Somerset Partnership NHS
NHS Foundation Trust

Annual Report and Accounts

2017/18

Somerset Partnership

Somerset Partnership NHS Foundation Trust

Annual Report and Accounts 2017/18

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Contents **Page**

PERFORMANCE REPORT

Statement from the Chief Executive, Peter Lewis

Welcome to Somerset Partnership NHS Foundation Trust's Annual Report for 2017/18 where we reflect on the Trust's achievements during the last financial year and our challenges throughout the year.

The year was considerably challenging once again, with another significant increase in demand for NHS services, combined with ongoing financial pressures. The Trust, we believe, was able to meet these various demands and continue to develop innovative, high quality clinical services.

As part of the drive to improve clinical services and our patients' experience of our care in Somerset, the Trust Board agreed in May 2017 to work more closely with Taunton and Somerset NHS Foundation Trust and subsequently, in February 2018, both boards subsequently agreed to explore a potential merger. The development of a strategic case for merger has commenced.

In support of this collaborative working, a joint executive team was appointed during the autumn of 2017. The aim of the alliance is to improve patient care and promote seamless services across the two trusts. Some of the projects being developed include joining-up stroke services and therapy services, improving community rapid response services and enhancing psychiatric liaison at the two acute hospital emergency departments in Somerset.

Strong collaborative working involving our partners at Yeovil District Hospital and Somerset County Council has also brought significant improvements for patients. For example, Somerset's Home First Service has helped reduce delays in discharge from our two district hospitals and get patients back home sooner with support for their social and health care needs. With Age UK involvement, we have been able to address social isolation as well and re-connect patients with voluntary and third sector services and local groups in their communities.

Our Alliance with Taunton and Somerset has also given both organisations the opportunity to refresh the Trust's values and behaviours and develop a new, shared set of values. The new proposed values – Outstanding Care, Working Together and Listening and Leading – reflect how we will work together to support communities across Somerset to live healthier lives. These values will go out to consultation with colleagues across both organisations in 2018/19 and once ratified, they will be central to how we both recruit new colleagues and our appraisal process.

During this year the Care Quality Commission published the report of their comprehensive re-inspection of the Trust, undertaken in March 2017. It was very good news that the overall Trust rating improved from 'requires improvement' to 'good' and that the CQC found significant improvements across all the services inspected, a testament to the hard work and dedication of our colleagues. A significant improvement was made by colleagues in the Trust's Learning Disability

Services which went from a rating of ‘inadequate’ in September 2015 to a rating of ‘good’ in 2017, and ‘outstanding’ for leadership.

During the year we launched a range of new mental health services including a new forensic CAMHS service, and the trust became a “test and learn” site for developing mental health and emotional well-being in schools.

The year also brought challenges: a national lack of registered nurses has had significant impact in Somerset. During the year a shortage of mental health and general nurses has meant we have had to temporarily close Magnolia mental health ward and the inpatient wards in Dene Barton, Shepton Mallet and Chard community hospitals. We continue to work closely with local communities and our recruitment campaigns are slowly starting to see improved staffing levels. We expect to re-open one community hospital in July 2018, and more once the impact of international recruitment drives takes effect. During the year we also re-opened the inpatient ward at Minehead Community Hospital which had been closed for six months due to nursing vacancies, after a significant local recruitment effort.

The Trust has continued to recognise and celebrate excellence across its workforce, including through monthly Employee and Team of the Month Awards, introduction of the Learner of the Month award and the annual Recognition Awards ceremony which included nominations from our patients, their carers and families. Trust staff were also successful in a number of national and regional awards including:

- Nomination for the Royal College of Nurses Patients Choice Award
- Winner of the University of the West of England Mentor of the Year Award
- Winner of the University of the West of England Best Practice Award
- Overall winners at the Community Hospitals Association Awards
- Association of Healthcare Cleaning Team of the Year Award.

During the year, the Trust has kept a firm focus on delivering the best possible care to those who use our services and a continued commitment to quality improvement. In addition, the Trust has also been able to maintain its strong financial performance. The year saw the organisation again deliver a surplus in keeping with the plan agreed with our regulators and the Somerset system, and as a consequence was able to secure £2.9 million of Sustainability and Transformation Funding.

None of our achievements this year would be possible without the hard work and dedication of our staff who remain our greatest asset. Somerset Partnership is privileged to have highly committed and caring people working across all its services, those on the front line and those in support. On behalf of the Board, I would like to thank all our colleagues for their remarkable commitment to our patients, their carers and families. We also remain extremely grateful for the continued support we have received from our patients, our carers, our volunteers, our Leagues of Friends, our extensive membership and of course our Council of Governors. We look forward to continuing to work with all our partners during the year ahead and ensuring that Somerset Partnership continues to work in collaboration with our partners across the

county, and beyond, to provide the best possible to all who use our services across Somerset and the wider region.

Signed

Peter Lewis **24 May 2018**
Chief Executive

Purpose and activities of the Trust

The Trust provides a wide range of community health, mental health and learning disability services, mainly across the area of Somerset which is administered by Somerset County Council, but also to some residents of neighbouring counties. It also provides a number of regional specialist services to patients from across the wider south west.

Services are provided to all age ranges, and include inpatient care for general and mental illness, minor injury units, a wide range of specialist services in both community health and mental health services, and specialist healthcare for adults with learning disabilities. Many of these are delivered from 13 community hospitals and our four principal mental health sites across the county but, as well as seeing people in Trust premises, staff are able to offer appointments in other community venues which may be more easily accessible to patients. Wherever possible the Trust seeks to support people in their own home or as close to their home as possible.

The Trust also provides community dental services on the Isle of Wight and in the County of Dorset. The Trust is commissioned by NHS England to provide mental health services to deaf children and young people who have mental health needs. This service is based in Taunton and covers the south west region.

Services are provided in partnership with other statutory agencies and a range of voluntary sector providers.

The Trust employs more than 4,000 members of staff, and has a turnover of £174 million.

Map of Services

History of the Trust

Somerset Partnership NHS Foundation Trust was authorised on 1 May 2008. The predecessor organisation, Somerset Partnership NHS and Social Care Trust, was formed in 1999, and was the first integrated health and social care partnership trust in England. The provision of social care services by the Trust was not subject to a Section 31 agreement; up until 2016, County Council staff have been attached to the Trust within an integrated management structure and remain employees of Somerset County Council.

On 1 August 2011, the Trust acquired Somerset Community Health, the arm's length community health service provider arm of NHS Somerset and is now the principal provider of community health, mental health and learning disabilities services in Somerset.

In 2015/2016, Somerset County Council decided to withdraw the management function of the mental health social work service for adults from Somerset Partnership NHS Foundation Trust which, during 2016/17, involved the withdrawal of the Council's social workers so they no longer operate within an integrated management structure with the Trust's mental health teams. In 2017/18 Somerset County Council further decided to take management of the Trust's public health nursing in house so all health visitor and school nursing services and staff will transfer to the Council from 1 April 2019.

At a joint meeting of the Somerset Partnership and Taunton and Somerset NHS Foundation Trusts' boards in May 2017, a Memorandum of Understanding was signed formalising both trusts' commitments to closer collaborative working. In February 2018, both boards subsequently agreed that the alliance arrangements will progress to the next stage and the development of a strategic case for merger has commenced.

Going Concern

In the preparation of the year end accounts the Board is required to undertake an assessment confirming the Trust will continue as a going concern (i.e. that it will continue in the business of healthcare provision for the foreseeable future).

The Trust has prepared its financial plans and cash flow forecasts on the assumption that funding will be received from the Department of Health. Discussions to date indicate this funding will be forthcoming. These funds are expected to be sufficient to enable the Trust to meet its obligations as they fall due. These funds will be accessed through the nationally agreed process published by NHS Improvement and the Department of Health.

The Directors have concluded that there is a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the next 12 months.

Financial Instruments

It is Trust policy to avoid the use of financial instruments when possible, thus minimising financial risk to the Trust. This means that the Trust's exposure to risks created by financial instruments is much lower than commercial organisations of the same size. The accounts state the Trust's accounting policies (note 1.13) and the nature and value of the risk that the Trust faces (note 26).

To the best of my knowledge, the information in this document is accurate.

Signed

PETER LEWIS **24 May 2018**
Chief Executive

Performance Report Analysis

During 2017/18 Somerset Partnership NHS Foundation Trust maintained high levels of performance across a broad range of indicators linked to the delivery of high quality care to patients. We consistently met the majority of applicable NHS Improvement Single Oversight Framework standards, and also met or exceeded the majority of CQUIN standards agreed with Somerset Clinical Commissioning Group, as part of the framework of commissioning for quality and innovation, during 2017/18.

In addition to the corporate level and divisional level quality and performance standards, against which we monitor our progress on an ongoing basis, we also routinely participate in all applicable projects managed by the NHS Benchmarking Network, in order to review our relative level of performance against peer organisations nationally. Analyses of the performance of Somerset Partnership against peer organisations indicate that we perform comparatively well across the whole range of our service portfolio, in terms of the quality of care delivered to patients and also the efficiency with which we use our resources.

As well as to maintaining consistently high standards against the NHS Improvement national reporting standards and CQUIN indicators during 2017/18, we have also maintained high compliance rates in relation to other key performance metrics including:

- waiting times for patients to access services;
- review of patient care plans;
- nutrition screening standards;
- standards of assessment for venous thromboembolism; and
- physical health assessments of patients admitted to mental health wards.

We have also maintained a focus on the importance of ensuring that colleagues are able to access a broad range of mandatory training. We maintained a mandatory training compliance rate in excess of 90% throughout 2017/18.

Trust Strategy and Business Model

Somerset Partnership NHS Foundation Trust provides integrated high quality community and mental health services across the county of Somerset and in the wider south west region. Patient safety and quality is at the heart of everything that we do. We have developed and employ an integrated approach to quality and patient safety and performance management, which is evidenced through the monthly Quality and Performance report, presented to our Trust Board, which outlines trends against a broad range of performance indicators, and patient safety and quality metrics.

A key priority for us remains our commitment to ensuring transparency in all areas of our work, supporting and encouraging all colleagues to report all incidents and near misses, in order to maintain a strong platform of high reporting and low harm

incidents. Our strategy places patient and carers first, ensuring that that they are at the very heart of everything we do. Patients should be involved in every aspect of their care and support us to understand how we can improve the services we provide. Central to this is our commitment to listening to and learning from patients, their carers and our colleagues, within the Trust and the partner organisations with which we work.

As part of this drive to improve clinical services and our patients' experiences of our care in Somerset, the Trust Board has agreed to work more closely with Taunton and Somerset NHS Foundation Trust and explore a potential merger. This Alliance is being developed in support of Somerset's Sustainability and Transformation Plan and subsequent Health and Social Care Strategy and the expected move to a county wide integrated care system.

As an Alliance we are taking a dual approach to developing our strategy and service provision, which is:

- provision of local services organised around groups of GP Practices, with a focus on the health and wellness needs of the population
- provision of consistent and standardised, more specialist services, organised at scale to meet the needs of the whole population
- working together with partners including other providers and primary care to deliver integrated care closer to the communities we serve.

The overarching strategy will follow these principles for the approach to delivery of services across Somerset:

- the services delivered by the alliance will be focused on the needs of the (Somerset) population
- the Alliance will support people to maintain their own health
- the Alliance will provide safe, high quality and accessible care consistently
- the Alliance will work with other stakeholders/providers to ensure that services are sustainable

Key Priorities

Our key priorities for 2018/19 include to:

- keep waiting times for our services as short as possible;
- improve our performance across all our quality account priorities;
- maintain safe and effective staffing levels across all our services;
- review how we provide assessment and community services for people with dementia;

- work with commissioners to review how we provide access to mental health care for children, young people, families and referrers;
- work with partners to develop and provide services focused on admission prevention, particularly enhanced primary care and rapid response;
- strengthen ways to treat patients in crisis in their own homes (admission avoidance) and our approach to early supported discharge from acute adult mental health wards;
- implement a consistent approach to understanding and reducing variation across our community hospital wards;
- review and modernise our referral and booking systems;
- take forward collaborative working arrangements with Taunton and Somerset NHS Foundation Trust;
- contribute to the delivery of the 2018/19 objectives of the countywide commissioning strategy for health and care and the Somerset Sustainability and Transformation Programme;
- enhance our current arrangements for engagement and closer working with the voluntary sector;
- deliver our agreed financial targets.

