across both sites – resources needed to support this • Plan to repeat review process following improvement actions in 6 months with clinical teams supporting this	CMO DOM DOM DOM/MIA CMO/ MIA AMD	Sept 26 Sept 26 Sept 26 October 26 March 27	• Initial meeting held with some YDH consultants which was described as positive. Further discussion needed to understand barriers to evidencing deviation from guidance and accountability for improvement. Executive members keen for strategic solution. • Weekly review of emergency CS across both sites not yet started. Resources need to be confirmed • Suggestion that this review is repeated at Musgrove site
Culture and Leadership Serious concerns regarding behaviour and leadership from Obstetric consultant body at YDH site, impacting culture and clinical outcomes for women and babies.	• Obstetric MIA to directly correspond with CMO regarding individual practice concerns identified in clinical case review - **Complete** • Clinical case review to be shared and presented at August executive meeting - **Compete** • MIA to review local guidelines that are impacted by the size of the service to ensure they are appropriate	Obs MIA	August 2026	• Individual communication and Review report shared with the trust. Report discussed for next steps in August meeting. Local guidelines for reduced fetal movements and small babies under review to ensure appropriate for size of organisation without compromising safety
MatNeoIST support	• Lead MIA and PLT to discuss further and identify actions to promote understanding and improve relationships • Proposed actions to be discussed and agreed by MIA and NIA team	Lead MIA PLT	Oct 2026	It was escalated that there appears to be a lack of awareness regarding what MatNeoIST is and the role of the M/NIAs by some senior clinicians, particularly obstetric and neonatal. This has led to some push back. M/NIAs keen to ensure relationship is collaborative and supportive.

MHRA Safety Alert: Wireless CTG Systems

NHS Somerset

DSI/2026/012 | Issued 17 September 2026

Key Patient Safety Concerns

- In rare circumstances, the fetal heart rate from one patient may appear on another CTG monitor if devices are operating on the same RF channel.
- Signal interference or loss may produce inaccurate or incomplete CTG recordings.
- These issues could result in delayed recognition of fetal compromise or unnecessary intervention.

Systems Affected

The risk primarily relates to older wireless telemetry CTG systems operating where only a limited number of channels are available.

Actions for Clinical Staff

The MHRA advises healthcare professionals to:

- Ensure wireless CTG devices are not operating on the same RF channel unless they are sufficiently separated to prevent interference.
- Verify CTG traces at the start of monitoring and throughout use by checking:
  - Maternal pulse, maternal and fetal clinical condition and that the displayed fetal heart rate belongs to the correct patient.
- Confirm transducers are correctly paired with the base station before monitoring starts.
- Ensure access to a wired CTG system if signal loss or crossover occurs.
- Keep transducers and docking stations clean and free from gel contamination.

Implications for Maternity Services

For maternity units, this alert reinforces the importance of:

- Regular clinical validation of CTG traces rather than relying solely on the monitor display.
- Awareness of RF channel allocation when multiple telemetry CTGs are being used simultaneously.
- Having clear escalation and backup arrangements if signal reliability is questioned.
- Including the risk of signal crossover in staff training and local fetal monitoring governance processes.

The **baseline compliance** / **compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.
Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply*.
Non-compliant: There is no, or very limited, evidence that the requirement has been met.
Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.
Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Summary by Action - Baseline		Compliance			
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant
1. Listening to women and families by rolling out Martha's Rule	1	0	0	0	1
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	1	2	0
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	1	1
5. Addressing inequalities in maternity and neonatal outcomes	3	0	1	1	1
6. Ensuring 24/7 safety and responsiveness of services	7	0	0	2	5
7. Trust review of homebirth services	2	0	0	0	2
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	2	1
9. Deliver safe and effective triage in maternity services	3	0	0	1	2
10. Post death care	2	0	0	1	1

MPH Triage AMOS Update

Somerset NHS Foundation Trust

The requested funding has been submitted to resolve the Medical cover for Triage.

Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	36%	55%	9%	0%	0%	£0.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	50%	40%	10%	0%	0%	£0.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	60%	20%	0%	20%	0%	£0.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	33%	33%	0%	0%	£0.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	63%	38%	0%	0%	0%	£0.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	40%	20%	40%	0%	0%	£0.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	90%	10%	0%	0%	0%	£0.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	50%	33%	17%	0%	0%	£476,775.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	40%	0%	60%	0%	0%	£0.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	43%	29%	29%	0%	0%	£0.00

YDH Triage AMOS Update

NHS Somerset NHS Foundation Trust

The requested funding has been submitted to resolve the Midwifery staffing gaps to cover Triage 24/7

Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	36%	55%	9%	0%	0%	£0.00
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	50%	40%	10%	0%	0%	£0.00
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	60%	20%	0%	20%	0%	£0.00
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	33%	33%	0%	0%	£0.00
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	63%	38%	0%	0%	0%	£0.00
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	40%	20%	40%	0%	0%	£0.00
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	80%	20%	0%	0%	0%	£0.00
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	58%	25%	17%	0%	0%	£196,889.00
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	40%	0%	60%	0%	0%	£0.00
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	43%	29%	29%	0%	0%	£0.00

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Perinatal Quality & Safety Report October 26 (Sept data)

Kindness, Respect, Teamwork
Everyone, Every day

Kate Beaumont

September 2026 Executive Summary

NHS Somerset NHS Foundation Trust

Overall position

September reporting shows 89 safety events, including 75 involving patients. No safety challenge/outcome selections reduced to 33%.

The September risk dashboard lists eight risks scoring 16 or above. These continue to require oversight.

Q2 complaints total 17, with 16 still open and six overdue. Clinical treatment and communication feature prominently.

Patient safety & learning

- September reporting includes two moderate-harm incidents and two deaths: a neonatal death on day 2 and a stillbirth at 31+1 weeks.
- Reviews identify gaps in documentation and risk assessment. Priorities include haemorrhage records, fetal monitoring and timely escalation.
- Low Apgar remains a negative national outlier. Local reviews report generally appropriate recognition and escalation of fetal compromise.

Operational resilience

YDH neonatal clinical leadership remains unfilled. Triage funding requests cover MPH medical and YDH midwifery staffing.

Training needs escalation. September O&G safeguarding children compliance is 45%. YDH neonatal nursing resuscitation compliance is 42% at 1 October.

Our focus remains action ownership, timely completion and evidence of improvements in care.

Monthly dashboard: September and Q2 position

NHS Somerset NHS Foundation Trust

Reported safety events

89 events in September
75 involving patients

September harm reporting

2 moderate-harm incidents
2 deaths reported

Risk register: August dashboard

8 risks score 16+
25 lower than original

Q2 clinical reviews

20 PPH cases >1.5 litres
15 OASI cases
No fourth-degree tears

Safeguarding children Level 3: September

O&G compliance 45%
Midwives 75%

Triage: latest data August

1,061 presentations
95.9% assessed on time

What needs our attention

- Q2 complaints: 16 remain open and six are overdue. We need to show families how their feedback informs improvements.
- Priorities remain neonatal leadership and staffing, training compliance and reliable tracking of learning actions.

Data quality and assurance gaps

33% of events lack a safety challenge/outcome selection. Duty of Candour audit: 100%, excluding two cases. National metrics are to July. September triage data are absent.

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Completed Reports

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Incident Summary:
P0 – low risk pregnancy. Attended CMW appointment at 40+2 and no FH heard. Transferred in and USS diagnosed IUD, condolences given. Had CAT2 LSCS at maternal request.

Cause of death: Placenta identified Delayed Villous Maturation (DVM).

The review group concluded there were no issues with care identified up to the point that the baby was confirmed as having died.

The review group concluded there were care issues following confirmation of the baby's death, which they considered may have made a difference to the outcome for the mother. This is in relation to the incomplete information provided, particularly regarding the risks and benefits of caesarean birth.

Learning identified, actions & next steps:

1. Review information sharing and consent around operative birth for bereaved families:
- Review CS consent form and identify if a bespoke form can be made for bereavement cases.
- Create an information leaflet about what to expect in theatre for a caesarean birth.
- Identify if there is already patient information leaflets provided to help support decision making of mode of delivery in bereavement case – family specifically identified how the baby may look was an important factor.

2. Discuss with co-ordinators process in hours to get consultant onsite if Labour Ward consultant isn't available at the time when confirming IUD with USS.

3. Parents should be offered to take their baby home:
- Maternity communications with mortuary to clarify process – as it was the mortuary who said this is not possible due to the postmortem pending.

MNSI - MI-050225
July 2026

NHS Somerset NHS Foundation Trust

Date of Incident: 03/12/2026

Incident Summary: P0 - spontaneous labour. FX delivery in theatre following a bradycardia. Baby required resuscitation and was admitted to SNU. Baby was then transferred to Southmead for cooling. Subsequent Normal MRI Result.

Safety prompts:

- How are staff supported to provide care in line with Trust guidance on one-to-one care, particularly when service acuity is high? How can staff be supported to use the escalation policy when a mother's need for one-to-one care cannot be supported? – Introduction of flow midwife at MPH and the use of escalation toolkit was included on PROMPT 25-26 study days.
- What mechanisms are available for team members to dynamically and collaboratively explore alternative care pathways, and to identify, challenge, and alert each other to potential bias? - RCOG toolkit was included on PROMPT 25-26 study days.
- How does the Trust support staff to formally categories CTG findings in emergency situations to ensure a shared and accurate understanding of fetal wellbeing and the appropriate urgency of response?

Learning identified, actions & next steps:

- Embed the local guidance on escalation when there is a delay following a request for an epidural, so that prolonged management of pain is avoided – Knowledge nugget was created.
- Implement a processes to monitor readiness and effectiveness of wireless cardiotocography (CTG) equipment and provides a backup system for continuous monitoring if wireless monitoring fails – CTGs have been added to the daily checklists.
- Align practice to guidance when a bradycardia is declared by supporting staff to prioritise treatment of a bradycardia instead of focus upon loss of contact, to prevent delays during the treatment of a bradycardia and to offer safe, timely emergency care – To continue to embed learning on Fetal monitoring study days.

Perinatal Mortality Review Tool (PMRT)
April 2026

NHS Somerset NHS Foundation Trust

Report Published: 12th October 2026 (Case ID: 103382)

P0 low risk booking.
Under FM for isolated unilateral talipes, identified at anomaly USS.
23+1 IUD diagnosed in triage on admission for RFMs.

Cause of death unknown – still awaiting PM results.

Grading of care as per PMRT findings:

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:
The review group identified care issues which they considered would have made no difference to the outcome for the baby.
Grading of care of the mother following confirmation of the death of her baby:
The review group identified care issues which they considered would have made no difference to the outcome for the mother.

Family Feedback:

Tried calling community midwife in the morning when she had not felt movements since the night before but couldn't get hold of her. She did speak to a community midwife later who said they would get someone to call her back, but they didn't, so she then called triage.

When presenting at front reception she said it felt like she wasn't expected and made her question whether we knew what we were doing and she wanted to leave.

Everyone who looked after them made them feel cared for and all their visitors. She said they really appreciated that nothing seemed to be too much trouble.

Learning identified and action required:

- To review process to ensure reception admin team are aware of when women/birthing people are presenting to attend Rowan suite – Bereavement pathways have been updated.
- To review communication in community hubs from admin staff and MSW when someone calls with antenatal concerns – Visuals aids to be added at community hubs for admin staff and MSWs.
- To consider whether misoprostol should be handled as a controlled drug.

MNSI – MI-054069
2025

(OLP-2092) Date of Incident: 13/12/2025

Incident Summary: Baby born at 37+3 via Cat 2 C/S – Transferred to SNU. Abnormal MRI.

Primip, low risk pregnancy. Prolonged ROM from 37+2 and commenced IOL.
Labour augmented and decision for Cat 2 CS due to labour not progressing, maternal pyrexia and CTG concerns.

Baby born with Apgars of 2,5,7, no tone & Transferred to SNU. Persistent low tone and no gag reflex was noted. Did not meet criteria for cooling.

An MRI was carried out which confirmed HIE that occurred prior to delivery.
He was transferred to tertiary center following further deterioration resulting in full resuscitation and placed on palliative care.
He was subsequently discharged and transferred to YDH children's ward on Palliative care and has since been discharged home with ongoing support.

Learning identified, actions & next steps:

MNSI recommendations

- It is recommended that Trust guidance is in line with national guidance regarding assessment and management of maternal pyrexia in labour.
- It is recommended that the Trust supports staff to maintain clinical oversight of the time interval for category 2 caesarean deliveries, to ensure a shared mental model within the multidisciplinary team, that reflects clinical urgency about the time of the birth.

Excellence Highlighted

- Effective neonatal resuscitation following NLS algorithm
- Early management of the potential reversable causes of hypotonia including early consideration of sepsis/encephalitis and appropriate antimicrobial cover including acyclovir.

PMRT Case ID: 102810
2026

NHS Somerset NHS Foundation Trust

ILP-56611 Date of Incident: 10/03/2026

Incident Summary:
NND at 34+3 following ELCS due to severe congenital abnormalities diagnosed at 15 weeks. Parents had the opportunity to spend time with their baby before sadly passing.

Grading of care:
Grading of care of the mother and baby up to the point of birth of the baby:
The review group identified care issues which they considered would have made no difference to the outcome for the baby.
Grading of care of the baby from birth up to the death of the baby:
The review group concluded that there were no issues with care identified from birth up to the point that the baby died.
Grading of care of the mother following confirmation of the death of her baby:
The review group concluded that there were no issues with care identified for the mother following the death of her baby.

What happened and why using SEIPS:
Person(s): *New staff unaware of specific terminology used – they were not aware of the situation/condition of baby following delivery.*
Task & Person Factor: Internal Environment Factor: *Difficulty in booking the ELCS – Should this be the responsibility of the Bereavement team to book.*

Learning identified, actions & next steps:

- Urinalysis not documented at every appointment.

Action – To re-shared the AN guideline with all staff & will Feed into a developing Working Group.

- Clexane prescribed without a conversation around administration – Advised to attend Triage.

Action – Learning to be shared regarding roles and responsibilities of Triage.

- Resuscitaire O2 cylinder leaking in theatre.

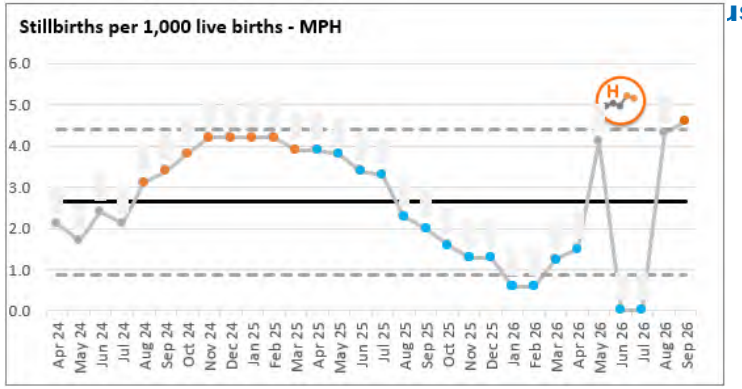
Action: Continue with Daily checks and monitor through the Trust Perinatal Governance Framework.

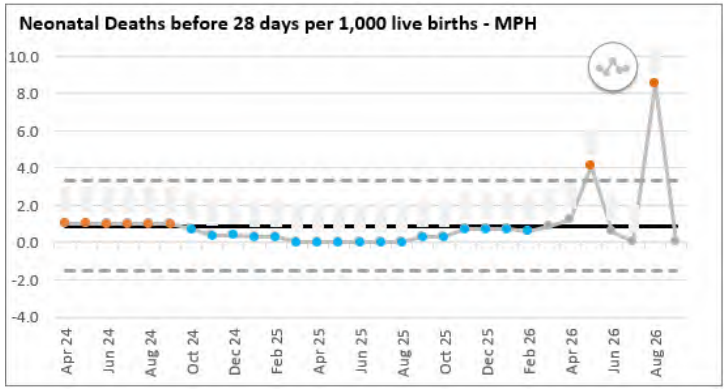
Excellence Highlighted
- Bereavement team provided excellent care and went above and beyond to aid this family in their journey.
- Excellent MDT communication between MPH and Bristol regarding patient care.

Learning From Death

- No maternal death reported in Q2 26-27

- Neonatal Deaths have seen an increase this quarter with 6 involving SFT input into the reviews.
- 21+ 3-week neonatal death
- 21 + 1-week neonatal death
- Term neonatal death, sadly died 8 days following birth at MPH at tertiary centre. Theme identified as co-sleeping. On-going Police enquiries.
- Neonatal death at YDH day 2. Theme identified as co-sleeping
- Term neonatal death 12 weeks post-natal. Theme identified as co-sleeping. On-going Police enquiries.
- Stillbirths reported 2 in Q2 26-27
- 40 +2 Intrapartum stillbirth t/f from home following homebirth. Rapid Review undertaken and PMRT.
- 31+ 1 Antepartum stillbirth. PMRT and Safety Review of antenatal care.



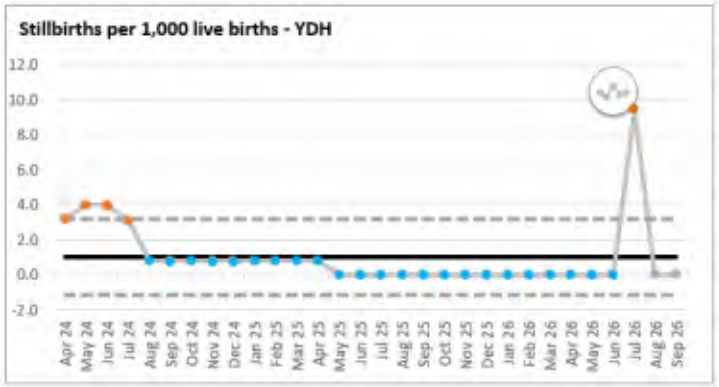


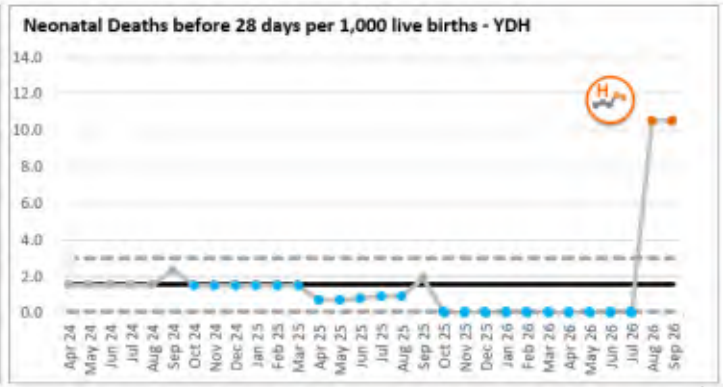
Neonatal Deaths

Date	Neonatal Deaths
2025/07	0
2025/08	0
2025/09	0
2025/09	1









Maternity Outcome Signal System (MOSS)

Somerset NHS Foundation Trust

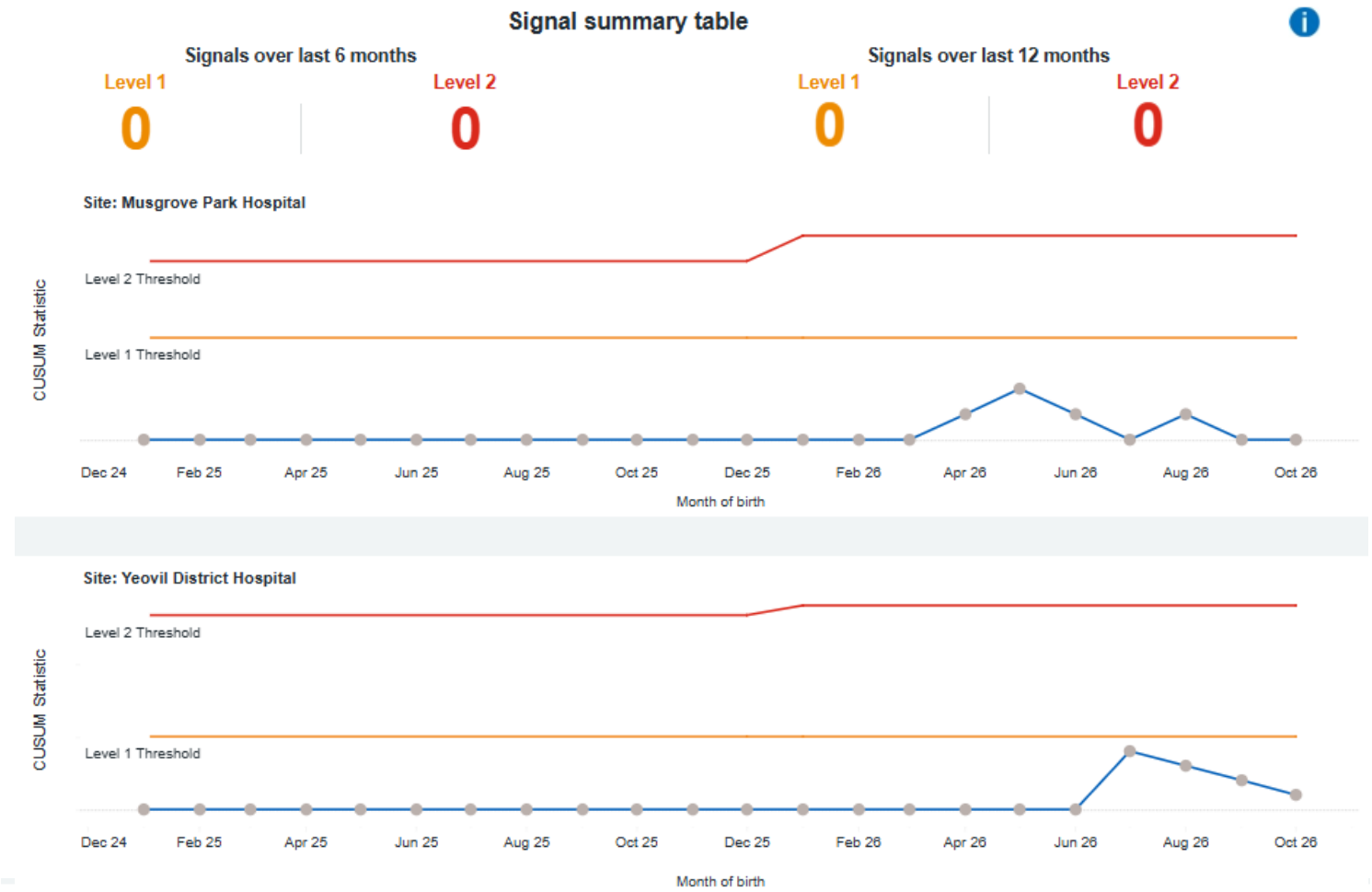




Table of Events - **Trust:** Somerset NHS Foundation Trust

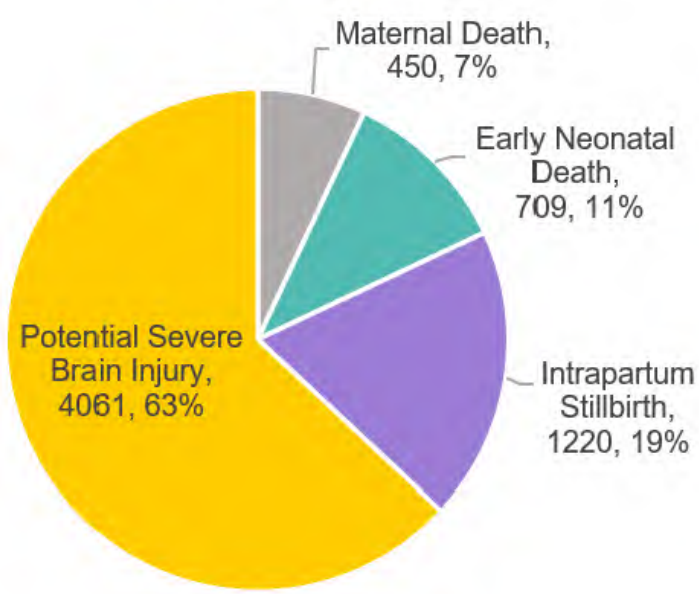
Date of term birth	Events (term only)	Site name
16 Aug 26	1 Term Neonatal Death(s)	Musgrove Park Hospital
24 Jul 26	1 Term Stillbirth(s)	Yeovil District Hospital
17 May 26	1 Term Stillbirth(s)	Musgrove Park Hospital
16 Apr 26	1 Term Stillbirth(s)	Musgrove Park Hospital

Somerset NHS Foundation Trust

Maternity referrals that met criteria*

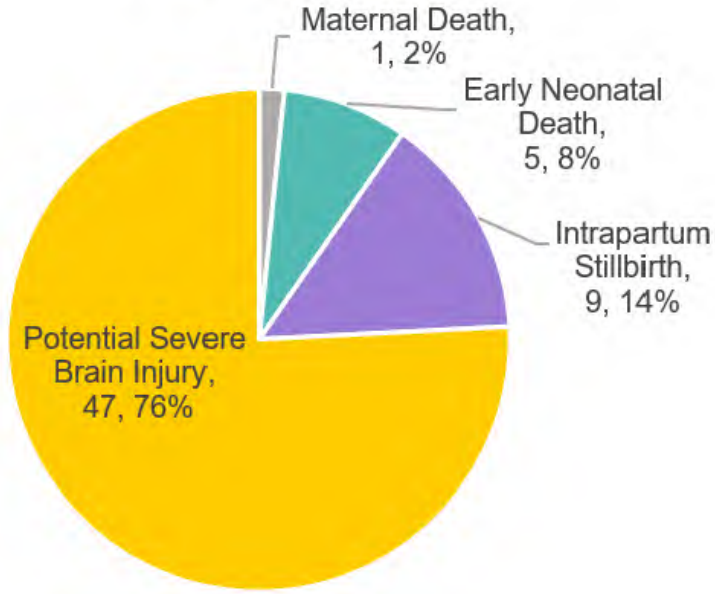
MNSI Maternity & Newborn Safety Investigations

National
1 April 2019 to
31 July 2026



6,440 referrals

LMNS / Trust
1 April 2019 to
8 September 2026



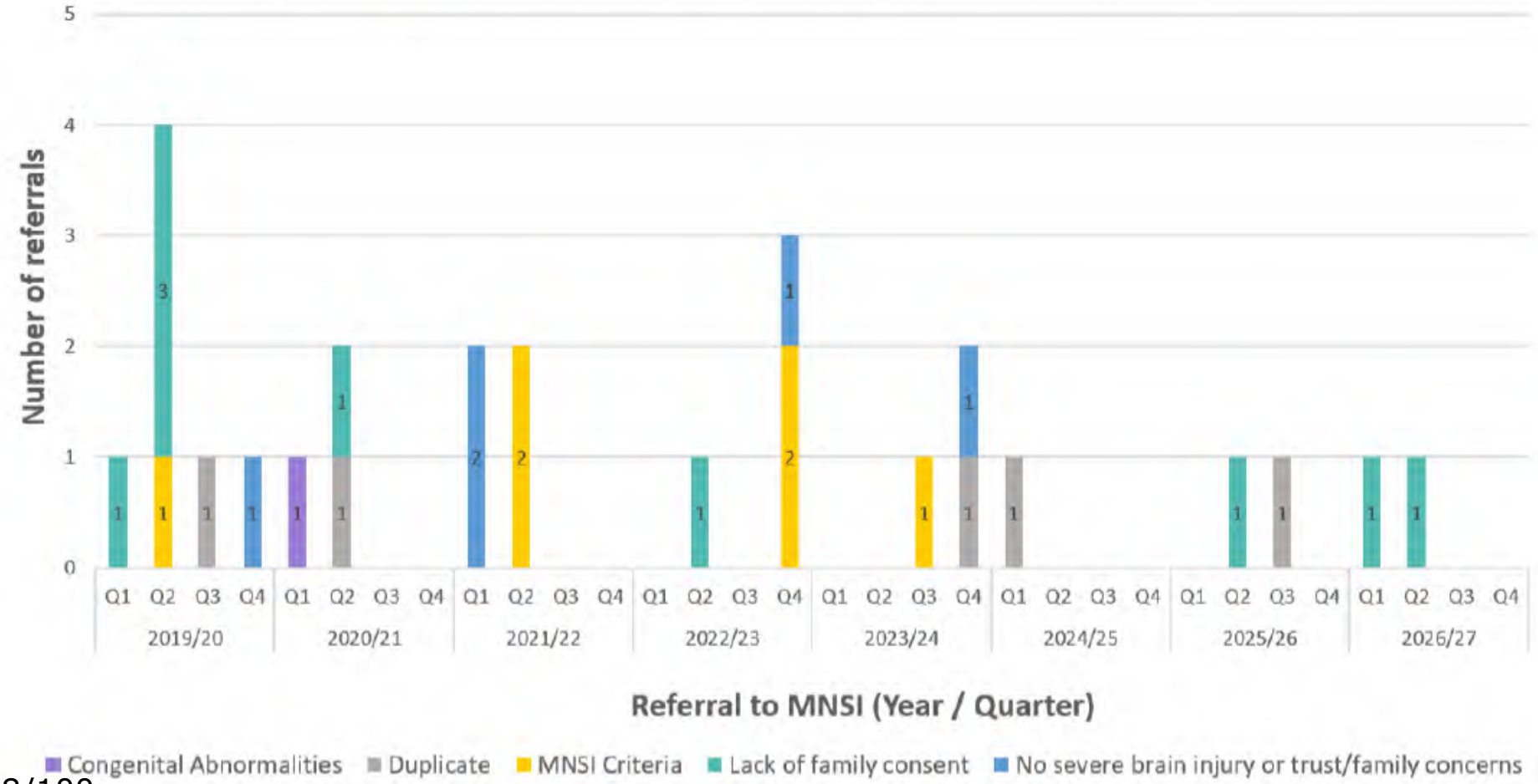
62 referrals

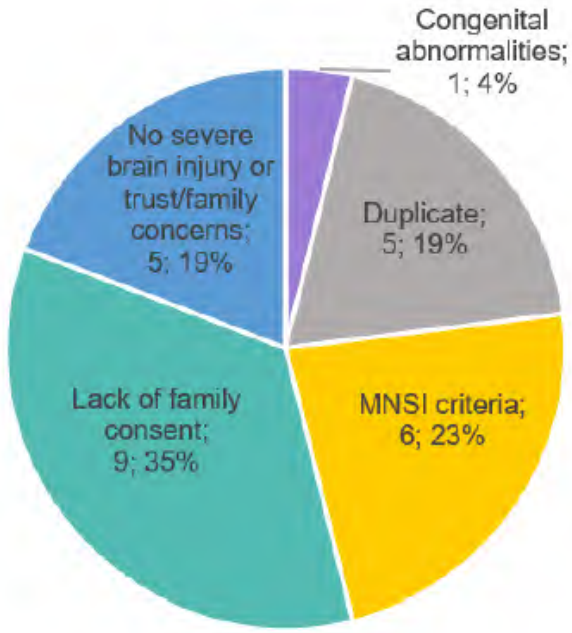
*Referrals that met criteria would either be progressed to investigation or rejected as either 'no family consent' or 'no severe brain injury or trust/family concerns'

Maternity referrals rejected - Trust

Breakdown of all rejected referrals

The charts below show **26** referrals that were rejected (1 April 2019 to 8 September 2026):

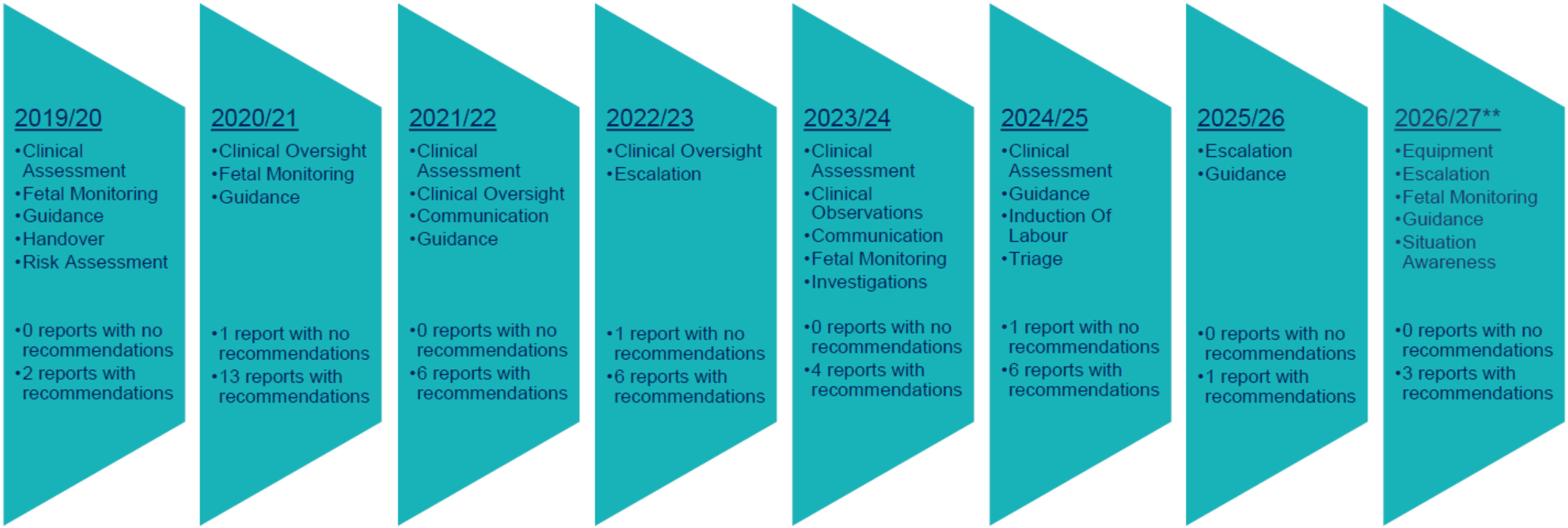




Trust top recommendations*

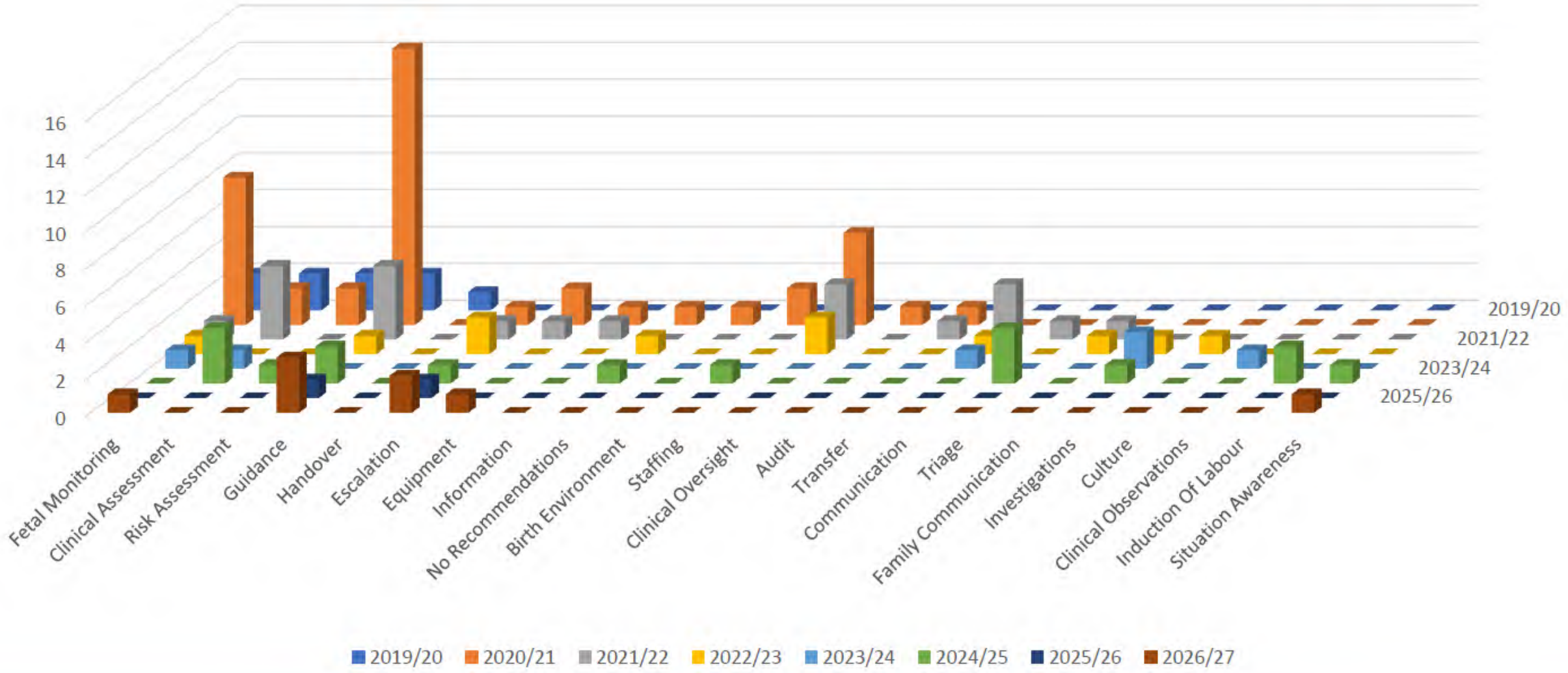
44 completed reports:
3 reports did not have recommendations for the primary healthcare provider.
41 reports did have recommendations for the primary healthcare provider.

MNSI
Maternity & Newborn Safety Investigations



*In alphabetical order and based on the year of report publication. The number of top recommendations listed may vary depending on their frequency.
**2026/27 is not a full financial year (Apr-Mar).

Trust top recommendations*



Any referrals made before 1st April 2019 have been excluded from this data set.

Saving Babies Lives

Q1 audit overview and action sign-off

April to June 2026 | MPH and YDH

Position summary & audit overview

Q1 update:

STATUS	ELEMENT	POSITION / NEXT ACTION	OWNER
90%	Smoking in pregnancy	Partially implemented <90%	Leanne Adams
85%	Fetal growth restriction	Partially implemented <90%	Lisa Chaplin
50%	Reduced fetal movement	Partially implemented ≤50%*	Lisa Chaplin
100%	Fetal monitoring	Fully implemented	Pawla Weekes
100%	Diabetes in pregnancy	Fully implemented	Esme Wilson-Hassard
96%	Reducing preterm birth	Partially implemented ≥90%	Esme Wilson Hassard

Leadership focus

Each element has now been reallocated, to matrons & the SBL care bundle having oversight from the Q&S matron. The monthly meeting should support compliance. Assurance processes to be confirmed.

***Implementation of RFM is categorised into 0%, 50% and 100%**

Source: Care Bundle V3 Q1 update shared 2 October 2026

What is going well

Fetal monitoring — 100%

100% appropriate escalation of identified concerns (53/53). Structured assessment at onset of labour reached 96%.

Reduced fetal movement — 94%

94% received computerised CTG. No PMRT cases were associated with RFM management issues.

Preterm optimisation — 99%

99.3% booking risk assessment; 100% mother's milk within 24 hours; no PMRT-related care issues.

Diabetes in pregnancy — 100%

All women with type 1 diabetes received CGM education/support; MPH reported compliance across available standards.

Smokefree service — 4/6

Opt-out referral 90%; four-week verified quits 69%; all contacts documented on BadgerNet.

Smoking pathway — 3.4%

Smoking status at booking 99.9%; 36-week CO offer and indicated-contact offer exceeded thresholds; SATOD 3.4%.

Overall message

Critical escalation and risk-identification processes are strong. The main opportunity is making reliable practice equally visible through consistent review, follow-up and documentation.

Key challenges requiring agreement

Four cross-cutting themes are driving the Q1 gaps

1 **Reliability during clinical pressure**

CTG peer review 56%; IA peer review 79%. Delays clustered around procedures, handovers, second stage and theatre transfer.

2 **Follow-up pathways and capacity**

Only 55% of recurrent RFM cases received next-working-day ultrasound. MPH lacked an ultrasound lead.

3 **Preterm optimisation consistency**

Thermal care was 71.4% overall with site variation; antenatal corticosteroids were 41.7%.

4 **Recording and sustained behaviour change**

Smoking status/CO updates at every indicated contact were 22.7%; 36-week smoking status 65%. Quit-date conversion was 26% and 36-week verified quit 23%.

actions for agreement

Confirm scope, owner and target date

Fetal monitoring	Feedback via fetal monitoring newsletter; reinforce early CTG/4-hourly IA peer review. Evidence specific FM risk assessment and update audit.	**SN**	**30 Sep 2026**
Reduced fetal movement	Embed Standard 1 in triage induction; ratify <28-week pathway; appoint MPH USS lead and validate Q2 data.	**KA / JR / AD / TS / BB / USS Lead**	**1–20 Sep 2026**
Preterm birth	Review four thermal-care cases and missed steroid opportunities; provide MDT education; implement PERIPrem grab box.	**RE / EF / LM**	**1 Oct–1 Nov 2026**
Diabetes	Continue compliance monitoring; reinforce recording of blood results at the correct gestation.	**PB / SL**	**Sep 2026**

Please note **All actions are summarise for the presentation; full details are available to review in the individual audit reports**

actions for agreement

Confirm scope, owner and target date

Smokefree Families Service	Review Q1 non-engagement reasons and introduce a standard follow-up contact process. Aim to increase quit-date setting from 26% to at least 40%.	**Smokefree Families Service Lead**	**End of Q3**
Smoking in Pregnancy Pathway	Monthly record review and team feedback. Aim to increase CO result/smoking-status recording at every indicated antenatal contact to at least 70%.	**Sarah Eliott**	**31 Dec 2026**

Decision required **Agree that the listed actions are sufficient, achievable and owned. Resolve any owner/date changes before sign-off.**

Maternal Care Bundle Update

Reporting position: October 2026

Expected full implementation: 31 March 2027

NHS Somerset NHS Foundation Trust

Overall assurance Position: Amber – delivery is progressing, with established governance, guidance and audit activity across several elements; however, cross-system dependencies, digital changes and completion of community and acute pathways require continued oversight and are risks to successful full implementation.

Element	Current position and assurance	Priority actions to March 2027	RAG
1. VTE	Progress is dependent on ICB-led collaboration across primary and secondary care. An ICB lead meeting is arranged for October.	• Agree ICB system guidance across primary and secondary care. • Confirm prescribing arrangements for LMWH in early pregnancy. • Agree referral processes and implementation milestones.	**Red**
2. Pre-hospital and acute care	Governance links are established and acute services have agreed MEWS implementation in principle. SOP, escalation, training, digital arrangements, pre-alert adoption and signage review remain in development.	• Finalise the MEWS SOP, escalation route and staff training plan. • Confirm the interim digital/EPR arrangements. • Complete the baseline audit for women cared for outside maternity. • Adopt the local pre-alert pathway and complete the signage review. • Agree the acute referral pathway with the MMC/MMN.	**Amber**
3. Epilepsy in pregnancy	Clinics and named multidisciplinary leadership are established, with monthly review of complex cases and access to MMN advice. The automated referral and tracking pathway and multidisciplinary guideline are outstanding.	• Ratify the Epilepsy in Maternity Care guideline. • Implement the referral and tracking pathway from self-referral/BadgerNet. • Evidence timely case review and medication assessment. • Agree arrangements for access to MMN MDT input.	**Amber**
4. Maternal mental health	The maternity mental health guideline was ratified in September 2026 and a baseline audit is complete. Compliance is strongest at booking and requires improvement at later antenatal and postnatal contacts. Digital EPDS development has been requested.	• Complete socialisation of the new maternity mental health guidance. • Register the audit and continue to monitor compliance. • Improve completion of the Whooley questions at all required antenatal and postnatal contacts. • Progress the request for a digital version of EPDS.	**Amber**
5. Obstetric haemorrhage	Guidance and compliance audits are in place. Community equipment and emergency-kit assurance remain incomplete.	• Source scales for measurement of blood loss in the community. • Complete the gap analysis for the community PPH emergency kit. • Address any gaps identified. • Continue audit monitoring of compliance.	**Amber**

Perinatal Quality Oversight Model

February 2026	Somerset NHS Foundation Trust Perinatal Quality Surveillance Reporting						
CQC Maternity Ratings	MPH	Overall	Safe	Effective	Caring	Well-led	Responsive
		Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
	YDH	Overall	Safe	Effective	Caring	Well-led	Responsive
		Inadequate	Inadequate	Good	Outstanding	Inadequate	Good
	BWCH	Overall	Safe	Effective	Caring	Well-led	Responsive
			Requires Improvement May 24			Requires Improvement May 24	
Maternity Safety Support Programme	Diagnostic review conducted November 2024, report received February 2025. Entered programme March 2025. Maternity and Neonatal Improvement Plan developed. Has now been uploaded as part of AMOS evidence on 08/01/2026. NHS England National Maternity Support Advisors: Christine Harding- Midwifery, Suzie Crowe - Obstetric						
Progress in achievement of Maternity Incentive Scheme year 7	We are in the reporting period for year 7 (2nd April 2025 to 30th November 2025). The Perinatal Governance Group receives a monthly update on MIS Year 7 progress. Full compliance achieved. MIS year 8 now published with submission March 2027.						