Trust key priorities in relation to Workforce and Organisational Development in 2017/18 are:

- to develop and engage our workforce to support the delivery of high quality and cost effective care;
- increase the engagement of all of our colleagues in what we do;
- improve the health and wellbeing of all colleagues, facilitating access to health checks and running targeted initiatives for all staff throughout the year, including wellbeing months;
- implement Year 1 of our People Strategy and monitor improvements;
- develop and implement a recruitment and retention strategy, to ensure that we recruit, retain, and support an empowered workforce;
- work as an alliance with Taunton and Somerset NHS Foundation Trust to engage colleagues in reviewing and embedding our values and behaviours;
- implement revised mandatory training and appraisal arrangements to enhance their quality, efficiency and effectiveness;
- develop and implement effective succession planning arrangements across the organisation.

Somerset Partnership NHS Foundation Trust has a total operating income of £174m. 2017/18 continued to be challenging financially, in which £4.2m of efficiency

savings were delivered. The Trust ended 2017/18 with an operating surplus of £4.0m before exceptional items (this included £2.9m of Sustainability and Transformation funding) which was in line with the budget agreed at the start of the financial year.

The Trust financial strategy is to deliver savings to manage cost pressures, so surpluses can be delivered for reinvestment in our services and facilities.

The key aims of the Trust financial strategy are to:

- effectively manage the budget in 2018/19;
- continue to maintain strong cash balances;
- continue to invest in our estate and infrastructure;
- support the delivery of our strategic themes and objectives;
- maximise efficiencies arising from benchmarking and national publications including the Carter Review, and explore the possibility of further efficiencies;
- deliver our cost improvement programmes.

In preparing the financial plans for 2018/19 the following assumptions have been made:

- there will be a tariff inflation level of 0.1%;
- pay costs will increase by 2.0% due to provisional pay rise and individual increases in spine point increments (it is assumed that pay rises in excess of 1% will be funded by the Department of Health);
- non-pay costs will increase by 2.0%.

We have also developed with our staff, our governors and our patients, a set of key quality priorities for the coming year which are set out in our Quality Account at the end of this report.

We aim to continue to promote learning and excellent practice and to be innovative in our service delivery, seeking opportunities to enhance the quality of service provision and to share the best practice across the organisation, in order to provide safe, high quality care for each and every one of the patients we serve.

Key issues and risks to the achievement of Trust objectives

During the year the most significant risks (managed in year) were:

Staffing Pressures - The Trust has continued to identify risks in a number of services around staffing pressures arising from vacancies, sickness absence and increasing levels of demand. This has led to the temporary closure or reduction of some services during the year and the extension of waiting times (with agreement of the Trust's commissioners) in other services. In particular, we had to temporarily close Magnolia Ward, the Trust's dementia ward for older people in Yeovil, due to

significant and sustained staffing pressures and have established a community based Independent Dementia Support Service (IDSS) to maintain services for these highly vulnerable patients. It was also necessary to temporarily close three community hospital inpatient wards at Dene Barton, Chard and Shepton Mallet, to ensure sustained provision of community hospital beds over the winter period in the face of significant staffing issues. An extensive recruitment campaign was maintained during the year, including continued overseas recruitment, but was not sufficiently successful and significant pressures remain. Detailed reports on staffing issues were presented to the Board during the year and a public consultation was undertaken in December 2017- January 2018 in relation to the temporary closure of the community hospital inpatient wards. These steps and the consultation have had an impact on the reputation of the Trust with significant public protest, a series of high profile media campaigns and legal challenges, all of which were managed in year.

Sustainability and Transformation Plan (STP) – the difficult progress of the development and implementation of the Somerset STP has continued to present a number of risks for the Trust in terms of its impact on existing strategic plans, capacity within the Trust to support the STP while maintaining focus on our core services, and the financial sustainability of the Trust within the wider Somerset health and social care system. The detail of the proposals for the STP have not yet been developed and much of its work has been superseded by the Somerset Clinical Commissioning Group's (CCG) development of a Health and Care Strategy which will be subject to widespread engagement and consultation over the next 18 months. Senior members of the Trust, including the Chief Executive, continue to occupy central roles in the STP Programme and during the year the Trust's Chairman has taken over the role of Chair of the STP Programme Executive Group. The delay in development of plans has had an impact on the Trust delivering some of its plans, particularly for mental health services, and this is being taken forward with the CCG. We will continue to ensure that the proposals align with our objectives for the delivery and sustainability of high quality, effective community health, mental health and learning disability services.

The system-wide risks in relation to the financial position have also been significant during the year and the Trust has worked with the CCG, Somerset County Council and partner organisations to manage these risks during the year. The year end position has been testament to the significant hard work of staff across the organisation to manage these pressures during the year.

Key Performance Measures

Single Oversight Framework targets

NHS Improvement's Single Oversight Framework sets out the key national standards which are applicable to Somerset Partnership as a service provider. We met, and in the majority of cases routinely exceeded, the majority of targets in 2017/18. The table below sets out our performance levels across the year:

Target	Threshold	Performance			
		Q1	Q2	Q3	Q4
Referral to Treatment Waiting Times: percentage of patients waiting within 18 weeks: (Incomplete pathways)	92%	98.9%	99.5%	99.3%	99.6%
Percentage of minor injury unit patients waiting under four hours from arrival to admission, transfer or discharge	95%	99.7%	99.8%	99.8%	99.7%
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	90%	96.8%	97.5%	97.2%	95.6%
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	76.2%	73.7%	57.1%	42.9%
Improving Access to Psychological Therapies (IAPT)/talking therapies: Percentage of people completing a course of IAPT treatment moving to recovery	50%	41.9%	40.8%	37.9%	38.2%
Improving access to psychological therapies (IAPT): • people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	87.1%	92.9%	93.5%	94.1%
• people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	99.2%	99.9%	99.3%	99.3%
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	95%	97.3%	95.8%	97.2%	99.0%

Commissioning for Quality and Innovation (CQUIN) Targets

Somerset Clinical Commissioning Group, our principal commissioner of services, sets annual targets under the framework for Commissioning for Quality and Innovation (CQUIN), the aim of which is to improve the quality of services delivered to patients. The achievement of the CQUIN standards generates additional income for the Trust, of up to 2.5%.

The 2017/18 national and local CQUINs agreed with Somerset Clinical Commissioning Group are set out in the table below:

CQUIN Requirement	Standards Required
1a –Improvement of Staff Health and Wellbeing	Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress. The two questions do not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question. Year 1 (17/18) The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2015 staff survey. Year 2 (18/19) The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2016 staff survey. • **Question 9a**: Does your organisation take positive action on health and well-being? Providers will be expected to achieve an improvement of 5% points in the answer "yes, definitely" compared to baseline staff survey results or achieve 45% of staff surveyed answering "yes, definitely". • **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 85% of staff surveyed answering "no". • **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 75% of staff surveyed answering "no".
1b – Healthy food for NHS staff, visitors and patients	Providers will be expected to build on the 2016/17 CQUIN by: Firstly, maintaining the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19 a.) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS). The following are common definitions and examples of price promotions: 1. Discounted price: providing the same quantity of a product for a reduced price (pence off deal); 2. Multi-buy discounting: for example buy **one** get **one** free; 3. Free item provided with a purchase (whereby the free item cannot

CQUIN Requirement	Standards Required
	be a product classified as HFSS); 4. Price pack or bonus pack deal (for example 50% for free); and 5. Meal deals (In 2016/17 this only applied to drinks sold in meal deals. In 2017/18 onwards no HFSS products will be able to be sold through meal deals). b.) The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS); The following are common definitions and examples of advertisements: 1. Checkout counter dividers 2. Floor graphics 3. End of aisle signage 4. Posters and banners c.) The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts; The following are common definitions and examples of checkouts; 1. Points of purchase including checkouts and self-checkouts 2. Areas immediately behind the checkout and; d.) Ensuring that healthy options are available at any point including for those staff working night shifts. We will share best practice examples and will work nationally with food suppliers throughout the next year to help develop a set of solutions to tackle this issue. Secondly, introducing three new changes to food and drink provision: In Year One (2017/18) a.) 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). b.) 60% of confectionery and sweets do not exceed 250 kcal. c.) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g In Year two (2018/19): The same three areas will be kept but a further shift in percentages will be required a.) 80% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). b.) 80% of confectionery and sweets do not exceed 250 kcal. • At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available

CQUIN Requirement	Standards Required
	contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g
1c – Improving the uptake of flu vaccinations for frontline clinical staff within Providers	Year 1 - Achieving an uptake of flu vaccinations by frontline clinical staff of 70% Year 2 - Achieving an uptake of flu vaccinations by frontline clinical staff of 75%
3a - Cardio metabolic assessment and treatment for patients with psychoses	**For 2017/18** To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas: a) Inpatient wards. b) All community based mental health services for people with mental illness (patients on CPA), excluding EIP services. c) Early intervention in psychosis (EIP) services. **And in addition, for 2018/19** To demonstrate positive outcomes in relation to BMI and smoking cessation for patients in early intervention in psychosis (EIP) services.
3b - Collaboration with primary care clinicians	90% of patients to have either an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP. A local audit of communications should be completed.
4 - Improving services for people with mental health needs who present to A&E.	**For 2017/18:** 1. Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable. **For 2018/19:** 1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions. 2. Reduce total number of attendances to A&E by 10% for all people with primary mental health needs.
5 - Transitions out of Children and Young People's Mental Health Services (CYPMHS)	This CQUIN aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS). This CQUIN is constructed so as to encourage greater collaboration between providers spanning the care pathway. There are three components of this CQUIN: 1. a casenote audit in order to assess the extent of Joint-Agency Transition Planning; and 2. a survey of young people's transition experiences ahead of the point of transition (Pre-Transition / Discharge Readiness); and 3. a survey of young people's transition experiences after the point of transition (Post-Transition Experience).
8b - Supporting Proactive and Safe Discharge – Community Providers	**Year 1 17/18** I. Part a) 60% of weighting for this measure Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories

CQUIN Requirement	Standards Required
	II. Part b) 40% of weighting for this measure Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate. **Year 2 18/19** III. Part a) 100% of weighting for this measure IV. Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from 2017/18. Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.
CQUIN 11 - Personalised Care and Support Planning	This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers. The second year will focus more on delivery of personalised care and support planning, the quality of conversations and the impact on individual levels of knowledge, skills and confidence. In year one there are three components: **Establishing provider systems** to ensure that personalised care and support planning conversations can be incorporated into care delivery and can be recorded as an activity. Also to ensure relevant cohorts of patients who would benefit most from the delivery of personalised care and support planning can be identified on IT systems. For the purpose of the CQUIN, personalised care and support planning conversations are defined as: • *Conversations between a care professional, a person with long-term conditions and their carer (if applicable) to understand what is important to that individual and what support they need in order to help build their knowledge, skills and confidence to manage their health and wellbeing.* • *Follow a process of sharing information, identifying support needs, discussing options, contingency planning, setting goals, developing an action plan, and monitoring progress.* • *Consider how to co-ordinate the individual's care across a number of different care settings, linking to other existing care plans, particularly for people with multiple conditions.* • *Consider physical and mental health as well as wider holistic wellbeing.* • *Resulting in an agreed, recorded, document that the patient and carer owns* Providers should submit a plan outlining their approach to delivering personalised care and support planning and how this will be recorded as