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
MNSI / NHSR / CQC or other organisation with a concern or request for action made directly with the Trust	0	0	0	0	0	0	0	0	0	0	1	1
Coroner Regulation 28 made directly to the Trust	0	0	0	0	0	0	0	0	0	0	0	0
Number of Incidents reported as moderate harm or above	1	4	5	3	3	0	4	0	10	1	2	*

August Maternity Staffing: Vacancy Rates

Data as at August 2026

Negative Numbers indicate that there is an overestablishment i.e. more FTE in post than is budgeted for. Budgets should be looked after by Managers & their Management Accountants & any queries should go through that route

Service Group	Service	Department	Cost Centre Name	Cost Centre	Budget WTE	Contracted WTE	Vacancy FTE	Vacancy Rate
CYP & Families Services	MATERNITY	MATERNITY	ANTENATAL CLINIC MPH	45050	8.00	6.66	1.34	16.8%
CYP & Families Services	MATERNITY	MATERNITY	ANTENATAL YDH	75740	5.79	5.79	0.00	0.0%
CYP & Families Services	MATERNITY	MATERNITY	MATERNITY ADMIN MPH	49030	13.57	13.33	0.24	1.8%
CYP & Families Services	MATERNITY	MATERNITY	MATERNITY ADMIN YDH	75744	5.71	5.19	0.52	9.1%
CYP & Families Services	MATERNITY	MATERNITY	SPECIALIST MIDWIVES	45040	20.67	16.42	4.25	20.6%
CYP & Families Services	MATERNITY	MATERNITY	NEWBORN HEARING	45070	4.40	4.40	0.00	0.0%
CYP & Families Services	MATERNITY	MATERNITY	INFANT FEEDING SPECIALISTS	45052	6.13	5.73	0.40	6.5%
CYP & Families Services	MATERNITY	MATERNITY	MATERNITY TRIAGE	45051	1.00	0.80	0.20	20.0%
CYP & Families Services	MATERNITY	MATERNITY	LMNS FUNDED ROLES	45054	2.80	1.80	1.00	35.7%
CYP & Families Services	MATERNITY	MATERNITY	ANC SCREENING	45053	4.20	4.20	0.00	0.0%
CYP & Families Services	MATERNITY	MATERNITY	MIDWIFERY INPATIENT MPH	45010	110.07	111.61	-1.54	-1.4%
CYP & Families Services	MATERNITY	MATERNITY	MIDWIFERY INPATIENT YDH	75738	55.46	50.15	5.31	9.6%
CYP & Families Services	MATERNITY	MATERNITY	COUNTYWIDE COMMUNITY MIDW	45020	76.02	75.61	0.41	0.5%

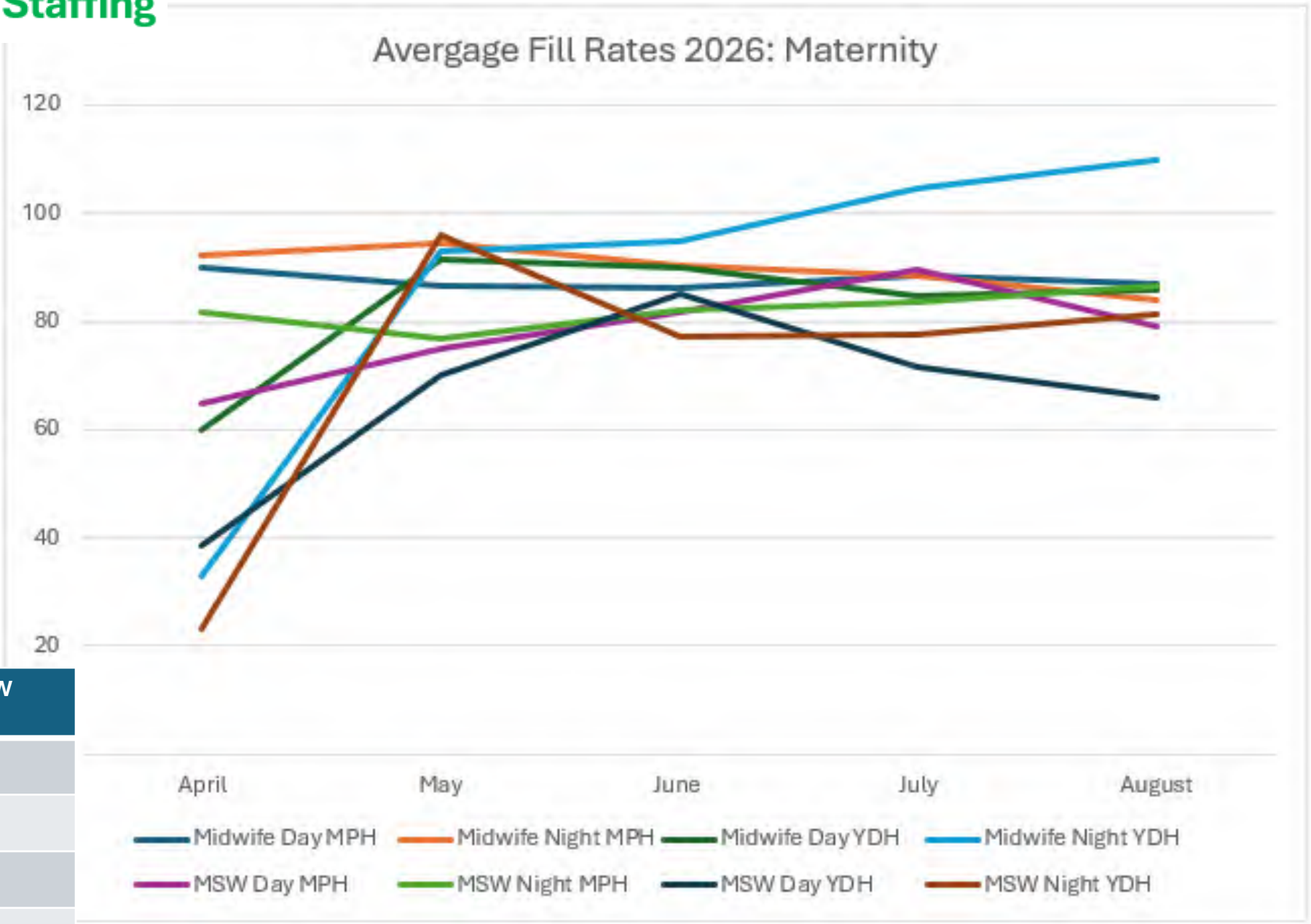
- MPH inpatient staffing is slightly above funded establishment, however the establishment has not yet been recalculated following the separation of services (from YDH closure).
- The outcome of the BR+ review will inform future establishment levels and ensure staffing is aligned to activity, acuity and service demand across Somerset maternity services.
- In addition, two recent midwife resignations have reduced resilience within the workforce and will further impact staffing capacity as these vacancies take effect.
- Specialist Team have successfully recruited to the Band 7 Professional Development Lead post
- Although some specialist teams show high vacancy percentages, these are often driven by single vacancies within small establishments and should be interpreted alongside the actual WTE vacancy position.
- Whilst several areas report high percentage vacancy rates, these are often driven by vacancies within small specialist teams where a single post can have a disproportionate effect on the reported percentage.
- Band 6 vacancies at YDH have been approved and currently out to advert, vacancies gaps are prominently due to maternity leave and a uplift in midwifery staffing at night to cover triage.
- Infant feeding roles have been filled.

August Maternity Staffing

↑ YDH MW night: Extra night shift added – not yet been added to template.

↓ MSW YDH/MPH due to vacancies & leavers

	MIDWIVES	MSW
MPH DAY	86.9%	79.1%
MPH NIGHT	83.9%	86.6%
YDH DAY	85.9%	65.9%
YDH NIGHT	110%	81.3%



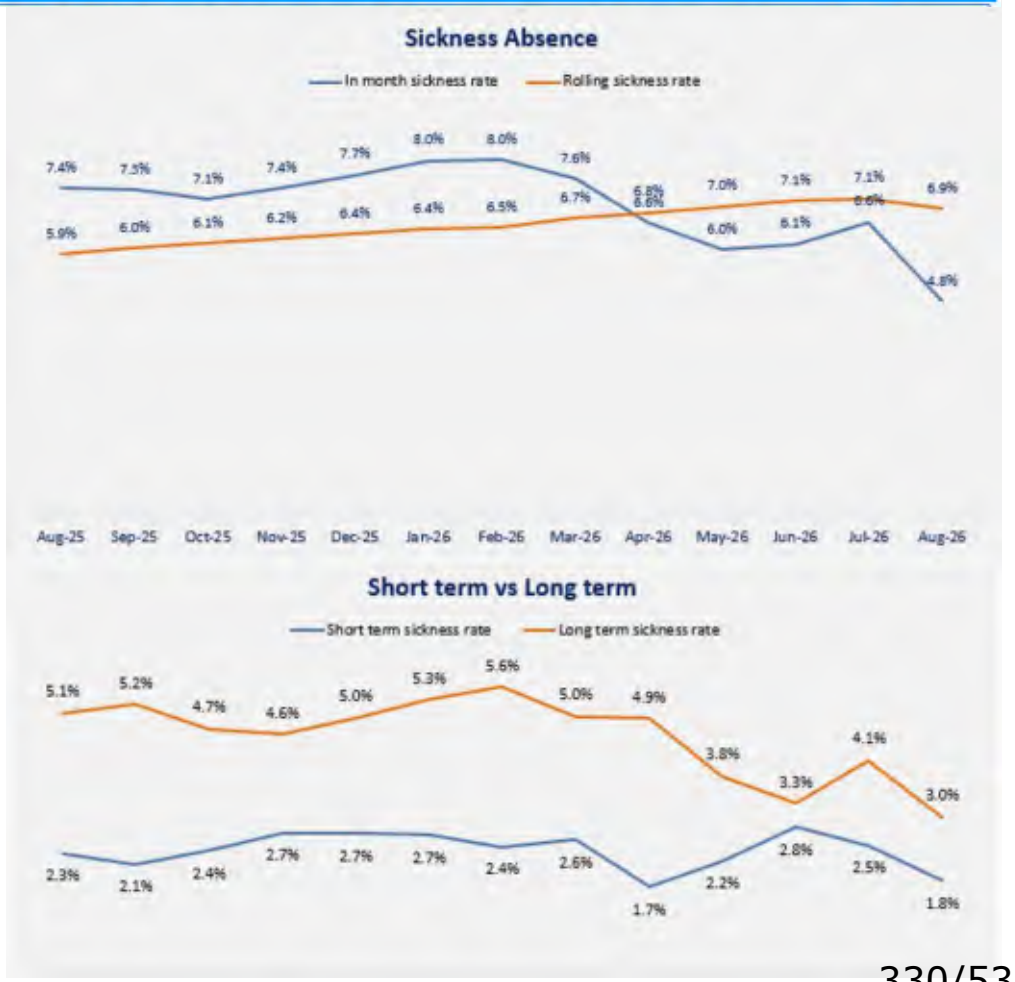
SAFTER STAFFING

SICKNESS: August 2026

Sickness %	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
In month sickness rate	7.4%	7.3%	7.1%	7.4%	7.7%	8.0%	8.0%	7.6%	6.6%	6.0%	6.1%	6.6%	4.8%
Rolling sickness rate	5.9%	6.0%	6.1%	6.2%	6.4%	6.4%	6.5%	6.7%	6.8%	7.0%	7.1%	7.1%	6.9%
Short term sickness rate	2.3%	2.1%	2.4%	2.7%	2.7%	2.7%	2.4%	2.6%	1.7%	2.2%	2.8%	2.5%	1.8%
Long term sickness rate	5.1%	5.2%	4.7%	4.6%	5.0%	5.3%	5.6%	5.0%	4.9%	3.8%	3.3%	4.1%	3.0%
In month days lost	705.69	678.05	683.69	692.55	740.05	762.53	692.76	726.83	612.78	574.76	569.12	637.16	465.72
In month days available	9,580.41	9,252.72	9,614.90	9,418.60	9,656.89	9,552.98	8,658.52	9,599.79	9,294.27	9,604.33	9,310.45	9,645.75	9,682.84
Rolling days lost	6,660.68	6,792.40	6,929.56	7,045.17	7,180.93	7,288.39	7,335.47	7,565.36	7,693.50	7,860.86	8,010.31	8,075.97	7,836.00
lable	113,129.06	113,043.81	113,090.12	113,115.00	113,066.44	113,027.08	112,952.56	112,856.89	112,844.02	112,948.56	113,126.60	113,140.83	113,243.26

e use the slicers below to view data for desired selection - to view multiple at once select first one and then hold CTRL and click others that you want to view - use cross to deselect

S10 Anxiety/stress/depression/other psychiatric illnesses	594.97	36.6%
S12 Other musculoskeletal problems	155.49	9.6%
S98 Other known causes - not elsewhere classified	154.96	9.5%



- **Overall sickness absence has remained a workforce pressure**, with rolling sickness rates consistently around 6-7% over the last 12 months. Encouragingly, there has been a recent improvement, with total sickness reducing to 4.8%.
- **Long-term sickness absence remains the predominant theme**, accounting for the majority of lost time and having the greatest impact on workforce resilience and staffing capacity.
- **Short-term sickness levels have remained relatively low and stable**, indicating generally good day-to-day attendance across the wider workforce.
- **The recent reduction in both overall and long-term sickness rates is positive**, although continued focus on staff wellbeing, attendance support and effective return-to-work processes will be important to sustain this improvement

Consultant Attendance Q1

Q1 Overall Results: MPH	Total				
Consultant Attendance: **Situation:**	No. of instances	No. of instances C called to attend		No. of instances C attended	% of Instances Attended
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input	3	3		3	100%
Any return to theatre for obstetrics or gynaecology	1	1		1	100%
Team debrief requested	2	2		2	100%
If requested to do so	15	15		14	93%
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary	1	1		1	100%
Caesarean birth for major placenta praevia / abnormally invasive placenta	1	1		1	100%
Caesarean birth for women with a BMI >50	2	2		2	100%
Caesarean birth <28/40	1	1		1	100%
Premature twins (<30/40)	1	1		1	100%
4th degree perineal tear repair	0	0		0	#DIV/0!
Unexpected intrapartum stillbirth	1	1		1	100%
Eclampsia	0	0		0	#DIV/0!
Maternal collapse e.g septic shock, massive abruption	0	0		0	#DIV/0!
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated	6	6		6	100%
Total	34	34		33	97%
Consultant OR Senior Doctor Attendance: **Situation:**	No. of instances	No. of instances called to attend		No. of instances attended	% of Instances Attended
Any patient in obstetrics or gynaecology with an EBL >1.5 litres and ongoing bleeding	15	C	9	C 9	60%
		D	11	D 11	73%
Trial of instrumental birth	30	C	13	C 12	40%
		D	25	D 25	83%
Vaginal twin birth	0	C	0	C 0	
		D	0	D 0	
Caesarean birth at full dilation	11	C	8	C 8	73%
		D	6	D 6	55%
Caesarean birth for women with a BMI >40	5	C	5	C 5	100%
		D	0	D 0	0%
Caesarean birth for transverse lie	2	C	2	C 2	100%
		D	1	D 1	50%
Caesarean birth at <32/40	2	C	2	C 2	100%
		D	2	D 2	100%
Vaginal breech birth	0	C	0	C 0	
		D	0	D 0	
3rd degree perineal tear repair	7	C	2	C 2	29%
		D	6	D 6	86%
Total	72	C	41	C 40	56%
		D	51	D 51	71%
		C & D	92	C & D 91	126%
		C			98%
		D			100%

	Site	Q1		
		Apr-26	May-26	Jun-26
Midwifery Coordinator supernumerary at start of each shift	MPH	100%	100%	100%
	YDH	100%	100%	100%
Women in active labour receiving 1:1 care	MPH	100%	100%	100%
	YDH	100%	100%	100%

Q1 Overall Results: YDH	Total			
Consultant Attendance: **Situation:**	No. of instances	No. of instances C called to attend	No. of instances C attended	% of Instances Attended
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input	0	0	0	#DIV/0!
Any return to theatre for obstetrics or gynaecology	0	0	0	#DIV/0!
Team debrief requested	0	0	0	#DIV/0!
If requested to do so	8	8	8	100%
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary	0	0	0	#DIV/0!
Caesarean birth for major placenta praevia / abnormally invasive placenta	0	0	0	#DIV/0!
Caesarean birth for women with a BMI >50	0	0	0	#DIV/0!
Caesarean birth <28/40	0	0	0	#DIV/0!
Premature twins (<30/40)	0	0	0	#DIV/0!
4th degree perineal tear repair	1	1	1	100%
Unexpected intrapartum stillbirth	0	0	0	#DIV/0!
Eclampsia	0	0	0	#DIV/0!
Maternal collapse e.g septic shock, massive abruption	0	0	0	#DIV/0!
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated	1	1	1	100%
Total	10	10	10	100%

Consultant Attendance Q2

Q2 Overall Results: MPH	Total					
Consultant Attendance: **Situation:**	No. of instances	No. of instances C called to attend		No. of instances C attended		% of Instances Attended
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input	2	2		2		100%
Any return to theatre for obstetrics or gynaecology	2	2		2		100%
Team debrief requested						#DIV/0!
If requested to do so	29	29		28		97%
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary						#DIV/0!
Caesarean birth for major placenta praevia / abnormally invasive placenta						#DIV/0!
Caesarean birth for women with a BMI >50						#DIV/0!
Caesarean birth <28/40						#DIV/0!
Premature twins (<30/40)						#DIV/0!
4th degree perineal tear repair						#DIV/0!
Unexpected intrapartum stillbirth						#DIV/0!
Eclampsia						#DIV/0!
Maternal collapse e.g septic shock, massive abruption						#DIV/0!
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated	2	2		2		100%
Total	35	35		34		97%
Consultant OR Senior Doctor Attendance: **Situation:**	No. of instances	No. of instances called to attend		No. of instances attended		% of Instances Attended
Any patient in obstetrics or gynaecology with an EBL >1.5 litres and ongoing bleeding	7	C	7	C	7	100%
		D	3	D	3	43%
Trial of instrumental birth	27	C	14	C	14	52%
		D	20	D	20	74%
Vaginal twin birth	1	C	1	C	1	100%
		D	0	D	0	0%
Caesarean birth at full dilation	11	C	7	C	7	64%
		D	8	D	8	73%
Caesarean birth for women with a BMI >40	5	C	5	C	5	100%
		D	3	D	3	60%
Caesarean birth for transverse lie	2	C	1	C	1	50%
		D	2	D	2	100%
Caesarean birth at <32/40	1	C	1	C	1	100%
		D	1	D	1	100%
Vaginal breech birth	2	C	2	C	2	100%
		D	1	D	1	50%
3rd degree perineal tear repair	3	C	1	C	1	33%
		D	3	D	3	100%
Total	59	C	39	C	39	66%
		D	41	D	41	69%
		C & D	80	C & D	80	136%
		C				100%
		D				100%

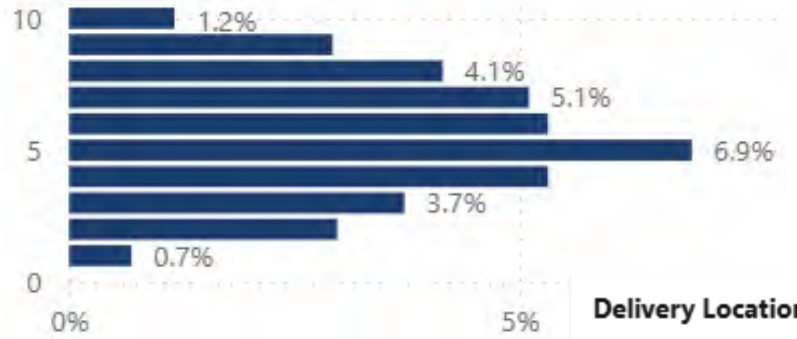
	Site	Q2		
		Jul-26	Aug-26	Sep-26
Midwifery Coordinator supernumerary at start of each shift	MPH	100%	100%	100%
	YDH	100%	100%	100%
Women in active labour receiving 1:1 care	MPH	100%	100%	100%
	YDH	100%	100%	100%

Q2 Overall Results: YDH	Total			
Consultant Attendance: **Situation:**	No. of instances	No. of instances C called to attend	No. of instances C attended	% of Instances Attended
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input	0	0	0	#DIV/0!
Any return to theatre for obstetrics or gynaecology	0	0	0	#DIV/0!
Team debrief requested	0	0	0	#DIV/0!
If requested to do so	14	14	14	100%
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary	0	0	0	#DIV/0!
Caesarean birth for major placenta praevia / abnormally invasive placenta	0	0	0	#DIV/0!
Caesarean birth for women with a BMI >50	0	0	0	#DIV/0!
Caesarean birth <28/40	0	0	0	#DIV/0!
Premature twins (<30/40)	0	0	0	#DIV/0!
4th degree perineal tear repair	0	0	0	#DIV/0!
Unexpected intrapartum stillbirth	0	0	0	#DIV/0!
Eclampsia	0	0	0	#DIV/0!
Maternal collapse e.g septic shock, massive abruption	0	0	0	#DIV/0!
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated	3	3	3	100%
Total	17	17	17	100%

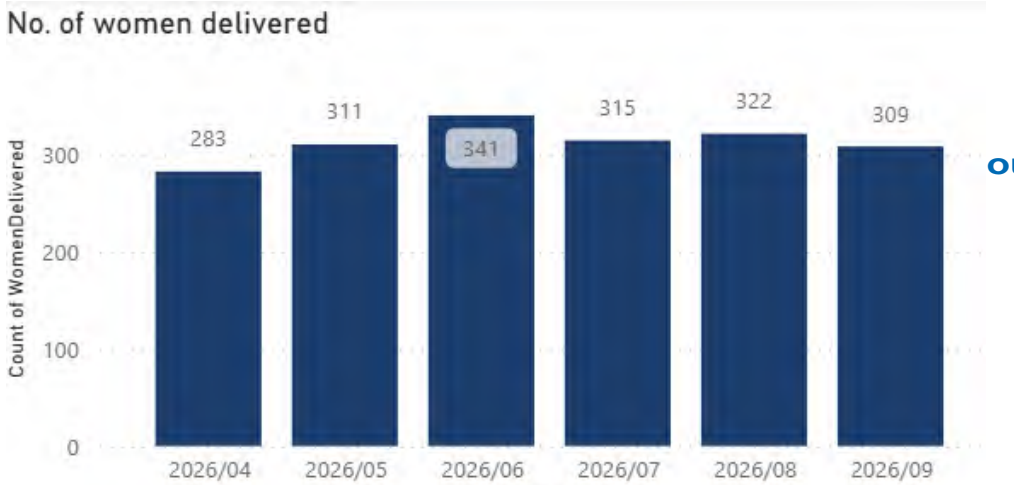
SFT Birth Overview

Somerset Foundation Trust

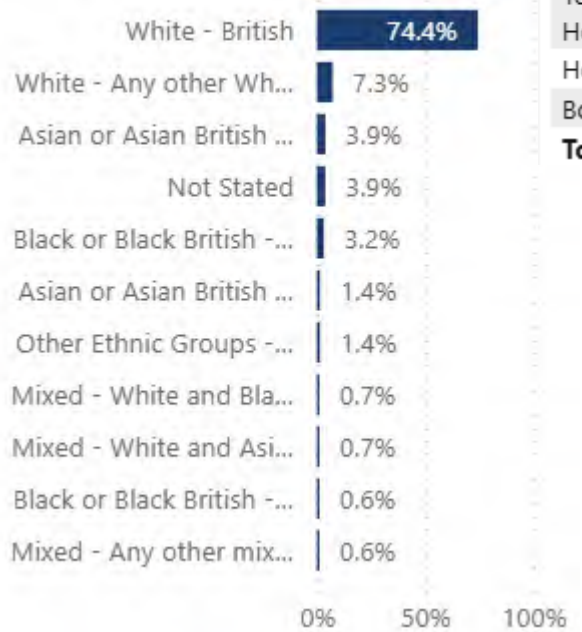
IMD decile



No. of women delivered



Ethnic Group



Delivery Location	Count of women	% of women
Musgrove Park Hospital	1355	70.4%
Yeovil District Maternity Hospital	472	24.5%
Home Birth	75	3.9%
Born Before Arrival	23	1.2%
Total	**1925**	**100.0%**

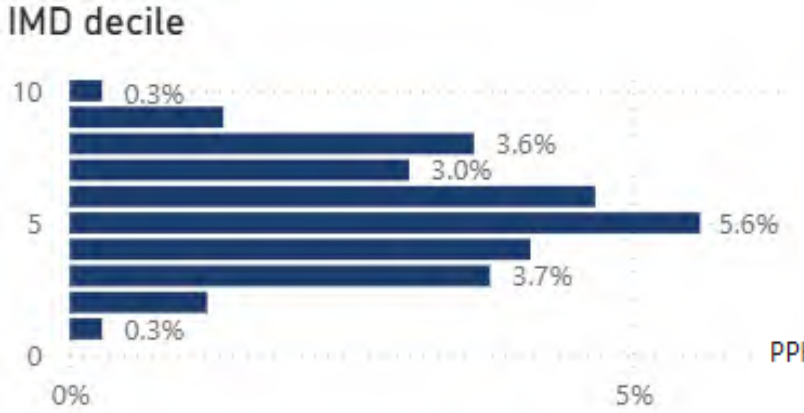
PPHloss	Count of women	% of women
<500ml	1156	61.5%
500-999ml	518	27.5%
1000-1499ml	139	7.4%
1500-1999ml	45	2.4%
>=2000ml	22	1.2%
	1	0.1%
Total	**1881**	**100.0%**

Tear	Count of women	% of women
Not Known	4	0.2%
3rd degree	36	1.9%
1st degree	147	7.8%
2nd degree	381	20.3%
No	1313	69.8%
Total	**1881**	**100.0%**

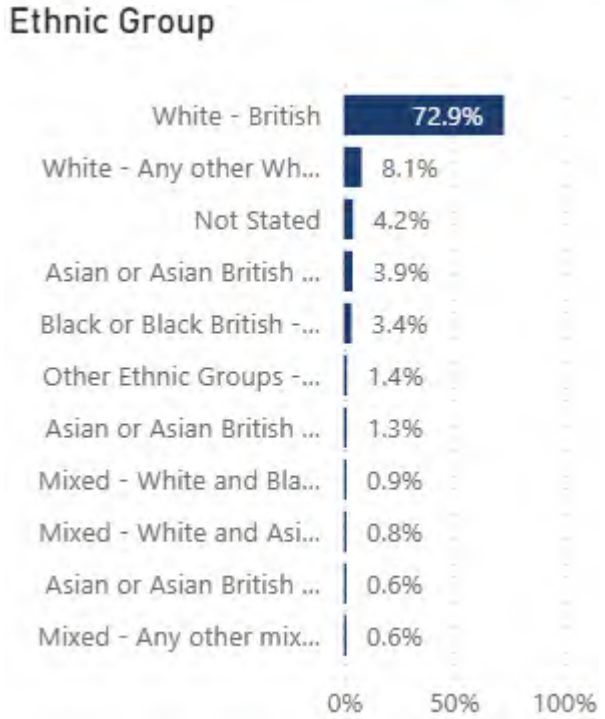
Date	Vaginal Deliveries (Unassisted)	Inductions	Instrumental Deliveries (Assisted)	Robson Group 1	Robson Group 2	Robson Group 5	Episiotomies For Unassisted Births	3rd/4th Tears (Unassisted Birth)	3rd/4th Tears (Assisted Birth)
2026/10	20	10	4	3	5	6	0	0	1
2026/09	131	63	31	9	40	55	2	4	3
2026/08	120	85	44	12	55	47	2	0	2
2026/07	142	70	33	5	41	52	9	3	3
2026/06	141	91	40	8	50	50	2	6	4
2026/05	133	89	42	13	45	44	9	4	2
2026/04	115	64	24	6	37	53	2	3	2
Total	**802**	**472**	**218**	**56**	**273**	**307**	**26**	**20**	**17**

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Musgrove Birth Overview

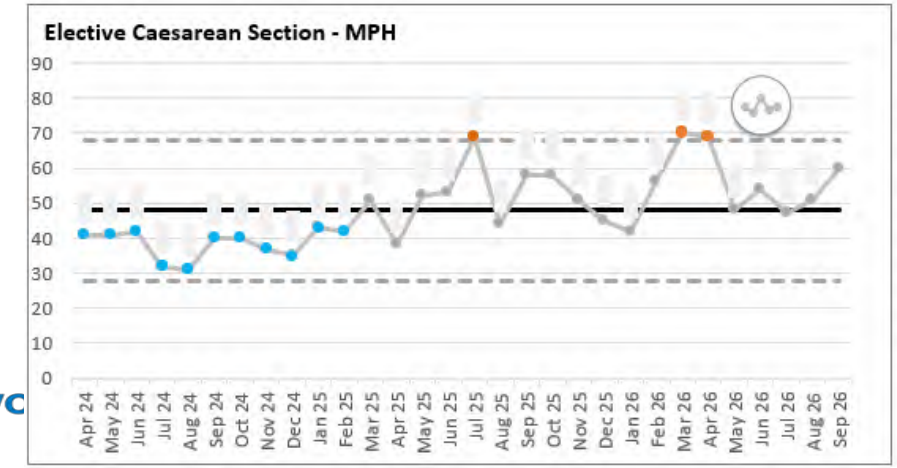


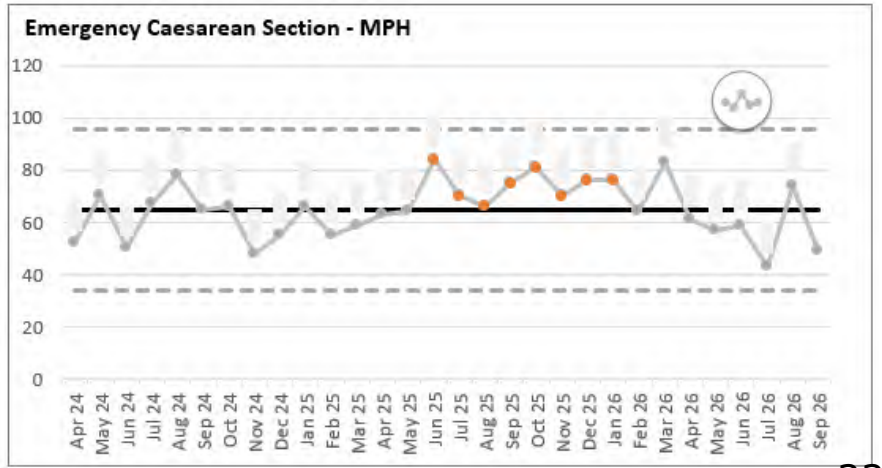




PPHloss	Count of women	% of women
<500ml	842	60.4%
500-999ml	391	28.0%
1000-1499ml	106	7.6%
1500-1999ml	37	2.7%
>=2000ml	17	1.2%
	1	0.1%
Total	**1394**	**100.0%**

Tear	Count of women	% of women
Not Known	4	0.3%
3rd degree	30	2.2%
1st degree	104	7.5%
2nd degree	300	21.5%
No	956	68.6%
Total	**1394**	**100.0%**



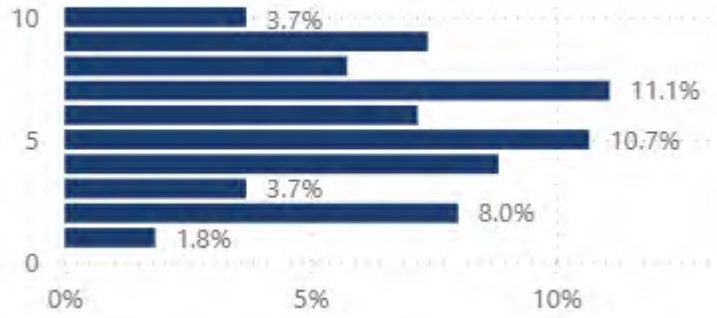


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Yeovil Birth Overview

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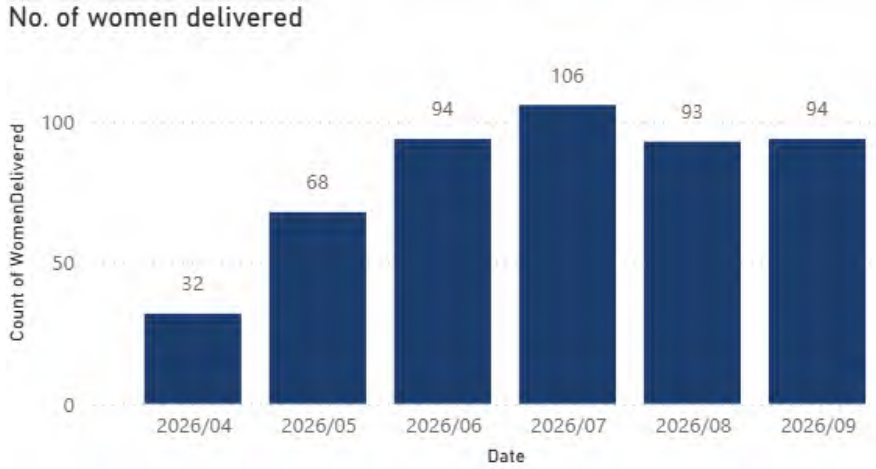
IMD decile



Ethnic Group

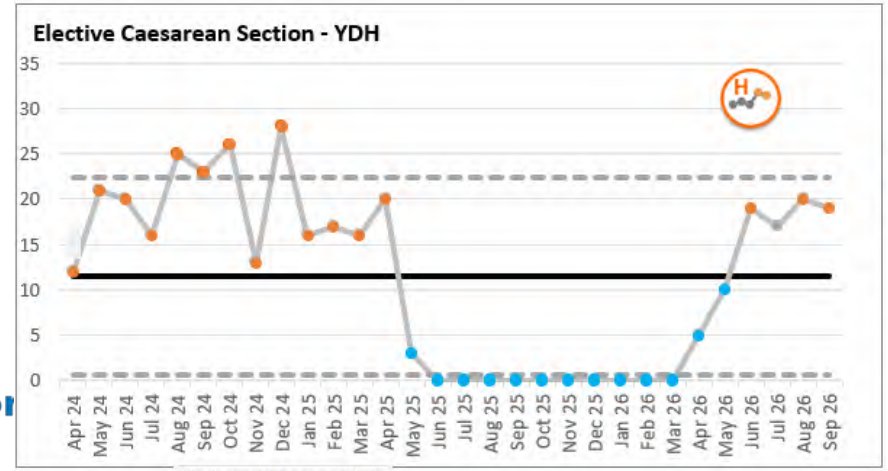


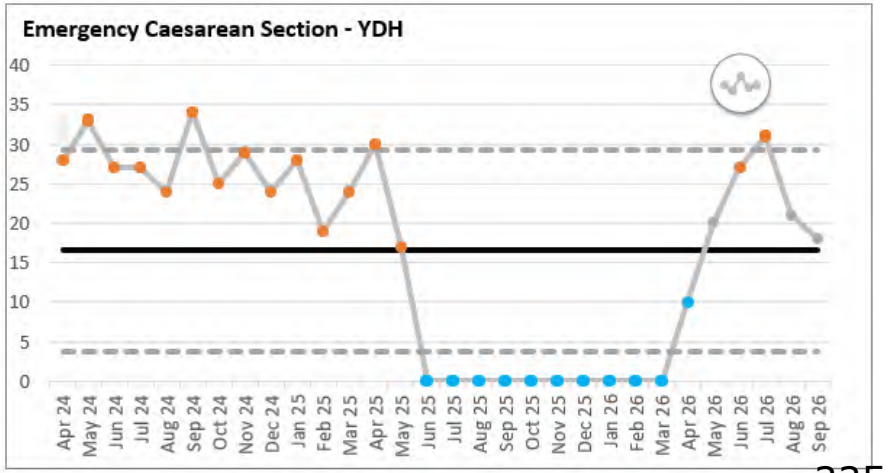
No. of women delivered



Tear	Count of women	% of women
3rd degree	6	1.2%
1st degree	43	8.8%
2nd degree	81	16.6%
No	357	73.3%
Total	**487**	**100.0%**

PPHloss	Count of women	% of women
<500ml	314	64.5%
500-999ml	127	26.1%
1000-1499ml	33	6.8%
1500-1999ml	8	1.6%
>=2000ml	5	1.0%
Total	**487**	**100.0%**

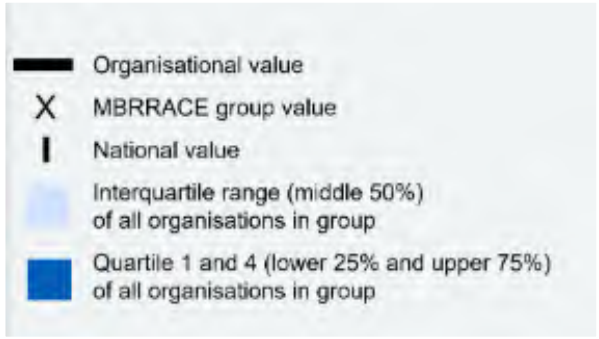




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National Clinical Quality Improvement Metrics (CQIMS)

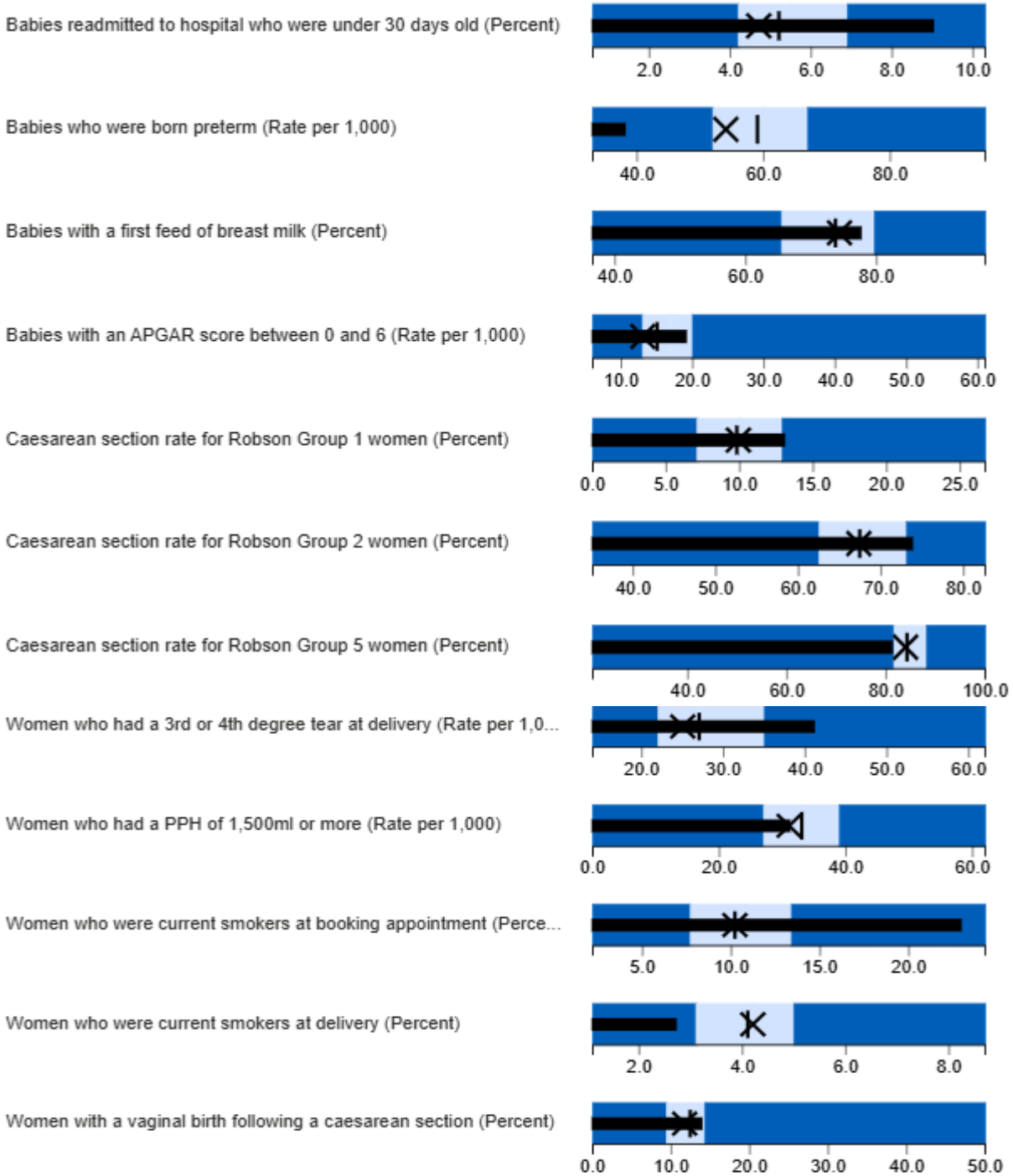
NB: most recent data July 2026



Areas to consider (positive/negative outliers):

- PPH >1.5L (positive)
- Babies readmitted to hospital who were under 30 days
- OASI
- Apgars score bet. 0-6 (negative)

This remains unchanged from the previous report and a continued area of focus.



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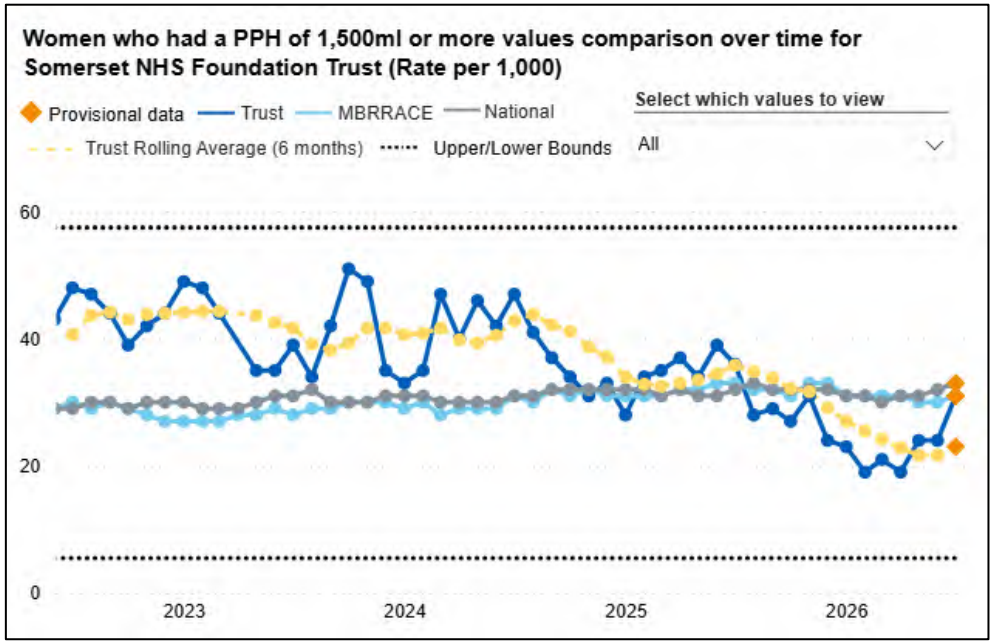
PPH>1.5L

20	18	1	18	12
Total cases	Primary PPH	Secondary PPH	HDU care	Debrief evidenced

Ethnicity Profile	Cases
White	17
Black African	1
Mixed ethnic groups	1

Women who had a PPH of 1,500ml or more (Rate per 1,000)

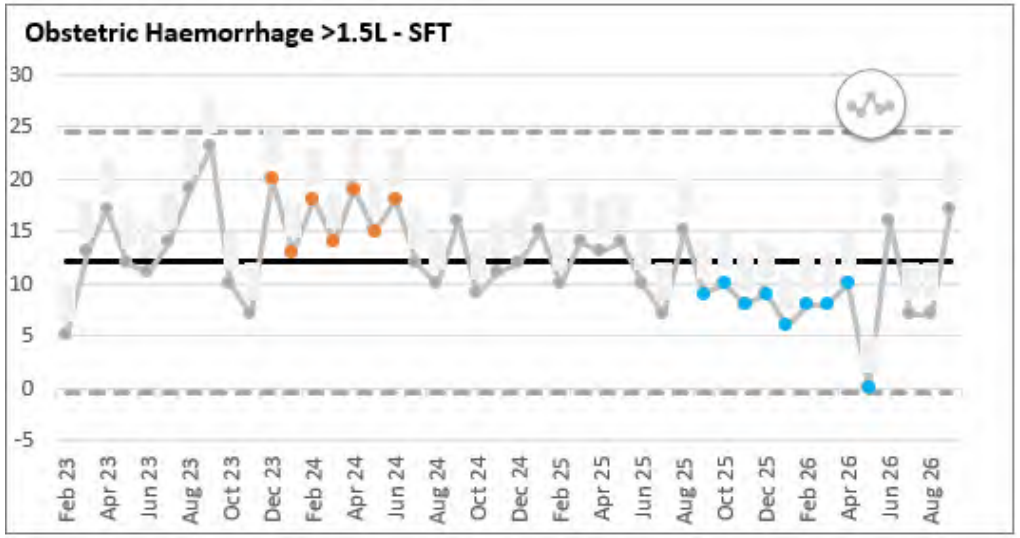




- → PPH proforma use was inconsistent: 6/14 (43%) used the proforma
- → The cause was not documented in 5 cases; some records also noted limited PPH documentation.
- → Risk assessments were not consistently completed: antenatal 5/20 and intrapartum 12/20.
- → Timely recognition and escalation documented in 16 cases.
- → Uterotonics were used in 18 cases with TXA in 17 cases.

Recent increase in PPH over 1.5l has been reviewed in Safety & learning Forum. Discussions identified clinical management of haemorrhage is generally good, but documentation, risk assessment and post-event learning processes remain inconsistent and agreed immediate actions are:

1. Reinforce PPH proforma use within theatres and anaesthetic teams.
2. Obtain feedback from planned simulation training to inform specific targeted actions.
3. Continue to review all PPH cases.
4. Explore development of a formalised structured obstetric postnatal debrief pathway.
5. Review Duty of Candour documentation.
6. Improve visibility of actions and progress arising from thematic reviews.

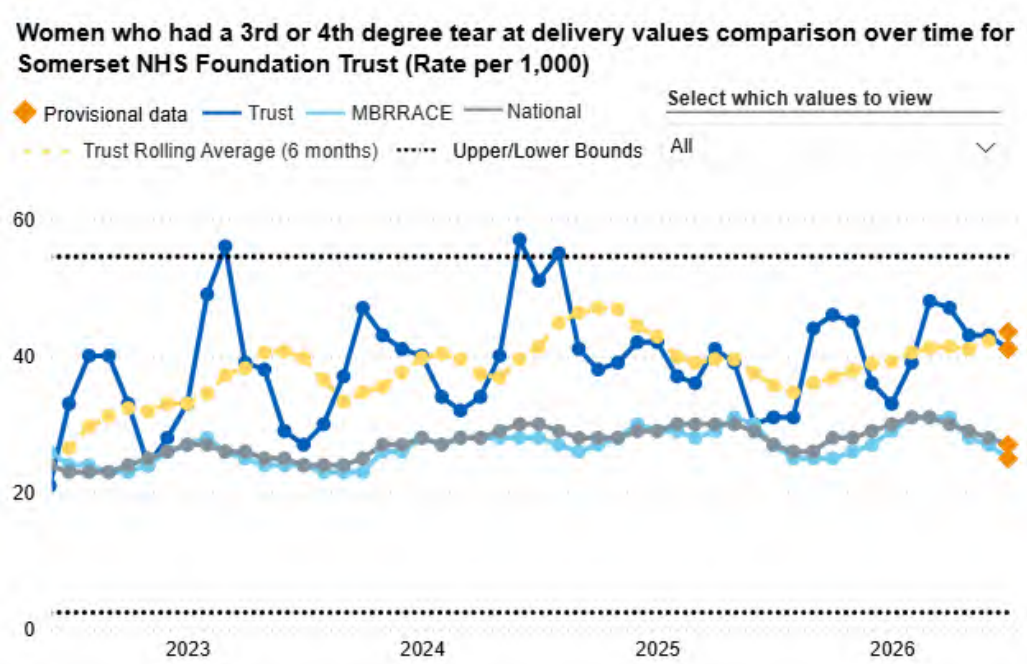


Obstetric Anal Sphincter Injury



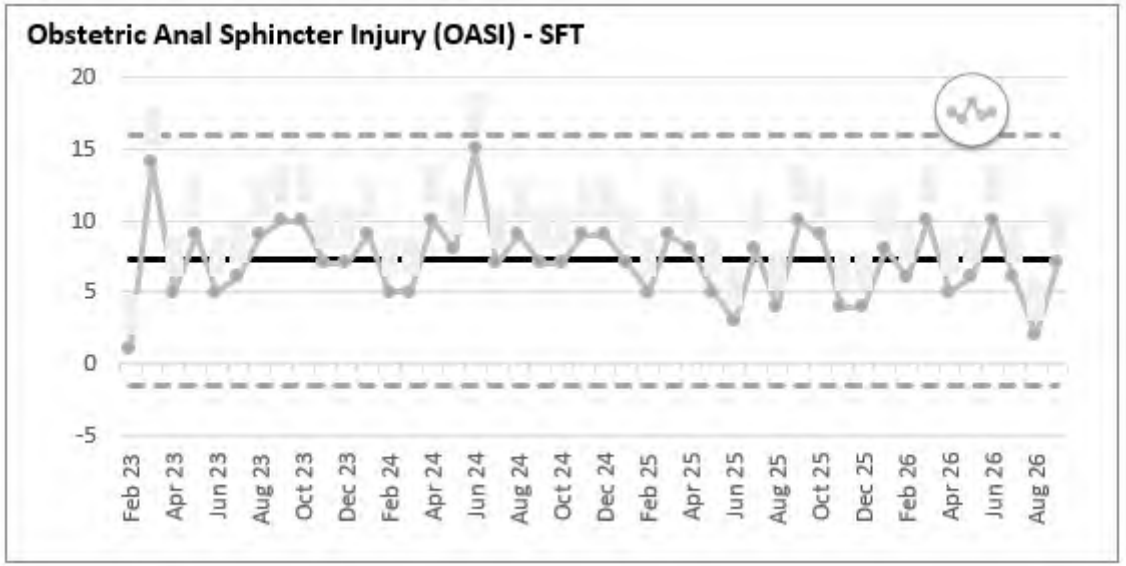
15	10	4	1	0
Total cases	3a	3b	3c	4

- Majority of 3rd tears occur in Primiparous women/birthing people.
- With no 4th degree tears within the quarter.
- Documentation of preventative measures and birth position remains inconsistent.



Documentation and escalation demonstrated good practice, with all OASI tears identified, repaired and appropriately managed.
Actions Q3:

- Improve AN education
- Obtain data on current OASI times to inform ongoing QI project
- Improve documentation
- Offer debriefs to all woman to understand implicit human factors.