CQUIN Requirement	Standards Required
	an activity, taking account of the pioneering work of the national Integrated Personal Commissioning team, the latest iteration of the TLAP personalised care and support planning tool and the NHS England handbook on personalised care and support planning. **Identifying relevant patient populations**. Providers should submit a plan outlining how they will identify the relevant patient population with one or more long-term conditions and with low levels of knowledge, skills and confidence (activation) to manage their health and wellbeing who would benefit from personalised care and support planning. They will need to take into consideration cohorts of patients who may already be participating in personalised care and support planning, for example people with learning disabilities, people with severe mental health issues who are part of the Care Programme Approach, people with complex needs who have personal health budgets or are part of the Integrated Personal Commissioning programme. This may require planning with commissioners and other providers to agree who will lead the care planning process, and also how multi-disciplinary teams can work together. To identify the cohort providers should: • Identify those patients with one or more long-term conditions as defined by the GP patient survey. People may be identified on clinical IT systems, for example using ICD10 codes or using risk stratification tools. People may be additionally identified through contact with care professionals as someone who would benefit from personalised support. Then **conduct a baseline review of patient activation** for those patients with long term conditions identified above. This means: • For those organisations already using the Patient Activation Measure, ensuring that all identified patients and carers have their activation levels recorded; this can be combined to create an organisational score, or • For those organisations not using the Patient Activation Measure, ensuring that all identified patients and carers are asked a local survey using two key questions from the existing GP patient survey (GPPS). Answers to these questions will use the same criteria as the GPPS and be given scores as described below to allow production of an organisational score. These are: ○ **Q32** – *In the last six months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?* Answering 'yes, definitely' = 1 point, 'yes, to some extent' = 0.5 points. Other answers = 0 points ○ **Q33** – *How confident are you that you can manage your own health?* Answering 'very confident' = 1 point, 'fairly confident' = 0.5 points. Other answers = 0 points. **Following this review of patient activation, the relevant population to be prioritised for personalised care and support planning will be defined as:** • Those with one or more long-term conditions as defined by the GP patient survey; AND • For those organisations already using the Patient Activation

CQUIN Requirement	Standards Required
	Measure those patients assessed at Level 1 or 2 in their activation level; **or** • For those organisations not using the Patient Activation Measure, those patients who score 0 points on the GPPS questions. **Ensuring that all relevant provider staff are sufficiently competent** in holding care and support planning discussions with patients and carers, through appropriate training. For the purpose of the CQUIN 'relevant provider staff' can be defined as: • *Those who have allocated time to support the patient and carer to develop their care and support plan; and* • *Have specific expertise or training in support for people with long-term conditions; and* • *Are in a position to be able to liaise with multidisciplinary teams as required to gather information pertinent to the care planning discussion, and to raise issues that are impacting on an individual's care or that need to be considered at an organisational level* • *Are a regular (at least annual) point of contact for the patient and carer* Appropriate training is defined as training that: • *Explores the role of care & support planning in empowering patients and carers;* • *Clearly defines the role and expectations of the member of staff and the patient and/or carer;* • *Provides a framework for staff to follow in having structured care and support planning conversations based around what is important to the person living with a long-term condition and their holistic needs, not just their medical needs;* • *Helps staff develop skills in motivational interviewing to help them in encouraging patients and carers to actively participate in planning discussions, and how to tailor their approach based on the individual's levels of knowledge, skills and confidence, and their communication needs; and* • *Helps staff deal with sensitive discussions such as consent, mental capacity, and end of life care*. In year two there are two components: **Reporting on the number of care and support planning conversations** that take place (with the expectation that at least one conversation takes place for each patient but the number of conversations will vary depending on individual's needs and levels of knowledge, skills and confidence). **Conducting a follow up review of patient's knowledge, skills and confidence** for the identified patient population. As above, organisations will either need to repeat the process of collecting individual Patient Activation scores using the Patient Activation Measure, or using the questions from the GP patient survey to ascertain levels of confidence and feelings of support.

Monitoring Performance, Improvements in Quality and Meeting National Targets

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

We have developed and employ an integrated approach to quality and patient safety and performance management, which is evidenced through the monthly Quality and Performance exception report, presented to our Trust Board. The reports incorporate metrics which span key national and local frameworks, including the NHS Improvement Single Oversight Framework, the framework for Commissioning for Quality and Innovation (CQUIN), and local commissioning intentions, with an emphasis on monitoring key aspects of quality improvement, harm reduction and patient safety.

The Quality and Performance report also focuses upon the delivery of high quality care from a patient and carer perspective, through regular reporting of patient experience data, patient engagement activity and issues raised through complaints and concerns. The Quality and Performance report is published monthly on our website and provides our Trust Board with regular information, across a broad range of quality and safety measures including slips, trips and falls, medication incidents, pressure ulcers, incidents involving restraint, ligatures and ligature points and patient and public involvement.

The Quality and Performance Report is continually reviewed, to ensure that it reflects the most current and relevant metrics and analysis. The Quality and Performance Report presents information relating to the five key questions which the Care Quality Commission considers when reviewing and inspecting services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well-led?
- Are they responsive to people's needs?

The Monthly Quality and Performance Report and accompanying dashboards assist the Board in its assessment of the achievement of our corporate objectives and key targets, and all of the measures are linked to the five Clinical Quality Commission themes.

The Quality and Performance Report is accompanied by both a quality measures dashboard and a corporate dashboard which sets out performance data for the reporting year. These reports allow the Board to evaluate whether we are meeting national and local standards and targets, and operating safely, efficiently and effectively, whilst improving the quality of our services. The Quality and Performance Report sets out what we are doing in respect of increased incident levels or where performance falls below set compliance standards

Our Quality and Performance Committee, a sub-committee of the Trust Board, provides high-level challenge and assurance, in relation to key quality and performance metrics. This detailed analysis and challenge complements Board discussions on performance, enabling a balance to be struck between effective Non-Executive Director scrutiny of the operational detail, whilst enabling the Board to remain focused on the key strategic issues. The Quality and Performance Committee receives a range of detailed tabulated and graphical performance information, at the level of individual service / ward, together with other key performance information.

In addition to the Quality and Performance report and corporate balanced scorecard, we also maintain directorate-level performance dashboards for each of our operational service directorates. Each directorate dashboard sets out the performance of the service directorate, in relation to key targets relating to the services managed within that directorate. This allows our key corporate performance measures to be managed at a more granular level, and to identify any areas of concern which may lie below an overall incidence of underperformance, or even areas of concern which are component elements of an aggregate level of performance which meets the required corporate level standard.

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

- a monthly senior managers' team meeting, chaired by the Chief Executive, combining review and challenge of Service Directorate progress against key objectives outlined on each dashboard, with an opportunity for Service Directors to share with the executive team issues of concern; and
- a monthly operational directorate finance and performance group meeting, chaired by the Chief Operating Officer, which focuses on the principal quality and performance issues pertaining to each service directorate, chiefly the exceptions arising from the divisional dashboards, as well as divisional level performance in respect of other key areas including mandatory training, and CQUIN targets.

The key purposes of these meetings include:

- to assess actual performance against plan;
- to assess risks to future delivery and agree mitigation plans;
- to determine and agree future performance management arrangements;
- to reward those divisions which perform well, by reducing the degree of performance management involvement;
- where performance declines, to identify the contributory issues and to have a clear escalation and de-escalation process;
- to focus on early performance management intervention with service directorate at risk of not meeting required standards;

- sharing examples of good practice and supporting service directorate to achieve performance standards; and
- holding service directorate to account for performance delivery.

Monthly review meetings are also held by each service directorate, chaired by the service director, and with representation from individual services managed within the service directorate, enabling a discussion of operational issues relating to each service.

Sustainable Health – environmental matters

The Trust is constantly striving to fully understand and reduce the environmental impact created through delivering quality healthcare services. We are also looking at how sustainable principles can help provide a better organisation for staff, patients and the local and global community. Sustainability has three core elements – environmental, social and economic – and Somerset Partnership aims to embed these sustainability themes fully throughout the whole organisation.

Our Carbon Reduction Group (CRG) has been tracking Trust carbon emissions since 2008, which has been a complex process due to the merger of two health organisations in 2011. We monitor our carbon footprint to see if we are reducing emissions. Throughout this period, the Trust has continued to grow, delivering more services to more patients but we have still been able to reduce emissions based on the metrics of: carbon emission per measure of activity, turnover, number of staff and patient contacts.

Carbon footprint		2008 / 09	2009 / 10	2010 / 11	2011 / 12	2012 / 13	2013 / 14	2014 / 15	2015 / 16	2016 / 17	2017/18	Difference from 2008/09
Emissions per Turnover	kgCO2e /£000s				65.1	62.1	60.7	61.2	58.5	44.6	44.2	32%
Emissions per no. of staff	KgCO2e /WTE	3.5	3.3	3.3	3.3	3.1	3.2	3.2	3.2	2.3	1.6	54%
Emissions per patient contact	TCO2e / contact	10.7	10.7	10.4	12.4	12.4	9.5	8.6	8.5	7.2	5.9	45%

As the table shows, by normalising the carbon footprint against these metrics, the full detail of the Trust's carbon reduction can be seen. Due to the complexities of the Trust's carbon footprint we had to undertake an exercise to re-baseline the data.

The Trust continues to be aware of and assess best practice and guidance from the across the NHS, other sectors and the NHS Sustainable Development Unit (SDU) to analyse what is applicable to the Trust. This includes details within the recent 'Sustainable Development in Health and Care report - 2016 Health Check' by the SDU which details how the NHS has achieved the Climate Change Act 2015 target and where efforts need to be directed to work towards the 2020 carbon target of a 34% increase from the baseline.

We have, as part of our Sustainable Development Management Plan produced a road map to achieve the 2020 target however implementation requires funding which is yet to be approved. This will impact on our ability to deliver the reduction required to meet the 2020 target.

Progress this financial year

The Carbon Reduction Group has several key representatives from various departments of the Trust who have all helped in progressing our sustainability agenda:

Facilities

The Facilities team is continuing to roll out new recycling consoles across many sites to broaden the types of materials that can be recycled, whilst encouraging staff to be more conscious of sorting waste to help reduce emissions and use of natural resources.

The Trust continues to attend and engage at regional events to ensure that any changes or opportunities to improve procurement methods are co-ordinated and to collaborate with other NHS organisations.

Information Technology

Wi-Fi connectivity is continually being improved to support our staff and provide facilities that best enable the work they do and help reduce the need for travel (a significant proportion of our carbon footprint);

IT infrastructure is being improved to allow the use of greater connectivity and productivity tools by staff which include video conferencing and assessing the potential where this can be used as a tool in clinical care delivery;

A new copier contract allowing greater patient record scanning to reduce paper, was implemented in 2016/17 to improve data security and further facilitate a seamless delivery of care. Better controls on printing are leading to a reduction in paper, ink and electricity usage and waste creation, all of which will help reduce costs and carbon; The reduction in printing seen in 2016-17 has continued this financial year and is estimated to be an additional 10%.

The IT department participated in the Blackmore Ricotech IT WEEE reuse programme during 2016 and saved 4729kg of carbon emissions by up-cycling 11676 kg of IT WEEE for reuse before destructive material recovery.

The IT department have replaced the central storage equipment at Foundation House for more energy efficient equipment which will directly reduce the energy consumption and also have an impact in reducing the air conditioning requirement for that space.

The Estates & Capital Projects Team

The Good Corporate Citizenship self-assessment has been updated by the NHS Sustainable Development Unit and the Trust has started the process of completing

the new tool. The Trust continues to annually assess its performance against national policy.

The CRG has developed a more intelligent utilities monitoring process that identifies over usage and allows detailed investigation to reduce cost and carbon emissions across the estate;

We continually assess how the estate is being used to ensure utilisation is high and the estate is at an optimum size. The IP2 programme is helping mobilise staff and provide more productive ways of working and a flexible estate to suit the needs of staff and to reduce carbon emissions. The work on the IP2 programme this year has enabled us to vacate Charterhouse (August 2017). The IP2 programme has also updated the Trust's Agile Working Policy and this should have a positive impact on our carbon footprint.

Where capital projects are being undertaken, the Trust always looks to specify and install modern energy efficient alternatives where possible. This has included LED lighting and replacement windows which will have an impact on the energy usage of the sites.

The Trust continues to monitor energy usage on a quarterly basis and actively monitor trends. Any anomalies identified are investigated by the estates team and acted on where appropriate.

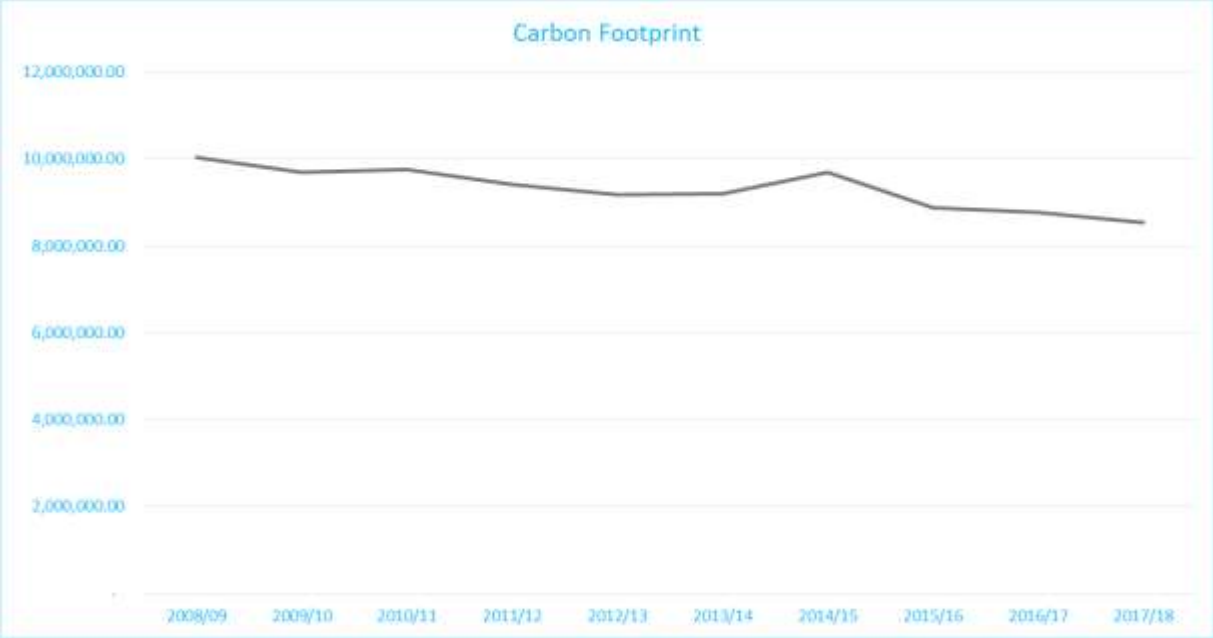
Finance and Travel

In 2016-17 we reported that staff business mileage has seen a reduction of 14% which reflects the good work undertaken to reduce business miles by improving the use of technology. There has been no significant change to this in 2017/18.

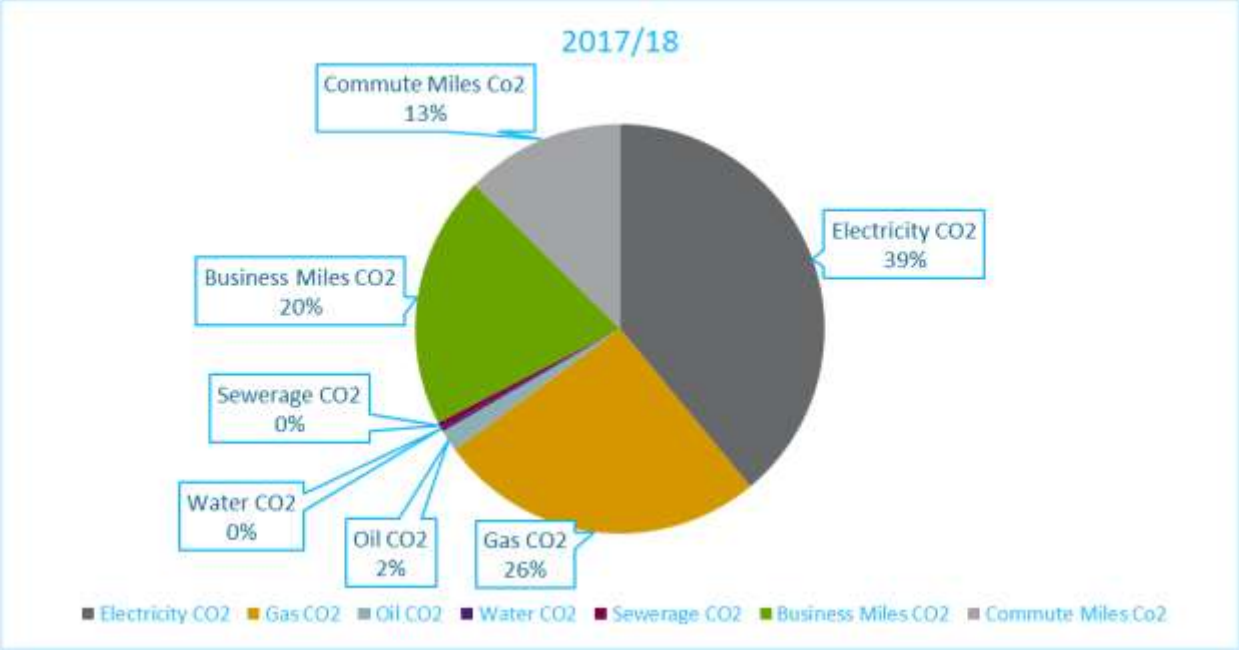
Trust Carbon Footprint

The following data reports the Trust resource usage and carbon emissions aligned to Sustainable Development Unit (SDU) and DEFRA guidelines. The data is interpolated for 2017/18.

The Trust's total carbon footprint for this year is indicatively 8,534 Tonnes of CO_2.



Breakdown of emissions in 2017/18 shows that electricity continues to be the largest area.



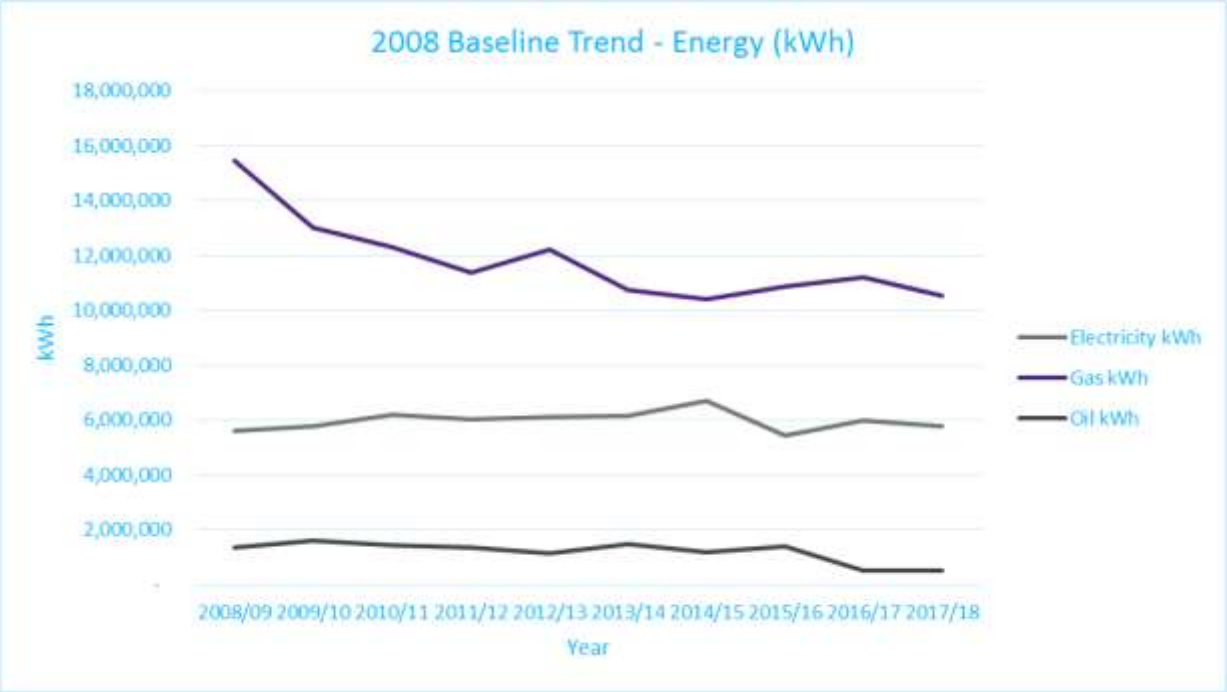
Energy

Somerset Partnership has been working to reduce energy usage and the associated carbon emissions for some time.

Across the estate invest-to-save measures have helped improve the condition, effectiveness and efficiency of heating systems to ensure patient comfort whilst reducing carbon emissions. One project delivered this year has seen the heating and hot water boilers replaced at Rydon and Holford mental health wards with modern

condensing type boilers and upgraded controls. This has led a reduction of more than 20% on the 2008/09 baseline in the use of gas and heating oil, even when the fuel usage is normalised against the external weather conditons demonstrating the immense reduciton in use of fossil fuels.

Energy usage is reviewed and analysed on a regular basis and any variation to the trend is investigated to ensure bad practices or misuse of energy are rectified in a timely manner.



Waste

Since the 2008/09 baseline waste to landfill has been reduced considerably as recycling was introduced in 2011/12. Overall waste carbon emissions have decreased significantly due to better recycling and waste management.

Travel

We continue to assess how travel emissions can be reduced and recent projects are expected to show significant travel reduction over the next few years. 2016/17 saw a significant reduction in business miles claimed (14%) and there has been no significant change to these levels for 2017/18.

Human Rights

We recognise our responsibilities under the European Convention on Human Rights (included in the Human Rights Act 1998 in the UK), which are relevant to health and social care. These rights include the:

- right to life;
- right not to be subjected to torture, inhuman or degrading treatment or punishment;
- right to liberty; and
- right to respect for private and family life.

The Trust is committed to ensuring it fully takes into account all aspects of Human Rights in its work, following on from the *Human Rights in Healthcare: A Framework for Local Action* (Department of Health, March 2007). This will ensure the Trust continues to meet its duty to respect human rights in all that it does.

Further details can be found at http://www.sompar.nhs.uk/about_us/equality_and_diversity/.

Modern Slavery and Human Trafficking Act 2015 Policy Statement

Introduction

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps taken to ensure slavery and human trafficking is not taking place in any of its supply chains and in any part of its business.

This statement sets out actions taken by Somerset Partnership NHS Foundation Trust to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

The Trust is committed to ensuring no modern slavery or human trafficking takes place in any part of our business or supply chain. We are committed to improving our practices to combat slavery and human trafficking. We are fully aware of our responsibilities towards patients, employees and the local community. We have robust ethical values which we use as guidance for our commercial activities. We also expect all suppliers to the Trust to follow the same ethical principles.

Policy on Slavery and Human Trafficking

We are committed to ensuring there is no modern slavery or human trafficking in any part of our business and, in addition require that our suppliers hold similar ethos.

We have robust multi agency Safeguarding Vulnerable Adults and Safeguarding Children policies in place and all staff receive mandatory safeguarding training which includes guidance on how to identify and report any concerns relating to modern slavery and human trafficking.

We follow employment checks and standards which include the right to work and depend on receiving suitable references.

We are committed to social and environmental responsibility and have zero tolerance of Modern Slavery and Human Trafficking. Any identified concerns regarding Modern Slavery and Human Trafficking would be escalated as part of the organisational safeguarding processes in conjunction with partner agencies.

We will:

- comply with legislation and regulatory requirements;
- ensure suppliers and service providers are aware we promote the requirements of the legislation;
- develop awareness of modern slavery issues;
- include modern slavery conditions or criteria in specifications and tender documents within the Supplementary Terms & Conditions;
- encourage suppliers and contractors to take their own action and understand their obligations about these new requirements;
- expect supply chain/framework providers to demonstrate compliance with their obligations in their processes.