Ethnicity Profile	Cases
White	9
Mixed - Other	1
Asian - other	2
Black African	1
Indian	2

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Apgar below 7 at 5 Mins

21	11	7
Cases reviewed	Emergency Caesarean births	NICU/SNU admissions

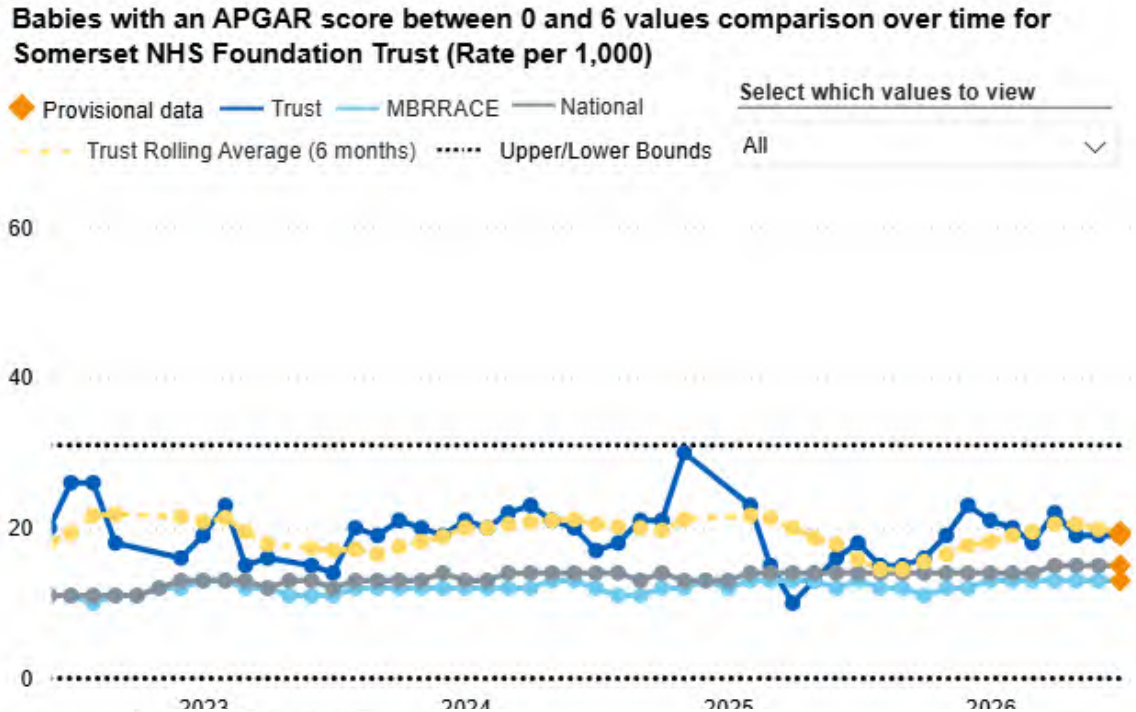
- → Recognition and escalation were generally appropriate where fetal compromise was identified. Common actions included senior escalation, expediting birth, position change, VE and FSE.
- → Some CTG classifications were not documented consistently.
- → Labour review records and escalation timing were variable in some cases.

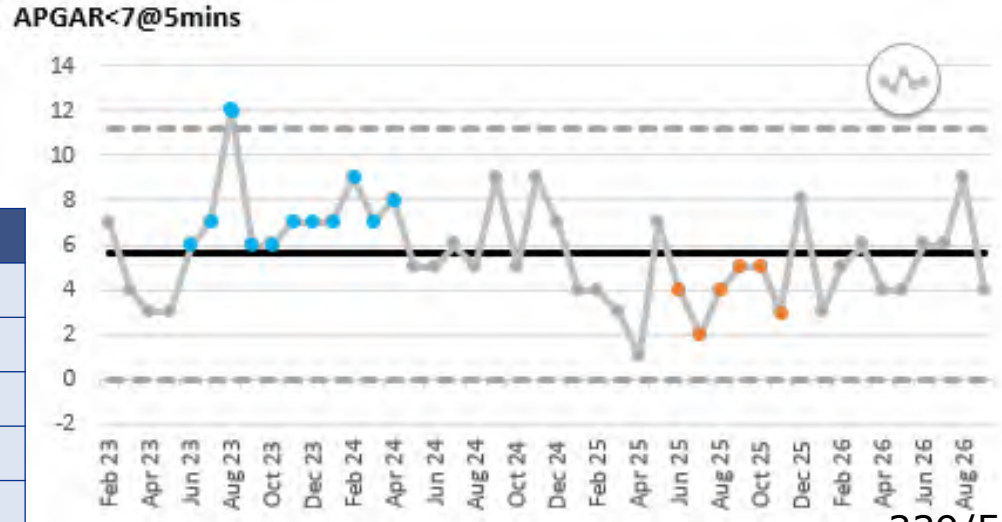
The review demonstrates generally appropriate recognition and escalation of fetal compromise.

Actions for Q3:

- Ongoing review of CTG interpretation at fetal Monitoring Training
- Thematic review to monitor themes through learning from ATAIN and governance reviews.





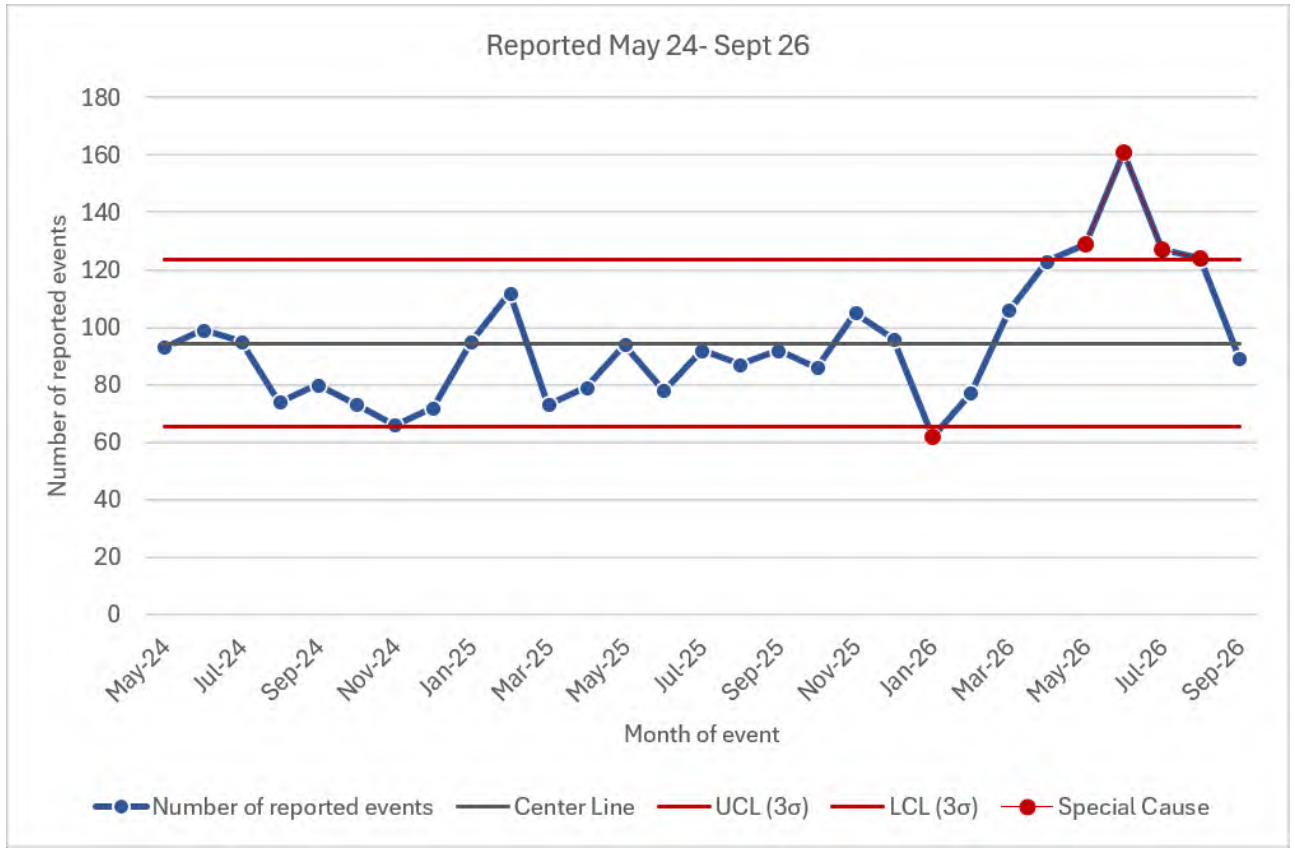


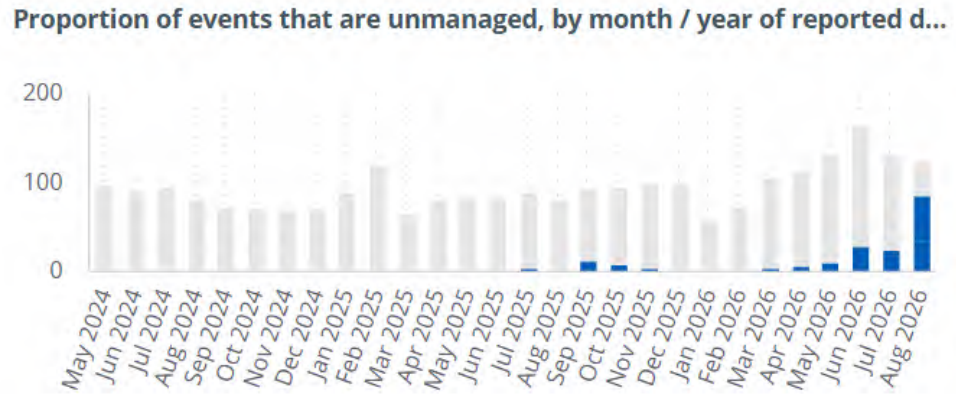
Ethnicity Profile	Cases
White	12
Mixed - Other	3
Not stated	3
Black African	2
Bangladeshi	1

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RADAR Safety Events Sept 2026 inc. Maternity, Obstetrics and Neonatal Unit

Somerset NHS Foundation Trust





Reported Events	Events involving Patients
89	75
Events involving Colleagues	**Events involving Others**
26	0

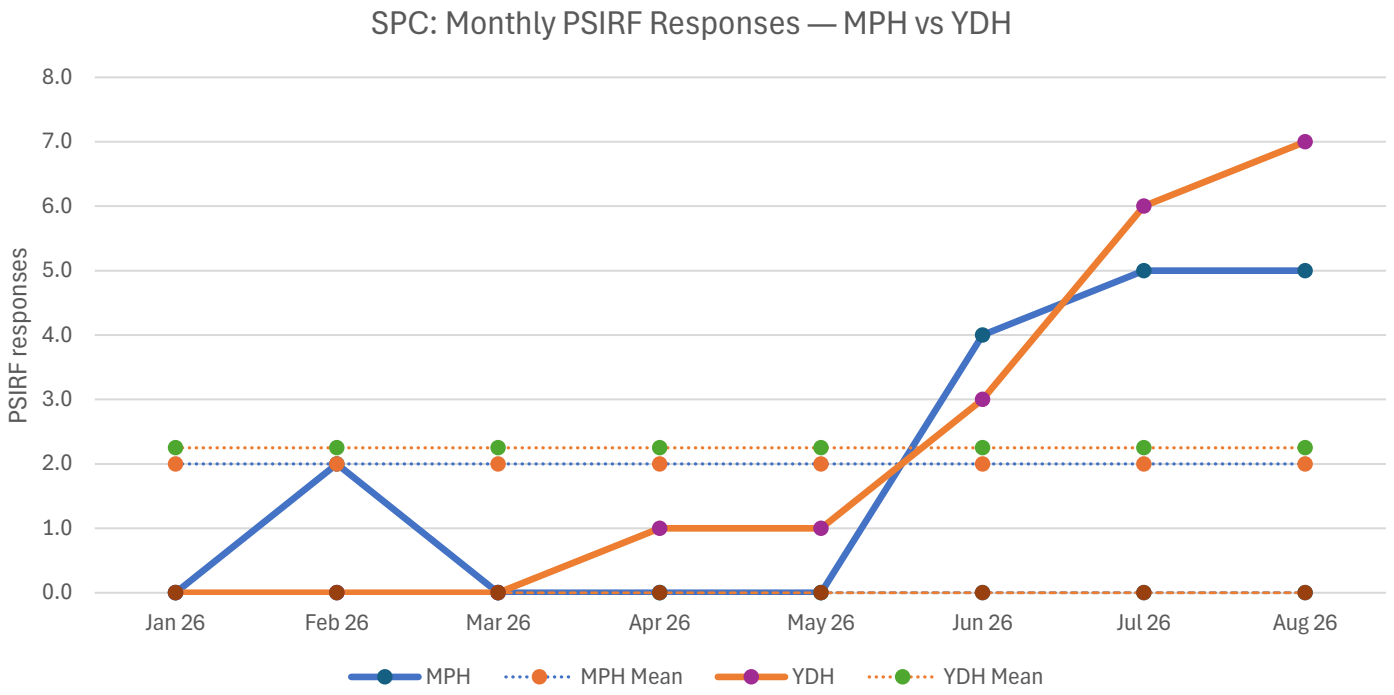


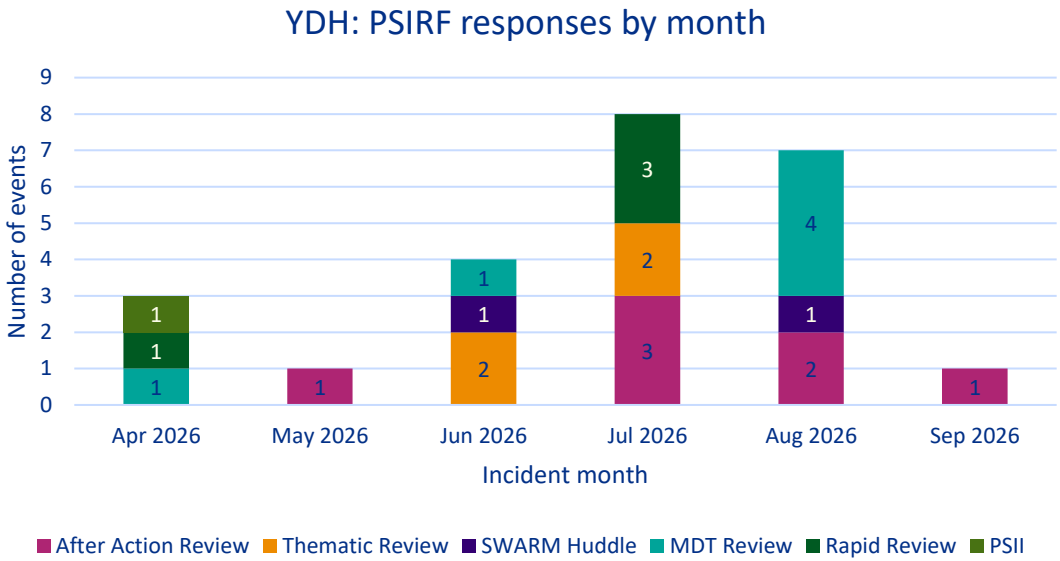
- Number of 'No safety challenge or outcome selected' decreased to 33%

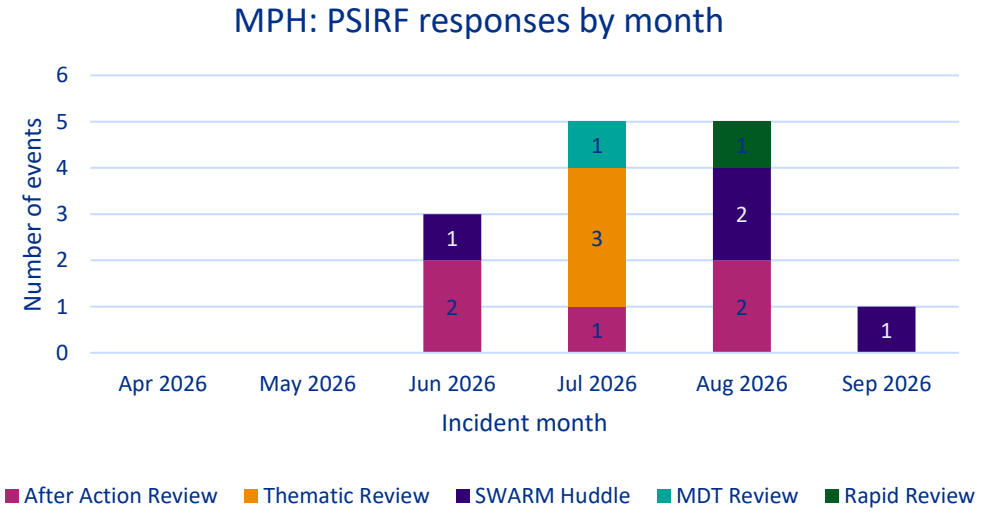
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Commissioned Learning Responses

NHS Somerset NHS Foundation Trust







MPH			YDH		
Total Births (May-Aug)	Total Reported Incidents	PSIRF Responses Commissioned	Total Births (May-Aug)	Total Reported Incidents	PSIRF Responses Commissioned
951	162 (17%)	16 (9.9%)	373	73 (19.6%)	19 (26%)

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Safety Events in Sept 26: Moderate harm or above

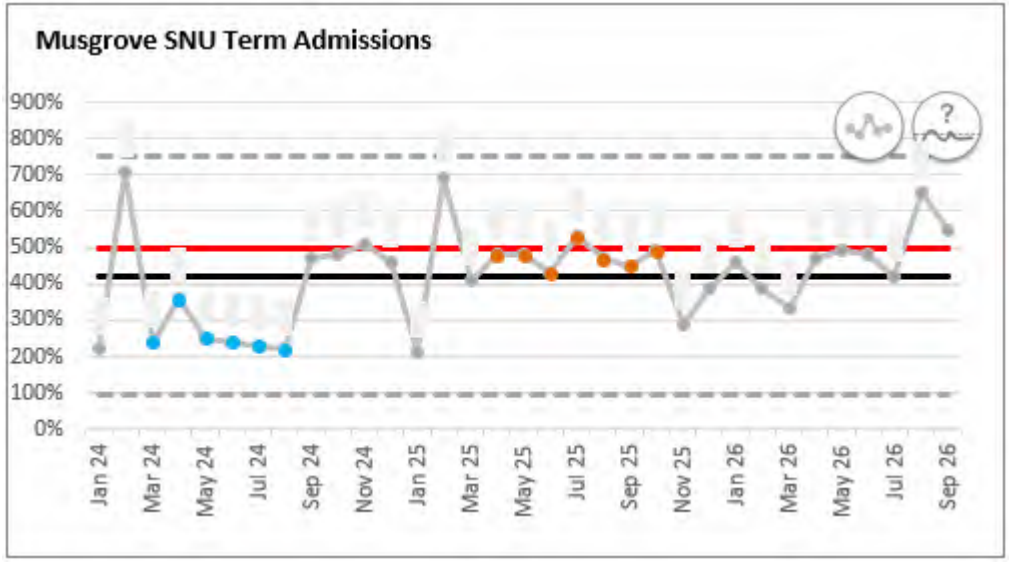
- 2 x moderate harm incidents reported including:
  - passive bilateral leg weakness following epidural insertion possible bacterial meningitis- on Stroke and Neuro ward
  - ATAIN review planned *pending

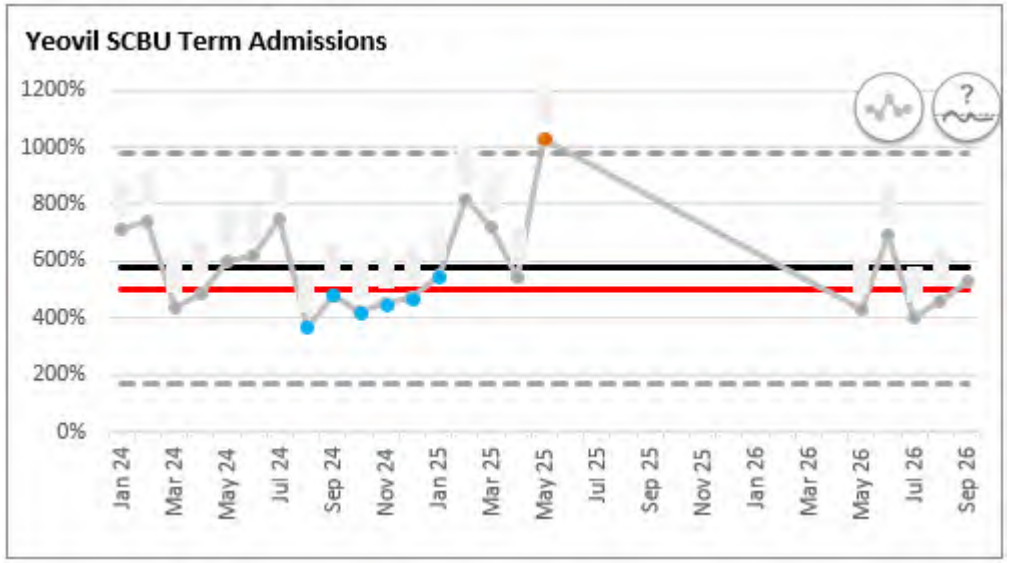
- 2 x deaths reported including:
  - 1 neonatal death at post-natal day 2 PMRT
  - 31+1 IUD

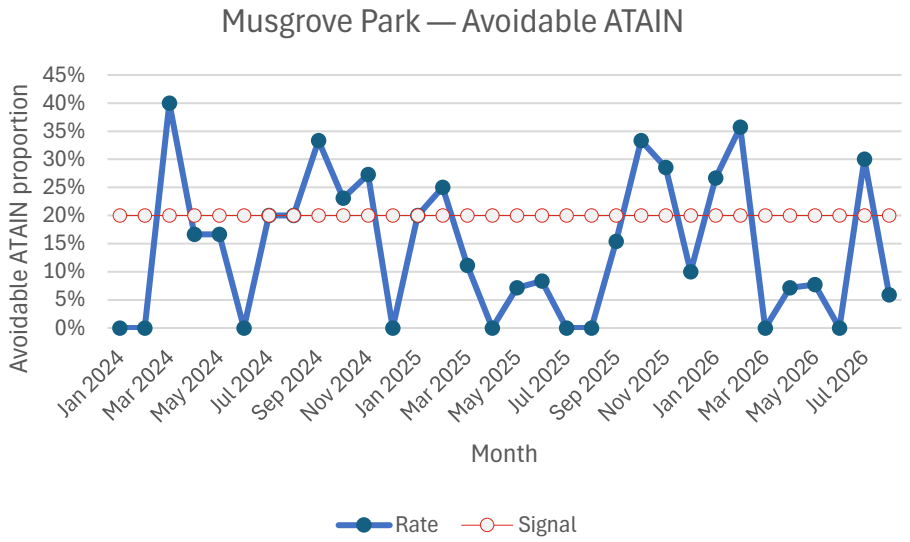
Family Engagement - Patient Safety Events						
Number of Events	Feedback Received		Not Applicable		Pending Involvement/ Review	
26 Cases	7	26.9%	11	42.3%	8	30.7%

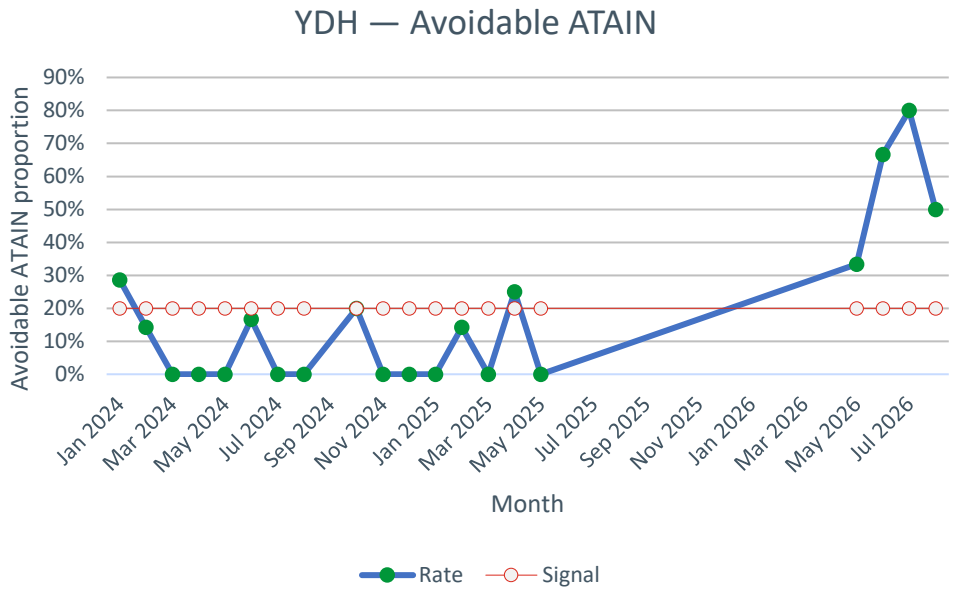
DoC Audit compliance is 100%.
*excluding 2 cases

Term babies admitted to Neonatal Unit









Somerset Foundation Trust

Alignment of processes following YDH reopening.

ATAIN numbers have risen over the last few months; this is believed to be due to a reduction in Total births.

MPH: 5.5%
YDH: 5.3%

MATERNITY & NEONATAL RISK DASHBOARD

REPORTING PERIOD: SEPTEMBER 2026 | 48 RISKS IN REGISTER

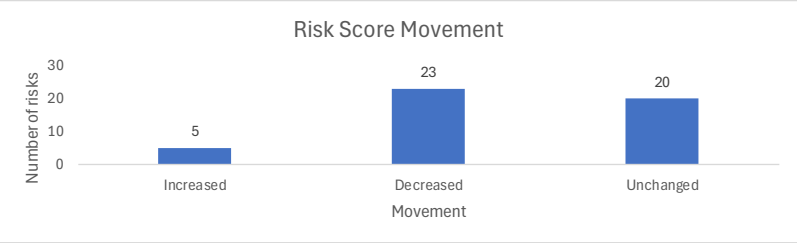
NEW RISKS — September 2026	SCORE INCREASES	SCORE DECREASES	CURRENT HIGH RISKS 16+
1	5	23	8

STORY IN BRIEF

The register shows 1 new risk created in September 2026. Comparing original with current scores, 5 risks increased, 23 decreased and 20 remained unchanged. There are currently 8 high-scoring risks at 16 or above; these require the closest oversight, with the full list shown below.

SCORE MOVEMENT SUMMARY

Movement	Risk count
Increased	5
Decreased	23
Unchanged	20



NEW RISKS ADDED IN September 2026

Reference	Created on	Title	Owner	Status	Current score
RSK-004157	30-Sep-2026	Delay to Rooms 5 & 6 refurbishment causing reduced capacity and care environment risks.	Lisa Chaplin	Planned	9

CURRENT HIGH-SCORING RISKS — 16+

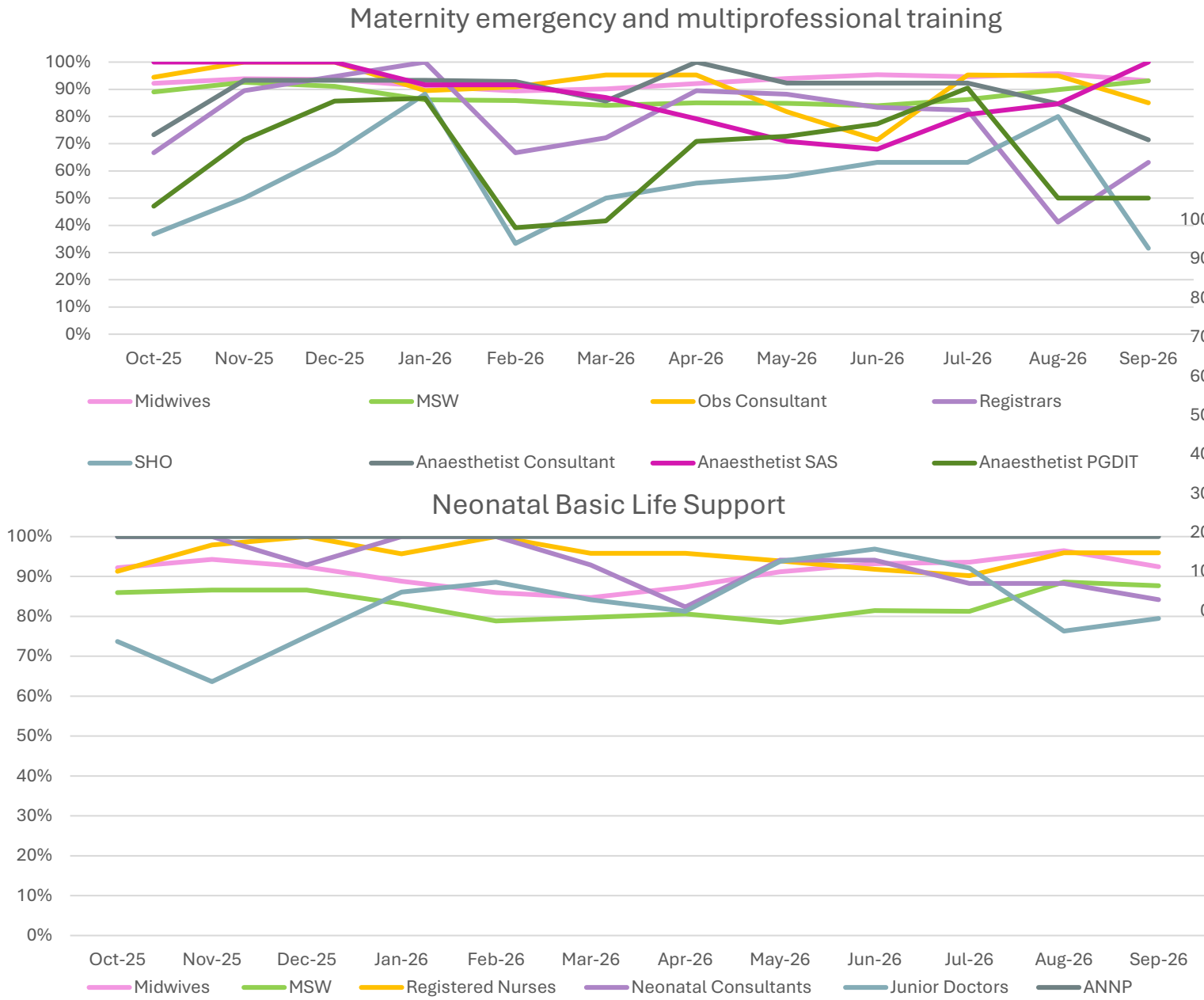
Reference	Title	Owner	Status	Current score	Target score	Next review
RSK-001897	Evacuation risk of the Neonatal Unit in the event of fire	Robyn Smart	Overdue	20	4	29-Sep-2026
RSK-002075	YDH Maternity & Neonatal culture	Sally Bryant	Overdue	20	10	29-Sep-2026
RSK-002606	Unable to provide safe fetal medicine services	Zillah Morris	Planned	20	4	20-Nov-2026
RSK-003032	Significantly limited theatre capacity in Maternity (MPH)	Alison Dennett	Overdue	20	10	30-Sep-2026
RSK-003480	Medical staffing for neonates not compliant with BAPM/MIS standards leading to reduced quality care	Pieter Van Hensbergen	Planned	16	4	28-Oct-2026
RSK-003482	Limited Recognition and Career Progression for Advanced Neonatal Nurse Practitioners (ANNPs)	Pieter Van Hensbergen	Planned	16	6	28-Oct-2026
RSK-003532	Insufficient obstetric and gynaecology medical workforce to support O&G activity at YDH & MPH	Zillah Morris	Planned	16	12	04-Jan-2027
RSK-003684	Safeguarding Risks to Unborn and Newborn Babies - Maternity & Neonatal Interface	Katie Hopwood	Planned	16	6	31-Dec-2026

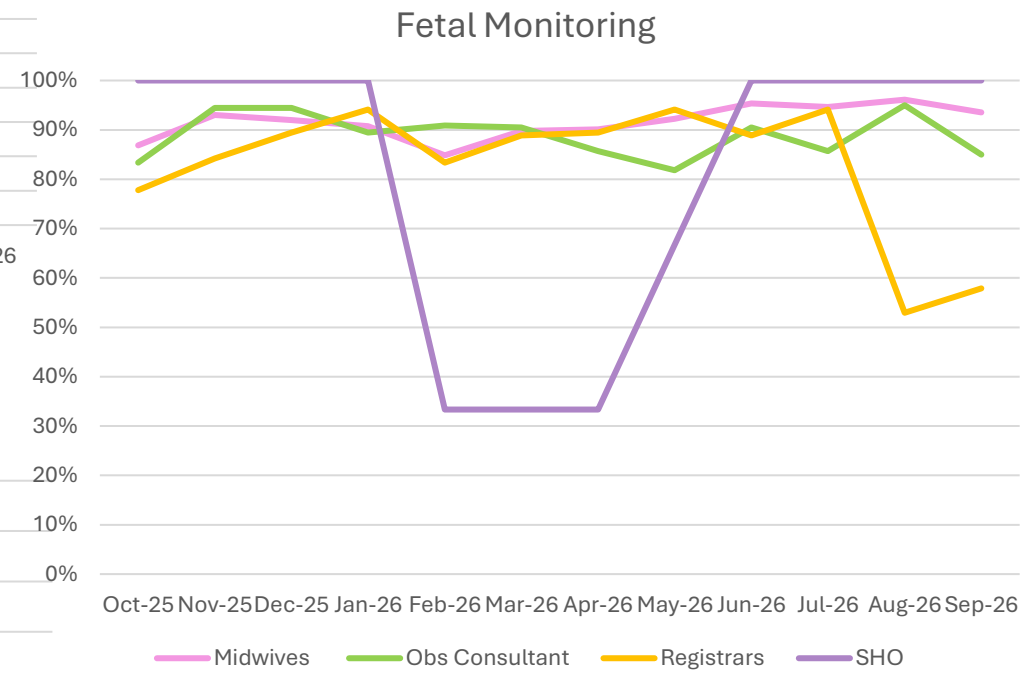
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Training Monthly Rolling Compliance Update

Somerset NHS Foundation Trust





Training Compliance Trajectory (figures correct on 1st Oct 26)

Somerset NHS Foundation Trust

- Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training. *Refer to training report for additional information*
- MIS Checkpoint Date 1: 24 July 2026 **not met** MIS Checkpoint Date 2: 30 November 2026

MPH	Midwives	Obstetricians			MSWs	Anaesthetists			Neonatal medical		Neonatal nursing (inc. ANNP)
		Consultants	Other	Rotational Medical Staff (Resident Drs/ SHOs		Obstetric Anaesthetics Consultants	Other	Rotational Anaesthetic Medical staff	Consultants	Other	
Obstetric emergency training (PROMPT)	95%	100%	54%	81%	94%	50%	100%	50%			
Fetal monitoring and surveillance	97%	91%	62%								
Neonatal resus training (including assessment)	96%				96%				90%	88%	100%

***No data provided by MPH NICU at the time of creation**

YDH	Midwives	Obstetricians			MSWs	Anaesthetists			Neonatal medical		Neonatal nursing (inc. ANNP)
		Consultants	Other	Rotational Medical Staff (Resident Drs/ SHOs		Obstetric Anaesthetics Consultants	Other	Rotational Anaesthetic Medical staff	Consultants	Other	
Obstetric emergency training (PROMPT)	91%	86%	100%	60%	100%	20%	100%				
Fetal monitoring and surveillance	95%	100%	86%								
Neonatal resus training (including assessment)	94%				95%				67%	67%	42%

Q2 Perinatal Complaints Overview

Headline position, recent volume and how concerns are received

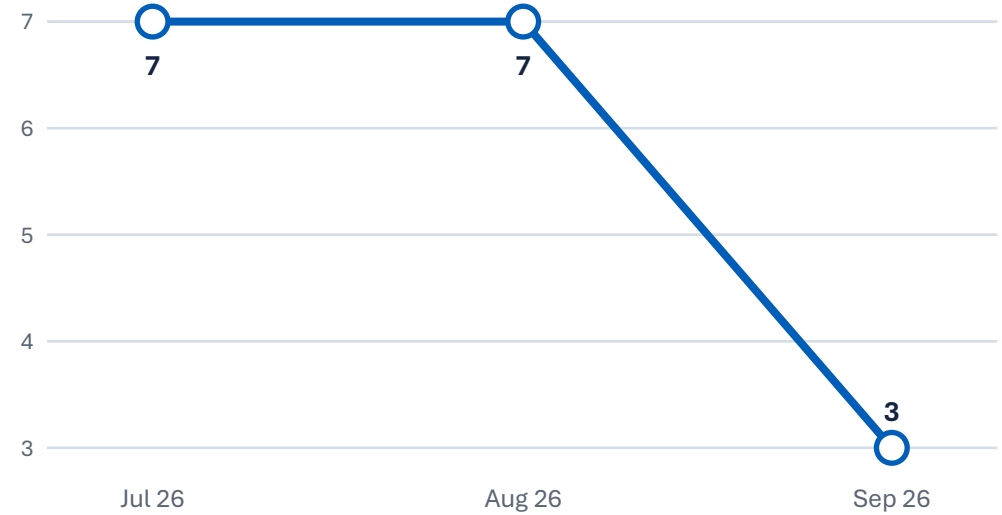
17 received

16 open

6 overdue

94% of received complaints remain open (16 of 17)

Monthly complaints received



Volume reduced in September

How complaints were received



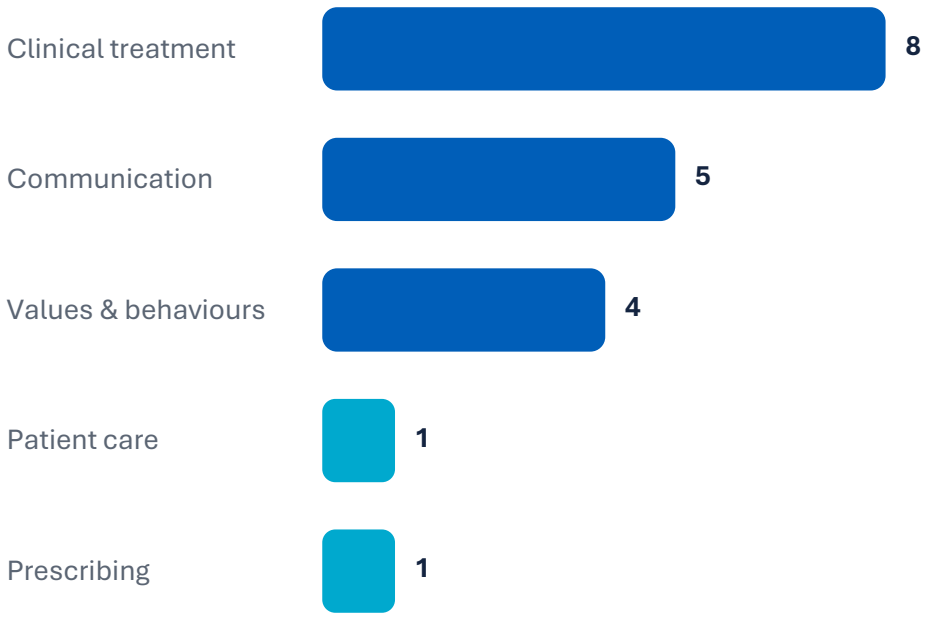
Engagement implication

Email dominates. Offer and promote accessible alternatives so people can raise concerns in the way that works for them.

What the complaints are telling us

Leading themes and next steps

Main complaint categories



The visible leading categories are clinical treatment, communication, and values & behaviours.

Detailed themes

4 Attitude

3 Communication

2 Mismanagement

10 Other visible themes

"Other visible themes" combines ten dashboard entries with a value of 1 each. Theme classifications may overlap.

Patient engagement: Learning next steps

1. **Understand**
   Where did our care or communication fall short?
2. **Co-design**
   What would a better experience look like?
3. **Include**
   Whose voice may be missing from email-led feedback? Are we missing vulnerable groups?
4. **Close the loop**
   How will people hear what changed?

Agree one action, owner and feedback route

Triage Update

Number of triage presentations	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Number of triage presentations	794	*1018*	*1008*	*1060*	*1061*	*1035*						
% triaged <15 mins of arrival	86.6	90.6	93.2	92.9	91.1	87.1						
% of women triaged in each category of urgency Red Orange Yellow Green	0 17% 58% 25%	1 18% 51% 29%	1 14% 50% 36%	*0.85%* *18.2%* *54.9%* *25.8%*	1% 16.6% *54.7%* *27.2%*	0.1% 15.4% *51.5%* *30.4%*						
% of women assessed within expected timeframes based on category of urgency:	94%	*93.2%*	*95%*	*95.4%*	*95.9%*	*91%*						
Number of breaches	105 (13.4%)	*91* *(8.4%)*	*70* *(7%)*	*75* *(7%)*	*95* *(8.9%)*	*134* *(12.9%)*						
% of women who leave without further reviews following initial triage	4	*3*	*7*	*11*	*10*	*9*						

% achieving obstetric review within expected time frames is 85.3% for Sept

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Break

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Ward Area Updates

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Willow Ward Update: Q2

BR+	Total Q2	Jul	Aug	Sept
Compliance	80% (Q1 70%)	80.6%	77%	80.2%
Acuity met	55% (Q1 42%)	76%	51%	40%
Red flags	6 (Q1 19)	2	2	2

ACTIONS:

- Self medication now live!
- Shift leader role & responsibilities continues to be developed
- Individualised feedback re: compliance KPI's

Red flag detail:

- Less number of red flags in Q2- acuity met higher in Q2
- Red flags for delayed analgesia.
- Red flags all during time of high acuity (-2.1)

IPC	Total Q2	Jul	Aug	Sept
Hand Hygiene	100%	100%	100%	*100%
Bare below Elbow	100%	100%	100%	*100%
Decontamination	100%	100%	100%	*100%

ACTIONS:

- Continue!

Safety Brief	Total Q2	Jul	Aug	Sept
Twice daily	92% (Q1 89%)	93.75%	90.3%	92%

ACTIONS:

- Shift leader role allocated and responsible for all daily checks/BR+/SB being complete.
- Allows for individual monitoring & accountability.

Freya Ward Update: Q2

BR+	Total Q2	July	August	September
Compliance	66.4%	63%	63.7%	72.5%
Acuity met	75%	59%	84%	82%
Red flags	19	9	5	5

Red flag detail:

- 1 - Delayed or cancelled time critical activity
- 3 - Delay in providing pain relief
- 1 - Missed medication during an admission
- 14 - Delay between admission for IOL and beginning process

ACTIONS:

- Trust self-medication process now embedded
- Out to recruitment to fill staffing gaps
- New handover board in place to improve oversight for MDT
- Shift leader role to be implemented – December 2026

IPC	Total Q2	July	August	September
Hand Hygiene	88%	90%	88%	85%
Bare below Elbow	98%	100%	100%	95%
Decontamination	83.3%	100%	100%	50%

ACTIONS:

- Data will be shared in Labour Ward Forum meetings for monthly MDT oversight
- Condemned commode – replacement on order

Safety Brief	Total Q2	July	August	September
Compliance	100%	100%	100%	100%

ACTIONS:

- Safety brief / Team of the Shift is completed with all staff on Labour ward at the beginning of every shift

Fern Ward Update: Q2

BR+	Total Q2	July	Aug	Sep
Compliance	%	87.9%	80.65%	72.5%
Acuity met	%	96%	93%	94%
Red flags	13	3	9	1

Red flag detail:

- **RF1** (x9) **RF2** (x2) Delay transferring women to LW for continued IOL
- **RF4** (x1) Delay providing pain relief
- **RF7** (x1) Delay between admission of induction and beginning of process.

ACTIONS:

- To keep reporting back to staff at team meetings – good compliance and when it falls short. Importance of accurate data. Missed data input - July x15, Aug x24, Sept x33.
- Ensure new staff have access to Birthrate.
- Introduction of self medication on ward and in line with Trust.
- Ensure IOL plans are written and prescribed before women attend for induction of labour.

IPC	Total Q2	July	Aug	Sep
Hand Hygiene	100%	100%	NR	100%
Bare below Elbow	97.8%	100%	NR	95.5%
Decontamination	100%	100%	100%	100%

ACTIONS:

- Named person x2 to carry out audit

Safety Brief	Total Q2	July	Aug	Sep
	130/184 **70.7%**	27/31 AM **87%** 21/31 PM **68%** **TOTAL: 77%**	24/31 AM **77%** 23/31 PM **74%** **TOTAL: 76%**	20/30 AM **67%** 15/30 PM **50%** **TOTAL: 58%**

ACTIONS:

- Ensure rotational staff are aware of signing the handover folder.
- Check staff have signed each morning

Labour Ward MPH Update: Q2

BR+	Total Q2	Jul	Aug	Sept
Compliance	71.85	80.65%	68.8%	66.1%
Acuity met	76.3	85%	66%	78%
Red flags	3	2	1	0

ACTIONS:

- Continue to review staffing and on calls daily
- Respond to sickness absence and try to cover shifts
- Recruitment – new midwives to start
- Peaks of unanticipated workload is unavoidable on LW

Red flag detail:

- Co-ordinator unable to maintain supernumerary and is NOT providing 1:1 care x 2 Coordinator looking after woman with D&V for less than 4 hrs
- Delayed or cancelled time critical activity

IPC	Total Q2	Jul	Aug	Sept
Hand Hygiene	95.5%	96	95	N/A
Bare below Elbow	97.5%	95	100	N/A
Decontamination	NS	N/S	N/S	N/A

ACTIONS:

- Decontamination audit not submitted due to LTS of auditor. Plan to allocate a deputy to avoid risk of non submission

Safety Brief	Total Q2	Jul	Aug	Sept
Twice daily	100%	100%	100%	100%

ACTIONS:

- Sharing of safety briefing is now embedded in practice

Ward Update YDH LW: Q2

BR+	Total Q2	Jul	Aug	Sept
Compliance	80.8%	80.65%	85.5%	76.1%
Acuity met	91%	85%	94%	93%
Red flags	24	17	3	4

ACTIONS:

- Continued effort to improve compliance through alarms set for coordinator
- RF criteria sent out for re-examination by team to ensure accuracy of data captured.

Red flag detail:

- RF1 x1- delayed or cancelled time critical activity
- RF4 x1-delay in providing pain relief
- RF7 x6-delay between admission for IOL and beginning process
- RF10 x2-coordinator not S/N- providing 1:1 care
- RF11 x14- coordinator not SN and not providing 1:1 care

IPC	Total Q2	Jul	Aug	Sept
Hand Hygiene	86%	88%	80%	90%
Bare below Elbow	96.7%	90%	100%	100%
Decontamination	100%		100%	100%

ACTIONS:

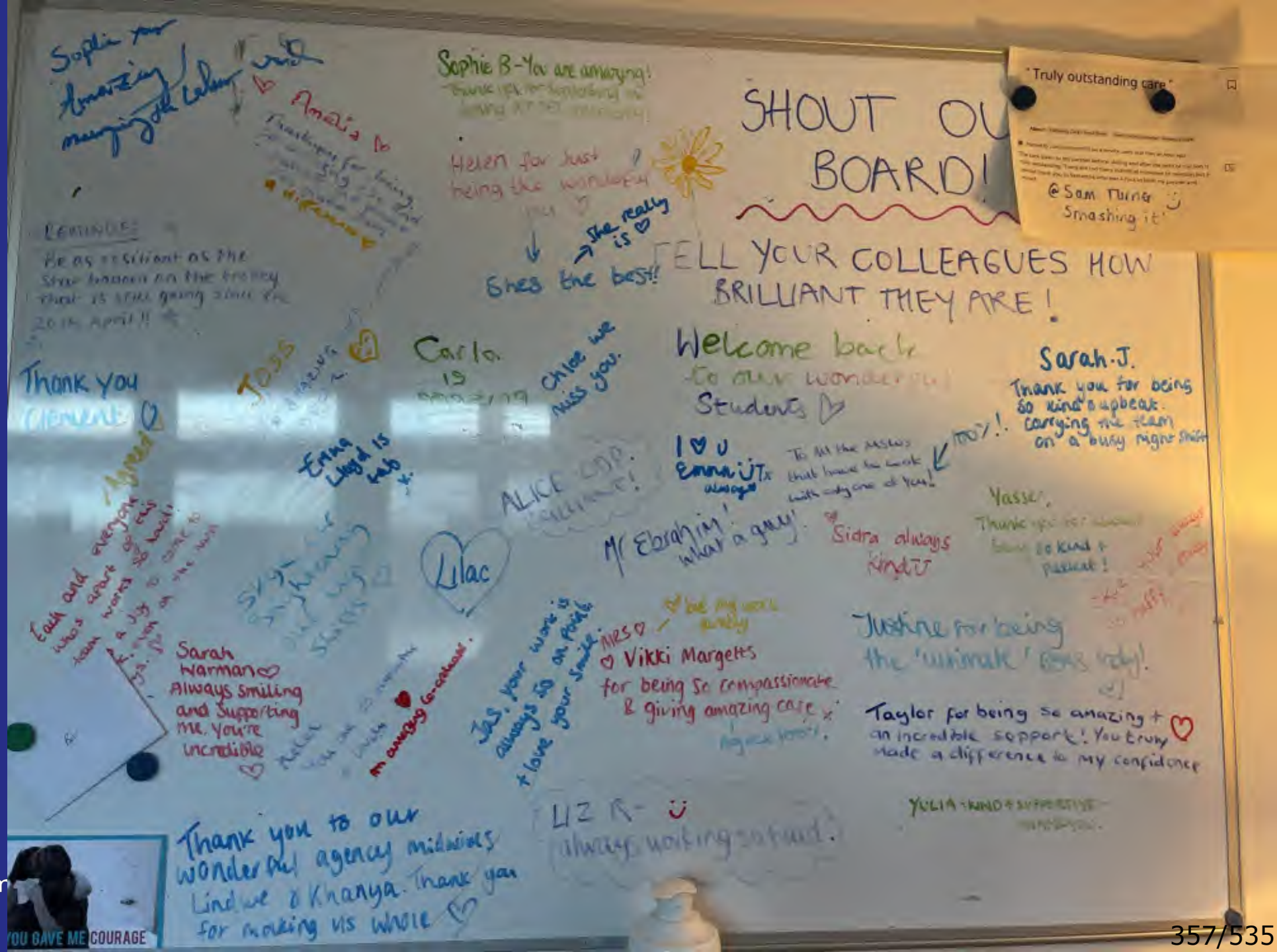
- Continue!
- Data collection from service users
- Uniform and BBE checks at handover

Safety Brief	Total Q2	Jul	Aug	Sept
Once daily				83.3%

ACTIONS:

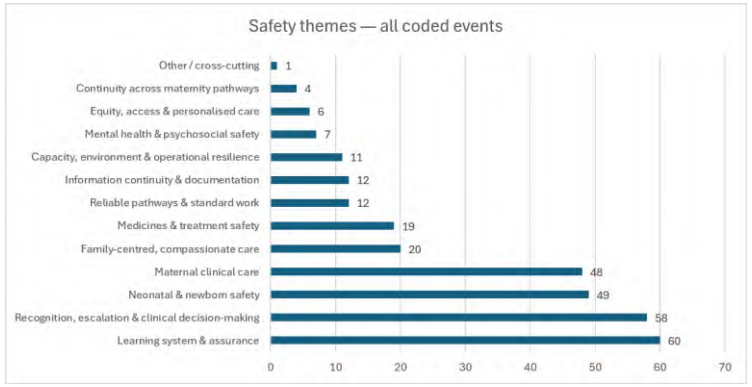
- July and August data not available- with governance
- Comms to coordinating team to remind to complete at weekend

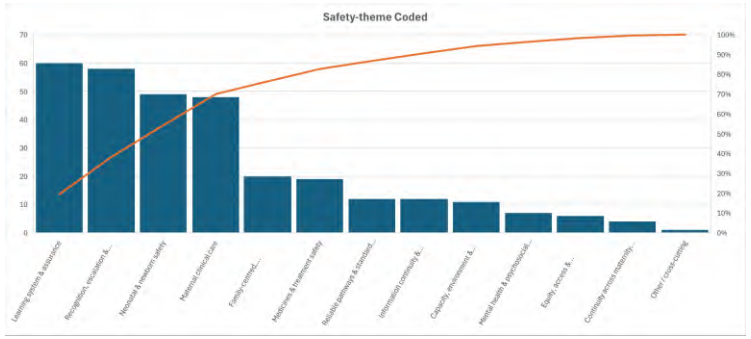
Shout Out Board



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Q2 2026–27 Perinatal Thematic Review of Safety Themes





Source-specific summary of learning and actions

PMRT — 17 actions + 1 tracker case

WHAT WE LEARNT
Most PMRT actions relate to bereavement and compassionate care. Other issues include interpreter access, late booking, missed checks, escalation of urine results, medicines and guidance that is not aligned.

WHAT WE NEED TO DO
Complete the bereavement pathway work; improve access to interpreters; close the gaps in urine-result and diabetes referrals; confirm medicines controls; and record how learning and family feedback have been used.

MNSI — 4 actions + 1 tracker case

WHAT WE LEARNT
The MNSI case shows gaps in safe-sleep information, antenatal safeguarding checks, digital prompts and access to emergency phones on antenatal and postnatal wards.

WHAT WE NEED TO DO
Make the safe-sleep field mandatory on BadgerNet and audit it; review missed antenatal opportunities; provide and test emergency phones.

Complaints — 9 narratives | 26 actions

WHAT WE LEARNT
Families repeatedly describe poor or delayed communication, weak handovers, missed escalation of results, unclear follow-up, gaps in informed choice and the emotional impact of care.

WHAT WE NEED TO DO
Use closed-loop checks for important results; hand over outstanding promises and personal plans; give regular updates during delays; provide clear discharge and follow-up plans; and check that families understand.

PSIRF — 18 tracker learning responses + 2 explicit actions

WHAT WE LEARNT
Multiple learning responses underway including AAR, MDT, thematic, rapid and SWARM reviews. Current review does not provide robust evidence of whether the learning has led to lasting change.

WHAT WE NEED TO DO
Complete the reviews; record the system factors and agreed controls; include family feedback; link the evidence; and confirm that changes have been checked and signed off.

Safety Event Tracker — 115 Q2 safety events

WHAT WE LEARNT
The most common event groups are ATAIN, PPH, delays in care, perineal trauma and low Apgar scores. Most safety events show low or no harm, but there are also cases involving moderate harm, severe harm and death.

WHAT WE NEED TO DO
Check for duplicate cases; monitor repeated events by site; link recommendations to named owners and measures; and use ethnicity and IMD data carefully until denominator data are available.

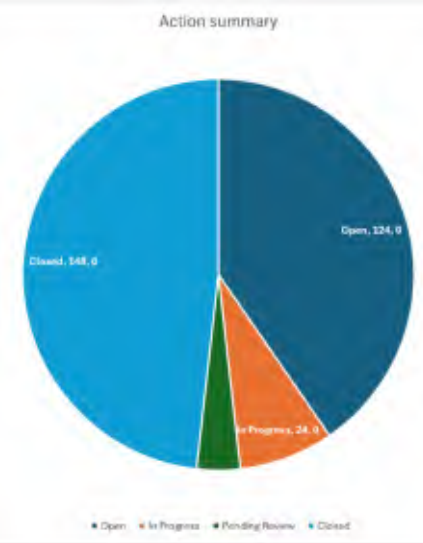
Maternal Care Bundle — 27 coded safety events

WHAT WE LEARNT
There are gaps across VTE, MEWS and acute pathways, epilepsy, mental-health screening and haemorrhage. Several interventions are not implemented or are only partly implemented, and some linked cells are broken.

WHAT WE NEED TO DO
Fix the links; add missing SMART actions; name the lead and deadline for each action; and report clear progress and committee-confirmed status for every intervention.

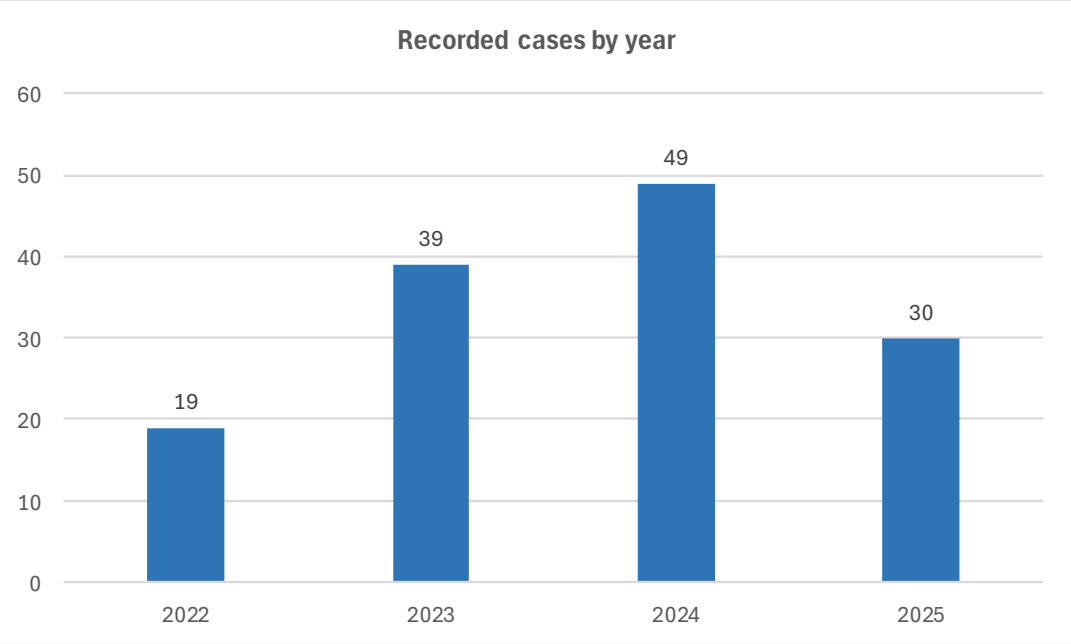
Priorities and what we do next

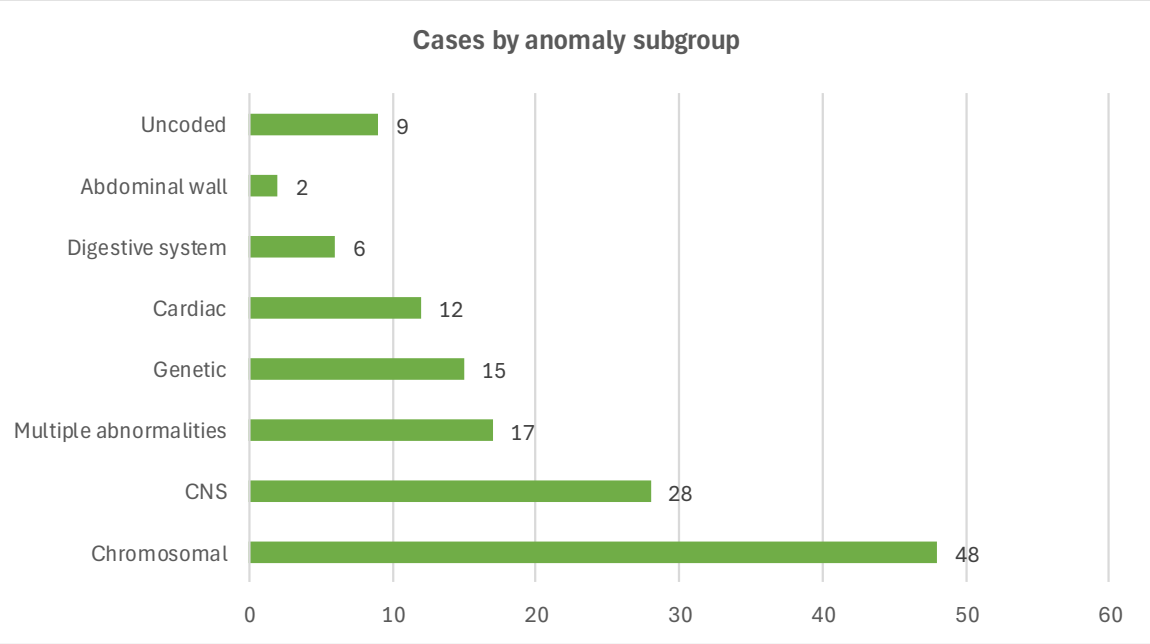
1	Make sure actions lead to change	Every active action and PSIRF response should have evidence, a clear route for sharing learning, a review date and final sign-off.	At least 90% of active actions have dated evidence and a named reviewer
2	Improve recognition and escalation	Bring CTG, delays, triage, MEWS, abnormal results and urgent referrals into one cross-site improvement plan.	Report compliance and time to escalation each month
3	Use one approach for key maternal and neonatal risks	Track haemorrhage, perineal trauma, ATAIN, resuscitation and newborn actions using the same core measures.	Show outcome and process trends by site
4	Improve handover and communication with families	plans, discharge information and updates when care is delayed. Check that families have understood.	Audit handovers and review complaint feedback
5	Complete the Maternal Care Bundle work	Fix broken links, add missing SMART actions and progress every intervention that is not or only partly implemented.	Board-confirmed status and clear progress for every intervention
6	Understand inequalities properly	Use ethnicity and IMD alongside maternity population data. Continue to monitor interpreter access and late booking.	Quarterly rates by site, with small numbers handled safely



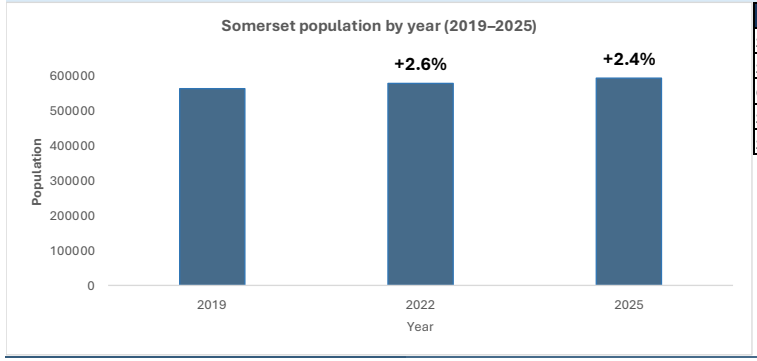
SFT Congenital Anomaly Thematic Review- 2022 -2025

RECORDED CASES	TIMING RECORDED	ANTENATAL (KNOWN TIMING)	PERINATAL / INFANT DEATHS
137	97.1%	94.7%	20





POPULATION AND BIRTH-DENOMINATOR CONTEXT



SFT birth denominators	
2019 total births	4,322
2022 total births	4,200
Change 2019–2022	-2.8%
2022 anomaly cases	19
2022 prevalence / 10,000	45.2

SFT Congenital Anomaly Thematic Review

SUMMARY

No.	Question	SFT result	National benchmark	RAG
1	Overall birth prevalence of congenital anomalies	19 cases from 4,200 births = 45.2 per 10,000 (2022)	2019: 216.4; 2022: 255.0 per 10,000	Green
2	Timing of first diagnosis recorded	133 of 137 cases (97.1%)	2019: 95.0%; 2022 not stated	Green
3	Cases first detected antenatally	126 of 133 with known timing (94.7%)	2019: 68.0%; 2022: 73.0%	Green
4	Contribution to mortality coding	125 underlying; 7 contributory; 5 uncoded	2019: 39.3% post-neonatal; 32.3% infant; 24.0% perinatal	Amber
5	Prevalence among mothers aged 25–29	32 recorded cases; prevalence rate unavailable	2019: 195.3 per 10,000 births	Amber
6	Chromosomal anomaly case profile	48 cases overall; 3 in 2022	National mortality: 2.2 perinatal; 2.4 infant per 10,000	Amber
7	Genetic anomaly case profile	15 cases overall; 1 in 2022	Down's syndrome: 25.4 per 10,000 births nationally (2019)	Amber
8	Cardiac anomaly case profile	12 cases overall; 4 in 2022	National mortality: 2.6 perinatal; 5.4 infant per 10,000	Amber
9	CNS anomaly case profile	28 cases overall; 4 in 2022	Anencephaly may be underrepresented in mortality statistics	Amber
10	Abdominal wall anomaly case profile	2 cases overall; 1 in 2022	Under-20 national prevalence: 24.0 per 10,000 births	Amber
11	Digestive system anomaly case profile	6 cases overall; 1 in 2022	Common factor in national infant and perinatal deaths	Amber
12	Multiple abnormalities case profile	17 cases overall; 5 in 2022	Cases may appear in more than one national subgroup	Amber
13	Congenital anomalies among mothers under 20	5 cases overall; 1 in 2022; rate unavailable	National rate significantly higher than ages 30–34; abdominal wall prevalence 24.0 per 10,000	Amber
14	Congenital anomalies among mothers aged 20–24	12 cases overall; 4 in 2022; rate unavailable	National age-specific rate not supplied	Amber
15	Congenital anomalies among mothers aged 25–29	32 cases overall; 3 in 2022; rate unavailable	2019: 195.3 per 10,000 total births	Amber
16	Congenital anomalies among mothers aged 30–34	36 cases overall; 7 in 2022; rate unavailable	2019: 195.9 per 10,000 total births	Amber
17	Congenital anomalies among mothers aged 35–39	30 cases overall; 2 in 2022; rate unavailable	2019: 243.7 per 10,000 total births	Amber
18	Congenital anomalies among mothers aged 40+	17 cases overall; 1 in 2022; rate unavailable	2019: 399.3 per 10,000; genetic rate markedly higher	Amber

SFT Congenital Anomaly Thematic Review

WHAT WE FOUND	WHAT IT MEANS	WHAT WE WILL DO NEXT
• SFT recorded 137 cases in 2022–2025; diagnosis timing was recorded in 97.1%, with 94.7% of known diagnoses detected antenatally. • In 2022, 19 cases among 4,200 births equated to 45.2 per 10,000, below the national reference of 255.0; question 1 is therefore rated Green. • Two 2022 perinatal deaths equated to 4.8 per 10,000 births. • Chromosomal anomalies were most common (48), followed by CNS (28), multiple abnormalities (17), genetic (15) and cardiac (12).	• National evidence identifies cardiac and chromosomal anomalies as leading mortality subgroups; no such 2022 SFT perinatal cases were coded in these groups. • SFT case counts were highest at ages 30–34 (36) and 25–29 (32) • National prevalence rises markedly after age 35, reaching 399.3 per 10,000 at age 40+.	• Monitor trends and continue the audit, including analysis by maternal age and anomaly subgroup. • Discuss findings with regional peers to understand population growth, case trends and variation in recording or ascertainment. • Work with public health partners on approaches to earlier intervention and clearer information for families and professionals. • Add missing birth denominators and review incomplete diagnosis-timing and mortality-coding records before repeating the RAG assessment.

PPH Uterotonics audit TXA & Misoprostol Q1-Q2 2026 Summary

**Guideline Reference POSTPARTUM HAEMORRHAGE (PPH) AND INSTIGATING THE MAJOR OBSTETRIC HAEMORRHAGE PROTOCOL IN MATERNITY issue date 06/01/2026*

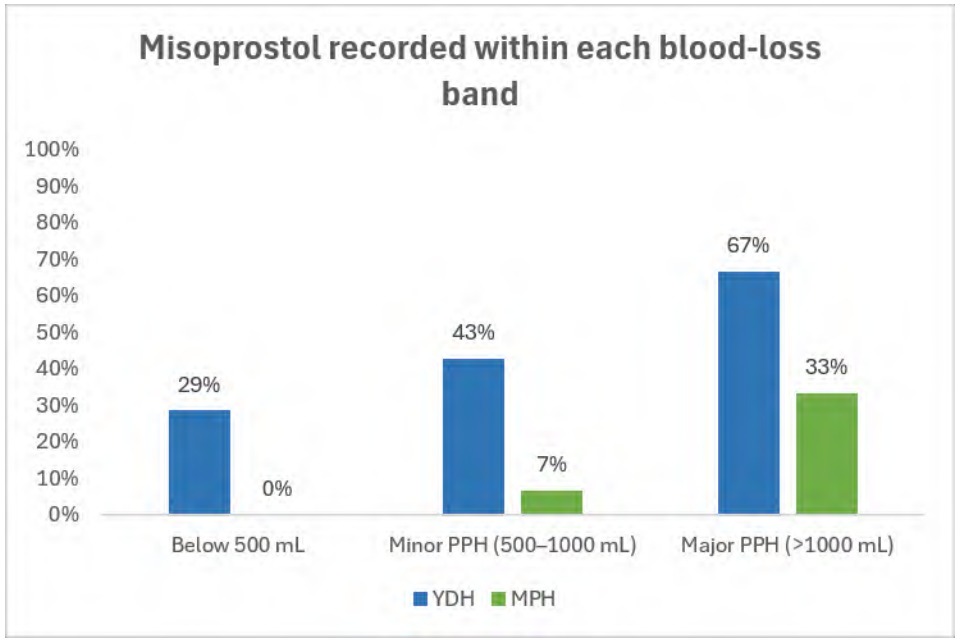
RECORDS REVIEWED	MISO RECORDED	MISO <500 mL	TXA PROPHYLACTIC
76	18	4	32%

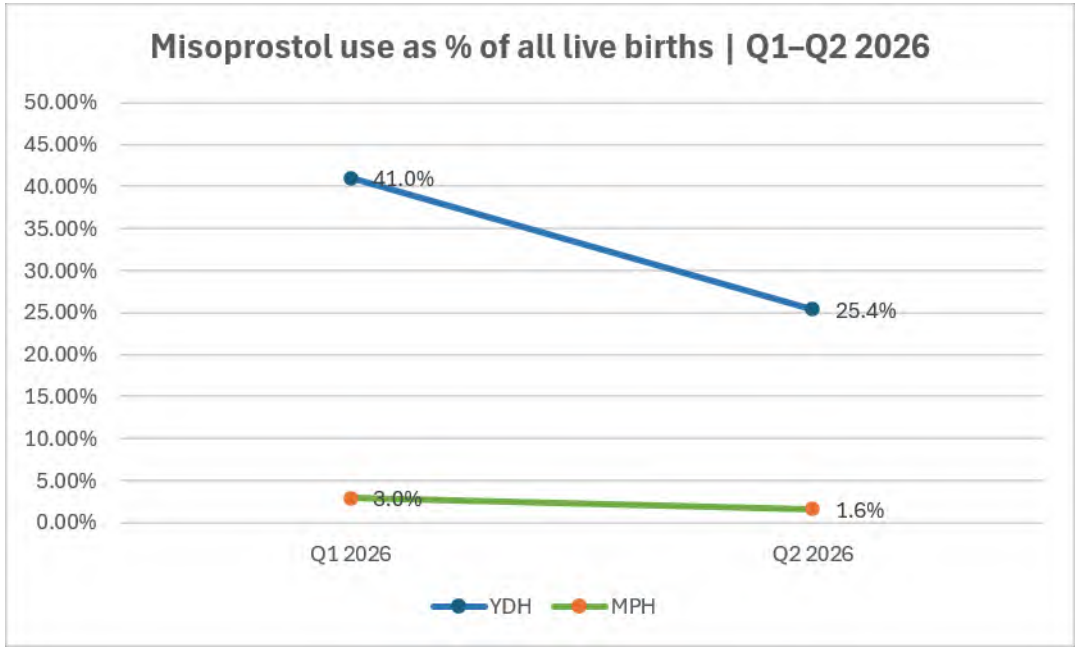
MISOPROSTOL | cross-site and PPH severity

Site	Reviewed	Miso yes	Use rate	<500 mL yes	Minor cases	Minor yes	Major cases	Major yes
YDH	38	15	39%	4	21	9	3	2
MPH	38	3	8%	0	15	1	6	2
Total	**76**	**18**	**24%**	**4**	**36**	**10**	**9**	**4**

TXA | summary cohort

Prophylactic	Elective CS	Emergency CS	Total
No	27%	41%	68%
Yes	27%	5%	32%
Total	**55%**	**45%**	**100%**





TXA & Misoprostol Review

SO WHAT?

Variation in misoprostol use between sites.
Four low-volume blood loss cases require review.
Use in PPH appears selective and may be clinically appropriate.
One-third of reviewed TXA use recorded as prophylactic.
Documentation limits assurance on appropriateness of use.

GUIDANCE PPH Management

Minor PPH (500-1000 mL): Give TXA 1 g. Use misoprostol 800 micrograms rectally only if the bleeding is due to uterine atony.
Major PPH (>1000 mL with ongoing bleeding or signs of shock): Give TXA 1 g IV if not already administered. Use misoprostol only when clinically indicated for uterine atony.
Ongoing bleeding: A second dose of TXA 1 g may be given after 30 minutes. At YDH, major obstetric haemorrhage is triggered at >1500 mL blood loss or earlier if there is significant clinical concern.
Prophylaxis: TXA may be considered after delivery for women undergoing high-risk caesarean birth. Misoprostol is not recommended for routine prophylactic use.

RISKS OF VARIATION

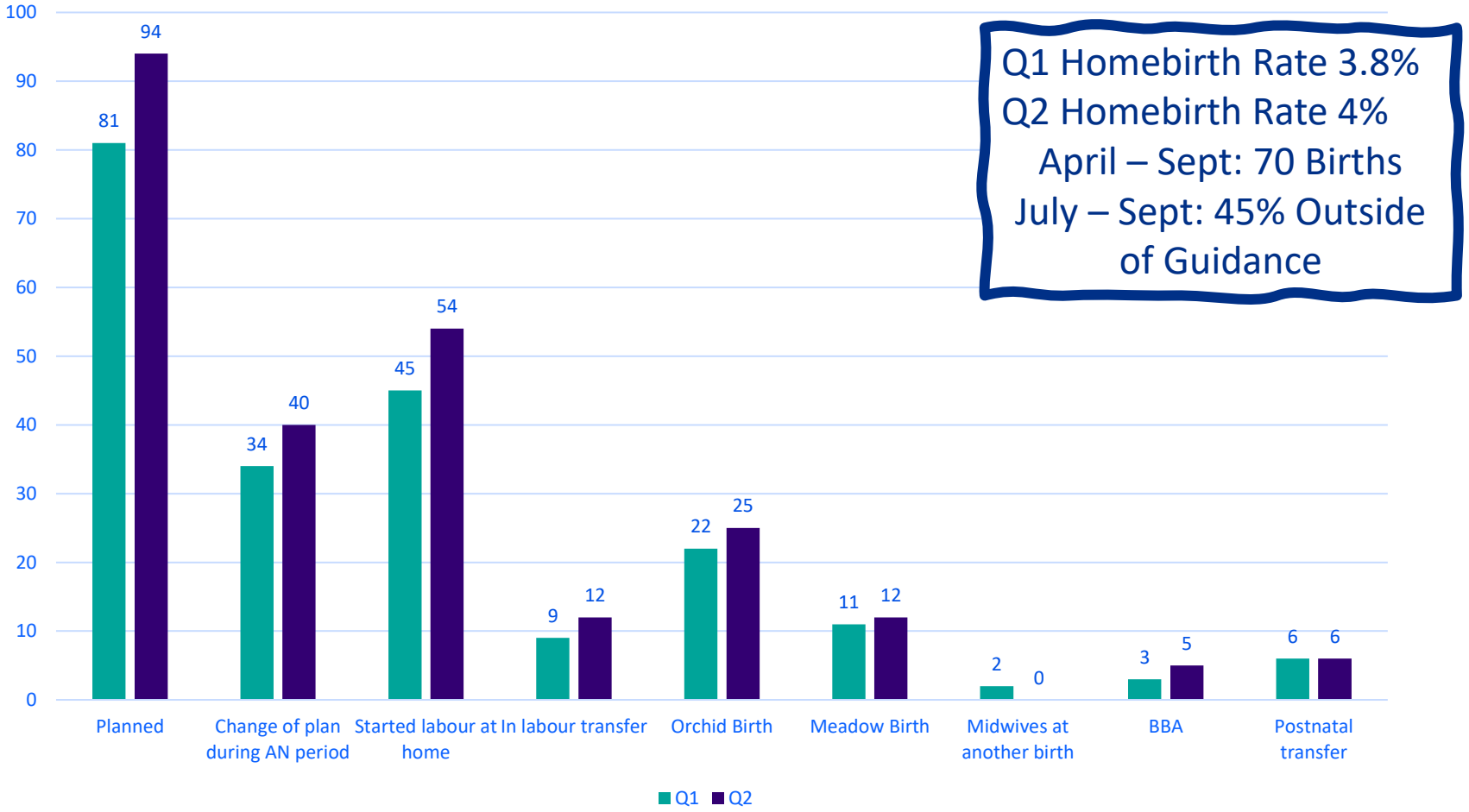
1. Avoidable harm – Unnecessary misoprostol may cause side effects and, if given before birth, uterine hyperstimulation.
2. Medication risk – TXA used without a clear indication may expose women to unnecessary adverse effects.
3. Delayed treatment – Non-standard practice may distract from first-line management and timely escalation.
4. Diagnostic uncertainty – Early treatment may make it unclear when PPH, atony or deterioration was recognised.
5.Governance risk – Incomplete documentation limits assurance, learning and review.
6. Variation in care – Differences between sites may lead to inconsistent treatment and documentation.

Next Steps to improve Safety

1. Improve standards of documentation of indication, blood loss, timing, dose and route.
2. Clinical prompts to be discussed for TXA, repeat dosing and indication-led misoprostol.
3. Document consent where feasible and record retrospective discussions after emergencies.
4. Review exceptions including low-volume misoprostol use and prophylactic TXA.
5. Re-audit monthly for 3 months to assess compliance, outcomes and variation.
6. Share review at Cross County Audit with Clinical teams and through site labour ward forums.
7. To be shared at Consultant meeting

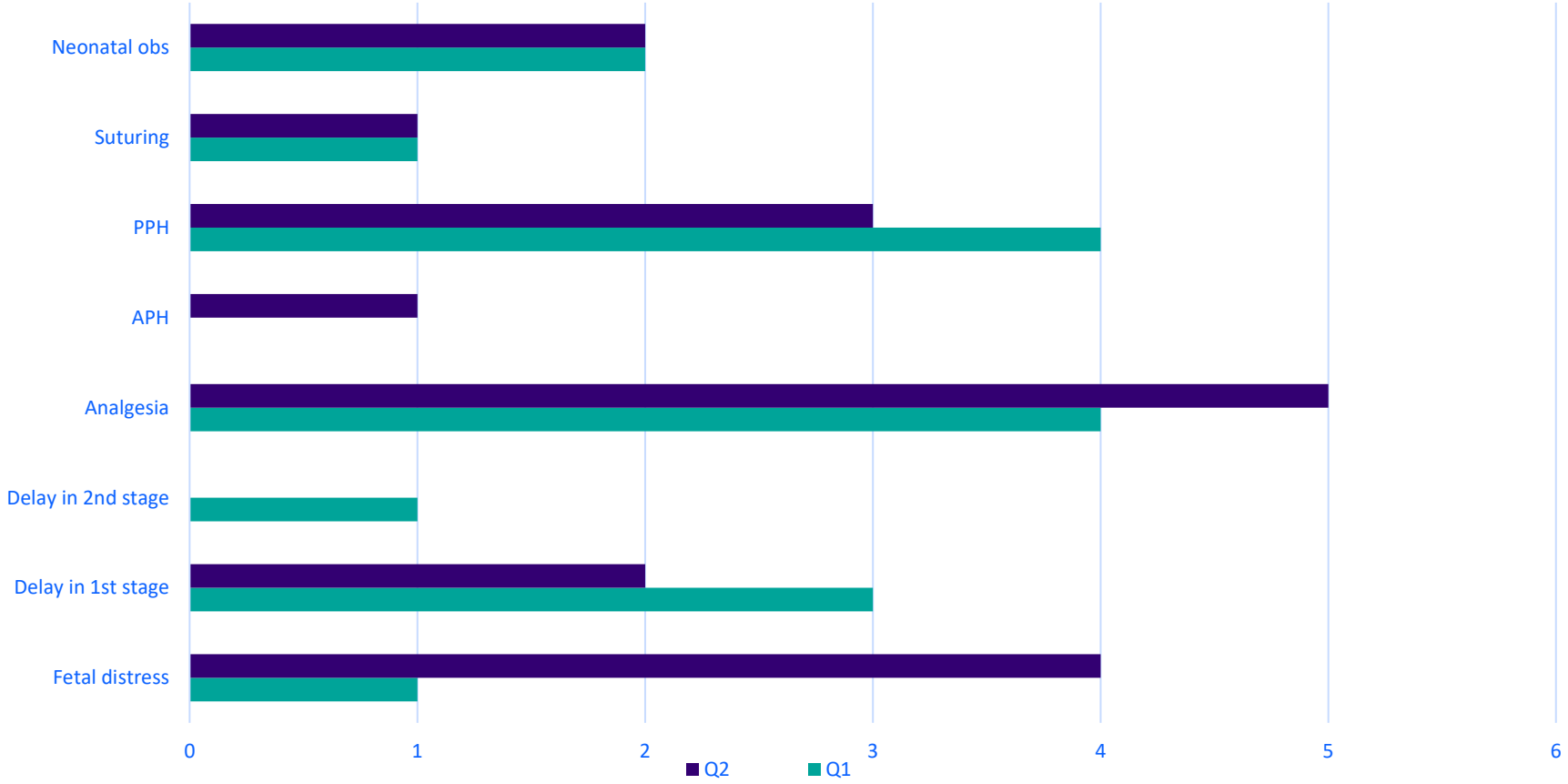
SFT Homebirth Quarterly Report

Q1&2 April – Sept 2026

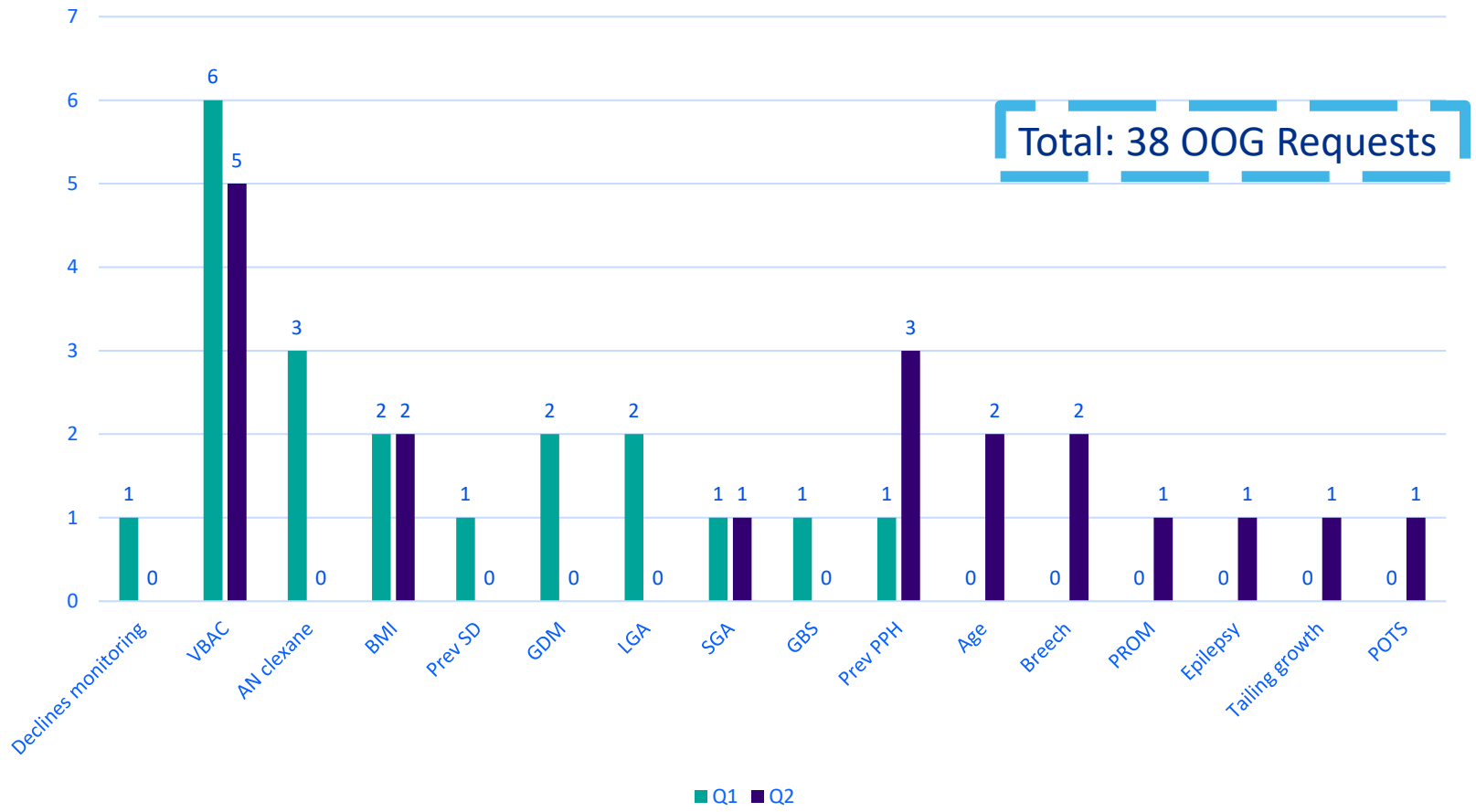


Q1 Homebirth Rate 3.8%
Q2 Homebirth Rate 4%
April – Sept: 70 Births
July – Sept: 45% Outside of Guidance

Number and Reason for Homebirth Transfer



Care Outside of Guidance Requests for Q1&2



Birth Before Arrival
April - Sept



BBAs
Q4 22
Q1 10
Q2 12

Birth Before Arrival
April - Sept



***Maternal and neonatal outcomes**: Q1&Q2*

- *Apgar scores <7 at 5 min: 1*
- *Postpartum haemorrhage rates >1L: 7*
- *Perineal trauma 3rd/4th degree tears: 1*
- *Neonatal admissions: 1*

Perineal 3rd/4th degree Trauma
1/70 births: 1.43%
UK National Rate: 3.5%

PPH
7/70 births: 10%
UK National Rate for Spontaneous Births: 4.75%
For Info: 1 VBAC, 1 MROP, 2 Physiological that changed to Active Management

Q4 Completed Actions

Implementation of 02 cylinders

SU to be triaged directly by homebirth team

Service improvement plans..

To encourage all multiparous women when ringing in early labour to attend the hospital or for the Homebirth Midwife to attend the home without delay to reduce risk of BBAs.

Thematic review of the 7 postpartum haemorrhage cases to identify any learning/themes

Community Homebirth Simulation Training Day with SWAST 17th November

Achievements 

Homebirth rates of 3.8% and 4%
Reduction in no of BBAs from Q4
Homebirth Midwives have attended additional Birth Outside of Hospital Emergency training days
Care outside of guidance MDT weekly forum

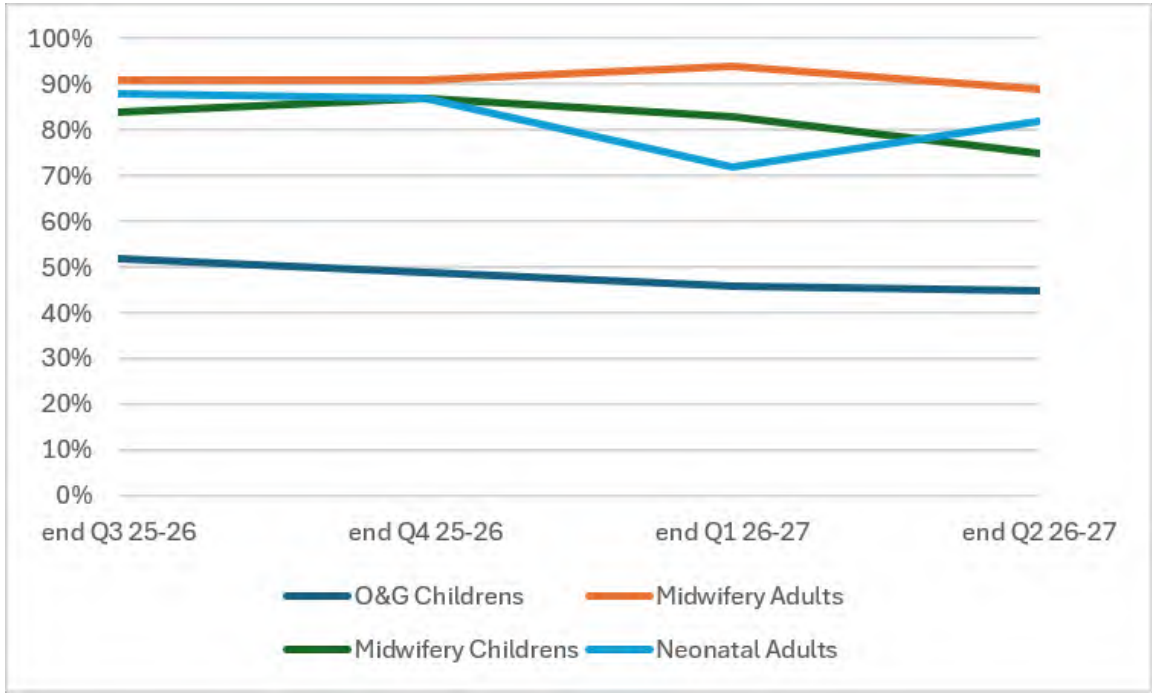
Safeguarding Training Update

Somerset NHS Foundation Trust

Safeguarding Staff Training Compliance as of **end Sept 26**:

	O&G	Midwives	Neonatal Nurses
Safeguarding Adults (Level 3)	94% compliant	89% compliant	82% compliant
	Change from previous month: -1%	Change from previous month: -4%	Change from previous month: -4%
Safeguarding Children (Level 3)	45% compliant	75% compliant	88% complaint
	Change from previous month: -4%	Change from previous month: -4%	Change from previous month: -2%

MatNeo Safeguarding Annual Compliance Rates



Kindness, Respect, Teamwork
Everyone, Every day

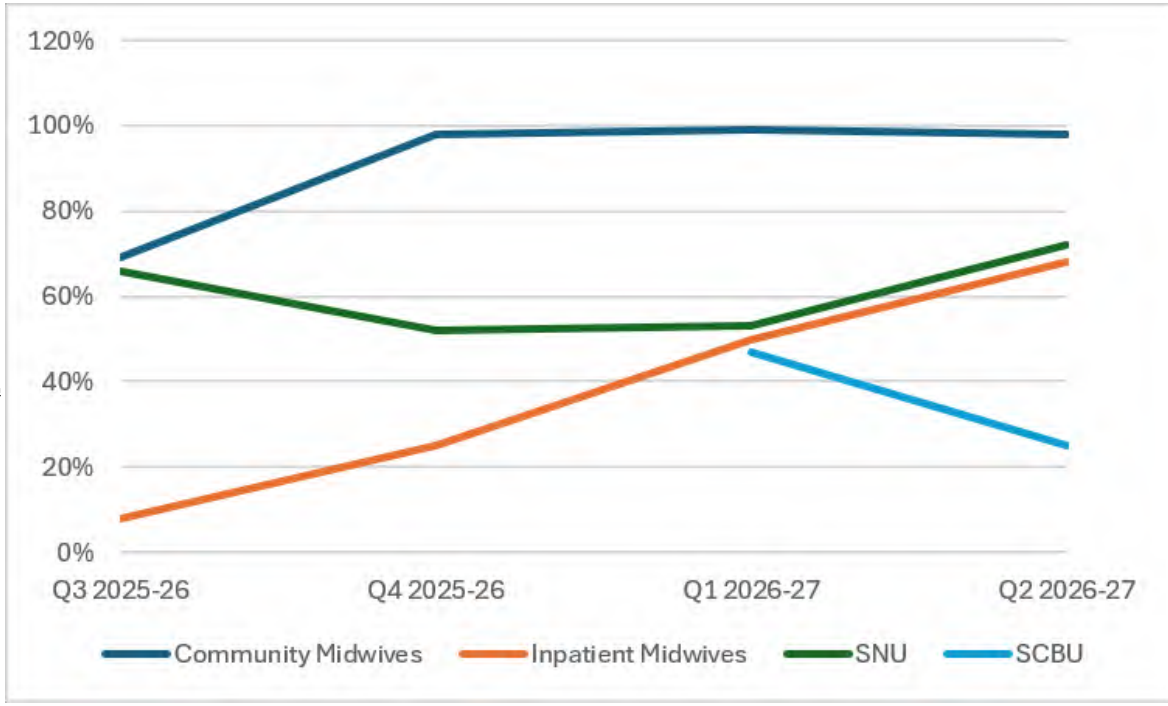
Safeguarding Training Update

Somerset NHS Foundation Trust

Safeguarding Supervision Compliance – 2026/27 Q2

Community Midwives	Inpatient Midwives	Neonatal Nurses		Obstetricians ***(NB: commenced Sept26)***
		MPH - LNU	YDH - SCBU	
96% (86/90)	68% (135/198)	72% (30/49)	25% (4/16)	38% (16/42)

MatNeo Safeguarding Supervision Annual Compliance Rates



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Safeguarding Update

Somerset NHS Foundation Trust

Key achievements/overview:

- 1 x NND, 1 x infant death (12 weeks) with learning identified in relation to professional curiosity in antenatal period and safeguarding documentation/communication by YDH neonatal team.
- 7-week-old infant NAI – ongoing SFT rapid review – initial learning in relation to escalation and documentation.
- CQC report – safeguarding.
- Maternity SG Admin Process audit outcome.
- Maternity specific teaching on induction programme.
- Plan for cross site neonatal nursing/medic safeguarding supervision.

Planned Focus:

- CQC action plan – safeguarding actions.
- Thirlwall Report – safeguarding recommendations.
- SG admin process – action plan and risk assessment – shared at CQAL. Risk to be agreed at Nov Governance.
- Development of Safeguarding Governance Framework – SG Operational Meeting & SG Assurance Committee.

Area of concern/slippage:

- Maternity SG Admin audit
  - 58% compliance for creation of alerts
  - 33% compliance for transfer of documents
- O&G Level 3 SG Children compliance – 49%.
- Midwives Level 3 SG Children compliance – 75%
- YDH neonatal supervision compliance - 25%
- Continued RADAR reports evidencing missed opportunities – 16 in Q2.

Mitigations:

- Exception reporting through Safeguarding Assurance Committee.
- Named Midwife to work with Governance Team to ensure actions from audit/learning reviews etc are added to appropriate action plan to enable robust tracking and oversight.
- Clear pathway for Named Midwife to escalate urgent concerns to Quinumvirate.

- **Items requiring escalation:** non-compliance with Safeguarding Training
- **Items for decision:**

Neonatal Update

Atain; July - Sept
36 overall; 5.48%,

Potentially avoidable admissions – 5; so far,
- Delay in Maternal ABX,
- Delay in progressing to delivery - HX of PROM
- Delay in ABX, delay in delivery,
- Delay in escalation for bleeding/ APH, delivery.
- 1 x NICU avoidable – longer peep advisable/ beneficial.

Theme;
- 2 x Rapid Report Reviews completed,
- 1 MNSI referral,
- C-sec delivery rate 63%,
  Reduction in Elec c-sec rate.
- Reduced episodes of hypothermia,
- Reduced number of 'hypoxia after delivery'

Actions;
- Review observation frequency for babies screened soon after delivery,
- Comms to team regarding newly introduced Discharge Guideline and Resources,
- Case to be used as 'interesting case' for team learning.
- 'Safer sleeping/ co-sleeping' actions implemented,

Incident reports
41

Top safety challenge
Clinical care concern.

Theme
Reduced reporting rate; 32 fewer than previous 1/4,
0 reports categorised as staffing, capacity, workload,
Issues associated with 'building and infrastructure' and 'security',

1 'Moderate' harm,
Reduced number of reports graded as 'low' harm,

Actions
Discussion with EPMA lead regarding cancelling of administered medication,
Works completed for issue with security doors, rodent/ pest control,
New ITU/ HDU observation charts introduced – include 'probe change',
Event task sent to Lab Manager,
Investigation into 5 cases of Bacillus cereus cases on umbilicus swabs.

Excellence reports
14
Themes
- Clinical expertise,
- Leadership,
- Teamworking,

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Maternity Meetings Exception Reporting

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Working group – Translation services

Somerset NHS Foundation Trust

Items requiring escalation:

Items for decision: To confirm double appointment requirement can be included with SOP

Key achievements/overview:

- Theme noted from incidents and PMRTs that translators were not being used throughout care for women and birthing people where the primary language is not English. This raises concern about informed decision making and understanding of information provided during their care.
- MNVP Stakeholders within this meeting.
- Consent forms – Caesarean birth forms have been translated into the 5 most common languages in Somerset and will be distributed.

Planned Focus:

- Antenatal care guidance suggests double appointments should be booked for women who require a translator – Data has been sent to Director of Midwifery regarding percentage of women/birthing people in Somerset who require this to ensure establishment has allowed for this.
- Consent forms – Translating the least common languages seen in Somerset.
- Triage cards – in draft format.
- Discussions regarding 'Pocket talk' with Patient Engagement and Involvement Manager.
- Maternity specific SOP in draft with Stakeholders.
- SPOA forms being reviewed to ensure requirement for translator is clear and therefore can be raised to CMW before booking appointment.