Trust staff must contact and work with the procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Procurement staff will:

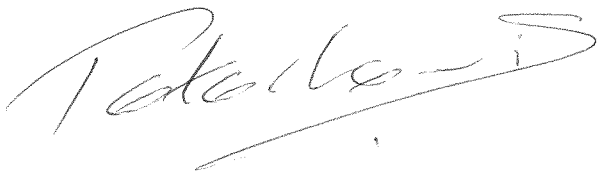
- check draft specifications include a commitment from suppliers to support the requirements of the Act;

- not award contracts where suppliers do not demonstrate their commitment to ensuring slavery and human trafficking are not taking place in their own business or supply chains;
- communicate clear expectations to our suppliers through a 'Supplier Code of Conduct';
- work with the procurement department to monitor compliance by suppliers with the requirements of the Act.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2018.

To the best of my knowledge, the information in this document is accurate.

Signed



PETER LEWIS **24 May 2018**
Chief Executive

FINANCIAL OVERVIEW AND REVIEW

Overview

Whilst continuing to deliver safe and high quality services the Trust has also met challenging financial targets. In 2017/18 it delivered an operational surplus of £4.0million (before the impact of technical adjustments arising from the annual revaluation of its estate, see page 26; note 13.2 annual accounts.

The Trust achieved its control total (agreed with NHS Improvement at the beginning of the year) and received £2.9m of Sustainability and Transformation funding, including £1.3m of additional monies for achievement of control total).

Inherent in the delivery of the surplus was the achievement of a cost improvement programme of £4.2 million and the Trust's contractual risk share obligations under the Somerset Sustainability and Transformation Plan. The cash generated by the surplus will be invested in the development of Trust services, including additional investment in information technology for our community based services and other developments linked to working smarter and maximising the use of the Trust's facilities.

The delivery of the financial surplus and associated cost improvement programmes is not easy and becomes increasingly more difficult with each passing year. The financial challenges for the Trust will therefore be even greater in 2018/19. Opportunities to expand the operations of the Trust will be limited and so focus will be directed at optimising the resources available and cutting costs.

Savings of the magnitude required over the coming years will require the Trust to be more radical in its approach to the delivery of services and for all the health and social care organisations in Somerset to work in closer collaboration to ensure the services are delivered as efficiently as possible.

Regulatory Ratings

The Single Oversight framework, as part of the NHS provider licence requirements, enables NHS Improvement to generate five ratings for each foundation trust, one based on its financial sustainability (continuity of services), one on the way it is managed (governance), one on agency spend and two measures based on financial efficiency. This aims to identify a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of these services and/or poor governance. To assess financial sustainability, NHS Improvement uses a continuity of service risk rating (COS) based upon capital service cover and liquidity metrics and to assess the financial efficiency, underlying performance and variance from the plan are used using the Income and Expenditure margin. The Trust achieved an NHS Improvement continuity of service rating of 1 for 2017/18. Further details are given on page 16.

Internal Audit

The Trust engaged PriceWaterHouseCoopers to provide an internal audit function during 2017/18 in order to evaluate and continually improve the effectiveness of the risk management and internal control processes in place.

External Audit

The financial statements were reviewed by the Trust's external auditors, KPMG, who issued an unqualified opinion, and the statements were approved by the board of directors on 24 May 2018.

Audit costs for 2017/18 were £82,800, comprising of statutory audit: £72,000 and audit-related assurance services: £10,800. (2016/17: £82,800, £72,000 for statutory audit and £10,800 for audit-related assurance services). The costs include unrecoverable vat.

Income Disclosure

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. In 2017/18 the Trust has not received any income for goods and services not related to the health service and there are no plans to do so within the five year business plan.

Directors' Responsibilities Statement

For each individual who is a director at the time this annual report was approved, so far as the directors are aware, there is no relevant audit information of which the auditors are unaware and the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Political Donations

Somerset Partnership NHS Foundation Trust has not made any political or charitable donations in 2017/18.

Better Payments Practice Code

The Better Payments Practice Code requires the Trust to aim to pay all undisputed invoices by the due date, or within 30 days of receipt of goods or receipt of invoice, or from the invoice date, whichever is the later. The results against this target for the financial year 2017/18 are shown below.

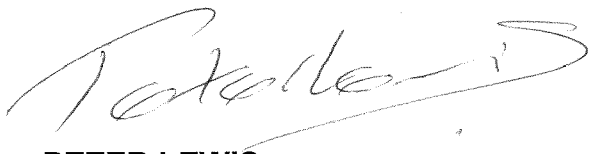
The Trust did not meet the target during 2017/18 due to delays in approving invoices.

	Number	£000
Total non-NHS trade invoices paid in period	39,122	58,526
Total non-NHS trade invoices paid within target	34,274	55.076
Percentage of non-NHS trade invoice paid within target	87.6%	94.1%
Total NHS trade invoices paid in period	778	15,846
Total NHS trade invoices paid within target	622	11,993
Percentage of NHS trade invoices paid within target	79.9%	75.7%

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

Financial Statements and Accounting Policies

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



PETER LEWIS **24 May 2018**
Chief Executive

REMUNERATION AND STAFF REPORT

Remuneration Report

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

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

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

Remuneration Committee

The Committee comprises all the Non-Executive Directors and is chaired by the Chairman of the Trust, Stephen Ladyman.

The Remuneration Committee is responsible for making recommendations to the Trust Board on the pay and conditions of service for executive directors.

The Committee met six times in the financial year 2017/18 with attendance as follows:

√ – in attendance X – not in attendance		**27 June 2017**	**16 August 2017**	**14 September 2017**	**2 October 2017**	**24 October 2017**	**6 March 2018**
Members:							
Stephen Ladyman	Chairman	√	√	√	√	√	√
Philip Dolan	Non-Executive Director	√	X	X	X	X	√
Judith Newman	Non-Executive Director (until 31 July 2017)	X					
David Wood	Non-Executive Director (Vice Chairman and Non-Executive Director until 31 July 2017))	X					

√ – in attendance X – not in attendance		27 June 2017	16 August 2017	14 September 2017	2 October 2017	24 October 2017	6 March 2018
Members:							
Liz Simmons	Non-Executive Director (Vice Chairman from 1 August 2017)	√	√	√	√	√	√
Barbara Clift	Non-Executive Director	√	√	√	√	√	√
David Allen	Non-Executive Director	√	√	X	√	√	√
Barbara Gregory*	Non-Executive Director	√	√	X	√	√	√
Jan Hull*	Non-Executive Director	√	√	√	√	√	√

*Barbara Gregory and Jan Hull were appointed from 1 June 2017 as Associate Non-Executive Directors and from 1 August 2017 as Non-Executive Directors.

Advice was obtained from the Director of People and Organisational Development who attended the meeting on 14 September 2017 in order to assist the Committee.

The Remuneration Committee's meetings covered the following items:

- **27 June 2017** - the Executive Directors' pay award and the appointment of the Chief Executive and Deputy Chief Executive of the Joint Management Team;

- **16 August 2017 -** legal advice in relation to the formation of the Joint Executive Team and Alliance with Taunton and Somerset NHS Foundation Trust, consultation feedback on appointing a Joint Executive Team, Joint Executive Team structure and the appointment of a Joint Executive Team and the process for appointing a new Chief Executive;

- **14 September 2017** - this meeting was conducted as a telephone conference call - appointments to the Joint Executive Team and progress in relation to the appointment of a Joint Chief Executive;

- **2 October 2017 -** approval of the appointment of a Joint Chief Executive; remuneration for the Joint Executive Team and appointment of the Director of Finance and Chief Nurse;

- **24 October 2017 -** approval of the remaining appointment into the Joint Executive Team, appointment and remuneration for the Deputy Chief Executive, interim arrangements and remuneration for the Director of People and Organisational Development and Chief Executive remuneration;

- **6 March 2018** - permanent contract for the Chief Nurse and process for appointing a permanent Director of People and Organisational Development.

Statement of Policy on the Remuneration of Senior Managers for Current and Future Years

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

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

The Trust will set executive remuneration taking account of data on pay available elsewhere for each particular role within the benchmark data. The benchmark data will be reviewed annually and will be based on the Hay scores. The principal benchmark will be the national public sector and the foundation trusts with an annual turnover of £125-£150 million will be used as a secondary benchmark. Additional factors, as defined by the Remuneration Committee, will also be taken into account.

The Trust does not operate a bonus scheme for Executive Directors.

Expenditure on consultancy

A total of £327,235 was spent on consultancy in 2017/18 (2016/17: £333,524).

Off payroll arrangements

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

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

Exit packages

The Trust has made one compensation payments via settlement agreement that was fully approved by NHSI for a senior member of staff. The Trust solicitors have been invited into the Trust to facilitate a learning session from this challenging case.

One director was paid £52,000 in lieu of notice during the year. The costs were shared equally between Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust.

Statement on remuneration levels higher than the British Prime Minister

The Trust had no employees earning above £150,000 (2016/17: 2 employees).

Employment Conditions of Other Employees

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

Analysis of the reasons for sickness absence showed the two main causes as stress/anxiety related and musculoskeletal. The Trust continues to support staff, providing a range of interventions to maintain well-being. These included referrals to the service for one to one support, rapid access to physiotherapy via the Physio4U service, access to counselling and the Talking Therapies service.

The future focus of activity for people services will relate to the Wellbeing Strategy and primarily involve, delivering a range of resilience, stress management and health promotion initiatives placing the emphasis on prevention rather than the management of sickness absence. This will occur within the framework of an overarching Wellbeing Strategy which is being informed by work being undertaken with partner organisations directly and as part of wider STP activity.

Council of Governors

As Somerset Partnership is a foundation trust, the Council of Governors is required to approve the remuneration and terms of service of the Chair and Non-Executive Directors. The Council of Governors has established a Remuneration and Nominations Committee in accordance with the Trust's constitution.

There was no remuneration paid to governors. During 2016/17 a total of £6,508.14 (2015/16: £8,207) of travel expenses were reimbursed to 15 governors (2015/16: 12 governors). Details of the governors are shown on pages 86 - 95.

Contracts of Employment

Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust signed a Memorandum of Understanding on 25 May 2017 with the aim to establish collaborative arrangements in order to improve the quality of care and services provided to our patients and service users.

In line with the Memorandum of Understanding, a Joint Management Team was appointed in October 2017. All Joint Executive Directors received new open-ended contracts - based on their original employing trust - with either Somerset Partnership NHS Foundation Trust or Taunton and Somerset NHS Foundation Trust. Secondment arrangements have been set up for their roles as Joint Executive Directors to the non-employing trust.

The contract position for Executive Directors employed by Somerset Partnership NHS Foundation Trust as at 31 March 2018 is as follows:

Director	Date of original contract	Date of new contract	Period of Notice
Andy Heron	20 January 2014	1 October 2017	3 months
Phil Brice	1 January 2012	1 October 2017	3 months
Pippa Moger	3 June 2013	2 October 2017	3 months

The contract position for Executive Directors employed by Taunton and Somerset NHS Foundation Trust as at 31 March 2018 is as follows:

Director	Date of new contract	Period of Notice
Peter Lewis	4 November 2017	6 months
Stuart Walker	1 October 2017	6 months
Hayley Peters	2 October 2017	6 months
Isobel Clements	1 November 2017	6 months
David Shannon	24 October 2017	6 months
Matthew Bryant	1 October 2017	6 months

The Trust has processes in place through supervision and annual appraisal to ensure that Executive Directors meet performance standards.There were no provisions for compensation or early termination other than the standard redundancy terms applicable to all NHS staff.

Executive Directors allowed to work elsewhere as a Non-Executive

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

Pensions and retirement benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts and details of senior employees' remuneration can be found on this page 43 of this report.

Salaries and Pensions Entitlements of Senior Managers

The following sections provide details of the remuneration and pensions of the Directors for the period ended 31 March 2018 and have been audited.