Area of concern/slippage:

- Trust SOP not being followed – for Maternity specific SOP in line with Trust – this is a priority as it has taken time to create. Includes points where use of Translators is a requirement but also considering personalised care when women/birthing people have chosen to have a friend or relative translate. Will also include a discussion with a woman on her own at a point in pregnancy to ensure social assessments are completed.

Mitigations:

Labour Ward Forum – MPH September 2026

NHS Somerset NHS Foundation Trust

Items for escalation:

1. Telemetry CTG patient identification safety alert.
2. Implementation challenges associated with Martha's Rule.

Items for decision:

Key achievements/overview:

1. Successful launch of the first site-specific PROMPT training programme with excellent multidisciplinary feedback and positive outcomes from simulation and governance-based learning.
2. Recruitment underway for a new obstetric consultant with fetal monitoring leadership responsibilities.
3. "Mission Control" Labour Ward Room 4 is now operational.
4. Clexane prescribing and discharge improvement project showing early benefits by reducing medication waste and discharge delays.
5. Improved obstetric review performance within triage against target times.

Planned Focus:

1. Continue PROMPT programme delivery and evaluate participant feedback across both sites.
2. Establish permanent fetal monitoring leadership arrangements and maintain educational delivery.
3. Embed huddle processes and optimise room utilisation.
4. Refine six-week Clexane supply process and continue monitoring outcomes.
5. Continue work to meet NHS England Maternity Triage Specification requirements.

Areas of Concern:

1. Limited senior obstetric and anaesthetic presence throughout PROMPT training days.
2. Vacancy in substantive fetal monitoring lead role.
3. Disruption caused by staff entering and leaving during huddles.
4. Delays and inefficiencies for women requiring long-term prescriptions.
5. Triage performance has fallen below target due to increased attendances and reduced staffing.

Mitigations:

1. Request for additional consultant PA time submitted to support all-day multidisciplinary attendance.
2. Interim cover being provided by ER until recruitment is complete.
3. Signage and agreed behavioural expectations to be introduced.
4. Ongoing review and process redesign by the ward team.
5. Revised staffing model being trialled from October; review of protected staffing arrangements underway.

YDH Labour Ward Forum – August 2026

NHS Somerset NHS Foundation Trust

Items requiring escalation: No Labour Ward Forum Meetings held in June, July or September

Items for decision:

Key achievements/overview:

- Guideline compliance improved to 81%.
- Positive Care Opinion feedback across inpatient services.
- Self-medication pathway implemented on Freya Ward.
- Optimal Cord Management training undertaken; further multidisciplinary work agreed.

Planned Focus:

- Anonymous MDT survey and repeat simulation on maternity theatre layout.
- Clarify ROTEM ownership, maintenance, training and competency.
- Restart instrumental birth, perineal protection and impacted fetal head training.
- Review elective caesarean workflow and newborn risk assessment / EOS screening.

Area of concern/slippage:

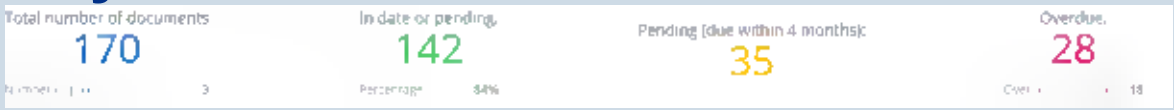
- Low junior doctor and CTG review attendance.
- Labour Ward red-flag compliance: June 82%; July 80.6%.
- Freya Ward: BR+ compliance 64% to 63%; acuity met 71% to 59%; 9 July red flags.
- Clinician capacity for guideline reviews
- Theatre layout
- ROTEM not ready for routine use.

Mitigations:

- Improve rota visibility and encourage MDT attendance.
- Additional night midwife recruited; Band 7 support and October establishment review being explored.
- Strengthen incident reporting, escalation and equipment checks.
- Clarify interventional radiology pathway and second-theatre readiness.

Guideline and Audit Group – Friday 18th September 2026

Key achievements/overview:



- 84% compliance achieved
- Caesarean section out for wider comment
- Intrapartum care draft in progress
- Significant number of guidelines assigned to reviewers following escalation at cross county meeting

Planned Focus:

- Continued focus on pending and overdue guidelines
- Outstanding NICE Self Assessments
- Ongoing review of audit programme (frequency of audits)
- Outstanding planning forms for 26/27 audit programme (6)
- Key guidelines under review: caesarean section, intrapartum care, bladder care in childbirth, maternal collapse, epidurals and spinals (incorporated in pain relief in labour)

Area of concern/slippage:

- Anti-d guideline outstanding – awaiting draft
- Intrapartum care nice self assessment overdue
- Receiving comments on guidelines within 2-week time frame
- Outstanding planning forms for 26/27 audit programme
- Large number of pending and overdue guidelines – risk of reducing compliance significantly (barriers include clinician time to allow thorough review)
- Guidelines requiring input from other services areas (i.e Anti-D Haematology)

Mitigations:

- Escalated to Perinatal Gov Lead – awaiting draft from Haematology for review – requested twice
- Escalated to Perinatal Gov Lead – guideline in progress, self assessment to follow
- Clear guidance sent to all staff regarding time frames and expectations of process
- Ongoing review at guideline and audit meeting
- Significant number allocated at CQAL to lead authors
- Escalated to management team and Governance escalation processes

Items requiring escalation: Anti-D guideline – draft still not received

Items for decision: none



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Any Other Business

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REPORT TO:	Quality & Governance Assurance Committee
REPORT TITLE:	Q2 2026–27 Perinatal Thematic Review of Safety Themes
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and Midwife
REPORT BY:	Sally Bryant, Director of Midwifery and Deputy to the Chief Nurse and Midwife
PRESENTED BY:	Sally Bryant
DATE:	October 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	To provide assurance on the safety and quality of maternity and neonatal services through a thematic review of Q2 safety events, demonstrating triangulation of recurring themes, actions and organisational learning.
Recommendation	The Quality & Governance Assurance Committee is asked to: • note the three triangulated Q2 safety priorities • support focused Q3 oversight of implementation and effectiveness
Links to Joint Strategic Aims (Please select any which are impacted on / relevant to this paper)	
☒ Aim 1: Contribute to improving the health and wellbeing of the population and reducing health inequalities ☒ Aim 2: Provide the best care and support to children and adults ☐ Aim 3: Strengthen care and support in local communities ☐ Aim 4: Respond well to complex needs ☒ Aim 5: Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture ☒ Aim 6: Live within our means and use our resources wisely ☐ Aim 7: Deliver the vision of the Trust by transforming our services through research, innovation and digital technologies	
How have you considered the needs and potential impacts on people with protected characteristics in relation to the issues covered in this report?	Yes. Q2 ethnicity and Index of Multiple Deprivation information is available for tracker cases. Findings are descriptive and should not be interpreted as evidence of disparity until appropriate denominator data are available. Interpreter access and equitable communication remain explicit within the improvement actions. All major service changes, business cases and service redesigns require a Quality and Equality Impact Assessment at each stage. A QEIA should be attached and any actions required to address negative impacts identified, where appropriate.
Public/Staff Involvement History	The Maternity and Neonatal Voices Partnership provides service-user feedback and works with Somerset NHS Foundation Trust colleagues as a quorate member of quality and safety meetings within the governance workstream. Complaints have also been used as a separate patient-voice check within this review.

Previous Consideration	The report has been reviewed and discussed at the Safety Champions Board and Perinatal Governance.
Reference to CQC domains (Please select any which are relevant to this paper)	☒ Safe ☒ Effective ☒ Caring ☒ Responsive ☐ Well-led
Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes ☐ No

SOMERSET NHS FOUNDATION TRUST
Q2 2026–27 PERINATAL THEMATIC REVIEW OF SAFETY THEMES

1. Background and purpose

1.1 Board-level summary

This report provides an integrated view of the principal perinatal safety themes identified in Q2 2026–27. It triangulates findings across independent sources including safety events, MNSI, PMRT, complaints, audits and ATAIN cases and sets out the actions required to translate learning into sustained improvement. National reports and recommendations have been considered throughout and actions aligned to existing actions and QI programmes to avoid duplication.

The review considered 307 coded quality and safety events from the Safety action log, Safety Event Tracker, complaint responses and meeting outcome letters and national projects including the Maternal Care Bundle and MIS year 8 programme. Three recurring priorities were identified, recognition of deterioration, escalation of clinical concerns and clinical decision-making; neonatal and newborn safety; and family-centred, compassionate care. These themes recur across multiple sources and are reinforced by the experiences described by women and families. The principal cross-cutting issue is not an absence of learning activity, but inconsistent evidence that actions have been implemented, understood, tested and formally assured.

1.2 Triangulated findings in Q2 2026-27

Recognition, escalation and clinical decision-making is supported by 58 formal safety events and formal complaint actions, including CTG interpretation, delays, triage, MEWS, abnormal results and access to senior review. Neonatal and newborn safety is supported by 49 formal safety events and three complaint actions, including ATAIN learning, resuscitation, transition after birth, low Apgar scores, newborn monitoring and feeding escalation. Family-centred and compassionate care is supported by 20 formal safety events and seven complaint actions, with recurring concerns relating to bereavement care, informed choice, communication, handover, follow-up and trauma-sensitive care.

There were no eligible cases for a MOSS review. NHSR claims scorecards are published annually, for the purposes of this report any themes, learning and recommendations from the most recent publication (October 2025) have been included for triangulation.

Priorities and areas of focus in Q2 26-27 were:

- Use of translators when English is not the primary language
- Use of antenatal steroids outside guidance
- Test results not followed up, mainly in the community
- Delay in antibiotics following temperature in labour
- Use of terbutaline outside guidance
- Instrumental deliveries including communication cross-teams and documentation

Action and learning

There is evidence of active review and improvement through investigations, After Action Reviews, SWARM huddles, MDT's and thematic review learning responses, audits, pathway and guidance changes, teaching, learning and review forums and debriefs. Actions include development of the bereavement pathway, improved interpreter access, strengthened safe-sleep documentation, provision of emergency phones and bleeps, closed-loop communication of results, haemorrhage uterotonics, and work relating to MEWS, acute referral routes, epilepsy and mental-health screening.

Assurance and residual risk

Assurance is currently partial. The safety events and associated learning responses do not consistently demonstrate that learning has changed practice or that improvement has been sustained.

Recurring themes indicate system issues rather than isolated events. Most events are identified as low or no harm incidents, however a smaller proportion do include moderate, severe and fatal outcomes. Timely closure of safety actions and testing and review of controls therefore remain important.

1.3 Q3 priorities

The immediate priorities are to complete and evidence the highest-risk outstanding actions and review completed actions through audit and testing including through Safety Walkabouts. Project work is underway to measure each actions validity; strengthen controls for recognition and escalation, neonatal transition and communication with families; linking recommendations to supporting evidence. Progress will be reported by theme and source, with overdue actions and barriers escalated through established governance routes. Broader actions including those from national programmes will be reported and managed through a dedicated project management resources and tracker to establish a robust assurance and oversight programme.

Equality considerations

Q2 ethnicity and Index of Multiple Deprivation information is available for all cases. Findings remain descriptive and should not be interpreted as evidence of disparity until appropriate denominator data are available. Interpreter access and equitable communication should remain explicit within improvement actions.

1.4 Thematic Review Methodology

This Q2 thematic review used reflexive, ground-up coding rather than applying predetermined categories. Relevant text was reviewed line by line, assigned descriptive codes and grouped into broader safety themes. Themes were then triangulated across 307 safety events from the identified quality and safety resources including safety investigations, After Action Reviews, SWARM huddles, MDT's and thematic review learning responses, audit actions, pathway and guidance changes, teaching and knowledge nuggets, learning and review forums, debriefs and complaints.

The analysis considered frequency, recurrence across data sources, patient impact, action status and evidence that learning had been implemented.

Three priorities were identified during the review:

- recognition and escalation
- neonatal and newborn safety
- family-centred, compassionate care.

Closing the learning loop is the main supporting priority because many actions remain open due to competing clinical priorities and lack of a dedicated project plan to review and action appropriately.

Some cases may appear in more than one source, so the figures describe coded evidence rather than unique incidents. Ethnicity and IMD findings are descriptive only as no agreed denominator data is currently available.

1.5 Summary of Findings:

307 safety events were reviewed. The clearest issues relate to how learning is followed through, how concerns are recognised and escalated, and the safety of care for mothers and babies. The Safety Event Tracker shows recurring issues relating to ATAIN, PPH, delays in reviewing, perineal trauma and low Apgar scores. The Maternal Care Bundle programme is supporting dedicated project work to implement MEWS, review acute referral routes, epilepsy pathway, improve mental-health screening and improve obstetric haemorrhage measures. Review of all closed complaints demonstrated the impact on families when communication, handover and follow-up are unclear. Q2 ethnicity and IMD information was available; however, disparities cannot be assessed reliably until denominator data are available.

Figure 1.0: Safety themes identified

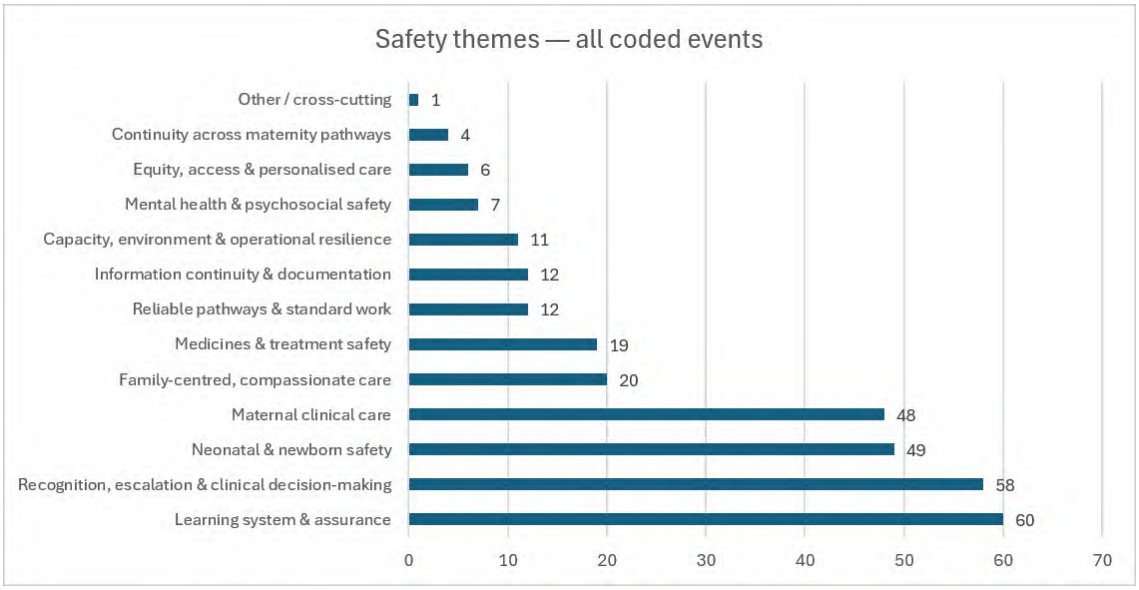


Table 1.0: Safety themes identified across all reported safety events in Q2 2026–27

Safety themes	Coded events	Active
Learning system & assurance	60	39
Recognition, escalation & clinical decision-making	58	36
Neonatal & newborn safety	49	10
Maternal clinical care	48	8
Family-centred, compassionate care	20	11
Medicines & treatment safety	19	12
Reliable pathways & standard work	12	9
Information continuity & documentation	12	11
Capacity, environment & operational resilience	11	9
Mental health & psychosocial safety	7	7
Equity, access & personalised care	6	3
Continuity across maternity pathways	4	3
Other / cross-cutting	1	1

Figure 2.0: Summary of actions arising from safety events

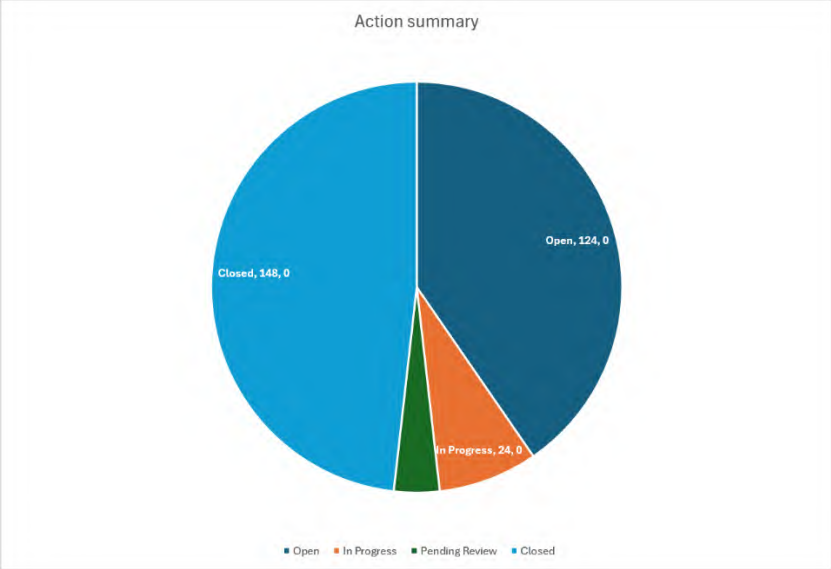


Table 2.0: Location of triangulated evidence for actions and learning themes

Evidence location	Link
Safety Action log	Actions coded where Event Date or Date Raised falls in Q2
Safety Event Tracker	Incident or review date falls in Q2; event, harm, PSIRF, ethnicity and IMD fields included
Maternal Care Bundle	All populated intervention/action lines coded across five elements
MNSI	Actions and combined-review evidence included
Local PMRT	Bereavement, access, escalation and pathway learning included
PSIRF	AAR, MDT, thematic, rapid and SWARM responses visible
ATAIN	Neonatal admission learning triangulated across both sources
Complaints	Patient voice triangulated with formal safety themes
Ethnicity / IMD	Descriptive Q2 case mix is available
MOSS critical safety checks	No alerts received

Creating a Learning system and assurance process theme describes the learning loop and how any findings from incidents, reviews and complaints result in sustained improvements in care. This theme is fundamentally about whether the learning loop is closed. Identifying learning or communicating an action is not sufficient assurance in itself and further work is underway to demonstrate that the action was implemented, staff understood what was required, practice has changed, and the impact of that change was tested and confirmed through reviews and auditing. This review found a high volume of learning activity, but evidence of consistent sharing, effectiveness and final assurance was often incomplete. The priority is therefore to move beyond recording actions as complete and towards demonstrating that changes are embedded, effective and sustained.

In this review, the governance themes identified which impact on successful change include:

- leading and supporting with timely learning responses
- audits and monitoring
- updating guidance or pathways
- sharing learning through teaching, forums and debriefs
- confirming that the action has had a measurable impact through assurance sign-off and programme board oversight.

Table 3.0: Priorities and next steps

Priorities and what we do next			
1	Make sure actions lead to change	Every active action and PSIRF response should have evidence, a clear route for sharing learning, a review date and final sign-off.	At least 90% of active actions have dated evidence and a named reviewer
2	Improve recognition and escalation	Bring CTG, delays, triage, MEWS, abnormal results and urgent referrals into one cross-site improvement plan.	Report compliance and time to escalation each month
3	Use one approach for key maternal and neonatal risks	Track haemorrhage, perineal trauma, ATAIN, resuscitation and newborn actions using the same core measures.	Show outcome and process trends by site
4	Improve handover and communication with families	plans, discharge information and updates when care is delayed. Check that families have understood.	Audit handovers and review complaint feedback
5	Complete the Maternal Care Bundle work	Fix broken links, add missing SMART actions and progress every intervention that is not or only partly implemented.	Board-confirmed status and clear progress for every intervention
6	Understand inequalities properly	Use ethnicity and IMD alongside maternity population data. Continue to monitor interpreter access and late booking.	Quarterly rates by site, with small numbers handled safely

Figure 3.0: Source-specific summary of learning and actions

Source-specific summary of learning and actions

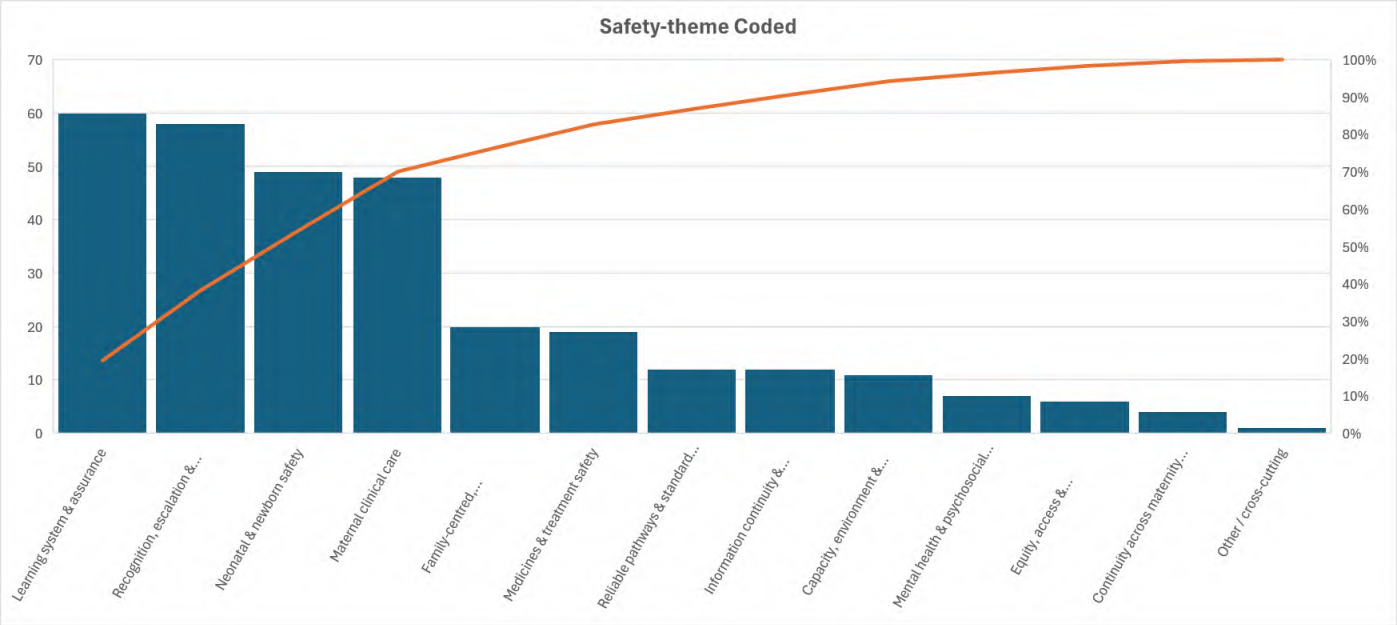
PMRT — 17 actions + 1 tracker case	MNSI — 4 actions + 1 tracker case
WHAT WE LEARNT Most PMRT actions relate to bereavement and compassionate care. Other issues include interpreter access, late booking, missed checks, escalation of urine results, medicines and guidance that is not aligned. WHAT WE NEED TO DO Complete the bereavement pathway work; improve access to interpreters; close the gaps in urine-result and diabetes referrals; confirm medicines controls; and record how learning and family feedback have been used.	WHAT WE LEARNT The MNSI case shows gaps in safe-sleep information, antenatal safeguarding checks, digital prompts and access to emergency phones on antenatal and postnatal wards. WHAT WE NEED TO DO Make the safe-sleep field mandatory on BadgerNet and audit it; review missed antenatal opportunities; provide and test emergency phones.

Complaints — 9 narratives | 26 actions	PSIRF — 18 tracker learning responses + 2 explicit actions
WHAT WE LEARNT Families repeatedly describe poor or delayed communication, weak handovers, missed escalation of results, unclear follow-up, gaps in informed choice and the emotional impact of care. WHAT WE NEED TO DO Use closed-loop checks for important results;	WHAT WE LEARNT Multiple learning responses underway including AAR, MDT, thematic, rapid and SWARM reviews. Current review does not provide robust evidence of whether the learning has led to lasting change. WHAT WE NEED TO DO Complete the reviews; record the system factors and

hand over outstanding promises and personal plans; give regular updates during delays; provide clear discharge and follow-up plans; and check that families understand.	agreed controls; include family feedback; link the evidence; and confirm that changes have been checked and signed off.

Safety Event Tracker — 115 Q2 safety events	Maternal Care Bundle — 27 coded safety events
WHAT WE LEARNT The most common event groups are ATAIN, PPH, delays in care, perineal trauma and low Apgar scores. Most safety events show low or no harm, but there are also cases involving moderate harm, severe harm and death. WHAT WE NEED TO DO Check for duplicate cases; monitor repeated events by site; link recommendations to named owners and measures; and use ethnicity and IMD data carefully until denominator data are available.	WHAT WE LEARNT There are gaps across VTE, MEWS and acute pathways, epilepsy, mental-health screening and haemorrhage. Several interventions are not implemented or are only partly implemented, and some linked cells are broken. WHAT WE NEED TO DO Fix the links; add missing SMART actions; name the lead and deadline for each action; and report clear progress and committee-confirmed status for every intervention.

Figure 4.0: Distribution of safety themes



Three key areas of focus to inform safety priorities Q3 26-27

1. Recognition, escalation and clinical decision-making — 58 safety events and three complaint actions. This theme appears in the action log, Safety Event Tracker and Maternal Care Bundle. The focus is on CTG interpretation, delays, triage, MEWS, abnormal results and access to senior review.

2. Neonatal and newborn safety — 49 formal safety events and three complaint actions. This theme appears in the action log, Safety Event Tracker and complaints. The focus is on ATAIN learning, resuscitation, transition after birth, low Apgar scores, newborn monitoring and feeding escalation.

3. Family-centred and compassionate care — 20 formal safety events and seven complaint actions. This theme appears in PMRT, the Safety Event Tracker and complaints. The focus is on bereavement care, informed choice, duty of candour, honest updates, plain language and trauma-sensitive care.

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REPORT TO:	Board of Directors
REPORT TITLE:	Thirlwall Inquiry Report Findings and Recommendations
SPONSORING EXEC:	Dr Melanie Iles, Chief Medical Officer
REPORT BY:	Robyn Smart, Associate Director for Maternity and Neonatal Services, and Jade Renville, Chief of Staff
PRESENTED BY:	Dr Mel Illes, Chief Medical Officer, and Professor Deirdre Fowler, Chief Nurse and Midwife
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 publication of Lady Justice Thirlwall's Inquiry report examining the events at the Countess of Chester Hospital and their implications following the trial, and convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies, is a sobering moment for all of us working in the NHS. In September 2026 NHS England wrote to Trusts with a range of immediate actions and expectations arising from the findings. In particular: *Every Trust Board to review the Thirlwall report and to consider its findings at the next available public Board meeting. [In doing so] Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.* The care, safety, and safeguarding of all patients is the principal duty of all of us. While many of the Inquiry recommendations relate directly to maternity and neonatal services, the learning extends beyond those services. The findings raise broader questions about how organisations identify and respond to concerns, how organisations seek assurance, how safeguarding responsibilities are

	discharged, and whether organisational cultures promote professional curiosity, challenge and learning.

Recommendation	This report provides the Board with an overview of the Inquiry findings, outlines actions already undertaken in response to the immediate findings and requirements, the measures we have currently in place, next steps and the areas for ongoing review, as well as providing an opportunity for reflection and discussion of risks and learning.

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: Although an EQIA is not required for the purposes of this briefing paper, the implementation of individual findings and recommendations may require an EQIA.

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)
N/A

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)
N/A

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

THIRLWALL INQUIRY REPORT FINDINGS AND RECOMMENDATIONS

1. BACKGROUND AND PURPOSE

1.1 The publication of Lady Justice Thirlwall's Inquiry report into the events at the Countess of Chester Hospital and their implications following the trial, and convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies, is a sobering moment for all of us working in the NHS.

1.2 In September 2026 NHS England wrote to Trusts with a range of immediate actions and expectations arising from the Inquiry's findings, including:

Every Trust Board to review the Thirlwall report and to consider its findings at the next available public Board meeting: Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.

Sudden and Unexpected Death in Children (SUDIC): The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within neonatal units. All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026. It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

National Bereavement Care Pathway for Stillbirth and Neonatal Death: Providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

Insulin: By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to Safe Insulin Use. Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.

Safeguarding: Trusts should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the **Insightful Provider Board Guide** is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

1.3 This report provides the Board with an overview of the Inquiry findings, outlines actions already undertaken in response to the immediate findings and requirements, the measures we have currently in place, next steps and the areas for ongoing review, as well as providing an opportunity for reflection and discussion of risks and learning

2. KEY FINDINGS AND RECOMMENDATIONS FROM THE INQUIRY

2.1 The Thirlwall Inquiry report has identified 17 key recommendations, summarised as follows. The report provides further detail.

Recommendation 1. CCTV and Monitoring: All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video).

Recommendation 2. Insulin: By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in NHS England's Getting It Right First Time (GIRFT) Neonatology: Guide to Safe Insulin Use.

Recommendation 3. Bereavement Care: The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.

Recommendation 4. Safeguarding and Contracts of Employment: All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members. This should include how to deal with concerns and suspicions about deliberate harm caused by staff. By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (Recommendation 9), for dealing with concerns and suspicions about deliberate harm.

Recommendation 5. Operating Systems (Interoperability): NHS England must provide, by 31 March 2027, a clear route to ensuring that computer systems are harmonised across the NHS by December 2028. Development of a mandatory information standard with requirements for interoperability between systems should be implemented. This should mean that data relating to babies and neonates in hospital may be

entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.

Recommendation 6. Monitoring Deaths in Hospitals: By 31 March 2027, hospital Trusts must have effective mechanisms for Board-level monitoring of all deaths of children and babies and a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.

Recommendation 7. Data Reporting: All hospitals with a neonatal unit should name a trained 'lead reporter' with responsibility for inputting data regularly and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise whether any alerts or a need for investigation have arisen and the investigation or action plan in place.

Recommendation 8. Sudden Unexpected Death in Infancy and Childhood (SUDIC): NHS England must immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital and direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board. The Department of Health and Social Care must complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027. SUDIC forms must be redesigned and shortened to keep bureaucracy to a minimum.

Recommendation 9. Suspicion of Deliberate Harm Protocol and Guidance: By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient. Guidance of no more than two pages should accompany the protocol. It must set out the factors to be considered when assessing the nature of the concerns and suspicions.

Recommendation 10. Panel of Experts: The Department of Health and Social Care to consider setting up a panel of independent experts to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients. Where necessary, a small team (always including clinicians from the relevant specialty/specialties) would be drawn from the panel to conduct a swift, technical investigation into the concerns.

Recommendation 11. Medical Examiners: The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out the steps to be taken by a medical examiner when dealing with the death of a neonate. The revised SUDIC guidelines (Recommendation 8) should be set out within the good practice guidelines for medical examiners. Medical examiners should ask direct questions of the attending practitioner as to whether there is a concern that a child has

been harmed or some other safeguarding concern. Where there may be a concern, the medical examiner should ensure there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life. There should be a pool of neonatologists who can assist medical examiners with their work until such time as it is possible to appoint the appropriate number of regional neonatologist medical examiners. Ring-fenced funding should be provided for this purpose. The medical examiner system should be reviewed again in 2027 by the Department of Health and Social Care. The review should include the adequacy of funding for medical examiners and their and offices.

Recommendation 12. Paediatric and Perinatal Pathologists: The Department of Health and Social Care and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 Paediatric and Perinatal Pathology Workforce Report.

Recommendation 13. Accountability and Regulation of Managers: The Department of Health and Social Care and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032. NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that the move is not proposed because of the manager's lack of capability or misconduct and that the manager meets the fit and proper person test. In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers. The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first.

Recommendation 14. Care Quality Commission (CQC): The CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field (in this case paediatrics/neonatology). Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patient safety. Inspectors and team leaders must always approach an inspection of neonatal services not as a box-ticking exercise but as a way to determine that babies in hospital are safe.

Recommendation 15. Assessment of the performance of CQC: There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year and, once the committee is satisfied, once every three years, or such other frequency to be determined by the select committee.

Recommendation 16. Parliamentary and Health Service Ombudsman: The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include investigating complaints that whistleblowing in the NHS has not been dealt with adequately and assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.

Recommendation 17. Implementation of Recommendations: A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.

3. CURRENT POSITION

3.1 There are established safeguards, processes and governance arrangements across the Trust, but these need to be reviewed fully against the findings and recommendations of the Inquiry so that learning can be implemented and embedded. In terms of progress to dates against each of the immediate actions identified by NHS England:

Sudden and Unexpected Death in Children (SUDIC): The Trust communicated to all relevant colleagues regarding the application of SUDIC processes, and this was shared with the Board by email on 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.

By 31st March 2027, all neonatal units must meet requirements for access control and storage of **insulin** as set out in GIRFT guidance: Local work has progressed, including a review of CCTV and insulin storage arrangements. Further work is progressing against the wider national requirements and assessment against getting it right first time (GIRFT) recommendations.

Safeguarding: We have a statutory duty to safeguard the welfare of all children and adults. Established safeguarding arrangements are in place across the organisation, supported by mandatory safeguarding training, named safeguarding professionals, clear escalation routes and established governance processes. Staff are expected to identify, escalate and act upon safeguarding concerns promptly, with access to specialist safeguarding advice and support where required. Training compliance is monitored through the Trust's performance management processes. Existing safeguarding arrangements are being considered through the Thirlwall Inquiry Stakeholder Group against the specific findings and recommendations of the Thirlwall Inquiry report.

National Bereavement Care Pathway for Stillbirth and Neonatal Death: Existing arrangements will be reviewed against the National Bereavement Care Pathway for Neonatal Death to ensure it is implemented by 31 August 2027. Progress is underway across maternity and neonatal services in line with the National Bereavement Care Pathway and other related documents.

4. NEXT STEPS

4.1 Internally, the Trust has convened an Thirlwall Inquiry Stakeholder Group to review and consider the actions required from the findings and recommendations of the Inquiry.

4.2 This multi-disciplinary group initially met on 15 October 2026, with perspectives from colleagues brought together from:

- Paediatrics
- Neonatal Services
- Maternity
- Obstetrics
- Safeguarding
- Governance

4.3 A Trust self-assessment tool to record progress against the immediate actions has been received from the South West Neonatal Network and Trusts are expected to complete and submit the Compliance Assessment tab for each neonatal site (due to the estate requirements) by 1 December 2026.

5. REFLECTIONS AND RECOMMENDATIONS

5.1 The Board recognises the profound impact of the events examined by the Thirlwall Inquiry and the importance of learning from its findings. The care, safety, and safeguarding of all patients is the principal duty of all of us. While many of the Inquiry recommendations relate directly to maternity and neonatal services (and ensuring that sufficient measures are in place to keep the babies and children in our care are safe, no matter what setting) the learning extends beyond these services.

5.2 The findings raise broader questions about how organisations identify and respond to concerns, how we seek assurance, how safeguarding responsibilities are discharged, and whether organisational cultures promote professional curiosity, challenge and learning, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. NHS England's Insightful Provider Board Guide provides a framework for Boards to consider these wider questions, the way in which we make decisions and receive and use information and data, ensuring it is clear, connected and triangulated sufficiently across services and would enable the identification of any emerging patterns.

5.3 The Board is asked to:

- Consider the findings and recommendations arising from the Thirlwall Inquiry report.

- Aligned to the principles described within NHS England's Insightful Provider Board Guide (particularly the Board's role in shaping culture[1]), reflect on whether it would have been possible for similar events to occur within our organisation and the assurances available regarding the safety of babies and children in our care.

- Consider whether the Trust's culture supports professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the NHS England regional team.

- Endorse the completion of a Trust-wide self-assessment and review of Trust arrangements against each of the 17 key recommendations.

- Note that immediate actions identified by NHS England have either been completed or are being progressed.

[1] Investigations into care failings continue to highlight the importance of an open culture. Staff, patients and service users should feel able to speak up and share concerns and see them escalated and acted on. Boards need to receive the right information about these to make decisions based on accurate and timely data and intelligence. NHS Insightful Provider Board Guide.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Trust Strategy, Objectives and Engagement
SPONSORING EXEC:	David Shannon, Director of Strategy & Digital Development
REPORT BY:	Richard Baum, Head of Strategic Planning
PRESENTED BY:	Richard Baum, Head of Strategic Planning
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	We brought the text of the Trust's new Strategy narrative to Trust Board for ratification in September. It described our high level strategy and how our seven strategic aims will help to improve the health of the population of Somerset, and how we will help to deliver the NHS 10 year health plan and the three key shifts (Treatment to Prevention, Hospital to Community, Analogue to Digital) Since September, three things have happened: 1) The Strategy narrative has been proofed and designed ahead of formal launch. 2) The Objectives and KPIs to deliver the Strategy have been developed further. 3) We have undertaken an extensive engagement process on the Strategy. The designed narrative has been created by the Trust's Communications Team, according to the house style, and will be part of a suite of related documents including a "Strategy on a page" for public display, and a version of the objectives and KPIs with the same design elements. We do not plan to distribute the narrative widely, but it will be made available online, with physical access available on request. The Objectives and KPIs have been developed after extensive discussion with senior medical, nursing and management colleagues within the Service Groups. Each of our seven Trust Aims has a series of Objectives, with each Objective having Key Performance Indicators for measurement over one, three and five years. We propose

	updating the Board on progress twice-yearly, as previously agreed. We have undertaken a series of engagement activities, giving us the opportunity to hear the views of internal and external stakeholders on the principles within the Strategy. Engagement began in June at the Council of Governors, and has also taken in the Trust AGM where we arranged a marketplace stall and talked to a range of visitors. The internal engagement since then has included presentations to the Service Group leadership teams, nursing and AHP roundtable, and team away days, as well as Team Brief coverage and a survey which has received over 50 responses. Externally, we have contacted over 50 partner organisations, and have attended engagement events of various sizes with many community partners, including Somerset Activity and Sports Partnership (SASP), Somerset Sight, Somerset Equalities Partnership, Fuel Poverty Forum, and the Somerset Community Foundation. Overall, respondents have been supportive of the strategic direction, particularly the focus on prevention, community-based care, partnership working and digital innovation. However, there was a strong message that success will depend on investing in colleagues, reducing inequalities, strengthening integration across services and providing clear evidence that the strategy is delivering meaningful improvements for patients, communities and staff. Engagement is continuing into November, including further community events, ahead of the formal launch of the Strategy to colleagues at Team Brief on November 18th.

Recommendation	Board is asked to note the designed Strategy narrative, and the engagement update. Board is asked for comments on the Objectives and KPIs.

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
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☒ **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)

The Strategy has been developed in consultation with colleagues from across Service Groups and corporate services. We have engaged with this range of colleagues to agree the Objectives, including at Senior Leadership Forum and Service Group triumvirate leadership teams.

Information on the engagement with colleagues and the public is included below.

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 has discussed the Strategy at its meetings in November 2025, January 2026, April 2026, May 2026, June 2026 and September 2026. A sub-group of the Board has

also met (including the Chair, Chief Executive, one further NED and two further Executive Directors) to provide further input and guidance. This has met on four occasions, most recently to approve the final version of the text which took on Board previous Board comments.

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

TRUST STRATEGY, OBJECTIVES AND ENGAGEMENT



NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust

Strategy

2027-32

Kindness, Respect, Teamwork
Everyone, Every day





Dr Rima Makarem (Chair)



Peter Lewis (CEO)

Welcome

Most of us do not think about healthcare until we need it.

We get on with our lives. We work, raise families, worry about different things entirely. And somewhere in the background, we assume that if something goes wrong the NHS will be there.

Often, that assumption is right. The NHS will be there, and is particularly good at responding when you have a crisis. But for too long it has been organised around the moment of illness rather than the years before it. Built to treat, not to keep well. Both are important. And for too long now, people have become ill when they shouldn't, have waited too long for treatment when they've needed it, and haven't always received the best possible care.

Somerset has chosen a different path.

We have chosen differently because the evidence is unambiguous. The best way to keep people healthy and to make them better when they are ill is not just making hospitals better, but keeping people out of them. It is preventing illness or catching it earlier. It is addressing the things like loneliness, poverty, and unmanaged long-term conditions, that make people sick in the first place.

This is not a new idea. It is, in fact, the oldest idea in medicine. What is new is having the structure to actually do it. Somerset, uniquely, has that structure.

Over the last six years, through a series of deliberate mergers, we have built something that exists nowhere else in the English NHS. One organisation, acute hospitals, community services, mental health and learning disability services and a quarter of the county's GP practices, directly operated, integrated in partnership with others. One system, one population of 600,000 people, focused on keeping people well, and delivering the best care in all our neighbourhoods, using cutting edge technology to do so.

Our aim is not complex. We want the people of Somerset to live more years in good health. We want those years to be shared more equally, because right now they are not. For example, a woman living with severe mental illness in Somerset dies, on average, 17.5 years earlier than her neighbour without it. That gap is not inevitable. It is a failure of system design, and it is one of the things this strategy exists to change.

The people of Somerset should experience care that sees them as a whole person, that reaches them before the crisis, that treats their mind and body as connected, that remembers who they are.

That is what we are building. That is what this strategy is for. For the people of Somerset, and those who care for them.

Dr Rima Makarem (Chair) and Peter Lewis (CEO)

Our local context in Somerset

The profile of our population, and the geography of Somerset, create unique challenges for health services, but we want to meet the specific needs of our population.

Locally, some of our health challenges include:

An ageing population

- Over 65s account for around a quarter of the population.
- Residents aged over 75 set to double.
- Increased demand on healthcare services, for age-related conditions and long-term care.

A changing population

- New economic developments bring highly-paid jobs.
- Potential to bring thousands of younger people and families into our area.

Rurality

- Approximately half of Somerset's population lives in rural areas.

Social mobility and young people

- Highest rates of school absence with 29% of children in secondary school and 15% in primary school.

Long-term health conditions

- 1 in 5 people in Somerset have a musculoskeletal long-term condition.
- 67.4% of adults are classified as overweight.
- approximately 80,000 are smokers.
- Around 15,000 obese children and 4,500 severely.

Health inequalities

- Harder to access health services due to factors such as economic or social conditions.

Our trust

Community services

We are across 13 community hospitals. We undertake over 600,000 clinic attendances in community settings in 2024/25.

Mental Health and Learning Disability services

We undertook over 35,000 outpatient appointments in Mental Health in 2024/25. We also have 10 mental health wards.

Urgent, Emergency and elective care

During 2024/25 we cared for over 120,000 patients who came to one of our urgent treatment centres.

Dental services for people with additional needs

We have 7 dental practices in Somerset and Dorset for people with additional needs. We had over 20,000 appointments in 2024/23.

Acute hospitals

We run Musgrove Park Hospital in Taunton and Yeovil District Hospital. Together these hospitals have 1,100 beds and 26 theatres, with 150,000 emergency attendances.

GP services

We operate a quarter of all GP services in Somerset via Symphony Healthcare Services.

The framework for our strategy

Our trust vision is

“Thriving colleagues, integrated care, healthier people.”

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

Creating and nurturing a positive culture for our colleagues will enable them to deliver improved, safer services to those who use them. We will develop a compassionate, inclusive and learning environment for colleagues built on our values of kindness, respect and teamwork, so that our colleagues can deliver better care and that we can work smarter to keep people healthier for longer. We know that every patient interaction provides an opportunity to identify risk, respond to concerns, and promote the safety and wellbeing of individuals. So we will continue to prioritise safeguarding as a core element of effective, safe and person-centred clinical care.

At Somerset NHS Foundation Trust (Somerset FT) , we believe inclusion is essential for our patients and service users, for our colleagues, and for better care. We listen to every voice and we work to remove every barrier. Successful implementation of our strategy will help us to deliver our vision and mission.

We have identified seven key objectives: four of these improve clinical services directly, and the other three build a stronger organisation by developing our workforce, optimising our resources, and harnessing technology. Every colleague contributes to delivering these aims every day.

We have established priority objectives and corresponding measures under each aim to support the delivery of this strategy, ensuring we can track our progress effectively over the next five years.

We will work with service users and partners to design and deliver better services. This will include:

- continuing to engage with service users, carers and the Somerset population to fully understand and meet their needs; and
- working in partnership with the Integrated Care Board, Somerset Council and Voluntary, Community, Faith and Social Enterprises (VCFSE), and with primary care to improve the health and wellbeing of everyone in Somerset.

Our aims



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 through a compassionate, inclusive and learning culture.



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



Aim 7:
Transforming our services through innovation, research and digital transformation.



> **We will provide assessment, treatment and follow-up care at home or in community settings as the default for many conditions.**

What will Somerset FT look like in five years' time?

In five years, Somerset FT will:

- **Contribute to improved population health and reduced health inequalities by providing inclusive and preventative services, focused on those who experience the greatest barriers to good health.**
- **Provide more integrated physical and mental health care and support for people, with seamless pathways across primary care, community services and acute care.**
- **Provide enhanced care and support in people's homes and in local communities. Neighbourhood health centres will be in every neighbourhood within Somerset, providing care, advice and wellbeing support.**
- **Deliver services transformed by digital technology to prevent illness and promote ongoing health and wellbeing.**

Holistic care at home and in neighbourhoods

We will provide assessment, treatment and follow-up care at home or in community settings as the default for many conditions. Acute hospitals will provide specialist care. There will be neighbourhood health centres in every neighbourhood, where people can access integrated support such as clinical advice, diagnostics and specialist input, alongside other services in a community hub, such as Council services and VCFSE support for day-to-day wellbeing.

Our network of community hospitals will offer an expanded range of services, including clinics, rapid advice and rehabilitation, and spaces that support people to proactively manage their health and recovery.

More joined-up, personalised care

We will use our unique range of primary care, community, acute, mental health, and learning disability services to create seamless pathways. People won't need to retell their story as they move between services and co-ordinated care plans will follow individuals as they move between services and as their needs change.

We will develop more personalised support for those who need us most. Services will be shaped around groups with the highest need - children and families, people living with frailty, and people with serious mental illness - so support is timely, consistent and tailored.



> **We will make big improvements to our mental health and learning disability services.**

Improved care for children and families

We will develop family hubs within our neighbourhood health centress, bringing together health services, council services and educational provision in a single location. Offering this collaborative family support can make a real difference to the lives of young people and parents, prevent problems from escalating, and help us to achieve our aim of providing the best care and support to people.

We will make improvements to our maternity services and facilities. In the long term, this will include a new maternity unit including maternity theatres at Musgrove Park Hospital. In the short term, we will make maternity services safer and provide a better experience of care for service users and families by implementing the recommendations of recent national reviews of maternity services. We will increase opportunities to access maternity services in local communities.

We will also make sure that there are smooth pathways for when children grow up and transition to adult services, to develop new ways to support our young people as they become adults and make sure nobody “falls through the gaps” of care.

Improvements for people with mental illness, autism, ADHD and learning disabilities

Mental health services have not developed as quickly as needed to meet increasing demand, nor have they improved at the same rate as physical health services.

As the only integrated provider of mental health, acute and community-based physical health services in England, we have a unique opportunity to put this right.

We will make big improvements to our mental health and learning disability services. We will treat more service users who need inpatient care in Somerset, reducing the harm and cost of caring for them outside Somerset.

We will also respond to the growing need for autism and ADHD care, developing services in partnership, and changing some of our pathways, to redirect resources where they are needed.

Our inpatient services will become safer in response to new national directives and we will do more for those in our population with serious mental illness, who we know suffer more physical illness, and die younger, than others. We will strengthen care for those with serious mental illness by implementng new pathways, interventions and risk protocols, and by improving the way we work with primary care and VCFSE partners.



> **We are committed to being an organisation that prevents ill health and helps people to stay well.**

Better outcomes and fairer access

We are committed to being an organisation that prevents ill health and helps people to stay well. We will deliver care that recognises the unique needs of the Somerset population, and those who experience the greatest barriers to good health. There are parts of Somerset where people live shorter, less healthy lives than other areas. People in underserved communities will see more targeted services, more flexible access and fewer barriers - leading to measurable reductions in inequalities, and improvements to experience of care and health outcomes.