Total remuneration 2017/18	Note	Salary	Taxable benefits *	Pension related benefits **	Total Remuneration	Recharges Salary	Recharges taxable benefits	Recharges Pension	Remuneration Net of recharges ***
Name and Title		**(Bands of £5,000)**	**(To nearest £100)**	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(To nearest £100)**	**(Bands of £2,500)**	**(Bands of £5,000)**
		£000		**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Peter Lewis, Chief Executive	1	n/a	n/a	n/a	n/a	60-65	0	17.5-20	75-80
Nick Broughton, Chief Executive	2	110-115	200	(137.5-140)	(27.5-30)	n/a	n/a	n/a	(27.5-30)
Andy Heron, Deputy Chief Executive & Chief Operating Officer (Mental Health & Community Services)		115-120	400	(25-27.5)	90-95	(25-30)	(200)	(5-7.5)	50-55
Sue Balcombe, Director of Nursing and Patient Safety	3	120-125	100	0-2.5	125-130	n/a	n/a	n/a	125-130
Phil Brice, Director of Governance and Corporate Development		95-100	100	40-42.5	135-140	(25-30)	0	(2.5-5)	100-105
Dr Andrew Dayani, Medical Director	4&5	35-40	0	n/a	35-40	n/a	n/a	n/a	35-40
Nick Macklin, Director of Workforce and Organisational Development	6	95-100	0	12.5-15	110-115	(35-40)	0	(0-2.5)	70-75
Pippa Moger,		115-120	0	75-77.5	195-200	(30-35)	0	(5-7.5)	150-155

Director of Finance									
Stuart Walker, Chief Medical Care Officer	5&7	n/a	n/a	n/a	n/a	45-50	0	7.5-10	55-60

Total remuneration 2017/18 (continued)	Note	**Salary**	**Taxable benefits ***	**Pension related benefits ****	**Total Remuneration**	**Recharges Salary**	**Recharges taxable benefits**	**Recharges pension related benefits**	**Remuneration Net of recharges *****
Name and Title		**(Bands of £5,000)**	**(To nearest £100)**	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(Bands of £2,500)**	**(Bands of £5,000)**
		£000		**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Hayley Peters, Chief Nurse	8	n/a	n/a	n/a	n/a	30-35	0	7.5-10	35-40
Matthew Bryant, Chief Operating Officer (Acute Hospital Services)	9	n/a	n/a	n/a	n/a	30-35	0	7.5-10	35-40
David Shannon, Director of Strategic Development & Improvement	10	n/a	n/a	n/a	n/a	30-35	0	7.5-10	35-40
Isobel Clements, Interim Director of People	11	n/a	n/a	n/a	n/a	25-30	0	2.5-5	30-35
Sarah Oke, Interim Medical Director	12	15-20	100	0	15-20	n/a	n/a	n/a	15-20
Stephen Ladyman, Chairman		45-50	300	n/a	45-50	n/a	n/a	n/a	45-50
Philip Dolan, Non-Executive Director		10-15	100	n/a	10-15	n/a	n/a	n/a	10-15
Barbara Clift,		10-15	400	n/a	10-15	n/a	n/a	n/a	10-15

Non-Executive Director									
Judith Newman, Non-Executive Director	[13]	5-10	270	n/a	5-10	n/a	n/a	n/a	5-10
Liz Simmons, Non-Executive Director		10-15	400	n/a	10-15	n/a	n/a	n/a	10-15
David Wood, Vice Chairman, Non-Executive Director	[14]	0-5	0	n/a	0-5	n/a	n/a	n/a	0-5
David Allen, Non-Executive Director		10-15	100	n/a	10-15	n/a	n/a	n/a	X-X
Jan Hull, Non-Executive Director	[15]	10-15	300	n/a	10-15	n/a	n/a	n/a	X-X
Barbara Gregory, Non-Executive Director	[16]	10-15	300	n/a	10-15	n/a	n/a	n/a	X-X

Notes

1. From 4 July 2017
2. To 3 November 2017
3. To 31 October 2017
4. To 23 June 2017 and opted out of the Pension Scheme on 1/5/15.
5. 100% of the salary for the Medical Director relates to their director role, there is no element relating to their clinical role.
6. To 31 October 2017
7. From 1 October 2017
8. From 2 October 2017
9. From 1 October 2017
10. From 24 October 2017
11. From 1 November 2017
12. From 23 June to 1 October 2017. The post holder is not in the NHS Pension Scheme
13. To 31 July 2017
14. To 31 July 2017
15. From 1 June 2017
16. From 1 June 2017

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

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

*** The Trust entered into an Alliance with Taunton & Somerset NHS Foundation Trust during 2017/18. As a result, a single Executive/Management Team was formed. The table of Salary and Pension entitlements of senior managers for 2017/18 includes the full entitlements paid to senior managers during the year. This is not the amount chargeable to the Trust. Recharges between the two organisations are shown separately in the table.

The equivalent disclosures for 2016/17 were as follows:

Total remuneration 2016/17	Note	**Salary**	**Taxable benefits**	**Pension related benefits**	**Total Remuneration**
Name and Title		**(Bands of £5,000)**	**(To nearest £100)**	**(Bands of £2,500)**	**(Bands of £5,000)**
		£000		**£000**	**£000**
Sue Balcombe, Director of Nursing and Patient Safety		105-110	100	47.5-50	150-155
Phil Brice, Director of Governance and Corporate Development		90-95	100	17.5-20	105-110
Dr Andrew Dayani, Medical Director	1&3	170-175	100	n/a	170-175
Dr Nick Broughton, Chief Executive		195-200	400	267-5-270	465-470
Nick Macklin, Director of Workforce and Organisational Development		100-105	0	12.5-15	115-120
Andy Heron, Chief Operating Officer		110-115	400	105-107.5	215-220
Stephen Ladyman,		40-45	300	n/a	40-45

Chairman					
Pippa Moger, Director of Finance and Business Performance		105-110	100	32.5-35	135-140
Barbara Clift, Non-Executive Director		10-15	200	n/a	10-15
Philip Dolan, Non-Executive Director		10-15	100	n/a	10-15
Roger Powell, Non-Executive Director	[2]	0-5	100	n/a	0-5
Judith Newman, Non-Executive Director		15-20	0	n/a	15-20
Liz Simmons, Non-Executive Director		10-15	300	n/a	10-15
David Wood, Vice Chairman, Non-Executive Director		10-15	100	n/a	10-15

Notes

1. Opted out of the Pension Scheme on 1/5/15
2. To 30 April 2016
3. 100% of the salary for the Medical Director relates to their director role, there is no element relating to their clinical role.

Pension Benefits	Note	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2018	Lump sum at age 60 related to accrued pension at 31 March 2018	Cash equivalent transfer value at 31 March 2018	Cash equivalent transfer value at 31 March 2017	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
Name and Title		**(Bands of £2,500) £000**	**(Bands of £2,500) £000**	**(Bands of £5,000) £000**	**(Bands of £5,000) £000**	**£000**	**£000**	**£000**	**£000**
Peter Lewis, Chief Executive	1	5-7.5	10-12.5	55-60	150-155	773	146	918	n/a
Nick Broughton, Chief Executive	2	(5-7.5)	(15-17.5)	50-55	155-160	931	1,017	(96)	n/a
Andy Heron, Deputy Chief Executive & Chief Operating Officer (Mental Health & Community Services)	1	0-2.5	(57.5-60)	25-30	0	412	444	(37)	n/a
Matthew Bryant, Chief Operating Officer (Acute Hospital Services)	1	2.5-5	2.5-5	30-35	80-85	417	52	468	n/a
Sue Balcombe, Director of Nursing and Patient Safety	3	0-2.5	0-2.5	45-50	135-140	0	897	(906)	n/a
Phil Brice, Director of Governance and Corporate Development	1	0-2.5	2.5-5	20-25	55-60	405	342	60	n/a
Dr Andrew Dayani, Medical Director	4	(0-2.5)	(0-2.5)	15-20	55-60	328	328	(3)	n/a
Nick Macklin, Director of Workforce and Organisational Development	5	0-2.5	0	10-15	0	167	146	20	n/a

Pension Benefits (continued)	Note	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2018	Lump sum at age 60 related to accrued pension at 31 March 2018	Cash equivalent transfer value at 31 March 2018	Cash equivalent transfer value at 31 March 2017	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
Pippa Moger, Director of Finance	1	2.5-5	5-7.5	25-30	65-70	401	343	55	n/a
Stuart Walker, Chief Medical Officer	1	5-7.5	12.5-15	55-60	150-155	890	129	1,018	n/a
Hayley Peters, Chief Nurse	1	5-7.5	10-12.5	35-40	95-100	445	115	560	n/a
David Shannon, Director of Strategic development & Improvement	1	2.5-5	7.5-10	30-35	75-80	337	82	419	n/a

Notes

1. Posts are shared between Somerset Partnership NHS Foundation Trust and Taunton & Somerset NHS Foundation Trust. Full pension figures attributed to the employee have been disclosed in the table above rather than the amount chargeable to the Trust.
2. To 3 November 2017
3. To 31 October 2017
4. To 23 June 2017 and opted out of the Pension Scheme on 1/5/15.
5. To 31 October 2017

As Non-Executive Directors do not receive pensionable remuneration there are no entries in respect of pensions for Non-Executive Directors.

Median pay

	2017/18	2016/17
Band of highest paid director's salary (£'000)	£95-100k	£185-190k
Median Total Remuneration	£22,683	£21,909
Ratio	4.31	8.44

The banded remuneration of the highest paid director in Somerset Partnership Trust in the financial year 2017-18 was £95-100k (2016-17, £185-190k). This was 4.31 times (2016-17, 8.44) the median remuneration of the workforce, which was £22,683 (2016-17, £21,909).

The calculation is based on full time equivalent staff at 31 March 2018 on an annualised basis. The median is a type of average, defined as the middle number in a sorted list of values.

In 2017-18, 33 (2016-17, 0) employees received remuneration in excess of the highest-paid director. Gross of recharges to Taunton and Somerset NHS Foundation Trust, 2 employees received remuneration in excess of the highest-paid director.

Remuneration ranged from £10,000 to £130,000 (2016-17 £10,000-£185,000),

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

The reason for the change in the multiple (a decrease of 4.13) is that the banded remuneration of the highest paid director has decreased. The remuneration of the highest paid director reflects their full time salary, however, this is a joint appointment across Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust and therefore costs related to this post are shared across the two organisations. The remuneration paid for this post is comparable with peers of similar sized Trusts.

The banded remuneration of the highest paid director in Somerset Partnership Trust (gross of recharges to Taunton and Somerset NHS Foundation Trust) in the financial year 2017-18 was £130-135k (2016-17, £185-190k). This was 5.73 times (2016-17, 8.44) the median remuneration of the workforce, which was £22,683 (2016-17, £21,909)

Cash Equivalent Transfer Values

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

arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Staff costs

	Permanent £000	Other £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	90,989	956	**91,945**	92,436
Social security costs	8,164	0	**8,164**	8,182
Apprenticeship levy	461	0	**461**	0
Employer's contributions to NHS Pensions	12,233	0	**12,233**	12,228
Termination benefits	173	0	**173**	0
Temporary staff	0	11,099	**11,099**	9,374
Total staff costs	112,020	12,055	**124,075**	122,220
Costs capitalised as part of assets	(300)	0	**(300)**	(255)

Employer contributions to the NHS Pensions Agency represent total employer pension contributions payable for the year.

Staff numbers

	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	84	26	**110**	100
Administration and estates	468	17	**485**	499
Healthcare assistants and other support staff	846	87	**933**	945
Nursing, midwifery and health visiting staff	958	76	**1,034**	1,070
Scientific, therapeutic and technical staff	548	7	**555**	539
Other	72	0	**72**	77
Total	2,976	213	**3,189**	3,092
of which				
Number of employees (WTE) engaged on capital projects	8	0	**8**	6

Retirements due to ill-health

During 2017/18 there were 5 early retirements form the trust agreed on the grounds of ill-health (2016/17: 1 early retirement). The estimated pension liabilities of these ill-health retirements are £310,782 (2016/17: £143,000).

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

Directors' remuneration and other benefits

	31 March 2018 £000	31 March 2017 £000
Total directors' remuneration excluding social security costs	**938**	979
Other taxable benefits	**2**	1
Employer pension contributions	**81**	114
	1,021	1,094
Number of executive directors to whom pension benefits are accruing	**3**	6

There were no other gains, incentive schemes or assets receivable by directors. The emoluments of the highest paid director were £97,849 (2016/17: £185,000). The Trust entered into an alliance with Taunton & Somerset NHS Foundation Trust during 2017/18. As a result, a single Executive/Management Team was formed. The emoluments of the highest paid director are net of recharges to Taunton & Somerset NHS Foundation Trust.

Reporting of compensation schemes-exit packages 2017/18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
£10,001 - £25,000	**1**	**0**	**1**
£25,001 - £50,000	**0**	**1**	**1**
£50,001 - £100,000	**1**	**2**	**3**
	2	**3**	**5**
Total resource cost (£)	**84,584**	**174,847**	**259,431**

There was 1 non-contractual payments made to an individual where the payment was more than 12 months' of their annual salary.

Two directors were paid in lieu of notice during the year; £33,823 and £53,025. The costs were shared equally between Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust.

Reporting of compensation schemes-exit packages 2017/18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
£10,001 - £25,000	**1**	**0**	**1**
£25,001 - £50,000	**0**	**1**	**1**
£50,001 - £100,000	**1**	**2**	**3**
	2	**3**	**5**
Total resource cost (£)	**84,584**	**174,847**	**259,431**

There was 1 non-contractual payments made to an individual where the payment was more than 12 months' of their annual salary.

Two directors were paid in lieu of notice during the year; £33,823 and £53,025. The costs were shared equally between Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust.

Trust Workforce

The Trust has a workforce of nearly 4,500, working in a range of inpatient, outpatient, and community team settings across a wide range of geographical locations. The rate of turnover was 12.12% in 2017/18.

Colleagues in post at 31 March 2018

	Q1 (Apr – Jun17)	Q2 (Jul – Sep17)	Q3 (Oct – Dec17)	Q4 (Jan – Mar 17)
Total Staff	4400	4443	4442	4444
Substantive	3809	3806	3769	3766
WTE	3006.38	3009.08	3010.3	3021.07
Bank	591	631	673	678
Bank % of Substantive	12.50%	12.81%	13.39%	12.12%

Colleagues groups and Gender

Staff group	Female	Male	Total
Non-Executive Directors	4	1	5
Chair and Directors	2	4	6
Senior Managers	21	10	31
Other Colleagues	3222	502	3724
Total	3249	517	3766

Workforce Information

The Trust has five Operational Divisions, described in the table below.

Operational Divisions - Head Count and WTE

Division	Departments	WTE	Headcount
Children , Young People and Families	CAMHS	132.93	159
	Health Visiting	149.10	186
	Other Children's Services	5.43	8
	Paediatric Therapy	59.79	86
	School Nursing	23.60	32
	Sexual Health	26.15	41
	Student Health Visitors	0.50	1
Community Support Services	Diabetic Service	26.35	38
	Dietetics	15.39	19
	Integrated Lifestyles	5.49	9
	Musculo-skeletal	93.27	121
	Other Community Support Services	13.00	21
	Podiatry	26.09	32
	Speech and Language Therapy	29.09	36
East Somerset Division	Community Hospital	312.32	423
	Day Services	13.96	26
	District Nursing	135.26	175
	Integrated Rehabilitation	41.07	58
	Older Person CMH	34.18	43
	Operational Management	8.73	10
	Other Community Health Services	24.06	28
	Primary Link	13.88	19
	Stroke Services	55.20	68
Mental Health Inpatient, Crisis and Specialist Care	Community Mental Health	111.73	140
	Crisis resolution	53.43	56
	Learning Disabilities	45.65	54
	Mental Health Inpatient Services	238.53	265
	Mental Health Specialist Services	27.31	33
	Operational Management	6.00	6
	Psychological Services	74.12	88
	Talking Therapies	74.32	88

Division	Departments	WTE	Headcount
West Somerset Division	Chaplains	1.70	4
	Community Hospital	355.63	482
	Day Services	21.23	28
	District Nursing	156.58	202
	Integrated Rehabilitation	54.04	68
	Mental Health Inpatient Services	69.01	82
	Older Person CMH	39.32	47
	Operational Management	7.80	9
		2581.24	**3291**

Medical Directorate - Head Count and WTE

Departments	WTE	Headcount
Medical Services	64.86	78
Pharmacy	17.19	19
TOTAL	**82.05**	**97**

Dental Directorate - Head Count and WTE – Dental Directorate

Departments	WTE	Headcount
Dental	107.70	139
TOTAL	**107.70**	**139**

Central Services - Head Count and WTE

Departments	WTE	Headcount
Finance, Information and Performance	78.87	84
Chief Executive Directorate (including Chairman and Non-Executive Directors)	4.08	9
Education and Training	26.83	29
Nursing Management	40.66	47
HR	24.70	22
Corporate Governance	15.63	18

Departments	WTE	Headcount
Facilities and Estate Management	7.93	10
Senior Operational Management	15	15
TOTAL	**213.70**	**234**

The following table shows the various roles in the Trust by whole time equivalent. Workforce levels within each role are monitored at Divisional level and data is presented quarterly to the Trust Board, alongside a range of other HR metrics to provide assurance that the necessary actions and plans are in place to maintain a competent and motivated workforce.

Whole Time Equivalent by Role

		Q1 (Apr-Jun)	Q2 (Jul-Sept)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
	Role	**WTE**	**WTE**	**WTE**	**WTE**
Additional Professional Scientific and Technical	Chaplain	1.82	1.82	1.72	1.70
	Clinical Psychologist	27.59	26.48	28.78	29.25
	Optometrist	1.00	1.00	1.00	-
	Pharmacist	14.86	14.46	14.56	13.52
	Practitioner	55.61	59.49	53.09	60.89
	Psychological Therapist - Qualified	-	-	0.40	-
	Psychological Therapist - Trainee	0.80	0.80	1.40	1.40
	Psychotherapist	45.43	45.79	44.30	43.41
	Social Worker	12.60	13.51	13.60	15.31
	Technician	0.43	2.31	2.31	2.31
	Group Total	**160.13**	**165.57**	**160.67**	**167.79**
Additional Clinical Services	Assistant Psychologist	8.39	5.73	5.80	5.40
	Assistant/Associate Practitioner	20.43	24.43	22.87	23.40
	Assistant/Associate Practitioner Nursing	2.60	14.17	15.00	20.49
	Dental Surgery Assistant	55.65	57.65	60.35	61.53
	Health Care Support Worker	641.88	628.84	610.18	602.10
	Nursery Nurse	10.96	9.84	9.84	9.84
	Phlebotomist	0.53	0.53	4.73	5.20

		Q1 (Apr-Jun)	Q2 (Jul-Sept)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
	Role	**WTE**	**WTE**	**WTE**	**WTE**
	Psychological Wellbeing Practitioner – Qualified	1.15	3.80	1.15	-
	Pre-Reg Pharmacist	-	-	1.00	1.00
	Technical Instructor	2.12	1.00	1.00	1.00
	Group Total	**743.70**	**735.41**	**729.78**	**729.97**
Administrative and Clerical	Analyst	19.35	20.49	19.89	19.89
	Apprentice	9.00	8.00	4.00	4.00
	Board Level Director	4.00	4.00	3.00	3.00
	Chair	0.60	0.60	0.60	0.60
	Chief Executive	1.00	1.00	-	-
	Clerical Worker	282.87	279..29	286.95	269.73
	Finance Director	1.00	1.00	1.00	1.00
	Manager	46.02	49.56	45.76	45.04
	Medical Secretary	29.99	29.45	32.62	31.05
	Non-Executive Director	1.00	1.01	1.01	1.01
	Officer	110.99	105.17	109.65	105.96
	Researcher	1.00	1.00	1.20	1.00
	Senior Manager	58.32	54.94	56.74	53.74
	Group Total	**569.42**	**559.11**	**566.42**	**540.01**
Allied Health Professionals	Art Therapist	2.20	2.20	2.78	3.30
	Chiropodist	28.22	28.71	29.21	26.91
	Dietitian	13.49	12.69	14.09	13.99
	Occupational Therapist	101.23	94.96	96.20	93.02
	Paramedic	2.00	3.00	3.00	3.00
	Physiotherapist	109.03	119.97	123.85	120.43
	Speech and Language Therapist	44.39	45.95	48.65	50.27
	Group Total	**300.56**	**307.48**	**317.03**	**310.92**
Estates and Ancillary	Support Worker	208.45	212.19	206.33	208.66
	Group Total	**208.45**	**212.19**	**206.33**	**208.66**
Medical and Dental	Associate Specialist	5.77	4.10	6.19	6.19
	Clinical Director - Dental	2.00	2.00	2.00	1.00
	Consultant	33.88	36.58	35.23	39.63

		Q1 (Apr-Jun)	Q2 (Jul-Sept)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
	Role	**WTE**	**WTE**	**WTE**	**WTE**
	Dental Officer	16.16	17.80	18.89	18.69
	General Medical Practitioner	1.36	0.09	0.09	0.09
	Medical Director	1.00	-	-	-
	Salaried Dental Officer	0.75	-	-	-
	Salaried General Practitioner	1.00	1.00	1.00	1.00
	Senior Dental Officer	4.00	3.40	3.40	4.40
	Specialty Doctor	6.67	6.83	8.03	7.43
	Specialty Registrar	7.98	9.80	9.80	9.80
	Staff Grade (Closed)	0.08	0.08	-	-
	Group Total	**79.91**	**81.67**	**84.62**	**88.22**
Nursing and Midwifery Registered	Community Nurse	198.20	215.48	213.06	212.56
	Community Practitioner	211.52	199.47	200.31	197.66
	Health Visitors	116.09	107.41	106.11	101.63
	Modern Matron	6.00	8.00	7.00	7.00
	Nurse Consultant	3.00	3.60	3.60	4.00
	Nurse Manager	48.36	49.36	54.16	53.86
	Sister/Charge Nurse	34.96	32.76	33.77	35.49
	Specialist Nurse	68.02	68.07	65.09	66.97
	Staff Nurse	259.13	253.95	261.61	257.12
	Student Health Visitor	1.00	-	-	-
	Group Total	**945.26**	**938.10**	**944.71**	**936.28**
Grand Total		**3008.43**	**3009.58**	**3010.30**	**2981.85**

Staff Sickness Absence

The following figures are reported in the annual accounts and are based on the financial year and reflect the statistics reported on the website of the Health and Social Care Information Centre:

Total number of staff years	3,065
Total days lost through sickness	53,467
Calculated absences per staff year	17

The Trust experienced monthly levels of sickness during 2017/18 ranging from 4.35% to 6.18%. These levels are elevated compared with the range of 4.25% to

5.51% during 2016/17; the Trust is committed to reducing levels of sickness absence, and the target to maintain sickness absence levels below 4% remains an important objective. In April 2017 the sickness absence rate was 4.35% with an average over the year of 4.99%.

Analysis of the reasons for sickness absence showed the two main causes as stress/anxiety related and musculoskeletal. The Trust provides a range of interventions to maintain well-being. These included referral to the service for one to one support, rapid access to physiotherapy via the Physio4U service, access to counselling and Talking Therapies. The Human Resource team continue to support managers to ensure early referral to Occupational Health and correct reporting of sickness events to aid future analysis.

The future focus of activity will be pro-active placing the emphasis on prevention rather than the management of sickness absence. This will occur within the framework of an overarching Health and Wellbeing Strategy which is being informed by work being undertaken with partner organisations directly and as part of wider STP activity.

Employees with disabilities

The Trust continues to demonstrate its commitment to respond to the needs of employees with disabilities. The Equal Opportunities Policy, Single Equality scheme and supporting action plan, Recruitment and Selection Policy and Managing Absence Policy all underpin this commitment.

We continue to offer job applicants who declare a disability (and meet the person specification for a post) an interview, as part of our commitment to the ‘two ticks’ disability symbol scheme.

An applicant’s disability does not form any part of the recruitment and selection process of the Trust, other than assurance of an interview if appropriately qualified. Details of the Occupational Health Pre-employment Assessment Report are not made known to the interview panel.