Using technology to deliver better care

People will have simple options to manage appointments, get advice and access parts of their record, with non-digital routes always available – technology will support choice, not create exclusion.

We will use AI and technology to detect illnesses quicker, provide clinicians and service users with more information, and advise on recovery and prevention. Digital technology will be designed to enhance inclusion and to reduce health inequalities.



> **Teams will work closer together across Somerset, with shared goals and fewer organisational boundaries between primary, community, acute, mental health and social care partners.**

Caring for our colleagues

Teams will work closer together across Somerset, with shared goals and fewer organisational boundaries between primary, community, acute, mental health and social care partners.

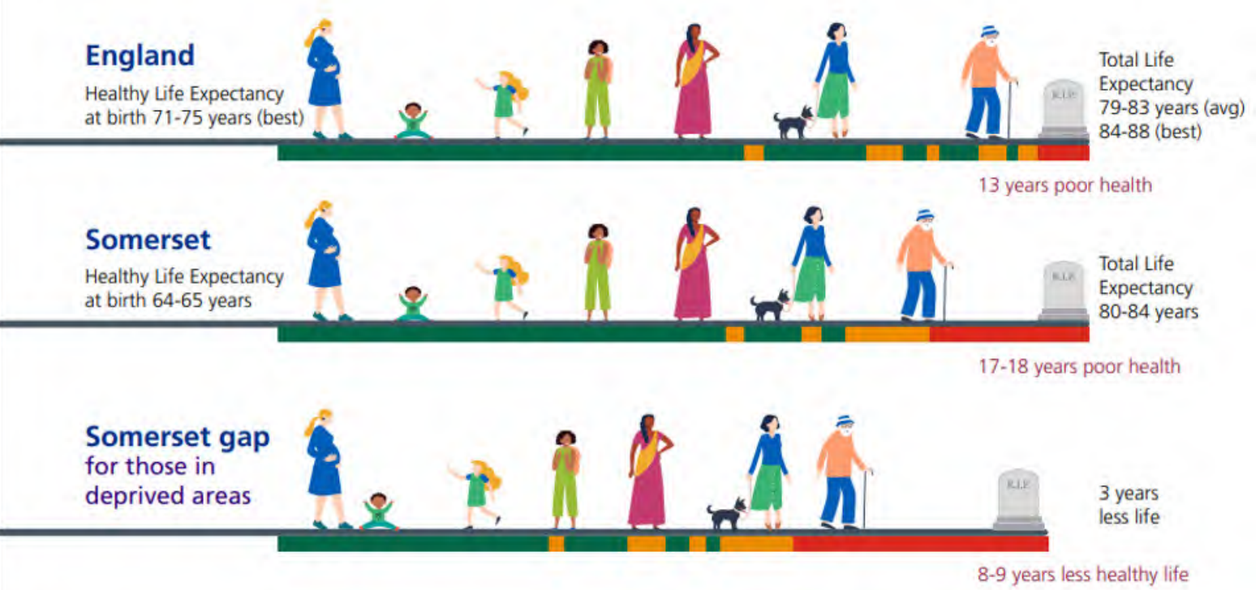
There will be more time for care, streamlined pathways, clearer roles and better use of technology. Automation will reduce duplication and administration, releasing time for direct patient care and proactive support.

We will create new roles for our colleagues that better focus on service users and pathways rather than episodes of care, and enable neighbourhood-based teams to offer true continuity of care for local people.

Our locations



AIM 1



> **“... healthy life expectancy in Somerset is 18.8 years lower than total life expectancy for females, and 14.8 years lower for males .”**

Our aims

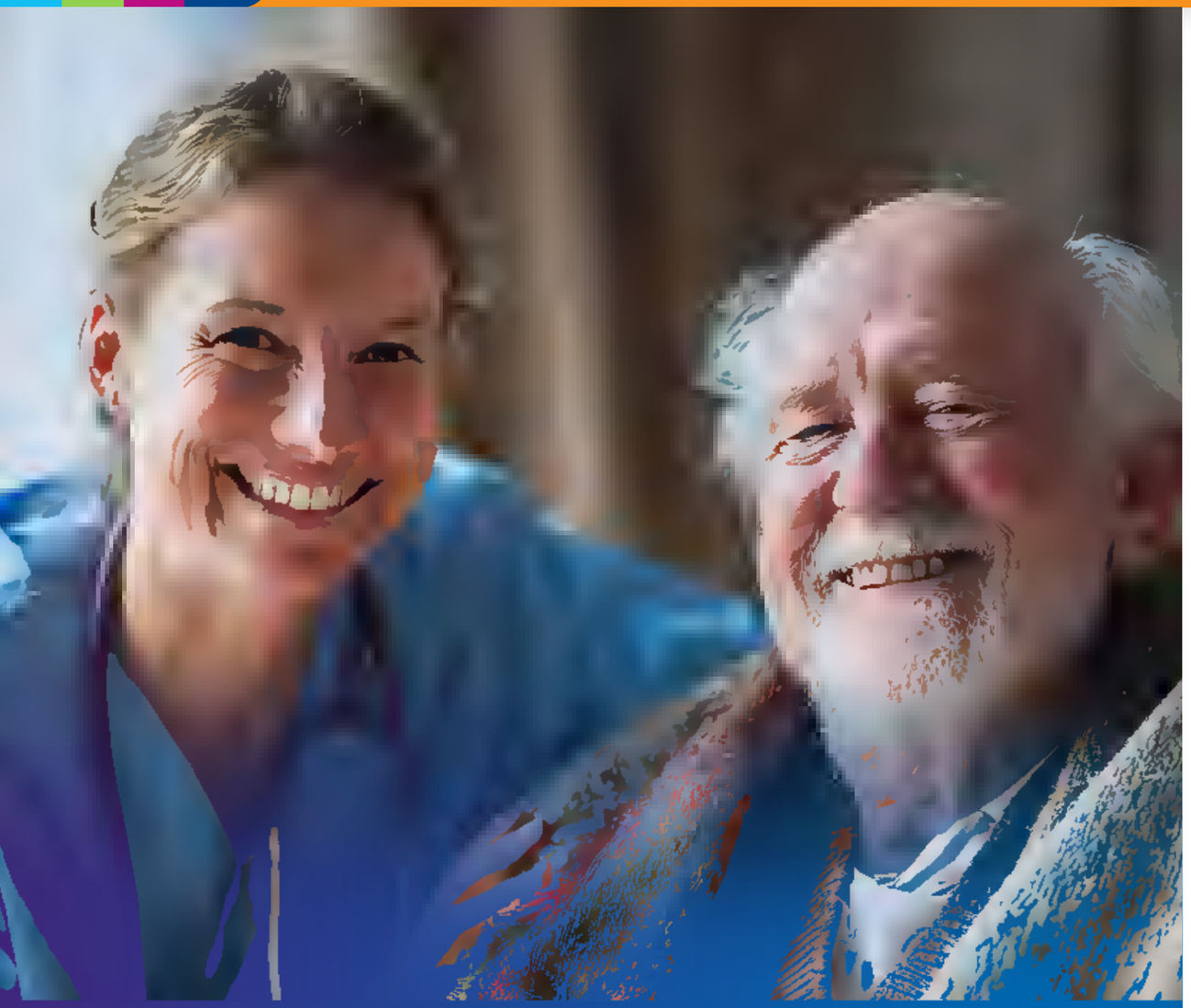
Contribute to improving population health and reduce health inequalities

In five years:

- **All residents will enjoy longer periods of good health. We will place greater focus on supporting specific communities that experience the greatest disadvantage, helping to ensure more equal health outcomes across Somerset.**
- **Children and young people will experience improved physical and mental health outcomes. We will work to ensure equitable access to integrated services which support early development, education and health.**
- **Fewer individuals living with serious mental illness will die prematurely, because we will enable faster access to early interventions and targeted support. In addition, people with learning disabilities or those experiencing problems related to substance misuse, or marginalisation - including homelessness, will have better care.**
- **Fewer people will develop preventable long-term conditions, such as cardiovascular disease and type 2 diabetes, and those affected will experience less severe health impacts.**
- **We will work with partners to positively impact the social, economic and environmental determinants of health, leading the way as an anchor institution in the county to positively impact economic wellbeing, education and employment.**

Today, healthy life expectancy in Somerset is 18.8 years lower than total life expectancy for females, and 14.8 years lower for males. In some areas of the county the gap is eight years wider still, and it is increasing.

For some groups, the situation is even worse. For example, the life expectancy of women in Somerset with a serious mental illness is 17.5 years lower than for women without serious mental illness. For men in Somerset the difference is 19.7 years. People in marginalised groups also experience health inequalities. Across England, people affected by homelessness die on average around 30 years younger than the general population, and Somerset is estimated to have the third highest number of rough sleepers of any local authority in England.



> **We will strive to ensure that everyone in Somerset has the opportunity to live a healthier, more fulfilling life, regardless of background or circumstance.**

We will start to address these inequalities by acting to prevent avoidable illness and disability in all parts of the services we deliver.

We will strive to ensure that everyone in Somerset has the opportunity to live a healthier, more fulfilling life, regardless of background or circumstance. We will promote wellbeing, prevent avoidable illness, and work to improve services so that all residents can live independently for longer.

To achieve this, we will take a proactive approach to address the health inequalities that persist in our communities. We will deliver services that value every individual, support early intervention, and deliver targeted support where it is needed. We will give equal priority to both physical and mental health.

We will enhance services for both younger children and older adults. We know that for the youngest in our community, improving children's health, including addressing issues like childhood obesity, can reduce lifelong health problems and early mortality. We will provide more care closer to home for frail older people, prevent frailty escalating and reduce admissions to hospital so that people can stay independent, at home, for longer.

We will do more to prevent long term conditions like diabetes and cardiovascular disease from occurring. Where people do develop these conditions, we will make sure that services are tailored to meet their needs, and that they stay healthier for longer.

We will also improve services for those with serious mental illness, whose lives are often shortened by poor care. We will also work to address growing mental health needs including ADHD and autism, working in partnership to increase our capacity to help, and to develop new services.

We will proactively take on our role as an anchor institution within our community, using our size and buying power to have a positive influence on local employment and businesses, building wealth in the local community and influencing the wider determinants of health.



AIM 2

Quality care

> We know that there are some health conditions which need more focus, to prevent serious illness. Our cancer services will diagnose more people earlier, to stop cancers becoming worse and doing more harm.

Our aims

Provide the best care and support to people

In five years:

- **People will only go to hospital if it's really necessary. People will get the help they need, when and where they need it, with more care and support delivered in the community.**
- **Access to our General Practice (GP) services will be easier and more consistent, helping to prevent illness, providing early intervention, and reducing pressure on urgent and acute services. We will work with wider GP and primary care services to make improvements for everyone across Somerset.**
- **There will be increased support for families, in local neighbourhoods, including new family hubs. The hubs will deliver locally-tailored services which will mean easier access and alternatives to having to go to hospital.**
- **Fewer people will become severely unwell or die from cancer, because we will detect more cancers earlier.**

Over the next five years we will work in partnership with other organisations to develop family hubs in every community, so that there is local access to children and young people's services alongside other health services. This will help to give everyone a good start in life and help to tackle wider issues such as education, housing, and finances, as well as health.

We know that there are some health conditions which need more focus to prevent serious illness. Our cancer services will diagnose more people earlier, stopping cancers becoming worse and doing more harm. Our dementia diagnostic services will intervene quicker, and work with partners to provide more care closer to people's homes so that dementia need not rob people of their independence. These initiatives will contribute to the wider objective of making sure that people only come into hospital when they need to, and that they get home as quickly as possible.



> ... we will make improvements to our maternity services and facilities including a new maternity unit including maternity theatres.

When people use our services, inside and outside of hospital, we will make sure that we deliver the best quality of care. For children, young people and families, for example, we will make improvements to our maternity services and facilities including a new maternity unit including maternity theatres at Musgrove Park Hospital. We will also increase opportunities to access maternity services in local communities. We will also improve services for children as they transition to adult services, to make sure nobody "falls through the gaps" of care.

We will also make improvements to primary care. We deliver more than 20% of the county's GP services through Symphony Healthcare Services. We will give people better access to GP services in the practices we operate, and work in partnership with other GP practices, meaning that we can improve diagnosis, reduce hospital admissions, and keep people healthier for longer.





> **Working in partnership to create new Neighbourhood Health Centres will help people stay healthy in their communities, and get into or return to work, bringing economic and social benefits to our whole population.**

Our aims

Strengthen care and support in people's homes and in local communities

In five years:

- **There will be easy to access, community-driven Neighbourhood Health Centres and Integrated Neighbourhood Teams across Somerset, provided in partnership with VCFSE organisations and local communities.**
- **Most outpatient care will be delivered virtually or in the community.**
- **People will be much more able to manage their own conditions and stay healthy at home because we will harness new technology.**

Over the next five years we will transform to provide care 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. This will help to make sure that people only go to hospital when necessary. We know that hospital care is expensive and that being in hospital unnecessarily can actually be damaging to health and independence. Our plans reflect the goals set out in 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.

Working in partnership to create new Neighbourhood Health Centres will help people stay healthy in their communities, and get into or return to work, bringing economic and social benefits to our whole population. It will also help to reduce travel time for service users. Our more integrated Neighbourhood Teams will help keep people healthy and out of hospital, by delivering care in better ways closer to people's homes. These will complement our network of community hospitals, which will be improved to offer an expanded range of treatments including rapid advice and diagnostics.

Outpatient care will also be transformed. More outpatient appointments will take place closer to people's homes rather than in acute hospitals. People will have more chance to use technology and book their own follow up appointments. We will also strengthen partnerships with local care providers, and strengthen rehabilitation pathways, to increase alternatives to hospital care.



> **“More outpatient appointments will take place closer to people’s homes rather than in acute hospitals.”**

We will work with local communities to shape services so that care is culturally appropriate and aligned with community priorities. We will strengthen collaboration with local forums, VCFSE networks and parish councils to design services around what matters to people. This will include partnering with schools and other key agencies to improve facilities and services for young people and families. We will also use neighbourhood-level data to identify and address health needs, particularly in areas affected by rural isolation or poverty.





“We will work in partnership with Somerset Council and other service providers to identify these young people, tailor packages to meet their needs, and ensure that they have the best start possible in life.”

Our aims

Respond well to complex needs

In five years:

- **Children with complex needs will achieve better health outcomes through enhanced, targeted support.**
- **Individuals with learning disabilities, autism, and ADHD, will benefit from more accessible and personalised services.**
- **People living with frailty will have greater opportunity to live independently, safely and with dignity, through tailored interventions delivered closer to home.**

We will deliver high-quality care to make sure that 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 will use new digital innovations to coordinate our services, better to provide seamless care that meets the specific personal needs of individual people, agree care plans, and work in ways that focus on what matters to the individual. We will deliver this approach to people at all stages of life, from birth to end-of-life care.

Our ageing population means that there is a high risk of more frail people needing more complex care. We will invest in new ways of preventing frailty, identifying it early, and providing care to frail people closer to home, with services working together in a more joined up way to meet individual needs.

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. We will work in partnership with Somerset Council and other service providers to identify these young people, tailor packages to meet their needs, and ensure that they have the best start possible in life.

Individuals with learning disabilities often encounter obstacles when seeking care. 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. In the coming five years, we are committed to working with colleagues in primary care to enhance the quality of care they receive.

Where people have complex needs, it is important that their specific needs are met. We will develop more personalised support for those who need us most, shaping services so that support is timely, consistent and tailored.



> **We will attract, develop, retain and inspire our colleagues by creating an environment where people thrive. Kindness, respect and teamwork will be part of everyone's experience, every day.**

Our enabling aims

We will not be able to make changes to our clinical services unless we have the right support services in place. Our three enabling aims focus on our people, our resources (money and buildings), and technology and research.

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

In five years:

- **Our workforce will be appropriately sized, skilled and sustainable to deliver our transformed services.**
- **We will have higher colleague wellbeing, resilience, experience, talent development, and retention because we will strengthen the management and leadership capabilities of our colleagues.**
- **Our colleagues and the wider Somerset community will have greater opportunities to work in a range of diverse roles within our organisation, as we strengthen our partnerships with education providers.**

Somerset FT's role as an anchor institution in the county means it can offer careers, development and learning to people from across Somerset, particularly those who may typically struggle to access these opportunities.

We will attract, develop, retain and inspire our colleagues by creating an environment where people thrive. Kindness, respect and teamwork will be part of everyone's experience, every day. We will continue to deliver a compassionate, inclusive and learning culture, with professionalism, candour and accountability at its heart. Every one of our colleagues will continue to deliver our values and leadership behaviours.

We will use our size and scope to work with others to develop the potential of the Somerset population, helping young people build lives and careers locally by offering employment and training opportunities. This will include increasing the numbers of medical undergraduates, nursing and therapy students, apprentices and others training with us.



“We will invest in training to equip our colleagues with the digital skills necessary to adapt to technological changes.”

We will invest in training to equip our colleagues with the digital skills necessary to adapt to technological changes. We will also continue to offer extensive training and development, to support and develop colleagues to change the way we work and deliver clinical services, especially in local communities.

Our status as an integrated trust providing physical and mental health across a whole county means that our teams can work closer together, with fewer organisational barriers and more shared goals. This means that we will be able to give colleagues more time to care, and invest in things to help them do that. This will include technology and automated processes, freeing them from administrative tasks and giving them more time to directly care for patients.

The type of care we can deliver will also change, helping colleagues think about whole pathways rather than episodes of sickness. We believe that a working environment which allows our colleages to give better care will help us attract an keep the best staff.



Live within our means and use our resources wisely

In five years:

- **We will deliver our services in a financially sustainable way.**
- **More of our services will be delivered from buildings that are fit for purpose, including some new healthcare buildings on hospital sites and in neighbourhoods across Somerset.**
- **Our carbon emissions will be reduced and our buildings will be made more sustainable and environmentally friendly.**
- **Corporate services will be transformed through greater use of Artificial Intelligence to enhance efficiency.**

The challenge of our population's increasing health need is significant and our budgets do not keep pace with rising demand. However, 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.



> **We will continue to develop our expertise in innovation and research, becoming a centre of excellence and helping our services maximise the potential of advances in technology and research outcomes.**

Transforming our services through innovation, research and digital transformation

In five years:

- **People will have more opportunities to take control of their own care, and clinicians will have easier access to information, because our new Electronic Health Record system will be in place.**
- **We will be better able to prevent, diagnose and treat illnesses by using new technologies, including Artificial Intelligence.**
- **We will have access to new and innovative methods of care because our clinical research capability will be greater.**

Using technology, our clinical services can do more, and provide people with a better experience of care. This is why we have invested significantly in planning for the introduction of a new single Electronic Health Record, due to go live in 2028. When in place, we will be able to provide seamless, integrated care using only one system. Clinical records will be instantly available to both service users and their clinicians, and service users won't have to give their details multiple times.

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

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



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Kindness, Respect, Teamwork
Everyone, Every day

Sept 2026 / Comms

Trust Strategy Delivery Plan – Objectives, Key Results and Year 1, 3 and 5 deliverables.

The table below shows the current draft Objectives that we propose to deliver under each of our aims, as part of the Trust Strategy.

The rationale for choosing the draft Objectives and Key Results is included in the Appendix. Our plan is to deliver these improvements across the life of the strategy, as detailed. Further work will continue over the coming weeks to refine and quantify the Key Results and to agreed deliverables.

Aim 1: Contribute to improving population health and reduce health inequalities

Objective	**Key Result**	**Deliverables in Year 1** **Establish baseline + early improvement**	**Deliverables by Year 3** **Demonstrable shift**	**Deliverables by Year 5** **Sustainable position**
Healthy **life expectancy** 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. Population Health Board	Slow the decline in healthy life expectancy at birth for the Somerset population (M & F)	Male: 62.8 years Female: 63 years (2022-24) Source: Public Health Outcomes Framework | Fingertips | Department of Health and Social Care (Area: Somerset UA)	Work with system partners to establish local, timely baseline data and agree realistic improvement trajectories	Monitor progress against partner-agreed improvement trajectories and contribute to system-wide action to improve outcomes and reduce inequalities
	Reduce smoking prevalence through interventions when people are in contact our services.	11.3% (2024) Source: Public Health Outcomes Framework | Fingertips | Department	Work with system partners to establish local, timely baseline data and agree realistic	Monitor progress against partner-agreed improvement trajectories and

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
		of Health and Social Care (Area: Somerset UA)	improvement trajectories towards national Smokefree ambition	contribute to system-wide action to improve outcomes and reduce inequalities
	Reduce hospital admission episodes for alcohol-related conditions	538/100,000 (2023/24) Source: Public Health Outcomes Framework | Fingertips | Department of Health and Social Care (Area: Somerset UA)	Work with system partners to establish local, timely baseline data and agree realistic improvement trajectories	Monitor progress against partner-agreed improvement trajectories and contribute to system-wide action to improve outcomes and reduce inequalities
	Slow the increase in obesity prevalence in adults	33.2% (2024/25) Source: Obesity, physical activity and nutrition | Fingertips | Department of Health and Social Care (Area: Somerset UA)	Work with system partners to establish local, timely baseline data and agree realistic improvement trajectories	Monitor progress against partner-agreed improvement trajectories and contribute to system-wide action to improve outcomes and reduce inequalities

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	Reduce under 75 mortality rate from causes considered preventable (Data source: Fingertips | Department of Health and Social Care- latest data 2022-24)	133.2/100,000 (2024) Source: Public Health Outcomes Framework | Fingertips | Department of Health and Social Care (Area: Somerset UA)	Work with system partners to establish local, timely baseline data and agree realistic improvement trajectories	Monitor progress against partner-agreed improvement trajectories and contribute to system-wide action to improve outcomes and reduce inequalities
Children and Young People Children and young-people will stay healthier, and report greater satisfaction with our services.	Increase reported satisfaction of children and young people with our paediatric services.	Undertake a baselining exercise	Baseline + 10%	Baseline + 20%
	Improved equity of access to paediatric care for those child and young people identified as having higher health and social care needs.	Implement a process between SFT and partners to enable the identification of children and young people with high needs.	80% of people on at least 3 different waiting lists are offered a targeted intervention.	100% of people on at least 3 different waiting lists are offered a targeted intervention.

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	Support reduction in the percentage of overweight / obese children at Reception age.	Undertake baseline exercise to understand the size of the current cohort and the factors that contribute to obesity.	Work in partnership with the Somerset system to deliver targeted interventions leading to a reduction in the percentage of overweight / obese children at Reception age.	Deliver a reduction of 10% of overweight / obese children at Reception age.
	Improved equity of access to paediatric care for those child and young people identified as having higher health and social care needs.	Implement a process between SFT and partners to enable the identification of children and young people with high needs.	80% of people on at least 3 different waiting lists are offered a targeted intervention.	100% of people on at least 3 different waiting lists are offered a targeted intervention.
Serious Mental Illness	Increase in annual physical health checks for people with SMI active within secondary MH services.	Meet government target of 73% of patients.	80% of patients	90% of patients

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
More people with Serious Mental illness will live longer and healthier.	Increase in the number of service users with a personalised care plan (Dialog+ or equivalent)	Baselining prior to CHMS transformation	90%	100%
	Increase in the number of service users with an SMI diagnosis who have received best evidence-based interventions as per NICE guidance.	Baseline audit	To follow after audit baselining	To follow after audit baselining
	Increase in annual physical health checks for people with SMI active within secondary MH services.	Meet government target of 73% of patients.	80% of patients	90% of patients

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Aim 2: Provide the best care and support to people

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Children and Families There will be a reduction in the use of secondary care services, as a result of more joined-up support available in neighbourhoods.	Increase in the number of service users accessing CYP neighbourhood hub services	Open the first CYP neighbourhood hub service and baseline number of service users	Increase the number of CYP neighbourhood hubs from one to four	Increase the number of users of each CYP neighbourhood hub by 10% from the baseline for each
	Increase in number of service users reporting satisfaction / benefit from using CYP neighbourhood hub services	Baseline satisfaction	Improve satisfaction by 10%	Improve satisfaction by 20%
	Reduction in referrals to secondary care paediatrics / CAMHS services	Maintain proportion of secondary care referrals relative to demand	Deliver a 10% reduction in referrals to secondary care paediatrics / CAMHS	Deliver a 20% reduction in referrals to secondary care paediatrics / CAMHS
Cancer Fewer people will die of cancer, because more cancers will be detected earlier and cancer	Targeting increased access to cancer services for people living in IMD deciles 1 & 2	Currently 35.8% of all referrals come from IMD deciles 1 & 2 further baseline data by pathway, cancer type and geography to be completed. Increase	Referrals from IMD 1–2 reach 39%. Reduce non-USC urgent referrals to 17% through clearer access routes, eg increased self-referral	Referrals from IMD 1–2 reach over 40%, with sustained reduction in non-USC urgent referrals to 15% or below. Inequalities monitoring is

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
patients will receive better care.		referrals from IMD 1–2 from 35.8% to 37% and reduce the proportion entering via non-USC urgent routes from 22% to 20%. Supported by implementation of targeted communications and community engagement in priority areas.	pathways and targeted case finding.	embedded in pathway performance reviews.
	Increase in number of patients self-referring	Establish pathway-level baseline and monthly reporting. Achieve at least 4,844 self-referrals and expand awareness of the existing self-referral offer. Implement Bladder self-referral pathway and review referral criteria for other pathways with the	Increase self-referrals by 20% from baseline to approximately 5,800 per year, through expanded pathways and targeted promotion to under-served groups	Increase self-referrals by 30% from baseline to approximately 6,300 per year. Self-referral is embedded as a routine, evaluated route into appropriate diagnostic services.

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
		option of expanding the criteria.		
	Increase in number of patients offered diagnostic test through case finding	Confirm baseline activity – YTD 2500 patients have been offered diagnostic tests through case finding. Deliver targeted case-finding pilots in high risk and deprived populations, including Capsule Sponge and Liver.	Scale successful approaches across priority groups and pathways for example pancreatic. Increase patients offered diagnostic tests through case finding by 25% from baseline.	Maintain an intelligence led case finding programme across priority pathways. Increase offers by 40% from baseline, with routine monitoring of uptake, conversion and equity of access.
	Increase the number of cancers diagnosed at stage 1 or 2	Maintain early stage diagnosis at or above the 2025 baseline of 62.4%. Deliver awareness campaigns, self-referral, case-finding and screening interventions to improve earlier diagnosis rates	Increase diagnosis at stage 1 or 2 by 5% to 67.4%, This will be delivered via new case finding programmes and roll out of future national screening programmes eg prostate.	Achieve and sustain 75% of cancers diagnosed at stage 1 or 2, while narrowing the deprivation gap in early diagnosis.

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Dementia Patients with dementia will have the chance to be as independent as possible.	All patients diagnosed with dementia by SFT are offered a referral to receive post-diagnostic support.	Baselining sample notes audit to establish baseline and inform efforts prior to Epic installation.	Epic in use, enabling data to be interrogated. 100% compliance.	100%
	Reduce waiting times for dementia diagnosis	National targets to be set	Improvement trajectory to be confirmed based on national targets	Improvement trajectory to be confirmed based on national targets
	Increase the proportion of people with dementia who remain within their current place of residence (own home or care home) during crisis.	Baseline performance	Improve on the Year 1 baseline data by 10%, by ensuring timely IDS assessment and a clear home-based care, risk and contingency plan for people where remaining in their current place of residency is safe and consistent with their wishes.	Sustain improvement in referral numbers into IDS and the proportion supported to remain in their usual place of residency on discharge from the service, by audit of data pulled from EPR and case review to strengthen the IDS home-treatment response.

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	Increase in dementia education across the organisation to ensure we have a workforce equipped with the skills and knowledge to support people living with dementia.	Dementia Education Team to map current compliance with training in these specific areas.	Deliver a consistent, prioritized programme of training to reach 100% of staff for Tier 1, and 75% of clinical staff working in community hospitals and COOP wards for Tier 2.	Maintain performance, and review training records. Use trolley training to refresh colleagues of key topics.

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Aim 3: Strengthen care and support in people's homes and in local communities

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Neighbourhood Healthcare 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.	Increase number of patients accessing care at our neighbourhood health centres and other community venues and diagnostic centres	Establish baseline position relative to number of NHCs / Diagnostic centres etc which are open	Increase baseline position by 20%	Increase baseline position by 30%
	Increase in the percentage/number of total SFT patient contacts currently delivered in an acute setting that are delivered in a community setting or remotely	Increase utilisation of UCR and Hospital at home service in accordance with current plan	20%	30%
	Increase in number of people supported by integrated neighbourhood teams across all primary care network areas	Establishment of INTs and Identification of the top1% of service use (frailty) which will form their caseload	25% increase	50% increase

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
		Identification of 3-5% of patients which will also form their caseload		
Multiple Long Term Conditions People with multiple long term conditions will go to hospital less, because they will have more joined-up care.	Establish a dataset and a system of reporting and accountability to deliver: - Reduction in number of service users with two or more LTCs being admitted to hospital as an emergency - Reduction in average LoS for service users with two or more LTCs admitted to hospital - Increase in percentage of the population with two or more LTCs receiving active care and support as part of the integrated neighbourhood team caseload	Establish dataset and system of reporting / accountability. Gain clarity over definitions and areas of responsibility	TBD	TBD

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Outpatients and Digital Technology 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.	Increase in proportion of patients interacting with the organisation digitally -	Increase in the number of patients using Netcall as the patient engagement portal to 20,000 by end of March	Full implementation of EPIC MYchart and increase the utilisation of self booking function by 50% in the first year	Roll out all available function of MYchart as the primary source of health record
	Increase in proportion of outpatient activity delivered virtually, or not on an acute site.	20%	40% Baselining remote monitoring technology uptake.	60% With 10% increase of patients being monitored remotely.
	Maintain upper quartile performance in terms of numbers of patients given PIFU across every specialty, aiming for upper decile	Maintain upper quartile performance	Upper quartile performance	Achieve top decile performance

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Aim 4: Respond well to complex needs

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Frailty People living with frailty will have more opportunities to live independently, safely and with dignity, supported by targeted services and resources	Increase in the number of medical ED attenders aged 65+ with a Clinical Frailty Scale assessment (Eng mean 36%)	MPH at England Mean, YDH at 60%	Both 70%	Both 100%
	Reduction in the number of frailty emergency admissions with LoS <7 days (65+) (Eng mean 57.3%)	MPH - 59% YDH - 41.%	To achieve Eng Mean across the Trust	To maintain Eng mean across the Trust
	Reduction in average LoS for people admitted with frailty (excluding 0 day LoS) aged 65+ (Eng mean 11.3)	MPH - 13.3 YDH - 15.9	To achieve Eng Mean across the Trust	To maintain Eng mean across the Trust
	Reduce re-Admissions of 1+days, within 30 day, for patients aged 65+ (Eng mean 15.5%)	MPH - 17.8% YDH - 15.3%	To achieve Eng Mean across the Trust	Achieve upper quartile performance in England.
People at high risk of harm There will be fewer admissions to Mental Health hospitals, and fewer deaths caused by intentional self-harm.	Reduction in admissions to Mental Health hospitals as a result of intentional self-harm and to prevent self-harm	Baselining	Trajectory to follow after baselining	Trajectory to follow after baselining

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Children with complex and special educational needs 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.	Increase in complex cases having multi-agency plans with clear lead professional arrangements	Baseline performance	75% of complex cases have multi-agency plans with clear lead professional arrangements	100% of complex cases have multi-agency plans with clear lead professional arrangements
	Increased evidence of children and young people remaining engaged with family, peer and community activities	Define family, peer and community activities and baseline performance	10% increase in children and young people engaged with family, peer and community activities	20% increase in children and young people engaged with family, peer and community activities
	Decrease in EHCP waiting times	Baseline current performance	80% target achievement	95% target achievement
	Improved school attendance and educational participation for children supported by our specialist services	Baseline current performance	5% increase in school attendance and educational participation for children supported by our specialist services	10% increase in school attendance and educational participation for children supported by our specialist services

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Continuity of care in the transfer from CYP to adult services Children and young people transferring from CYP to adult services will be satisfied with their experience of the transfer.	Increased satisfaction with experience of transfer from CYP to adult services	Baseline current performance	5% increase in satisfaction with experience of transfer from CYP to adult services	10% increase in satisfaction with experience of transfer from CYP to adult services
Learning Disabilities, Autism and ADHD 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.	Increase in Primary Care capacity to provide ADHD services, so as to free Secondary Care resource for more complex cases.	Establish baseline of primary care capacity, with ICB support. Increase GP surgery presence by merging current LD nursing team into Primary Care.	Build on baseline position, target TBC after baselining	Build on baseline position, target TBC after baselining
	Increase in levels of service for people with Autism, addressing gaps in service, identifying those with concerning behaviour, and working in partnership.	Increase primary-care-based Autism staffing numbers. Baselining performance.	Build on baseline position, target TBC after baselining	Build on baseline position, target TBC after baselining

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
People who frequently use our services People who frequently use our services will use them less frequently due to more personalised, coordinated care planning. High Intensity Users defined as X10 attendances in 3/12	Reduction in ED attendances, admission unit attendances, open referral attendances, and emergency admissions for people who frequently use our services	NHS Right Care – Target - 20%-40% reduction in first 2 years. SFT HIU – Maintain national target trajectory of -40% reduction attendances– (Currently -73% across all ages) Working with 193 people in 2025.	Embed current HIU Hybrid model from Acutes in to Community within SFT as business as usual. Predicted trajectory likely to be working with 200 people per year. If reduction in attendances continues on current path could reach -82%. Support growth of HIU thinking and model of care further upstream through PCN and Community education support, guidance and consultation. Utilising A&Es as baseline – Outwards towards UTCs and PCNs.	Sustain HIU culture and adaptable multi service approach to maintain consistent reductions in cohort. With HIU expansion, so threshold of HIU can reduce and cohort of patients worked with can increase. Establish HIU Thinking within SFT culture across Acutes, Community services, and VCSFE with Personalised Care at the core of the system changes. Sustain predicted reduction of non elective admissions on current trajectory to 7,987 by 2030.

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	Increase in the number of frequent user patients with Personalised Care Support Plan (PCSP) within first 3 months of activation	SFT HIU Achieved -20% - Aim to increase annually – 1st year 30%	Increase number of people known to HIU with PCSP. 2nd – 3rd year 40% target Cultural change needed with Personalised Care thinking to be standardised for every frequent attender we see.	Embedding PC across whole system thinking aligned with HIU approaches to multi-agency holistic care. Consider & review measurability in Qualitative Care Planning in alignment with Quantitative Care planning.

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

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Sustainable Workforce Our clinical services will be appropriately staffed to provide quality care because we will achieve a sustainable workforce supply.	**Workforce Skills and Capability** Reduction in number of roles identified as hard to recruit or sustain	Baseline number of roles identified as hard to recruit to or sustain (using available data and service-level insight)	Reduction in roles identified as hard to recruit to or sustain, informed by improved workforce data	Minimal hard-to-recruit roles supported by strong internal and local supply pipelines
	Increase in number of colleagues completing development and training programmes, including apprenticeship pathways.	Baseline number of staff completing development and training programmes, including apprenticeship pathways	Increased proportion of staff completing development aligned to service need and emerging priority roles	High and sustained participation in development aligned to service need, with equitable access across staff groups
	Reduction in identified workforce capability risks	Initial baseline of workforce capability risks identified through available data sources and local intelligence	Workforce capability risks increasingly identified and tracked through developing workforce planning approaches	Workforce capability risks systematically identified and managed through embedded workforce planning and pipeline intelligence
	Local Workforce Pipelines Increase in % of vacancies filled through internal, local and	Baseline % of vacancies filled through internal, local and pipeline routes (including pre-employment programmes)	Increased % of vacancies filled through internal, local and pipeline routes, with more consistent data capture	Majority of vacancies in key roles filled through sustainable local pipeline routes

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	pipeline routes (including pre-employment programmes)			
	Increase in conversion from trainees, apprentices, work placements and pre-employment programmes into employment	Initial baseline of conversion from trainees, apprentices, work placements and pre-employment programmes into employment	Improved conversion rates from pipeline and pre-employment programmes into employment, including clearer insight on local and target populations	Consistently high conversion from pipeline activity into employment, with strong representation from local and target populations
	Increase in number and scale of active pipeline pathways linked to roles identified as hard to recruit or sustain	Baseline number and scale of active pipeline pathways linked to roles identified as hard to recruit or sustain	Expanded and more consistent pipeline pathways across roles informed by service need, developed in partnership with education and community organisations (Somerset Academy)	Fully embedded “grow your own” model, supported by mature workforce planning and strong community-linked entry pathways
	Targeted Recruitment Reduction in vacancy rate (overall and roles identified as hard to recruit or sustain)	Vacancy rate (overall and roles identified as hard to recruit or sustain)	Reduced vacancy rates, supported by improved pipeline and local recruitment activity	Sustained low vacancy rates across key roles

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	Reduction in time to hire	Baseline time to hire	Reduced time to hire, including increased recruitment via pipeline and pre-employment routes	Efficient, pipeline-enabled recruitment model reducing reliance on external labour markets
	Increase in proportion of appointments from local and target populations to more consistently reflect local communities.	Baseline understanding of diversity and local representation within recruitment outcomes	Improved diversity and increased proportion of appointments from local and target populations, supported by better data and insight	Workforce profile consistently reflects local communities and target populations
	Workforce Stability Reduction in agency and bank staffing	Agency reduced by 30% of total pay bill	Reduced agency spend supported by improving pipeline supply and retention	Minimal reliance on agency staffing due to strong internal and local supply pipelines
	Increase in retention	Baseline turnover rate (overall and in key roles)	Improved retention in key staff groups, including those recruited through local pathways	Stable workforce with consistently high retention across staff groups

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	Increase in workforce continuity and experience	Baseline % of shifts filled by substantive workforce	Increased % of shifts filled by substantive workforce in priority services	Majority of service delivery covered by experienced, substantive workforce
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.	**Development and Career Opportunities for Colleagues** Increase in access to development and career progression for all colleagues support career pathways across the organisation	Baseline number of colleagues participating in development programmes, including apprenticeships	Increased participation in development aligned to clearer career pathways and service need	High and equitable access to development and progression opportunities across the workforce
	Increase in number of colleagues supported to develop new skills and progress internally	Baseline internal progression rate (promotions and role moves), where data is available	Improved and more consistently measured internal progression rates	Strong internal talent pipelines supporting progression into key roles
	Increase in number of colleagues accessing career pathway support career pathways across the organisation	Baseline number of colleagues accessing career support (e.g. coaching, guidance)	Increased access to structured career pathways and career support across staff groups	Career pathways fully embedded, transparent and consistently applied across the organisation

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	Opportunities for Local People and Talent Pipelines Increase in opportunities for local people to access employment and training	Baseline number of people participating in pre-employment programmes (e.g. work experience, internships, volunteering, apprenticeships)	Increased participation in pre-employment programmes, including targeted outreach to local communities	Pre-employment programmes established as a core entry route into the workforce at scale
	Increase in numbers of apprenticeships, work experience and entry routes	Initial baseline of participation from local and/or target populations	Increased and more consistently measured proportion of participants from local and target populations	Strong and sustained representation from local and target populations across all pipeline activity
	Increase in clear and accessible entry pathways into careers within the organisation	Baseline number of people progressing into employment or training through pipeline routes, where data is available	Improved progression rates from pre-employment programmes into employment within the organisation	High and consistent conversion from pipeline programmes into employment, supporting measurable community impact
	Partnerships and Community Capacity			Strategic, long-term partnerships embedded as a

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	Increase in partnerships with schools, colleges and community organisations	Baseline number of active education, community and voluntary sector partnerships	Increased number and depth of partnerships supporting	core delivery model for workforce pipelines
	Increase in joint programmes to support access into NHS careers	Baseline number of joint programmes or initiatives delivered	Expanded joint programmes delivering pre-employment, skills development and access to careers	Co-designed programmes consistently delivering routes into employment for local people
	Increase in neighbourhood-based workforce to support care closer to home	Baseline number of learners or local people engaged through partner activity	Increased reach and engagement of local communities, supported by improved data and coordination	Demonstrable contribution to community capacity, local employment and social outcomes

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Colleague wellbeing and experience Services will be more sustainable, and provide higher quality care, because we will be better able to retain colleagues.	Increase in NHS People Promise score across all domains, prioritising we are compassionate and inclusive, and we are safe and healthy.	Deliver Compassionate leadership programme to 25% by September 2027.band 7+ as at 22/05/2026 number was 8%. Have Wellbeing Champions in 50% of services currently -	Deliver Compassionate Leadership to 60% of Band 7+ Wellbeing Champions in 75% of services	Deliver Compassionate leadership to 90% of Band 7+ Have wellbeing champions across 95% of services
	Reduction in sickness absence specifically S10 absence reasons relating to mental health ? Add inclusion metrics	Stabilisation or less than 1% growth in S10 to remain 27% Reduction om average duration of S10 episodes by 5%	5% reduction in overall S10 absence rate vs baseline 10% reduction in average duration of S10 absence	10% reduction in overall S10 absence should now be 17% Sustained reduction in episode duration of 10-15%
	Stabilise retention rate across all colleague groups Add inclusion metrics Add staff group metrics	Stabilisation of turnover rate across all groups remaining at 9.9% 1-2% improvement in turnover in priority areas: SSL Corporate 12.8% Mental Health 11.8% Neigbourhoods 11.6%	Reduction in variability of turnover between service groups	Sustained reduction in turnover rate Stable retention across all service groups

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

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Financial Sustainability Our services will be delivered in a financially sustainable way, to ensure their viability.	Year-on-year reduction in recurrent deficit	0.5%	1.5%	2.5%
	Increase in productivity of 2% per year (i.e. 10% over the term of the Strategy)	2% increase in productivity against Y0 baseline	6% increase in productivity against Y0 baseline	10% increase in productivity against Y0 baseline
	Reduction in proportion of spend in the acute hospitals, and an increase in proportion of spend in communities / neighbourhoods	1% change	3% change	10% change

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	At least maintain proportion of expenditure on Mental Health services	Maintenance of Y0 baseline	Maintenance of Y0 baseline	Maintenance of Y0 baseline
Estates and Facilities Our services will be delivered from accommodation that is fit for purpose, to maximise the quality of care and service user satisfaction.	Increase in % of hospital and community estate used for clinical services			
	Delivery of planned new and refurbished buildings	Delivery of in flight schemes: Surgical Centre CDC programme	Delivery of pipeline of 2 new neighbourhood health centres and designation of appropriate community health estate to	Development of the FullBusiness case for the New hospital Programme at Musgrove Park Hospital.

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
		Stroke Configuration Planned deployment of Community Health Centre Model	neighbourhood health centres, bringing together Primary care, community and VCSFE services Deliver refurbishment of YDH tower to address building safety act compliance	
	Increase in service user satisfaction with clinical care environment			
Climate and the environment	Reduction in Trust-wide net carbon			

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
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.	emissions (based on NHSE return)			

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Aim 7: Transforming our services through innovation, research and digital transformation

Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
Electronic Health Record Every patient and clinician will have easy access to a single online care record	Implementation of Epic across all services in April 2028	Hitting milestones per the Healthset delivery plan	Successful go-live and stabilisation phase complete. Business case year 1 deliverables achieved and optimisation commenced	Delivery of 5-year benefits e.g. reduction in duplicate pathology tests, uptake of MyChart etc
	Improved digital, data and technology maturity (as per national maturity assessment and Healthcare Information and Management Systems Society **(**HIMSS) maturity assessment)	Baseline digital maturity assessment	Increase in digital maturity assessment into upper quartile	Remain in upper quartile of digital maturity and HIMSS level 6/7 achieved
	Improved colleague satisfaction with digital, data and technology	Baseline colleague satisfaction (local or national EPR survey)	Improvement in colleague satisfaction (local or national EPR survey)	Improvement in colleague satisfaction (local or national EPR survey)
	Improved patient satisfaction with digital engagement and correspondence with the Trust	Baseline patient complaints related to digital communication and correspondence	Reduction in complaints and improvement in satisfaction	Reduction in complaints and improvement in satisfaction

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
		Baseline patient satisfaction		
	Improved partner (e.g. primary care) satisfaction with digital engagement and correspondence with the Trust	Baseline partner complaints related to digital communication and correspondence Baseline patient satisfaction	Reduction in complaints and improvement in satisfaction	Reduction in complaints and improvement in satisfaction
Using technology to transform care We will use new technology and artificial intelligence to improve patient experience of care, and	Achievement of the cyber-assessment framework and data protection toolkit requirements	Compliance with the interim CAF measures and 2026/27 ESPT	Compliance with the full cyber-assurance framework	Maintenance of compliance with the full cyber-assurance framework
	Increase in clinic productivity as a result of utilising Ambient Voice Technology	Full Trust deployment of AVT to outpatient setting and test in UEC settings, with 30% utilisation by March 2027 and 80% by October 2027	Embed AVT and generative AI into Epic	5-year plan at this stage is not possible due to the scale and change in AI

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
transform enabling services and functions	Increase in efficiencies driven out using Robotic Process Automation (RPA) and AI agents	Set up AI Lab and training programme Deploy training package for colleagues Approve AI and automation roadmap for corporate and administrative workflows	Deploy agentic AI in all applicable corporate and Clinical-ops departments and workflows Integrated digital front-door for corporate services Extend AI and automation roadmap to clinical workflows	5-year plan at this stage is not possible due to the scale and change in AI Trust will have an adoption and implementation scale to we horizon scan and asses new technology for implementation within 12 months
	Using technology to deliver clinical improvements e.g. increase diagnostic reporting capacity			
Better information for care Patients and clinicians will have more accurate and timely information so that they can make better decisions about care	Reduction in clinical errors due to information	Baseline clinical incidents related to digital systems	Safe transition to Epic and reduction in clinical incidents related to legacy systems and paper records Monitoring of clinical incidents from Epic	Full learning system embedded in optimisation processes to continuously improve safety

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
	Reduction in information governance incidents due to the remove of paper records and decommissioning of legacy systems	Baseline information governance incidents related to paper records and digital systems	70% reduction in governance incidents related to paper records and digital systems. Safe transition to Epic, removal of paper records and decommissioned legacy systems Reduction in information governance incidents related to paper records and digital systems	Full learning system embedded in optimisation processes to continuously improve data security
	Increase in the number of real time dashboards deployed	Baseline current dashboards and audit use of data portal for accessing data Set up data literacy training programme	Majority of reporting and dashboards available real-time via self-service in Epic Majority of data teams work spent analysing and modelling data	5-year plan at this stage is not possible due to the scale and change in AI

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Objective	Key Result	Deliverables in Year 1 Establish baseline + early improvement	Deliverables by Year 3 Demonstrable shift	Deliverables by Year 5 Sustainable position
		Deploy training package for colleagues	Clinical coding supported by AI and real-time coding in Epic	
Research We will have better research capability, and grow a targeted portfolio of specialist research to help develop clinical services for our patients.	Increase the Percentage of commercial trial activity to non-commercial trial activity	Increase from 5% to 7.5%	Increase to 20%	Increase to 35%
	Increase in percentage of clinical trials set up within 90 days	Increase from current 67% (Oct 26) to 80%	Maintain performance at 80%	Maintain performance at 80%

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NHS Somerset NHS Foundation Trust

Trust Strategy Engagement Update

Introduction

1. We are undertaking a period of engagement on the new Trust Strategy, prior to its launch later this year.

2. The engagement covers both internal colleagues and external partners. We have presented the high level slides outlining the Strategy's purpose and key themes across our aims. We have also given colleagues and partners the opportunity to answer three questions related to the evolving strategy via an online survey:
    a. What feels most important to you in the Strategy?
    b. What would success look and feel like for you, your team, your organisation or your community?
    c. If there was one thing we should measure to show that we are making a difference, what would it be?

Update – internal

3. We launched internal engagement with an article in Our News inviting people to view the slides and fill in the survey. So far we have had 52 responses to the survey.

4. Overall, respondents have been supportive of the strategic direction, particularly the focus on prevention, community-based care, partnership working and digital innovation. However, there was a strong message that success will depend on investing in colleagues, reducing inequalities, strengthening integration across services and providing clear evidence that the strategy is delivering meaningful improvements for patients, communities and staff.

5. We have attended / are scheduled to attend several engagement sessions for colleagues, including the Psychological Therapies Away Day, Nursing Roundtable, Medical Leadership Team, Symphony Healthcare Services away day, Safeguarding team away day, and several Integrated Neighbourhood team sessions.

Update - external

6. We contacted over 50 partner representatives in mid-September, explaining our strategy refresh process and offering them the opportunity to both see the presentation and engage directly at their convenience. We also attended the Trust AGM, hosting a Strategy marketplace stall where we made contact with representatives from a range of community partners.

7. We have attended engagement events of various sizes with many community partners, including Somerset Activity and Sports Partnership (SASP), Somerset Sight, Somerset Equalities Partnership, Fuel Poverty Forum, and the Somerset Community Foundation.

8. There are no consistent themes emerging from feedback, aside from general approval for the principles in the Strategy. The engagement has, however, created and deepened relationships between SFT and its partners, and has allowed us to start some discussions about closer working and specific actions to take forward improvements together.

Next steps

9. Internal and external engagement will continue, with a range of further event attendances planned including Young Somerset (11th November), the GPSU (18th September) and at the Thrive Somerset Convention (25th September). We will continue to collate feedback at these events and via the survey, reflecting on any emerging themes and making any changes necessary.

10. The Strategy will be more formally launched later in the year, with a key date being Team Brief on 18th November. There will also be a range of publicity materials (Strategy on a page etc) launched at the same time.

11. Following the launch of the Strategy, we will commence regular performance reporting against KPIs to enable ongoing communication and engagement with partners regarding progress and opportunities.

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Wellbeing Guardian Report
SPONSORING EXEC:	Isobel Clements, Chief People Officer
REPORT BY:	Rosemary Novak, Head of Colleague Support Services
PRESENTED BY:	Graham Hughes, Wellbeing Guardian
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	Systemic overview of wellbeing including compassionate leadership programme and multilayered wellbeing activities
Recommendation	To support the recommended continuation of work in the report

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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)
The data reported is drawn from staff surveys, People Services data and research which included SFT colleagues as participants and stakeholders

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

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

WELLBEING GUARDIAN REPORT

1. BACKGROUND AND PURPOSE

This report provides the Board with assurance on the current position of colleague health and wellbeing across Somerset NHS Foundation Trust, highlighting key workforce indicator, emerging risks and areas of improvement activity. It follows the previous Wellbeing Guardian update presented to the Board and reflects the current priorities of the Colleague Support and Wellbeing Service in response to workforce pressure, organisational transformation and evolving national expectations regarding colleague health, wellbeing and inclusion.

The report focuses on:

- Current workforce wellbeing data and colleague experience
- The implications of emerging trends
- Actions being taken in response
- Progress against the NHS Staff Health and Wellbeing Standard
- Development of the Trust's reasonable Adjustments steering group as part of the Executive Inclusion Objectives.
- Future priorities and opportunities to maximise impact within available resources.

2. WHERE ARE WE NOW?

The wellbeing of colleagues continues to be influenced by a combination of operational pressures, financial constraints, workforce shortages and organisational change. Despite these challenges, there are positive indicators that demonstrate continued investment in creating compassionate, inclusive and supportive working environments. Body of report.

Data continues to identify stress, anxiety and mental health-related absence (S10) as one of the most significant indicators of colleague wellbeing. During September 2025 to September 2026 approximately 25% of sickness absence days were attributable to anxiety, stress, depression or other psychiatric conditions. An average of 5,526 FTE days were lost each month, representing an estimated month cost of £893,892. Trends indicate increasing demand and continued pressure on colleagues across many services.

Referral activity to the Colleague Support Service has remained relatively stable at approximately 50 referrals per month; however, there has been an increase in colleagues identifying workplace stress as a contributing factor to their referral, particularly during the latter part of 2026.

People Pulse results show a modest but positive improvement in perceptions of compassionate and inclusive working environments, with a 0.17-point increase in the People Promise score between January and July 2026. Feedback gathered through wellbeing champions and organisational consultation continues to indicate that workplace stress, team functioning and the quality of local leadership remain significant determinants of colleague experience.

Colleague feedback also highlights ongoing variation in access to basic wellbeing enablers such as rest facilities, protected breaks and out-of-hours access to hot food, demonstrating that organisational wellbeing is influenced not only by support services but by colleagues' day-to-day working environments.

3. WHAT DOES THIS MEAN?

The data suggests that whilst many colleagues remain engaged and committed to delivering high-quality care, workforce wellbeing continues to be significantly affected by both operational and organisational pressures.

The increasing prevalence of workplace stress within support service referrals is particularly notable when considered alongside organisational transformation programmes, continued service pressures and financial constraints. Whilst sickness absence associated with stress inevitably impacts productivity and cost, it may also indicate that colleagues are increasingly recognising when support is required and accessing appropriate interventions, potentially reducing longer-term presenteeism and burnout.

The evidence reinforces the importance of focusing on wellbeing as a system issue rather than solely an individual responsibility. Current research, local consultation and colleague feedback consistently identify leadership behaviours, team culture, psychological safety, inclusion and working conditions as some of the most influential factors affecting colleague wellbeing.

For the organisation, this means that sustainable improvements are most likely to be achieved through approaches that strengthen local leadership capability, improve working environments, embed inclusive practices and enable teams to support wellbeing collectively.

4. WHAT ARE WE DOING?

The Trust continues to adopt a multi-layered and systemic approach to colleague wellbeing, recognising that effective support requires action at individual, team and organisational levels.

Compassionate Leadership

The Compassionate Leadership programme remains a significant component of the Trust's approach. Since launch, 22 programmes have been delivered, with over 320 Band 7 and above leaders attending and 237 of those

completing the full 2-day programme. Feedback remains consistently positive, with participants reporting increased confidence in supporting wellbeing, improving team culture and applying compassionate leadership practices within operational settings.

Specialist Support Services

The Trust continues to provide access to

- Occupational Health Services
- Colleagues support Services
- Physio4U
- Financial wellbeing support
- Post-incident reflective conversations
- Wellbeing Champion networks

Work is also progressing to improve efficiency and value through improvements to Occupation Health processes, DNA reduction initiatives and service pathway reviews.

Organisational Wellbeing Infrastructure

Development is underway to strengthen the governance arrangements through a more integrated Colleague Safety and Wellbeing approach, recognising the close relationship between colleague's experience, wellbeing, inclusion, safety and organisational performance. This will provide a stronger framework for prioritising activity, monitoring progress and embedding shared accountability across service groups

FOCUS AREA ONE: NHS STAFF HEALTH AND WELLBEING STANDARD

Publication of the NHS Staff Health and Wellbeing standard during 2026 provides greater clarity regarding organisational expectations and leadership accountability for colleague wellbeing.

The Trust has commenced a Health and Wellbeing Framework self-assessment to establish a baseline against the Standard and identify areas of good practice and future development priorities. Early findings indicate strengths in:

- Visible organisational commitment to colleague wellbeing
- Established specialist support services
- Compassionate leadership development
- Strong wellbeing champion engagement
- Access to wellbeing interventions across multiple service areas

The assessment also highlights opportunities to strengthen:

- Consistency of wellbeing experience across different sites and services
- Access to basic wellbeing facilities

- Local ownership of wellbeing activity
- Measure of outcomes and impact
- Alignment of wellbeing, safety and inclusion agenda

This work will inform future Trust-wide priorities and provide a framework for continuous improvement.

FOCUS AREA TWO: REASONABLE ADJUSTMENTS

Reasonable Adjustments remain a key Executive Inclusion Objective and an important mechanism through which the Trust can improve colleagues experience, inclusion and retention.

A multidisciplinary steering group has been established involving inclusion leads, network representatives and colleagues with lived experience. The group is applying quality improvement methodology to address several areas identified through colleague feedback and organisational learning, including:

- Improving consistency of reasonable adjustment processes
- Simplifying access to support and information
- Streamlining assessment and procurement arrangements

Increasing management understanding of legal responsibilities and good practice.

Strengthening support for colleagues with long-term health conditions, disability, menopause and other adjustments needs.

Further progress in this area is expected to improve colleague experience, support retention and contribute to the Trust's wider ambitions around inclusions, belonging and workforce equity.

5. RECOMMENDATIONS

The Board is asked to note the continued commitment across the organisation to supporting colleague wellbeing and the progress made in developing a more systemic approach to health, wellbeing and inclusion.

The Board should also recognise that colleague wellbeing needs to continue to grow at a time when resources available to support this work are reducing. As a result, the future focus of Colleague Support and Wellbeing Service will increasingly prioritise interventions that can have trust-wide impact and build sustainable capability within teams and leaders, rather than relying predominately on individual support interventions.

This includes:

- Expanding compassionate leadership capability
- Strengthening manager confidence and skills
- Embedding the NHS Staff Health and Wellbeing Standard

- Advancing the reasonable Adjustments programme
- Using data and wellbeing champion intelligence to target organisational priorities
- Supporting local team to create environments where colleagues can thrive

Whilst capacity challenges remain, the service continues to identify opportunities to achieve greater reach through prevention, education, colleague empowerment and system-wide improvement activity. This approach is expected to deliver the greatest benefit to the largest number of colleagues whilst maintaining targeted support for those with the most complex needs.

ROSEMARY NOVAK, HEAD OF COLLEAGUE SUPPORT SERVICES

APPENDICES:

Appendix A: Supporting Data



NHS
Somerset
NHS Foundation Trust

Wellbeing Guardian Report: Appendix A: Systemic intervention and multilayered wellbeing activity

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Everyone, Every day

Dr Rosemary Novak

03/11/2026

Creating a Health & Wellbeing Culture

NHS Somerset NHS Foundation Trust

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

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

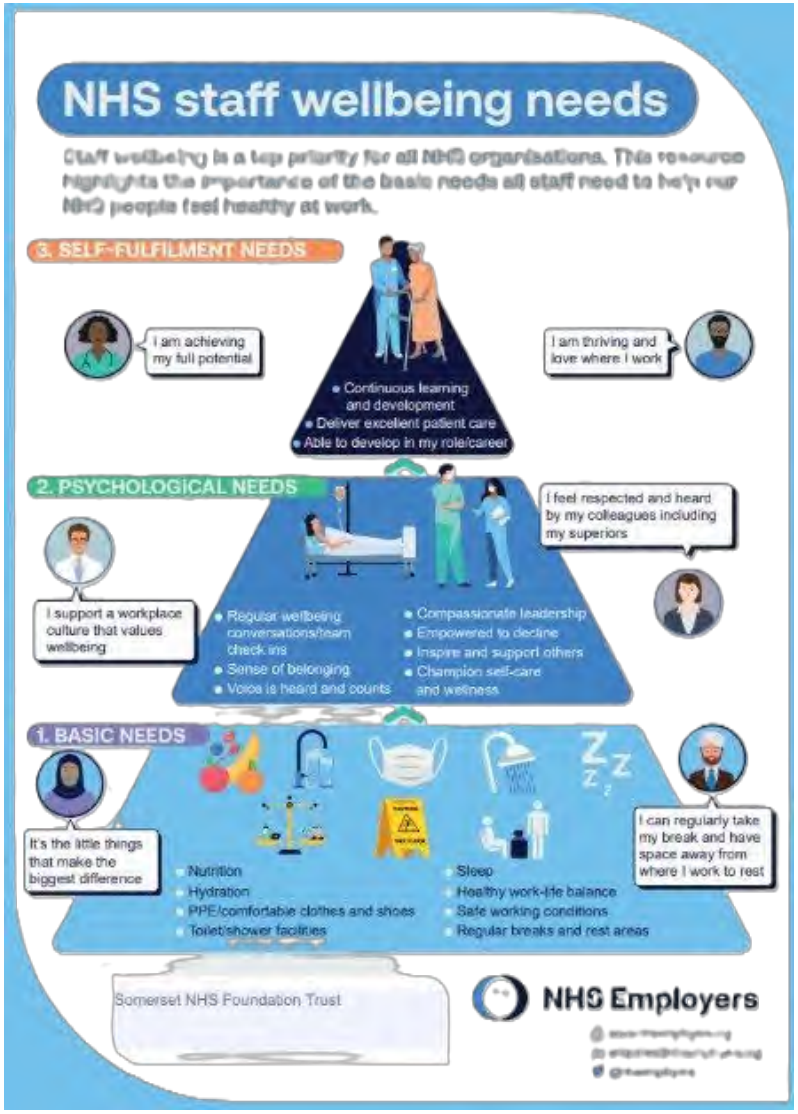
NHS Health & Wellbeing Framework

NHS Somerset NHS Foundation Trust



Getting the basics right

Impact of work environment and working conditions



NHS Somerset NHS Foundation Trust

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NHS
Somerset
NHS Foundation Trust

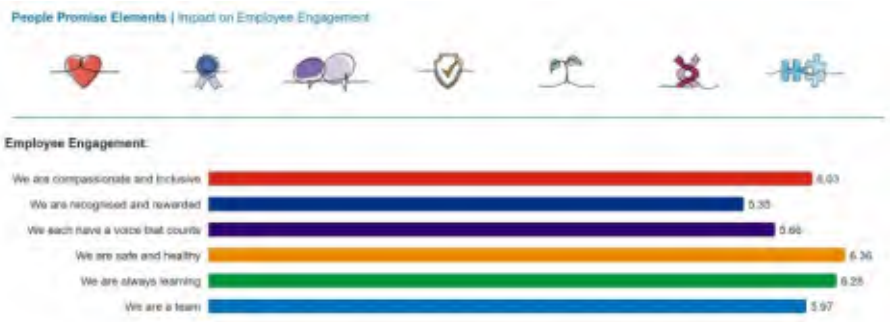
Data & Research

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Somerset
NHS Foundation Trust

Results from 2026 Pulse Surveys

Jan 2026



Employee Engagement Metrics:

Field	Employee Engagement	Motivation	Involvement	Advocacy
We are compassionate and inclusive	6.03	5.37	6.07	5.85
We are recognised and rewarded	5.35	5.42	5.21	5.42
We each have a voice that counts	5.66	5.79	5.60	5.80
We are safe and healthy	6.36	6.67	6.54	5.88
We are always learning	6.25	6.44	6.72	5.67
We are a team	5.97	5.46	5.99	5.47

July 2026

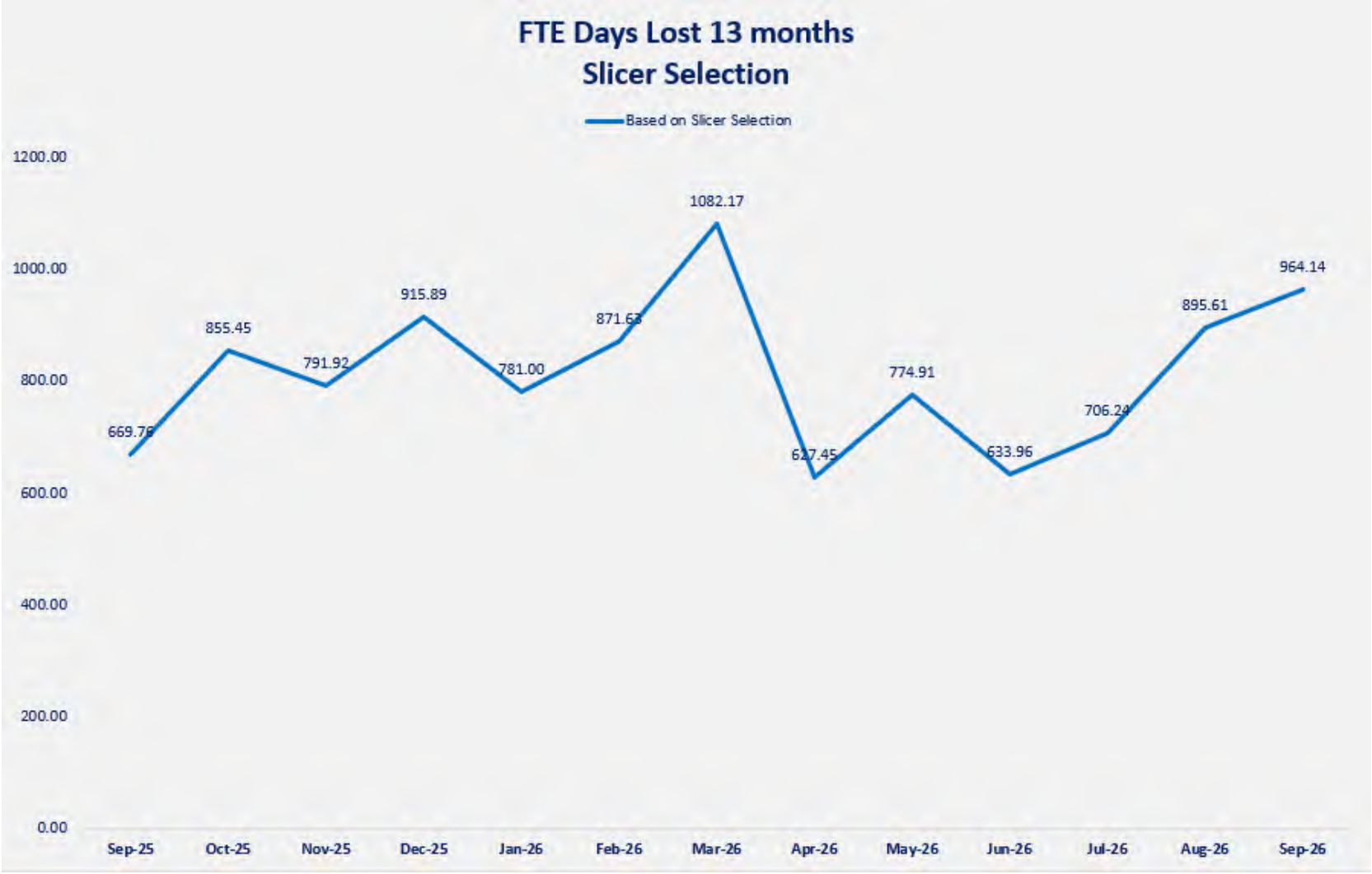


Employee Engagement Metrics:

Field	Employee Engagement	Motivation	Involvement	Advocacy
We are compassionate and inclusive	6.20	6.42	6.07	6.12
We are recognised and rewarded	6.02	6.25	5.94	5.87
We each have a voice that counts	6.18	6.63	5.83	6.08
We are safe and healthy	6.34	6.52	6.33	6.16
We are always learning	6.49	6.83	6.54	6.10
We work flexibly	5.67	5.92	5.54	5.54
We are a team	6.34	6.73	6.11	6.18

S10 Sickness Absence 25/26

Somerset NHS Foundation Trust

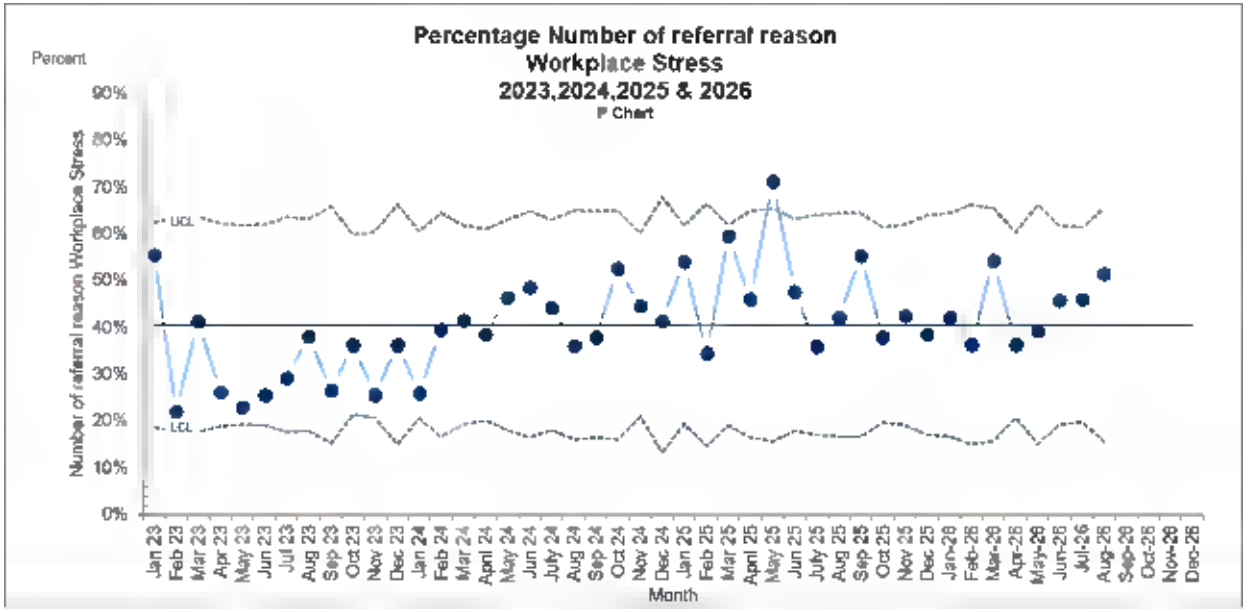


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Colleague Support Service Referrals show increasing workplace stress

- Total number of referrals remains stable at approximately 50 per month across 2025 and 2026
- Self-rated Workplace Stress as reason for referral has increased year on year





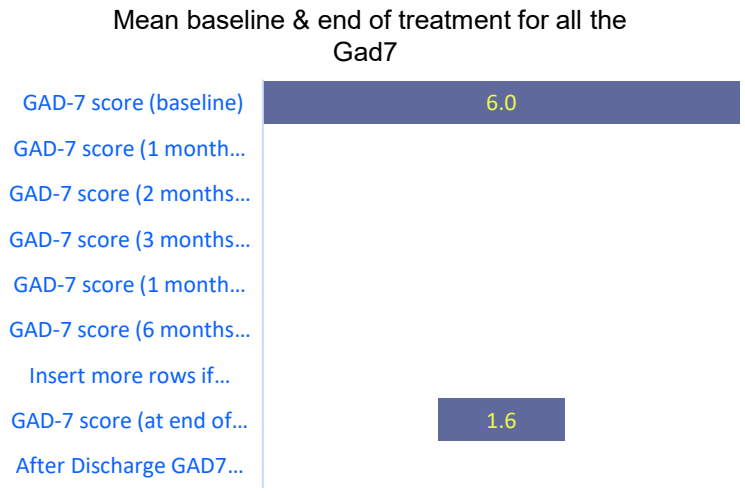
NHS
Somerset
NHS Foundation Trust

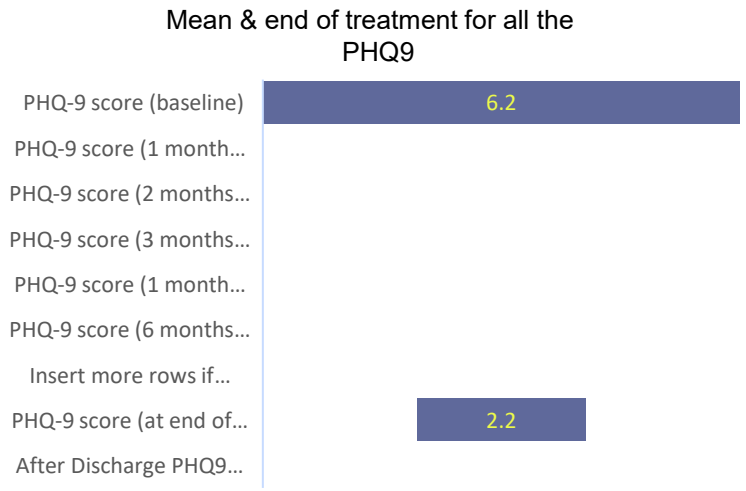
Data & Research - So What?

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Impact of Colleague Support Line:

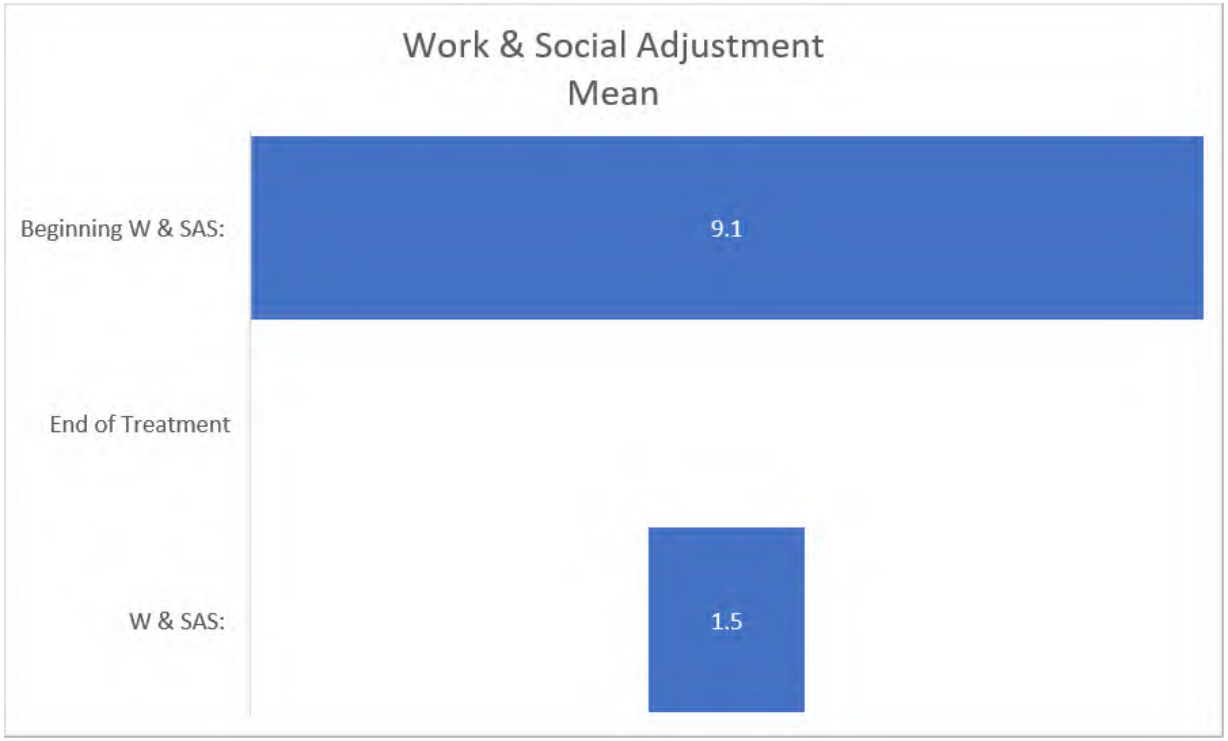
Scales of Anxiety and Low Mood:



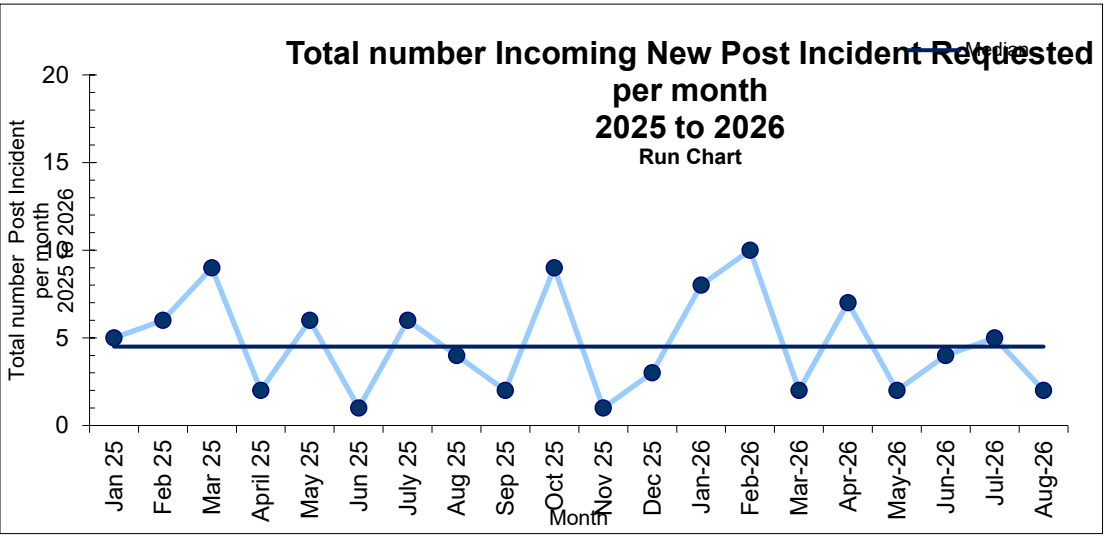


Work and Social Adjustment Scale

Measures the impact of difficulties across domains of daily life…. Including at work



Post Incident Reflective Conversations



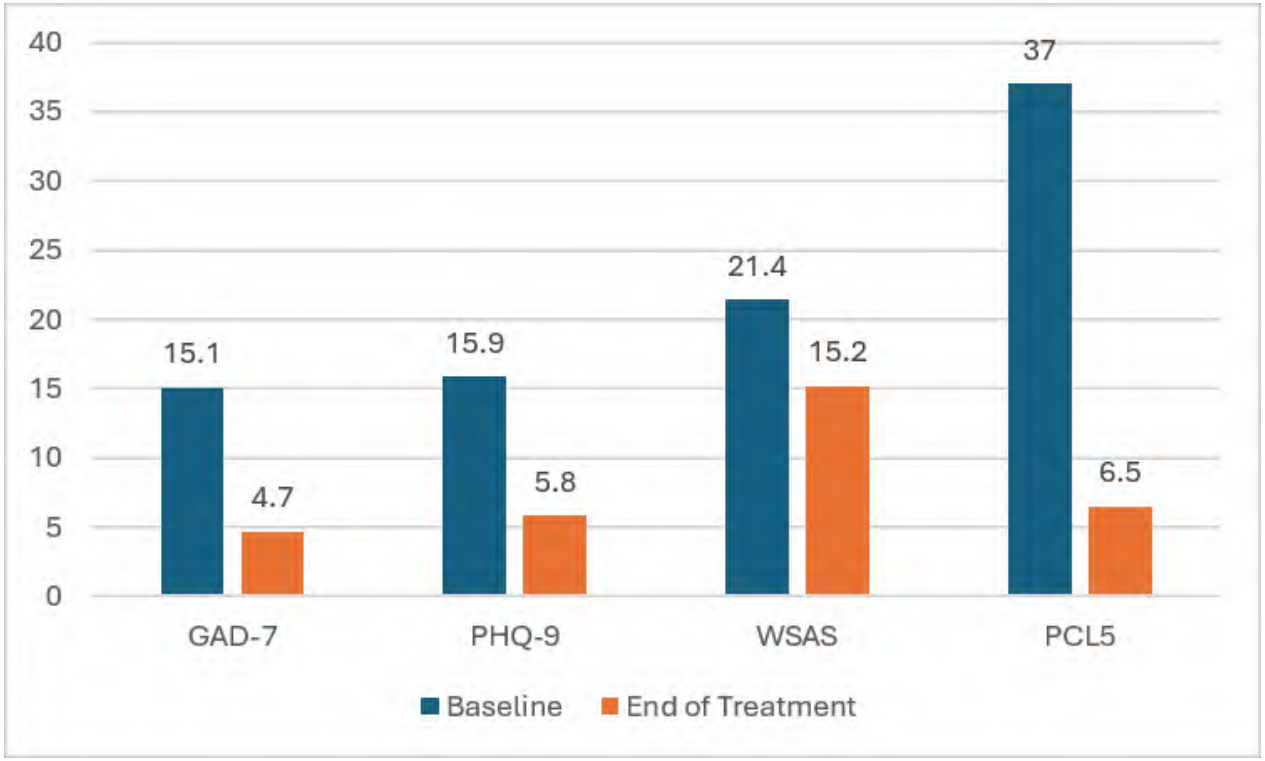
Colleague Feedback:

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

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

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

Level 5: Specialist Psychological Intervention Outcomes



Services & programmes managed by CSWS

- Occupational Health Service from PAM
- NHS Health Checks for 40-74 age group – moving to an in-house provision in the next few months
- Reasonable Adjustment Programme
- Financial wellbeing offers & the Cost of Living Group
- Physio4U Service - commissioned in-house 60 slots per month supporting MSK conditions run by the physio team (CSWS part commissioning team)

Feedback from Wellbeing Champions recent survey June 26

1. What are the main themes you have been discussing with your team over the last couple of months? Tick all that appl
y





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Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Workforce Resilience Framework
SPONSORING EXEC:	Isobel Clements, Chief of People and Organisational Development
REPORT BY:	Kirstie Lord, Deputy Chief People Officer
PRESENTED BY:	Isobel Clements, Chief of People and Organisational Development
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	The delivery of safe, effective and sustainable healthcare is dependent upon a resilient workforce. Whilst the Board receives assurance across a range of workforce metrics, there has not previously been a consolidated assessment of what these indicators collectively tell us about the resilience of our workforce and our capacity to respond to future operational, financial and transformational challenges. This paper introduces an emerging workforce resilience framework and sets out how the Trust intends to strengthen workforce assurance through the development of a comprehensive workforce dashboard.
Recommendation	The Board is asked to note the findings of the initial workforce resilience assessment, endorse the development of workforce resilience reporting as part of the Trust's workforce assurance framework, and support the implementation of the integrated workforce dashboard, recognising its role in strengthening evidence-based decision making, workforce planning, organisational sustainability and delivery of the People Strategy.

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

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

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

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

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

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]
N/A

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

WORKFORCE RESILIENCE FRAMEWORK

1. BACKGROUND AND PURPOSE

1.1 Through the integrated scorecard the Board receives regular reports covering a broad range of workforce indicators, including vacancy rates, retention, sickness absence, employee relations, mandatory training, and job planning. These measures provide valuable insight into specific aspects of workforce performance and risk.

1.2 As the workforce environment becomes increasingly complex, there is growing recognition that understanding individual metrics in isolation does not provide a complete picture of the overall resilience of the workforce. Workforce resilience encompasses the ability of individuals, teams and organisations to adapt, recover and continue to perform effectively in the face of operational pressures, service transformation, workforce shortages and organisational change.

1.3 Emerging thinking from Gartner identifies workforce resilience as a multidimensional concept influenced by factors including colleague wellbeing, engagement, adaptability, organisational support, leadership, skills development and workforce capacity. This approach recognises that resilience is not represented by a single measure but instead requires consideration of a range of indicators that together provide insight into the health and sustainability of the workforce.

1.4 Whilst the Trust already collects and reports many of the indicators associated with workforce resilience, these have not previously been brought together within a single framework to provide an overall assessment of workforce resilience across the organisation. As part of the Year 4 delivery plan for the People Strategy, work is underway to develop an integrated workforce dashboard that will consolidate key workforce metrics into a single source of insight. This will enable the Trust to establish a workforce resilience score, benchmark trends over time, and provide the ability to analyse resilience at Trust, service group and cost centre level.

1.5 The purpose of this paper is therefore to:

- Introduce the emerging Gartner workforce resilience framework and its relevance to the Trust.
- Provide an initial assessment of workforce resilience using existing workforce indicators.
- Demonstrate how current workforce data aligns to the resilience domains.

- Update the Board on progress against the People Strategy Year 4 commitment to develop an integrated workforce dashboard and resilience measurement approach.
- Seek Board support for the development of workforce resilience reporting as a key component of future workforce assurance arrangements.

2. WORKFORCE RESILIENCE FRAMEWORK

2.1 Understanding Workforce Resilience

There is increasing recognition across healthcare and wider industry that workforce resilience should be considered as a strategic organisational capability rather than solely an individual characteristic. Gartner defines workforce resilience as the ability to sustain or improve organisational performance through disruption without compromising the health of the workforce.

This recognises that resilient organisations are characterised not only by operational performance, but also by workforces that remain healthy, engaged, adaptable and capable of responding to changing demands. This perspective aligns with guidance from the CIPD, which describes resilience as the ability to recover from adversity, adapt positively to challenges and maintain wellbeing over time. Importantly, both approaches recognise that resilience is influenced not only by individual factors but also by leadership, organisational culture, working practices, workforce supply and the wider employment environment. The Kings Fund similarly identifies workforce shortages, vacancy pressures, excessive workload, workforce planning challenges, training investment and retention risks as key determinants of organisational resilience.

Having reviewed a range of established models, the Gartner framework (appendix 1) has been adopted as the basis for this initial assessment as it provides a practical structure through which existing Trust workforce information can be analysed and interpreted. The framework identifies three key domains that together influence overall workforce resilience:

Healthy Colleagues

This domain considers workforce wellbeing, capacity and sustainability. It examines whether colleagues have the physical, psychological and practical resources required to perform effectively whilst maintaining their own health and wellbeing. Key indicators include absence levels, workforce supply, retention, burnout, stress-related illness, temporary staffing reliance and work-life balance.

Healthy Relationships

This domain focuses on the quality of relationships across the organisation, including leadership effectiveness, team culture, psychological safety, engagement and trust. Measures include staff engagement, team working, line management effectiveness, employee relations activity, speaking-up culture and confidence in organisational leadership.

Healthy Work Environment

This domain considers the organisational conditions that enable colleagues to thrive. It includes inclusion and belonging, equality of opportunity, access to learning and development, workforce representation, recruitment effectiveness and organisational policies and practices that support sustainable employment.

3. SOMERSETS WORKFORCE RESILIENCE ASSESSMENT

3.1 A review has been undertaken of workforce indicators currently reported through the Integrated Performance Report, People Committee reporting, workforce inclusion reporting, employee relations reporting and the NHS Staff Survey (appendix 2). Whilst these measures have historically been reviewed separately, collectively they provide insight into workforce resilience across the Trust.

Healthy Colleagues

The analysis indicates this is currently the least resilient of the three domains and represents the principal area of workforce risk. Workforce resilience within this domain is being challenged by a combination of workforce supply pressures, health and wellbeing indicators and operational demand. Vacancy levels remain high and sickness absence continues to exceed desired levels, whilst long-term absence related to stress, anxiety and depression remains a significant concern. Continued reliance on temporary staffing reflects ongoing workforce capacity pressures. Evidence from the NHS Staff Survey also suggests increasing levels of burnout and high levels of presenteeism, indicating that many colleagues continue to attend work despite not feeling well enough to perform effectively.

A notable strength within this domain is employee retention, which remains strong and suggests colleagues continue to demonstrate a significant commitment to the organisation despite wider workforce pressures. Flexible working arrangements also continue to be viewed positively by colleagues; however, concerns relating to workload and capacity remain evident.

Overall, the Healthy Employees domain suggests a workforce that remains committed and engaged but where sustainability risks are increasing, particularly in relation to workforce supply, health and wellbeing.

Healthy Relationships

The Healthy Relationships domain presents a more balanced picture. NHS Staff Survey results continue to demonstrate strong team-working and positive perceptions of line management and immediate leadership. These indicators represent important protective factors and contribute positively to organisational resilience.

However, several measures indicate opportunities for improvement. Colleague engagement scores have declined over time, as has the "Voice That Counts" measure, suggesting colleagues may feel less connected to organisational decision-making. Whilst colleagues generally report feeling able to raise concerns, confidence that concerns will be acted upon has reduced. This is particularly evident amongst disabled colleagues, who report lower levels of confidence and psychological safety.

Employee relations data provides a further insight into organisational health. Elevated levels of formal HR casework, employment tribunal claims and suspensions suggest areas where organisational trust, early resolution and workplace relationships may require further attention. Whilst these indicators do not necessarily demonstrate poor culture, they do represent potential early warning signs of organisational strain and should continue to be monitored closely.

Overall, the domain reflects generally strong local leadership and team culture, but highlights the importance of continuing to strengthen engagement, trust and psychological safety.

Healthy Work Environment

The Trust demonstrates the strongest performance within the Healthy Work Environment domain. Staff survey data shows positive perceptions of inclusion and belonging, whilst workforce representation measures demonstrate continued progress in increasing diversity within senior leadership roles. Mandatory training compliance remains strong and appraisal performance continues to improve.

Nevertheless, opportunities remain to improve workforce equity. Analysis of recruitment and progression data continues to identify disparities affecting ethnic minority and disabled colleagues. Learning and development opportunities remain moderate and recruitment delays continue to impact organisational workforce supply and operational resilience.

Overall, this domain demonstrates a positive and improving organisational environment, although further work is required to address equity gaps and workforce access to opportunity.

3.2 **Overall Assessment**

Bringing workforce indicators together through the Gartner framework provides a useful mechanism for understanding resilience across the organisation. The assessment suggests that Somerset's workforce resilience is currently supported by strong retention, effective local leadership, positive team culture, high levels of inclusion and improving workforce diversity. These factors provide important protective characteristics that contribute to organisational resilience.

However, the analysis also highlights a number of interconnected risks. Workforce supply pressures, high vacancy levels, sickness absence, burnout indicators, recruitment delays and increasing employee relations activity collectively suggest that workforce resilience should be regarded as stable but fragile. Whilst no individual metric presents a significantly new risk to the Board, considering these measures collectively provides a more holistic understanding of workforce sustainability and the organisation's capacity to respond to ongoing operational and transformational demands.

Importantly, this analysis demonstrates that the Board already receives much of the information required to understand workforce resilience. The opportunity moving forward is therefore not to create additional reporting, but to bring existing intelligence together within a single framework that allows trends, relationships between indicators and emerging risks to be more readily identified.

4. WORKFORCE DASHBOARD DEVELOPMENT

4.1 As a reminder, the development of an integrated workforce dashboard is a key Year 4 deliverable within the People Strategy under the Data and Digital priority.

The People Committee endorsed the ambition to strengthen workforce intelligence in recognition that, across the organisation, gaps in workforce insight and fragmented data systems limit the effectiveness of strategic workforce planning. Whilst the Trust holds significant volumes of workforce data, information is often sourced from multiple systems and reports, making it more challenging to identify connections between workforce indicators, understand emerging trends and support timely decision-making.

The vision for this deliverable is to strengthen digital capability through more connected systems, standardised reporting processes and enhanced people analytics. This will provide a more comprehensive understanding of workforce performance and resilience, support evidence-based decision-making, improve workforce planning, and contribute to the Trust's wider financial sustainability and transformation objectives.

The agreed scope of the programme includes:

- Removal of existing gaps within workforce reporting, including the incorporation of Equality, Diversity and Inclusion (EDI) metrics.
- Improved use of NHS Staff Survey, Pulse Survey and colleague experience data to better understand workforce risks and opportunities, and ensure insight leads to targeted action.
- Enhanced support for leaders and managers in the interpretation of workforce data, enabling insights to be translated into informed operational and strategic decision-making.
- Development of a single integrated workforce dashboard providing a consistent source of workforce intelligence across the organisation.

Delivery of this People Strategy commitment remains on plan. Development of the dashboard is progressing as scheduled, with user testing and refinement due to commence from January 2027, followed by implementation of the full dashboard from April 2027.

Once implemented, the dashboard will provide workforce intelligence at Trust, Service Group and Cost Centre level, allowing leaders to move beyond retrospective reporting towards more proactive identification of workforce risks and opportunities. In particular, the dashboard will support the identification of resilience "hotspots", trends over time, and variation between services, enabling earlier intervention where workforce sustainability may be at risk.

Pending full implementation of the dashboard, workforce resilience reporting will be introduced through the existing People Committee Performance Report enabling the Trust to monitor resilience trends over time and identify areas requiring targeted intervention. This will provide an initial resilience score across the three Gartner domains.

This phased approach will allow the Trust to begin building organisational understanding of workforce resilience immediately, whilst ensuring the full dashboard is subject to appropriate testing and validation before formal implementation.

5. RECOMMENDATION

5.1 The Board is asked to note the emerging approach to measuring workforce resilience and the adoption of the Gartner Workforce Resilience Framework as a structured methodology for assessing the health, sustainability and adaptability of the Trust's workforce.

Recognise that, whilst the Trust already receives a wide range of workforce metrics, this is the first time these indicators have been considered collectively to provide an overarching assessment of workforce resilience and organisational sustainability.

Endorse the proposed approach to workforce resilience reporting through the three domains of healthy colleagues, healthy relationships and healthy Work environment.

Note the progress of the Year 4 People Strategy Data and Digital deliverable, including the development of an integrated workforce dashboard, and that delivery remains on track with user testing commencing in January 2027 and implementation planned from April 2027.

Support the introduction of workforce resilience measures within the People Committee Performance Report from quarter 3, 2026/27, pending implementation of the full dashboard solution.

Agree that workforce resilience reporting should become part of the Trust's ongoing workforce assurance framework, enabling the Board to better understand emerging workforce risks, monitor progress over time, and target interventions at Trust, Service Group and Cost Centre level where resilience may be under pressure.

KIRSTIE LORD, DEPUTY CHIEF PEOPLE OFFICER

Appendix 1: Gartner Workforce Resilience Framework
Appendix 2: Trust measures mapped to Gartner framework

APPENDIX 1: GARTNER WORKFORCE RESILIENCE FRAMEWORK



APPENDIX 2 – TRUST MEASURES MAPPED TO GARNER FRAMEWORK

Domain	Measure	Currently Reported
Healthy Employees	Vacancy Rate %	Integrated Performance Report People Committee Measures
Healthy Employees	Sickness Absence – rolling 12 month absence	Integrated Performance Report People Committee Measures
Healthy Employees	Stress & Anxiety – Long term absence linked to stress, anxiety and depression	Workforce Reports Integrated Performance Report
Healthy Employees	Burnout – Staff Survey burnout indicators	
Healthy Employees	Temporary Staffing Reliance – bank and agency rates	Integrated Performance Report People Committee Measures
Healthy Employees	Retention rates	Integrated Performance Report People Committee Measures
Healthy Employees	Work-Life Balance – Staff Survey flexible working score	
Health Employees	Presenteeism – staff survey question	
Healthy Relationships	Team Working – staff survey	

Healthy Relationships	Line Management – staff survey	
Healthy Relationships	Staff Engagement – staff survey	
Healthy Relationships	Voice & Involvement – staff survey voice that counts score	
Healthy Relationships	Psychological Safety – staff survey speaking up and raising concerns measures	
Healthy Relationships	Speaking up Culture - staff survey speaking up and raising concerns measures	
Healthy Relationships	Formal HR Cases	Integrated Performance Report People Committee Measures Board Disciplinary, suspension and Employment Tribunal report
Healthy Relationships	Suspensions	Board Disciplinary, suspension and Employment Tribunal report
Healthy Relationships	Employment Tribunals	Board Disciplinary, suspension and Employment Tribunal report
Healthy Work Environment	Inclusion & Belonging – staff survey	Annual inclusion board report
Healthy Work Environment	Workforce Equity – progression and recruitment perception for protected groups	Annual inclusion board report Integrated Performance Report People Committee Measures
Healthy Work Environment	Female Senior Representation	Integrated Performance Report

Healthy Work Environment	Ethnic Minority Senior Representation	Integrated Performance Report
Healthy Work Environment	Disability Leadership Representation	Integrated Performance Report
Healthy Work Environment	Recruitment Equity	Annual inclusion board report
Healthy Work Environment	Learning & Development – staff survey	
Healthy Work Environment	Appraisal Compliance	Integrated Performance Report People Committee Measures
Healthy Work Environment	Mandatory Training	Integrated Performance Report People Committee Measures
Healthy Work Environment	Time to Hire	People Committee Measures
Healthy Work Environment	Flexible Working – staff survey	

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Month 6 Group Finance Report
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer
REPORT BY:	Mark Hocking, Deputy Chief Finance Officer
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	The Finance report sets out the overall income and expenditure position for the Group. It includes commentary on the key issues, risks, and variances, which are affecting financial performance.
Recommendation	The Board is requested to discuss and note the report.

Links to Strategic Aims
(Please select 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)
n/a

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

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

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

SOMERSET NHS FOUNDATION TRUST

MONTH 6 GROUP FINANCE REPORT

1. SUMMARY

1.1 The Trust recorded a deficit of £8.877m, this was £6.582m adverse to plan for the month. Cumulatively, the Trust has a deficit of £28.212m which is £6.582m adverse to plan.

1.2 The September headlines were:-

September agency expenditure was £1.591m, £0.041m higher than August and £0.106m higher than for the same period in 2025/26. Vacancies continue to drive usage.

The Trust delivered £4.025m of CIP in September, £1.492m adverse to plan, with recurrent savings of £1.139m (28%). Delivery of our efficiency programme continues to present a significant risk to delivery of our financial plan. Further detail is set out in the CIP section of this report.

Ongoing operational challenges continue to place considerable financial pressure on service groups, with particularly sustained pressures across Medical Services, Surgical Services, and CYP & Families.

2. INCOME AND EXPENDITURE

2.1 Table 1 below sets out the Group summary income and expenditure account to 30 September 2026:

Table 1: Income and Expenditure Summary September

Statement of Comprehensive Income	Annual Budget	Current Month 6			Year to date		
	£000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000	Budget £000	Actual £000	Fav./ (Adv.) Variance £000
Income							
Patient Care Income	1,100,957	95,391	91,677	(3,715)	552,131	539,490	(12,640)
Other Operating Income	91,691	2,067	3,174	1,108	36,469	41,515	5,046
Total operating income	**1,192,648**	**97,458**	**94,851**	**(2,607)**	**588,599**	**581,005**	**(7,594)**
Operating expenses							
Employee Operating Expenses	(800,638)	(66,397)	(70,465)	(4,067)	(407,781)	(412,464)	(4,683)
Drugs Cost: Consumed/Purchased	(94,084)	(7,662)	(8,285)	(623)	(47,073)	(45,252)	1,821
Clinical Supp & Serv Exc-Drugs	(74,184)	(7,617)	(6,992)	625	(44,509)	(43,410)	1,099
Supplies & Services - General	(36,617)	(2,938)	(3,568)	(630)	(18,173)	(19,911)	(1,738)
Other Operating Expenses	(176,045)	(14,076)	(13,407)	669	(87,191)	(82,635)	4,556
Total operating expenses	**(1,181,569)**	**(98,691)**	**(102,717)**	**(4,026)**	**(604,726)**	**(603,672)**	**1,055**
Operating Surplus/Deficit	11,079	(1,233)	(7,866)	(6,633)	(16,127)	(22,667)	(6,540)
Finance Expense	(15,032)	(1,258)	(1,266)	(8)	(7,476)	(6,726)	750
Finance Income	2,510	209	171	(38)	1,255	1,326	71
Other	1	0	0	(0)	(1)	0	1
Overall Surplus/(Deficit)	(1,442)	(2,282)	(8,961)	(6,679)	(22,348)	(28,067)	(5,719)
Depr On Donated Assets	2,106	177	147	(30)	1,056	578	(477)
Donated Assets Income	(810)	(203)	0	203	(405)	(117)	288
Amortisation	0	0	3	3	0	18	18
PFI UK GAAP Adjustments	146	13	(66)	(79)	67	(624)	(691)
Impairments	0	0	0	0	0	0	0
Adjustments to control total	1,442	(12)	84	96	718	(145)	(862)
Adjusted Financial Performance	0	(2,296)	(8,877)	(6,582)	(21,630)	(28,212)	(6,582)

2.2 The tables below set out pay expenditure and whole-time equivalent (WTE) information by month. In September, total staffing was 13,024 WTE, 129 WTE under the planned establishment for the month of 13,152 WTE with the following variances:

- Substantive staffing was 312 WTE under the establishment plan.
- Bank 176 WTE over plan.
- Agency 39 WTE over &
- Locums 32 WTE below the plan

Table 2: Pay expenditure information

2026/27 Monthly Pay Expenditure analysis	Apr-26 £000	May-26 £000	Jun-26 £000	Jul-26 £000	Aug-26 £000	Sep-26 £000	2026/27 In Month Budget	F/(A) Variance £000	2026/27 Total £000	2026/27 YTD Budget	F/(A) Variance £000
Temporary staff											
Bank Staff	2,141	2,377	2,231	2,257	2,448	2,444	1,487	(957)	13,897	9,490	(4,407)
Medical Agency	924	1,122	1,128	1,042	1,139	1,108	882	(226)	6,462	4,831	(1,632)
Medical Locums	1,995	1,213	1,354	1,392	1,076	1,368	880	(487)	8,398	5,000	(3,398)
Nursing Agency	268	273	291	332	304	395	211	(184)	1,863	1,207	(656)
Other Agency	99	83	79	104	107	87	41	(47)	558	228	(330)
Total Temporary Staff	**5,426**	**5,067**	**5,082**	**5,127**	**5,074**	**5,403**	**3,501**	**(1,902)**	**31,178**	**20,756**	**(10,422)**
Nursing	17,332	17,351	17,493	17,353	17,151	18,740	17,774	(966)	105,420	105,492	72
Support to Nursing	6,156	6,228	6,299	6,308	5,953	6,210	6,278	68	37,154	37,034	(120)
Medical	14,773	14,506	15,396	15,378	15,259	15,430	14,813	(616)	90,742	89,421	(1,321)
AHP's	10,005	10,001	10,018	9,900	9,925	10,092	10,252	160	59,941	61,222	1,281
Infrastructure Support	10,738	10,764	10,831	10,721	10,750	10,887	9,251	(1,636)	64,690	67,204	2,513
Other	4,077	4,392	3,885	3,876	3,407	3,701	4,528	827	23,337	26,648	3,311
Substantive Staff	**63,081**	**63,240**	**63,922**	**63,535**	**62,444**	**65,060**	**62,896**	**(2,164)**	**381,284**	**387,021**	**5,737**
Total All Staff	**68,507**	**68,308**	**69,004**	**68,663**	**67,518**	**70,463**	**66,397**	**(4,066)**	**412,462**	**407,777**	**(4,685)**
% Temporary	7.92%	7.42%	7.37%	7.47%	7.51%	7.67%	5.27%		7.56%	5.09%	

Table 3: WTE information

2026/27 Monthly Workforce analysis	Apr-26 WTE	May-26 WTE	Jun-26 WTE	Jul-26 WTE	Aug-26 WTE	Sep-26 WTE	In Month WTE	In Month Budget WTE	F/(A) Variance WTE
Temporary staff									
Bank Staff	501.04	509.73	492.12	512.34	541.32	530.40	530.40	354.06	(176.34)
Medical Agency	44.23	46.00	47.29	52.11	53.66	50.40	50.40	39.40	(11.00)
Medical Locums	87.24	61.40	69.38	73.43	61.69	68.53	68.53	100.58	32.05
Nursing Agency	37.33	35.87	41.02	44.83	44.34	56.11	56.11	26.14	(29.97)
Other Agency	9.98	13.37	14.87	20.72	21.07	14.27	14.27	15.80	1.53
Total Temporary Staff	**679.82**	**666.37**	**664.68**	**703.43**	**722.08**	**719.71**	**719.71**	**535.99**	**(183.72)**
Nursing	3,498.85	3,491.45	3,490.04	3,486.92	3,508.65	3,549.28	3,549.28	3,584.12	34.83
Support to Nursing	1,871.31	1,866.84	1,864.11	1,857.72	1,869.84	1,857.42	1,857.42	1,805.77	(51.65)
Medical	1,286.66	1,290.47	1,295.21	1,290.46	1,353.67	1,354.41	1,354.41	1,301.01	(53.40)
AHP's	1,640.72	1,636.99	1,640.25	1,633.83	1,644.04	1,676.29	1,676.29	1,721.37	45.08
Infrastructure Support	2,707.30	2,708.42	2,710.40	2,707.32	2,700.69	2,703.89	2,703.89	2,905.74	201.85
Other	1,183.95	1,176.90	1,166.84	1,168.18	1,165.13	1,163.81	1,163.81	1,298.71	134.90
Substantive Staff	**12,188.79**	**12,171.08**	**12,166.86**	**12,144.43**	**12,242.03**	**12,305.11**	**12,305.11**	**12,616.72**	**311.61**
Total All Staff	**12,868.61**	**12,837.45**	**12,831.54**	**12,847.86**	**12,964.11**	**13,024.82**	**13,024.82**	**13,152.71**	**127.89**
% Temporary	5.28%	5.19%	5.18%	5.48%	5.57%	5.53%	5.53%	4.08%	

2.3 Total agency and locum costs in month were £2.958m, this is an increase of £0.332m compared with August. Agency costs were £0.041m higher than in August at £1.591m. There was a decrease of £0.031m in medical agency, a £0.091m increase in nursing agency and a decrease in other agency of £0.020m. Medical locum costs were £0.291m higher than August.

2.4 Reducing temporary staffing expenditure remains a key priority. Actions include strengthening rostering arrangements and progressing targeted recruitment to hard-to-fill medical vacancies, which accounted for 68% of

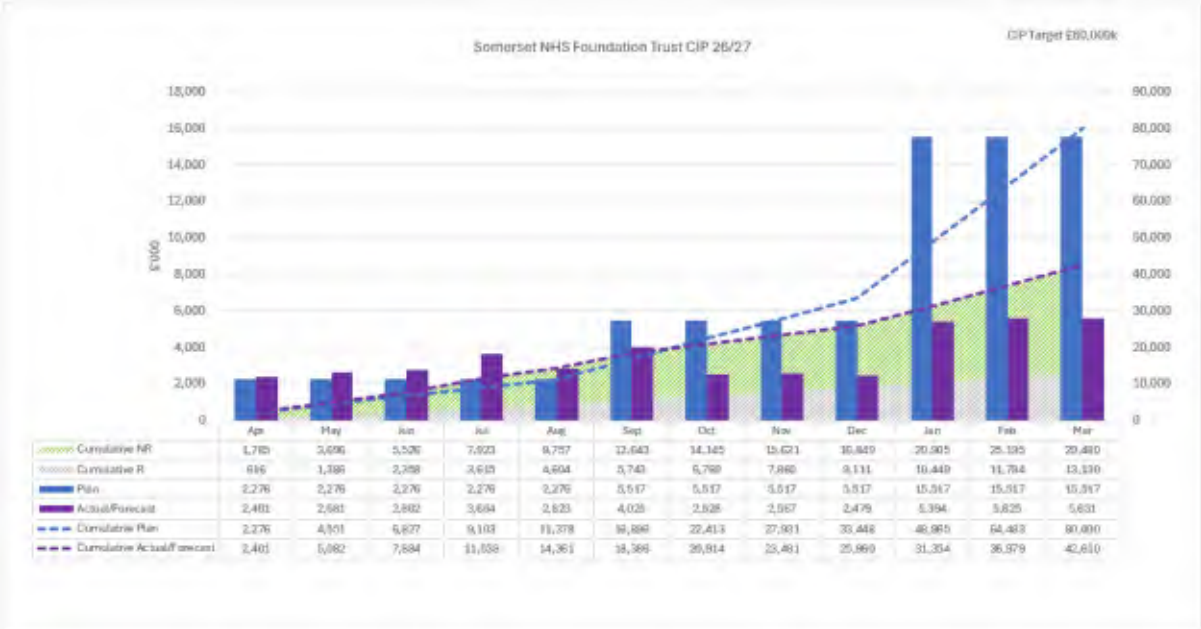
medical agency expenditure in September. Successful substantive recruitment is therefore central to reducing reliance on temporary staffing.

3. COST IMPROVEMENT PROGRAMME

3.1 In September, total savings of £4.025m were delivered, this was £1.492m adverse to plan for the month. Recurrent savings were £1.139m (28% of total).

3.2 The Trust has paused work on the proposed subsidiary expansion. This pause therefore creates a £30m gap in the financial plan, of which £10m relates to recurrent savings. In addition the elements of the transformation programme and some service level plans are not progressing at the pace needed.

3.3 A summary of year to date delivery and forecast is shown in the table below:-



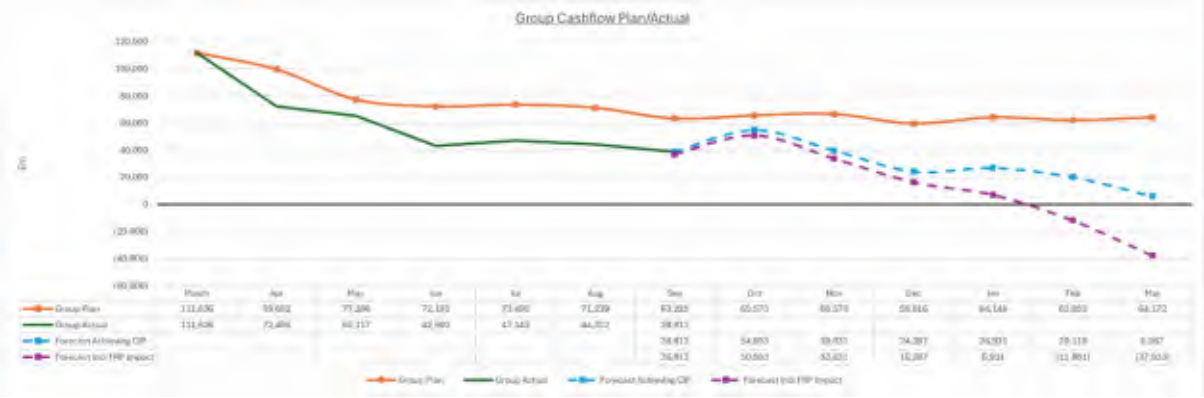
4. CASH

4.1 Cash balances at 30 September were £38.8m, £24.4m lower than plan. If we are unable to mitigate the risk to delivering a balanced plan, modelling indicates there will not be sufficient cash in February to support operational delivery.

4.2 Additional cash management measures will be required should we be unable to make further improvements in our run rate. This could include delaying internal capital expenditure. Access to cash support is tightly controlled and we must be able to demonstrate that strict internal cost and cash containment controls are in place and actively used.

4.3 The current cash flow forecast is set out below:

Chart 2: Cash flow Actual/Plan



5. STATEMENT OF FINANCIAL POSITION

Aug-26	Sep-26	Movement		Mar-26	Sep-26	Movement in Year
£000	£000	£'000		£000	£000	£000
46,756	46,978	222	Intangible Assets	38,864	46,978	8,114
448,351	448,076	(275)	Property, plant and equipment, other	451,177	448,076	(3,101)
25,346	25,157	(189)	On SoFP PFI assets	26,291	25,157	(1,134)
87,591	86,891	(700)	Right of use assets	89,327	86,891	(2,436)
14	14	0	Investments	14	14	0
14	14	0	Other investments/financial assets	14	14	0
3,476	3,479	3	Trade & other receivables >1yr	3,340	3,479	139
611,548	**610,610**	**(938)**	**Non-current assets**	**609,028**	**610,610**	**1,582**
13,567	14,669	1,102	Inventories	13,022	14,669	1,647
17,316	18,403	1,087	Trade and other receivables: NHS receivables	10,586	18,403	7,817
31,253	32,685	1,432	Trade and other receivables: non-NHS receivables	22,684	32,685	10,001
0	0	0	Non current assets held for sale	0	0	0
44,312	38,813	(5,499)	Cash	111,836	38,813	(73,023)
106,449	**104,571**	**(1,878)**	**Total current assets**	**158,129**	**104,571**	**(53,558)**
(120,576)	(126,053)	(5,476)	Trade and other payables: non-capital	(134,715)	(126,053)	8,662
(10,223)	(10,573)	(350)	Trade and other payables: capital	(42,354)	(10,573)	31,782
(30,167)	(31,740)	(1,573)	Other liabilities	(12,074)	(31,740)	(19,667)
(12,820)	(12,807)	13	Borrowings	(12,695)	(12,807)	(112)
(8,570)	(8,943)	(373)	Provisions <1yr	(8,908)	(8,943)	(36)
(182,357)	**(190,117)**	**(7,760)**	**Current liabilities**	**(210,746)**	**(190,117)**	**20,629**
(75,908)	**(85,546)**	**(9,638)**	**Net current assets**	**(52,617)**	**(85,546)**	**(32,929)**
(110,014)	(108,289)	1,725	Borrowings >1yr	(112,107)	(108,289)	3,817
(2,669)	(2,669)	0	Provisions >1yr	(2,725)	(2,669)	56
(1,057)	(1,035)	22	Other liabilities > 1Yr	(1,164)	(1,035)	129
(113,740)	**(111,993)**	**1,746**	**Total long-term liabilities**	**(115,996)**	**(111,993)**	**4,003**
421,900	**413,070**	**(8,830)**	**Net assets employed**	**440,416**	**413,070**	**(27,344)**
			Financed by:			
466,225	466,225	0	Public dividend capital	466,224	466,225	0
60,819	60,819	0	Revaluation reserve	60,819	60,819	0
(3,722)	(3,722)	0	Other reserves	(3,702)	(3,722)	(20)
(2,471)	(2,471)	0	Financial assets at FV through OCI reserve	(2,471)	(2,471)	0
(99,307)	(108,267)	(8,960)	I&E reserve	(81,325)	(108,267)	(26,942)
			Other's equity			
358	488	130	Non-controlling interest	871	488	(383)
421,900	**413,070**	**(8,830)**	**Total financed**	**440,416**	**413,070**	**(27,344)**

6. CAPITAL

6.1 Schemes are being progressed in accordance with the agreed programme for the year. Year to date, capital expenditure is £22.846m compared with the plan of £16.138m, resulting in an overspend of £6.707m. This overspend is

primarily due to timing differences in EHR and general IT spend against plan. A summary of the programme is shown in Table 4 below.

Table 4: Capital Programme Summary

Capital Programme 2026-2027	Plan £000	Revised Budget £000	YTD Plan £000	YTD Actual £000	Variance Act v plan YTD £000
Backlog Maintenance	6,169	6,120	1,470	1,830	360
Essential Facilities Improvement Works	1,367	1,367	447	555	109
Service Redesign Enabling Works	5,142	4,225	2,516	2,535	19
Service Redesign Enabling Works - Major	3,176	2,776	580	581	1
Infrastructure	0	0	0	0	0
Rolling IT & Digital Development	18,165	18,165	6,601	10,183	3,582
Equipment Replacement	5,285	4,564	1,284	2,462	1,179
Subsidiary Companies	260	260	65	128	63
Leases	4,258	4,258	2,409	1,904	(506)
Total Internal Capital Envelope	43,822	41,735	15,371	20,178	4,807
Externally Funded Capital Schemes	**Plan £000**	**Revised Budget £000**	**YTD Plan £000**	**YTD Actual £000**	**Variance Act v plan YTD £000**
Total Additional Schemes	22,808	19,014	767	2,667	1,900
TOTAL TRUST PROGRAMME	66,630	60,749	16,138	22,846	6,707

6.2 The Strategic Estates Group is responsible for overseeing delivery of the capital programme and ensuring expenditure remains within available financial resources. Should the adverse cash impact of the Trust's forecast financial position not be sufficiently mitigated, it may be necessary to consider rephasing elements of the internally funded capital programme to protect the Trust's cash position.

7. CONCLUSION & RECOMMENDATION

7.1 Operational pressures, activity underachievement and shortfalls in our efficiency programme are driving the in-month adverse performance against plan and are creating a material and ongoing risk to the delivery of our financial plan. In response, the Trust have implemented a series of turnaround actions to recover the financial position and continues to develop its financial recovery plans in response to these pressures.

7.2 The Financial Recovery Plan includes a range of mitigating actions to address our financial challenges. The plan extends beyond CIP delivery and includes actions to address activity challenges and wider operational pressures. However, the actions identified do not currently fully mitigate the forecast financial position, leaving a residual unmitigated risk of £25m.

7.3 Further mitigating actions continue to be developed and assessed to determine what additional measures can be taken to address the financial challenge and reduce the residual unmitigated risk.

7.4 The Board is asked to note the in-month financial performance, ongoing financial challenges and actions being taken address these.

CHIEF FINANCE OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Healthset Programme
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	Stuart Hill, Chief Digital Information Officer
PRESENTED BY:	Stuart Hill, Chief Digital Information Officer Luke Gompels, Chief Clinical Information 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	The Healthset programme's overall status remains good, with delivery broadly on track towards the planned April 2028 go-live. System build is progressing, supported by the recruited analysts, digital clinical leadership and subject matter experts from across the Trusts. The programme governance is providing assurance over delivery, enabling timely decision making and management of risks. Internal Trust governance is in place, alongside programme governance, to support local decision making and readiness activities. An organisational readiness assessment has been undertaken with NHS England; its findings are awaited. The NHS England Programme Initiation Assurance review is underway. The programme remained broadly within approved business case financial assumptions. Affordability depends on continued cost control and delivery of planned benefits. Workforce capacity, organisational readiness, data governance and existing-system dependencies remain risks. The Board can take reasonable assurance from progress and controls at this stage.
Recommendation	The Board is asked to note the good programme status, take reasonable assurance from progress and controls, and note the continuing risks and ongoing external assurance activities.

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: The paper has financial, workforce and ICT implications associated with programme delivery, recruitment, colleague release and implementation activity. These are reflected in the body of the report.					

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:

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 programme has been informed through established programme governance and engagement with colleagues across the Trust as part of the procurement process. Wider colleague involvement will increase as implementation progresses and engagement will build at each stage of the programme, through to go-live. Plans for patient and wider

public engagement will be developed, with a particular focus on the benefits of the patient portal.

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 paper consolidates Programme and Trust Board Sub-Committee assurance reporting. This paper provides a consolidated assurance position for the Trust Board.

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

HEALTHSET PROGRAMME

1. EXECUTIVE SUMMARY

The Healthset programme's overall status remains good, with delivery broadly on track towards the planned April 2028 go-live. System build is progressing, supported by the recruited analysts, digital clinical leadership and subject matter experts from across the Trusts.

The programme governance is providing assurance over delivery, enabling timely decision making and management of risks. Internal Trust governance is in place, alongside programme governance, to support local decision making and readiness activities.

An organisational readiness assessment has been undertaken with NHS England; its findings are awaited. The NHS England Programme Initiation Assurance review is underway.

The programme remained broadly within approved business case financial assumptions. Affordability depends on continued cost control and delivery of planned benefits.

Workforce capacity, organisational readiness, data governance and existing-system dependencies remain risks. The Board can take reasonable assurance from progress and controls at this stage.

2. PROGRAMME DELIVERY

Programme delivery remains a good status, which reflects the overall delivery confidence at this stage in the programme.

System build and clinical workflow design are progressing, with key analyst roles now in place and good engagement across the Trusts. Technical work covers third-party system integration, data migration, reporting and infrastructure. The plans for systems to be retained or replaced are currently undergoing validation. A Trust-wide survey is scheduled to ensure the technical estate is ready for go-live and to inform the end user device plans.

3. QUALITY, SAFETY AND CLINICAL ASSURANCE

The Programme Board oversees delivery, key decision making and risk management, supported by clinical, operational and technical design authorities. Data and reporting governance continues to develop.

Clinical and patient safety arrangements provide a shared approach to identifying hazards, managing risks and preparing safety cases. Information governance work continues, including the programme-wide Data Protection Impact Assessment (DPIA).

The NHS England organisational readiness assessment has been undertaken, with findings awaited. The Programme Initiation Assurance review is underway, covering clinical safety, organisational and operational readiness, data and technical assurance. Findings and actions will be reported through programme and Trust governance.

4. WORKFORCE AND RESOURCING

Resourcing has improved through the recent round of recruitment, although some vacancies remain. Delivery depends on timely colleague release, training and sufficient clinical, operational and technical capacity, for which plans are in place over the coming months.

5. FINANCES

The programme remained broadly within approved business case financial assumptions. Financial governance and contingency arrangements are in place to support management of emerging pressures.

Continued oversight is required over expenditure across financial years, revenue costs and local implementation requirements. Affordability also depends on planned benefits and timely retirement of legacy systems.

6. KEY RISKS AND DEPENDENCIES

The main risks are workforce capacity, organisational readiness, affordability, data governance and existing-system dependencies. These remain subject to programme and Trust oversight, with escalation where required.

Programme leadership continues to review the risk profile and mitigating actions. Current risk themes are reviewed through Programme Board and established governance routes. There are no risks requiring escalation at this stage.

7. RECOMMENDATION

The Board is asked to note the good programme status, take reasonable assurance from progress and controls, and note the continuing risks and ongoing external assurance activities.

STUART HILL, CHIEF DIGITAL INFORMATION OFFICER
LUKE GOMPELS, CHIEF CLINICAL INFORMATION OFFICER

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Quality and Governance Assurance Committee meeting held on 30 September 2026
SPONSORING EXEC:	Mel Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Inga Kennedy, Chair of the Quality and Governance Assurance Committee
DATE:	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 Committee met on 30 September 2026 and reviewed safer staffing arrangements, learning from deaths, winter preparedness, progress against Strategic Aim 2, internal audit escalation reporting and a range of governance and patient safety matters. The Committee also considered learning arising from the Thirlwall Inquiry and the governance arrangements supporting Artificial Intelligence and Ambient Voice Technology. Assurance was received regarding safer staffing, learning from deaths, winter planning and progress against Strategic Aim 2. The Committee also received assurance through the Internal Audit Escalation Report regarding governance, patient safety and organisational learning arrangements. Key areas requiring continued oversight include workforce resilience, governance and assurance arrangements for Artificial Intelligence technologies, learning from the Thirlwall Inquiry, and delivery of the Winter Plan.
Recommendation	That the Board **notes** the assurance provided and the key risks highlighted, particularly those relating to workforce capacity and resilience, delivery of the Winter Plan, learning arising from the Thirlwall Inquiry, and governance arrangements for Artificial Intelligence and Ambient Voice Technology.

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

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE MEETING HELD ON 30 SEPTEMBER 2026

1. BACKGROUND AND PURPOSE

1.1 This report provides a summary of the key items discussed at the Quality and Governance Assurance Committee (Q&GAC) focus meeting held on 30 September 2026, including assurance received, areas of concern and risks or issues to be escalated to the Board.

2. ASSURANCE RECEIVED

2.1 The Committee received assurance regarding the Trust's response to the findings of the Thirlwall Inquiry, including arrangements to strengthen organisational learning, speaking-up culture, leadership oversight and the identification and escalation of patient safety concerns.

2.2 Assurance was received regarding safer staffing arrangements, including workforce planning and recruitment activity to address workforce challenges across a number of services. The Committee welcomed the introduction of the monthly safer staffing report to strengthen oversight and assurance arrangements.

2.3 The Committee received assurance through the Quarter 1 Learning from Deaths Report, noting that no deaths had been identified as more likely than not due to problems in care and that learning themes and actions continue to be monitored through established governance arrangements.

2.4 Assurance was received regarding winter preparedness and planning arrangements. The Committee approved the Winter Plan and Board Assurance Statement on behalf of the Board and received assurance that robust planning and governance arrangements are in place, while recognising the significant risk associated with ongoing SFT challenges and the lack of an aligned system wide plan.

2.5 The Committee also received assurance regarding progress against Strategic Aim 2 and through the Internal Audit Escalation Report, which provided oversight of governance arrangements and progress against quality, patient safety and governance audit recommendations.

3. AREAS OF CONCERN OR FOLLOW UP

3.1 Members highlighted the need for further assurance regarding governance and oversight arrangements for Artificial Intelligence technologies, particularly Ambient Voice Technology, including patient safety, information governance and patient engagement arrangements.

3.2 The Committee noted ongoing workforce resilience concerns across a number of services, including community hospitals, neonatal services, urgent treatment centres and Oral and Maxillofacial Surgery services.

3.3 Members highlighted the need to strengthen the triangulation of learning from deaths, child death and perinatal mortality reporting to support organisational learning and the earlier identification of emerging risks.

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

4.1 The Committee highlighted continuing risks relating to workforce capacity and resilience across a number of clinical services.

4.2 Members also highlighted the need to maintain oversight of actions arising from the Thirlwall Inquiry and ensure that learning is reflected within the Trust's governance, quality and risk management arrangements.

4.3 The Committee reinforced the importance of maintaining Board oversight of winter preparedness and delivery of the Winter Plan, particularly in the context of wider system, workforce and financial pressures.

4.4 The Committee also highlighted the ongoing need for assurance regarding the governance and risk management of emerging technologies, including Artificial Intelligence and Ambient Voice Technology.

INGA KENNEDY, CHAIR OF THE QUALITY AND GOVERNANCE ASSURANCE COMMITTEE

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Audit Committee meeting held on 21 October 2026
SPONSORING EXEC:	Pippa Moger, Chief Finance Officer Jace Renville, Chief of Staff to the Chief Executive
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Paul Mapson, Chair of the Audit Committee
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 Audit Committee met on 21 October 2026 and reviewed the Quarter 1 Board Assurance Framework and Corporate Risk Register, internal and external audit progress, counter fraud activity, limited assurance reviews and a range of governance, risk management and internal control matters. The Committee also received six-monthly risk reports from the Quality and Governance Assurance Committee, People Committee and Finance Committee. Assurance was received regarding the continued development of the Board Assurance Framework and corporate risk management arrangements, delivery of the Internal Audit Plan, external audit preparations, progress against counter fraud work programmes and the management of limited assurance audit recommendations. The Committee welcomed the positive assurance received through a number of internal audit reviews, including Data Quality and Mortuary Controls, and noted progress in closing historic audit recommendations. The Committee highlighted workforce planning, recruitment controls, onboarding processes, financial sustainability and information governance as areas requiring continued oversight through the Trust's governance arrangements.
Recommendation	The Board is asked to **note** the assurance provided and the key risks identified, including those relating to workforce planning, recruitment controls and onboarding processes, financial sustainability, information governance and the continued development of the Board Assurance

	Framework, and to support ongoing work to strengthen governance, risk management and internal control arrangements across the Trust.

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)

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☒ 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)

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

Previous Consideration

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

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE AUDIT COMMITTEE MEETING HELD ON 21 OCTOBER 2026

1. PURPOSE

1.1 The Audit Committee met on 21 October 2026 to review the effectiveness of internal control, risk management, governance and assurance arrangements across the Trust. This report provides assurance to the Board on matters discussed, highlights areas of concern, and identifies risks requiring escalation or continued oversight.

2. ASSURANCE RECEIVED

2.1 The Committee reviewed the Quarter 1 Board Assurance Framework (BAF) and Corporate Risk Register and received assurance regarding the continued development of the refreshed BAF and strengthening of strategic risk management arrangements. The Committee welcomed progress made in improving alignment between strategic objectives, risk management and assurance processes and supported further refinement of the framework.

2.2 The Committee received assurance that corporate risks continue to be actively managed through established governance arrangements. Members noted that a number of risks relating to workforce capacity, financial sustainability, information governance and operational delivery remain above target levels and require ongoing oversight.

2.3 The Committee received assurance regarding delivery of the 2026/27 Internal Audit Plan and welcomed the Moderate Assurance opinions received for the Data Quality and Mortuary Controls reviews. Assurance was also received regarding progress in implementing audit recommendations, with a significant number of historic recommendations now closed.

2.4 Assurance was received from External Audit regarding preparations for the 2026/27 audit cycle and the transition of responsibilities within the External Audit team. The Committee noted that no significant concerns had been identified.

2.5 The Committee received assurance regarding counter fraud activity, including progress against the annual work plan, proactive fraud prevention work, ongoing investigations and implementation of counter fraud recommendations. Assurance was also received regarding arrangements for managing Limited Assurance audit reviews, losses and special payments and procurement waiver processes.

2.6 The Committee also received assurance through the six-monthly risk reports from the Quality and Governance Assurance Committee, People Committee and Finance Committee, which highlighted continued oversight of workforce, financial and quality governance risks.

3. AREAS OF CONCERN OR FOLLOW UP

3.1 The Committee noted the need for further development of the Board Assurance Framework, particularly in relation to assurance methodologies and strengthening links between strategic objectives, delivery plans and risk assessments.

3.2 Concerns were raised regarding recruitment controls, pre-employment checks and onboarding processes. Whilst improvements had been made, members agreed that these risks should be escalated for wider Board consideration.

3.3 The Committee noted ongoing pressures associated with Subject Access Requests and wider information governance requirements, recognising that increasing demand and complexity continue to present risks across the NHS.

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

4.1 The Committee highlighted workforce-related risks as a significant challenge for the Trust, including workforce planning, recruitment, onboarding controls and workforce transformation. Members agreed that recruitment and onboarding risks should receive further Board consideration.

4.2 The Committee noted that financial sustainability remains one of the Trust's highest-scoring corporate risks and requires continued oversight through established governance arrangements.

4.3 Members highlighted the importance of maintaining effective controls in areas subject to ongoing counter fraud investigations, particularly in relation to additional payments, waiting list initiatives and sickness absence processes.

4.4 The Committee noted the importance of continued development of the Board Assurance Framework and Corporate Risk Register to support effective oversight of strategic risks and organisational performance.

PAUL MAPSON, CHAIR OF THE AUDIT COMMITTEE

Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the People Committee meeting held on 16 September 2026
SPONSORING EXEC:	Isobel Clements, Chief People Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Graham Hughes, Chair of the People Committee
DATE:	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	he People Committee met on 16 September 2026 and reviewed key workforce, culture and organisational development priorities. Assurance was received regarding progress with the Medical Job Planning Improvement Programme, the Health Set Programme, workforce resilience, staffing solutions and delivery of service-level People Plans within CYP and Families and Medical Services. The Committee also reviewed progress against the Transforming People Services programme, implementation of the NHS Staff Standards and Leadership Framework, and development of the Trust's Anchor Institution agenda. The Committee received assurance regarding workforce resilience, leadership development, workforce planning, inclusion and talent development. Positive progress was noted in medical job planning compliance, Health Set programme delivery, workforce diversity and the development of workforce pipelines through apprenticeships, supported internships and widening participation initiatives. Concerns remain regarding sickness absence, vacancy levels, recruitment delays, increasing reliance on temporary staffing and wider workforce supply challenges. These areas will continue to be monitored closely.
Recommendation	The Board is asked to **note** the assurance provided and the key risks identified, including sickness absence, recruitment performance, workforce supply and workforce resilience, and to **support** continued focus on workforce

	planning, colleague wellbeing, inclusion and delivery of the People Strategy..

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
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- ☐ **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

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Equality
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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)

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE PEOPLE COMMITTEE MEETING HELD ON 16 SEPTEMBER 2026

1. PURPOSE

1.1 The People Committee met on 16 September 2026 to review key workforce, organisational development and strategic people priorities. This report provides assurance to the Board on matters discussed, highlights areas of concern, and identifies risks requiring escalation or continued oversight.

2. ASSURANCE RECEIVED

2.1 The Committee received assurance regarding continued progress of the Medical Job Planning Improvement Programme, noting NHS England reportable compliance had increased from 6% to 93% and that the programme is evolving towards a multi-professional, service-level approach to workforce planning.

2.2 The Committee received assurance regarding progress of the Health Set Programme, including successful recruitment to key leadership posts, strengthened governance arrangements and the return of programme status from "Watch" to "Good".

2.3 The Chief People Officer's Report provided assurance regarding progress with the Transforming People Services programme, implementation of the NHS Staff Standards and Leadership Framework, workforce resilience and organisational listening arrangements. Assurance was also received regarding development of the Anchor Institution programme and workforce inclusion initiatives.

2.4 The Committee received assurance that workforce resilience remains strong in a number of areas, including retention, flexible working, mandatory training compliance, line management and team working. Assurance was also received regarding improvements to staffing solutions, rostering and workforce deployment arrangements.

2.5 The CYP and Families and Medical Services People Plans provided assurance regarding workforce sustainability, compassionate leadership, workforce capability, inclusion, colleague wellbeing and talent development. Members welcomed the comprehensive approach being taken to address workforce challenges and support future service delivery.

3. AREAS OF CONCERN OR FOLLOW UP

3.1 The Committee identified several areas requiring continued focus. Vacancy levels continue to rise, recruitment performance has deteriorated and workforce flow challenges are contributing to delays in filling posts and increased reliance on temporary staffing.

3.2 Members noted that sickness absence remains a significant challenge, particularly long-term absence, and recognised the relationship between workforce pressures, colleague wellbeing and service resilience.

3.3 The Committee also highlighted ongoing workforce supply challenges across a number of professional groups and agreed that continued oversight of recruitment, retention and workforce sustainability would be required.

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

4.1 The Committee agreed that workforce sustainability remains the key risk within Strategic Aim 5, driven by vacancy growth, recruitment delays, workforce supply challenges and sickness absence.

4.2 Risks relating to workforce resilience, colleague wellbeing and increasing reliance on temporary staffing continue to require close monitoring due to their potential impact on service delivery and patient care.

4.3 The Committee also noted the importance of maintaining focus on leadership development, inclusion and workforce planning to support the long-term sustainability of the workforce and successful delivery of the Trust Strategy.

GRAHAM HUGHES, CHAIR OF THE PEOPLE COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Mental Health Legislation Committee meeting held on 15 September 2026
SPONSORING EXEC:	Melanie Iles, Chief Medical Officer
REPORT BY:	Julie Hutchings, Board Secretary and Corporate Services Manager
PRESENTED BY:	Alex Priest, Chair of the Mental Health Legislation Committee
DATE:	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 Committee met on 15 September 2026 and reviewed Mental Health Act and Mental Capacity Act governance arrangements, the Patient and Carer Race Equality Framework, restrictive interventions, Approved Mental Health Professional services, out-of-area placements, complaints, CQC activity and current risks relating to Mental Health Services. Assurance was received regarding compliance with the Use of Force Act, Mental Health Act and Mental Capacity Act arrangements, workforce resilience, governance processes and the management of out-of-area placements. Key areas requiring continued oversight include CAMHS Tier 4 provision, patient flow and discharge arrangements, and environmental risks within inpatient mental health services.
Recommendation	That the Board **notes** the assurance provided and the key risks highlighted, particularly those relating to CAMHS Tier 4 provision and provider collaborative arrangements, patient flow and access to appropriate placements, and environmental risks within Mental Health Services. The Board is also asked to note the positive assurance received regarding restrictive interventions and compliance with the Use of Force Act.

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
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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)

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

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

SOMERSET NHS FOUNDATION TRUST

ASSURANCE REPORT FROM THE MENTAL HEALTH LEGISLATION COMMITTEE MEETING HELD ON 15 SEPTEMBER 2026

1. PURPOSE

1.1 This report provides a summary of the key items discussed at the Mental Health Legislation Committee meeting held on 15 September 2026, including assurance received, areas of concern and risks or issues to be escalated to the Board.

2. ASSURANCE RECEIVED

2.1 The Committee received assurance regarding progress with implementation of the Patient and Carer Race Equality Framework (PCREF), including staff engagement, co-production activity and work to improve the quality of equality and demographic data across Mental Health and Learning Disability Services.

2.2 The Committee received positive assurance regarding compliance with the Use of Force Act and the Trust's governance arrangements for restrictive interventions. Members were assured that robust training, oversight and quality improvement processes are in place and noted that restrictive intervention rates remain low compared to peer organisations.

2.3 The Committee received assurance regarding Mental Health Act governance arrangements, including progress with training development, policy review, data quality improvements and preparations for implementation of forthcoming Mental Health Act reforms.

2.4 The Committee received assurance regarding Mental Capacity Act and Deprivation of Liberty Safeguards arrangements, including the Trust's response to the recent Supreme Court judgment and the extensive staff training implemented to support the revised legal framework.

2.5 The Committee also received assurance regarding Approved Mental Health Professional services, out-of-area placements, forensic services and actions arising from previous CQC Mental Health Act monitoring visits. Members noted positive progress in workforce resilience, service development and the management of patients requiring specialist placements.

3. AREAS OF CONCERN OR FOLLOW UP

3.1 The Committee noted continuing challenges regarding access to CAMHS Tier 4 inpatient provision and the absence of a sustainable long-term solution across the wider provider collaborative footprint.

3.2 Members discussed ongoing environmental and estate-related risks within inpatient mental health services, including issues arising from the Pyrland Ward improvement programme and wider ward environment considerations.

3.3 The Committee also noted the need for continued focus on patient flow, discharge arrangements and access to appropriate placements to support care in the least restrictive environment.

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

4.1 The Committee highlighted the importance of continued Board oversight of CAMHS Tier 4 provision and provider collaborative arrangements, recognising the ongoing regional challenges associated with specialist inpatient capacity.

4.2 Members noted continuing estate and environmental risks within Mental Health Services and the importance of maintaining clear escalation routes and organisational accountability for mitigating actions.

4.3 The Committee highlighted the significant assurance received regarding restrictive interventions and compliance with the Use of Force Act and agreed that this assurance should be communicated to the Board. Members were assured that appropriate governance, training and monitoring arrangements are in place and that restrictive interventions remain subject to robust oversight.

ALEX PRIEST, CHAIR OF THE MENTAL HEALTH LEGISLATION COMMITTEE

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Assurance Report from the Charity Committee meeting held on 20 October 2026
SPONSORING EXEC:	David Shannon, Director of Strategy & Digital Development
REPORT BY:	Katie Fry, Executive Assistant
PRESENTED BY:	Graham Hughes, Chairman of the Charity Committee
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 Charity Committee met on 20 October 2026 and reviewed investment performance, engagement with the Yeovil League of Friends, fundraising activity, the appropriate use of charitable funds, smaller funded items, major projects, and the quarterly finance report and approvals. The Committee received assurance on the charity's financial position, investment recovery, fundraising and project delivery, while identifying matters requiring continued oversight, including donor intent, additionality, recurring commitments and governance across the Leagues of Friends.
Recommendation	The Board is asked to note the assurance provided by the Charity Committee and the matters for ongoing oversight, including investment performance, governance arrangements with the Leagues of Friends, use of charitable funds in line with donor expectations and the principle of additionality, and delivery of major charitable projects.

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.					

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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

THIS REPORT WAS PRODUCED USING AI

ASSURANCE REPORT FROM THE CHARITY COMMITTEE MEETING HELD ON 20 OCTOBER 2026

1. BACKGROUND AND PURPOSE

1.1 The Charity Committee met on 20th October 2026 to review investment performance, fundraising and charitable activity, financial performance, governance arrangements, major projects and the appropriate use of charitable funds. The Committee provides assurance to the Board that charitable funds are being managed in line with donor expectations, regulatory requirements and the principle of providing benefit above and beyond normal NHS provision.

2. ASSURANCE RECEIVED

INVESTMENT PERFORMANCDE AND OVERSIGHT

2.1 The Committee received an update from CCLA. The investment fund had risen by more than 8% to the end of June and increased by 2% in quarter three, compared with approximately 1% for competitors and 1.2% for the benchmark. Since the end of quarter three, the fund had risen by a further 0.52% while the market was broadly flat at 0.05%. CCLA reported changes to improve diversification, including reduced exposure to some software companies, increased bank and infrastructure holdings, and an increase in commodities from approximately 2% to 3% of the portfolio. The Committee agreed that CCLA representatives would attend twice yearly rather than quarterly.

RELATIONSHIP WITH LEAGUE OF FRIENDS

2.2 The Committee received an update on constructive engagement with the Yeovil League of Friends. Work will continue to develop suitable policy templates for adoption across the Leagues of Friends and to strengthen governance arrangements. The Committee also noted a potential £100,000 contribution towards the orthopaedic ward, which will be followed up. Discussion reinforced that charitable funds should not generally meet ongoing running costs that the Trust could not sustain

FUNDRAISING REPORT

2.3 The Committee received positive updates on fundraising and community engagement. These included the first corporate volunteering activity in an NHS garden, a significant funding bid with Open Mental Health partners linked to Hinkley Point C, £10,000 raised by the musician performing in the Musgrove concourse, continued activity arising from Lewis Gregory's testimonial, early sponsorship for the charity golf day, and Cycle 42 for

Cancer growing to approximately £30,000 in the current year. The Committee also welcomed a new quarterly overview of smaller funded items, including vein finders and other equipment and improvements supporting patient care and experience.

MAJOR PROJECTS

2.4 The Committee reviewed progress on major charitable projects. A significant balance from the Glastonbury Festival donation was expected to be directed towards the proposed Oncology Same Day Emergency Care development, subject to agreement that the use remained consistent with the donor's wishes. Progress was also reported on the Glastonbury Community Hospital garden, the Surgical Centre garden at Musgrove, the young people's mentoring project with Open Mental Health partners and cardiology work.

3. FINANCIAL POSITION AND APPROVALS

3.1 Quarterly income was £368,000, taking income for the period to £827,000, almost £200,000 above the equivalent prior-year period, largely due to legacy income. Quarterly expenditure was £191,000, with total expenditure for the period of £449,000. Total fund balances were just over £7.6 million, an increase of nearly £600,000 from the start of the year. approximately £1.8 million was being held for outstanding commitments and projects. The Committee ratified business cases 217, 218 and 219 after considering whether the proposals represented appropriate charitable expenditure above and beyond normal NHS provision.

4. AREAS OF CONCERN OR FOLLOW UP

4.1 The Committee identified matters for continued follow up. These include monitoring the charity's investment performance and the effect of market concentration; obtaining donor agreement for the proposed use of the Glastonbury Festival donation; and applying consistent scrutiny to requests for charitable funding, particularly items that may ordinarily fall within Trust responsibilities.

5. RISK AND ISSUES TO BE REPORT TO THE BOARD

5.1 The Board should note the increasing pressure on charitable funds as Trust finances become more constrained. The Committee reaffirmed the importance of additionality, the donor test and avoiding unsustainable recurring commitments. The Board should also note the need to maintain donor confidence and clear governance when deploying donated funds and working with the Leagues of Friend

KATIE FRY, EXECUTIVE ASSISTANT

Somerset NHS Foundation Trust

Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Report from the Research and Innovation Committee meeting held on 15 September 2026
SPONSORING EXEC:	David Shannon, Director of Strategy and Digital Development
REPORT BY:	Katie Fry, Executive Assistant to the Director of Strategy and Digital Development
PRESENTED BY:	Olena Doran, Committee 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	This paper presents the Summary of the Research and Innovation Committee meeting held on 15 September 2026. Members received updates on the Trust's innovation portfolio, research priorities and capability, and considered opportunities to strengthen collaboration with academic, industry and system partners. Discussions focused on research capacity, clinical academic development, innovation pathways, funding opportunities and support arrangements for researchers. The meeting identified actions to strengthen links with partner organisations, improve support and guidance for researchers, consider research capability gaps and risks, and invite a representative from the Regional Research Delivery Network to a future meeting.
Recommendation	The Board is asked to **note** the key themes, opportunities and actions arising from the Committee meeting.

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: Workforce, ICT and patient/population impact are relevant due to the Committee's focus on research capability, digital health, innovation, service transformation, and reducing rural and coastal health inequalities. No immediate financial decision is requested through this paper.					

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)
The minutes record early engagement on the Committee's purpose, priorities and future partnership approach..

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 minutes are presented to the Trust Board for information as part of reporting from its sub-committee governance arrangements.

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

REPORT FROM THE RESEARCH AND INNOVATION COMMITTEE MEETING HELD ON 15 SEPTEMBER 2026

1. PURPOSE

1.1 The Research and Innovation Committee met on 15 September 2026 via Microsoft Teams. The Committee received updates on the Trust's innovation portfolio, research priorities and capability, and explored opportunities for collaboration with academic, industry and system partners to support the development of research and innovation across Somerset.

2. KEY POINTS FROM THE MEETING

2.1 The Committee received an overview of the Trust's innovation portfolio and forward pipeline. Members noted the range of commercial, digital and service innovations being developed across the organisation and discussed opportunities to strengthen links with academic and industry partners to support innovation, commercialisation and proof-of-concept activity. The importance of ensuring appropriate value is secured from commercial partnerships was also highlighted.

2.2 Members received a presentation on the Trust's research priorities, strengths and current capability. The Committee noted established areas of expertise, including oncology, cardiology, diabetes, weight management and surgery, together with the opportunities presented by the Trust's integrated care model. Members discussed the need to strengthen research infrastructure, increase capacity for investigator-led research and further develop clinical academic careers across professional groups.

2.3 The Committee discussed the challenges experienced by researchers in navigating research processes, accessing support and securing funding. Members welcomed ongoing work to strengthen internal arrangements and agreed the importance of developing clearer guidance and support for researchers.

2.4 The Committee considered a range of partnership, funding and development opportunities presented through academic partners, including innovation grants, workforce development funding, studentships and collaborative research opportunities. Members agreed that stronger engagement with partner organisations would support greater awareness and uptake of future opportunities.

3. ACTIONS AND NEXT STEPS

3.1 The Committee agreed to strengthen links between the Trust's innovation function and partner organisations to support collaboration and identify future opportunities.

3.2 Members agreed that a representative from the Regional Research Delivery Network should be invited to a future meeting to discuss regional priorities and opportunities for alignment with the Trust's research ambitions.

3.3 The Committee requested further high-level information on research capability gaps, risks and development priorities to support its assurance role and identify areas where partners may be able to provide support.

3.4 The Committee also requested further work to improve guidance and support for researchers and agreed that an update on progress should be presented at a future meeting.

4. RECOMMENDATION

4.1 The Board is asked to receive the report of the Research and Innovation Committee meeting held on 15 September 2026 for information and note the key themes and actions arising.

OLENA DORAN, CHAIR OF THE RESEARCH AND INNOVATION COMMITTEE