Successful applicants who have a disability are assessed by Occupational Health and where practical and possible, adjustments to the workplace are made.

We are committed to retaining colleagues who become disabled during their employment. In these circumstances, an assessment process identifies the options available-including remaining in the current post or alternative employment within the Trust, if this is appropriate. Wherever possible we will make reasonable adjustments to accommodate employees with a disability.

Colleagues with disabilities have equal access to opportunities for promotion, appraisal and development.

Engagement

We use a variety of methods to provide colleagues with information about the Trust, the NHS and any changes which may affect them

- Whats-on@SomPar – used until February 2018, this was a fortnightly newsletter which updated staff on activities across the Trust and shared lessons learned from incidents, complaints and audits. In February 2018, this was replaced with Staff News, a weekly joint newsletter with Taunton and Somerset NHS Foundation Trust to make sure staff across both Trusts were kept informed at the same time with information about the alliance, and other Trust news;
- Chief Executive's blog;
- Joint Management and Staff Side Committee;
- Service and Team Managers' away days and cascade briefings to all teams; and
- direct communications to all staff from the Chief Executive and members of the executive team.

Senior Managers meet regularly with Executive Team members to discuss financial, performance, operational and other issues of importance at the Senior Managers' Operational Group. Operational and Professional managers meet with the Chief Executive and the Executive Directors two / three times per year, to hear and discuss updates in relation to partnership working, our financial and clinical performance and any other relevant national and local issues. These meetings are also used to engage managers in the Trust's annual business planning process, particularly in identifying priorities for the future together with a range of consultative activity.

The Trust has continued to support its 'See Something Say Something' initiative which was introduced in response to the Robert Francis report into the events at Mid-Staffordshire NHS Foundation Trust. This campaign is designed to empower colleagues to speak out about good practice, or practice which they feel is not of an appropriate standard. A training package developed by colleagues has been delivered across the Trust to develop awareness and encourage colleagues to speak out. This initiative has won a national award for Innovation and Best Practice.

The Trust has formal mechanisms for engaging with staff. These include the Joint Management and Staff Side Committee (JMSSC), and individual supervision and appraisal. The JMSSC plays a key role in discussing issues which affect staff, and in formal consultation and negotiation with the Trust.

In addition to the above, we conduct consultation exercises where appropriate when significant changes are planned. In 2017/18, this included consultation on:

- the development of new Trust values and a supporting behaviours framework; and
- the development of our Organisational Development Strategy, 'Our Partnership'.

Colleague Involvement in Performance

Each Division has a performance scorecard which is discussed monthly at the Senior Managers Operational Group meeting, circulated to colleagues, and discussed in divisional meetings. Managers share performance information with their teams and take action to improve performance where this falls short of targets.

Occupational Health and Colleague Well-Being

We continue to provide a Well@Work Service as part of our commitment to supporting the well-being of colleagues, which has been well utilised.

As part of the Staff Well-Being Strategy, we started a programme of stress risk assessments, fulfilling the Trust's obligations and duty of care for staff and their well-being. The risk-assessments have enabled targeted interventions throughout 2016/17.

The Occupational Health service is provided by an independent contractor, and managed as part of the Well@Work service.

Our workforce has access to a range of services to support their physical and mental well-being including quick access to physiotherapy, counselling support, one to one discussions with the Well@Work team and Somerset Talking Therapies.

The Trust has a Colleague Health and Wellbeing strategy that included the wellbeing month of March and a conference that has been organised for April to highlight and continue to support colleague health and wellbeing.

Staff Survey

The 2017 staff survey was completed between September and December 2017 with a 40% response rate equating to feedback from 1,471 colleagues, which was a decrease on the response rate of 46% in 2016 but is below the average response (45%) in respect of comparable Trusts.

Overall Staff Engagement

Our overall staff engagement score has increased from 3.77 in 2016 to 3.79 in 2017 which is comparable with the national average of 3.79.

Key Findings

In respect of changes since 2016, colleagues report feeling more positive about:

- Confidence and security in reporting unsafe clinical practice (KF31);
- Effective team working (KF9); and
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents (KF30).

The responses for KF 31 and KF9 are in line with average results for benchmark results. Despite a local improvement, the response for KF30 is worse than the average response for benchmark Trusts.

More generally, colleagues have reported a better than average sense that the Trust provides equal opportunities for career progression / promotion (KF21) and better than average levels of:

- staff experiencing discrimination at work (KF20);
- staff feeling unwell due to work related stress in the last 12 months (KF17);
- staff experiencing physical violence from staff in last 12 months (KF23); and
- reporting most recent experience of harassment, bullying or abuse (KF27).

Despite the 11 individual questions relating to Trust managers having improved from 2015 to 2016, these have not shown a significant increase from 2016 to 2017. Conversely, colleagues report worse than average levels of receiving appraisals in the last 12 months.

In comparison with benchmarked Trusts it is also disappointing that colleagues report less positive experiences in respect of:

- quality of appraisals (KF12);
- quality of non-mandatory training, learning or development (KF13);
- fairness and effectiveness of procedures for reporting errors, near misses and incidents (KF30);
- working extra hours (KF16);
- ability to contribute towards improvements at work (KF7);
- satisfaction with level of responsibility and involvement (KF8);
- recognition and value of staff by managers and the organisation (KF5);
- good communication between senior management and staff (KF6);
- support from immediate managers (KF10);
- satisfaction with the quality of work and care they are able to deliver (KF2);
- agreeing that their role makes a different to patients and service users (KF32);
- effective use of patient / service user feedback (KF32);
- reporting most recent experience of violence (KF24); and
- experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (KF25)..

Pleasingly, the percentage of colleagues prepared to recommend the Trust as a place to work has increased (1%) and is above average although this is of course a figure that we would wish to see reaching consistently higher levels. Similarly an above average percentage of colleagues report that if a friend or relative needed treatment they would be happy with the standards of care offered (71% v 66%) although this has fallen 1% since 2015.

More disappointingly, the percentage of colleagues reporting that the care of patient / service users is the Trust's top priority has fallen from 74% in 2015 to 70% in 2016 and is now below the national average of 73%. Similarly, the percentage of staff who

believe that we act on concerns raised by patients / service users has fallen from 77% in 2015 to 72% in 2016. This is below the national average of 75%.

In addition to the staff survey numerical results, we receive a free text comment report detailing observations from survey responders. Only 22 comments were received this year. A number of these were entirely positive about the experience of working for the Trust. The areas of dissatisfaction were related to lack of involvement with changes that affect work (5), lack of support and poor communication from managers (5), lack of feedback (5), insufficient staff members (5), bureaucracy (4), and fairness / confidence issues around reporting or being involved in incidents etc. (2).

In 2016/17 we held a series of engagement events where we received some very honest and useful feedback about what it felt like to work for the Trust and the things that colleagues would like to see change. As a consequence of operational pressures and as part of our cost control measures we elected not to replicate that approach this year. At this juncture therefore we have not been able to validate some of our assumptions arising from the initial analysis of the data. However as indicated below we have plans to secure valuable additional feedback virtually.

For information, the table below shows the five top and bottom key ranking scores for the Trust.

	2017		**KF no. 2015**	**2016**	
Top 5 Ranking Scores	**Trust**	**National average for combined MH/LD & Community trusts**		**Trust**	**National average for combined MH/LD & Community trusts**
KF21. Percentage of staff believing that the organisation provides equal opportunities for progression or promotion	90%	86%	21	90%	88%
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	1%	2%	11	2%	2%
KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	61%	57%	17	34%	39%
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	8%	11%	27	62%	58%
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	37%	40%	20	10%	11%

	2017		KF no. 2015	2016	
Bottom 5 Ranking Scores	**Trust**	**National Average for combined MH/LD & Community Trusts**		**Trust**	**National Average for combined MH/LD & Community Trusts**
KF32. Effective use of patient/service user feedback	3.46	3.69	KF12	2.93	3.10
KF12. Quality of appraisals	2.93	3.10	KF9	3.76	3.87
KF16. Percentage of staff working extra hours	74%	71%	KF13	3.97	4.08
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or public in last 12 months	31%	26%	KF3	87%	89%
KF6. Percentage of staff reporting good communication between senior management and staff	30%	34%	KF32	3.44	3.68

Future Priorities

Pleasingly, the CQC spoke very positively about the changes in culture they perceived had occurred between their inspection visits and how colleagues have reported feeling more positive about how it felt to work at the Trust. Engagement was one of the areas where CQC feedback suggested the experience of colleagues had improved. To further enhance this we invested in Questback, a multi-functional on-line platform, which will enable real time communication with colleagues, provide opportunities for conducting surveys and support on-line special interest communities. We will use this system to explore further with colleagues reasons why staff experience is less positive than we would wish and how we can improve how it feels to work at the Trust.

Clearly, howeve,r there are some apparent themes emerging including the quality / receipt of feedback, confidence in raising concerns, improving the effectiveness of management interventions / interactions, enhancing the quality of colleagues' appraisal experience and access to non-mandatory training and providing colleagues with the opportunity to better influence change at work.

Counter Fraud

Under the NHS Standard contract the Trust complies with the requirements to have in place and maintain appropriate counter fraud arrangements. This includes compliance against the 2017-18 NHS Counter Fraud Authorities (NHSCFA) Fraud, Bribery and Corruption standards.

From 1 April 2017 the Trust directly employed a Local Counter Fraud Manager to address the NHSCFA standards with the Director of Finance having responsibility for

overseeing and providing strategic management and support for all the counter fraud, bribery and corruption activity within the organisation.

This has included addressing all key principles identified by the NHSCFA and the implementation of a revised Anti-Fraud, Bribery and Corruption policy which has been made widely available to staff.

During 2017-18 the Trust has completed a Self-Review Tool (SRT) submission to the NHSCFA with an overall self-assessed rating of GREEN.

NHS Constitution

The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights and responsibilities of patients, the public and staff as well as the pledges which the NHS is committed to achieve.

The NHS Constitution and Handbook to the NHS Constitution were updated in 2015 and reviewed again in 2017 to include an addendum in respect of ambulance response times. It is planned to publish a consolidated handbook in 2018.

As part of our work during 2017/18 we have sought to ensure that the values, behaviours and principles set out in the NHS Constitution are foremost in our plans. We reviewed our Trust values in 2016 with colleagues throughout the organisation to support the principles of the NHS Constitution.

During 2017/18 we were involved in a number of reviews of our care and governance systems, including a follow up inspection by the Care Quality Commission and an independent assessment of our achievements against the NHS Improvement Well Led Framework, which focused on how we provide access to our services, the quality of care and environment, respect and confidentiality and involvement in care – all of which are key principles enshrined in the NHS Constitution. You can find information on the outcome of these reviews in our report.

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

The National Health Service Act 2006 (NHS Act 2006) states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Somerset Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Somerset Partnership NHS Foundation Trust and of its income and expenditure, items of other comprehensive income and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.[1]

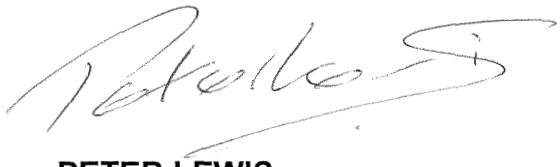
The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether

[1] The standard wording of the last bullet is "use the going concern basis of accounting unless they either intend to liquidate the Group or the parent Company or to cease operations, or have no realistic alternative but to do so". The only circumstance under which an Accounting Officer would prepare the accounts on a non-going concern basis is if they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

due to fraud or error and for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed



PETER LEWIS
Chief Executive **24 May 2018**

ACCOUNTABILITY REPORT

Directors' Report

Board of Directors

The Trust's Board of Directors reserve certain powers and decisions which may only be exercised or made by them in formal session. These powers and decisions are set out in the Scheme of Delegation (which may be obtained from the Secretary to the Trust) together with the decisions which are delegated to Executive Directors or to Board Committees.

The Board should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.

The Board, and in particular Non-Executive Directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant advisor for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.

Non-Executive Directors

Stephen Ladyman, PhD, Chairman from 1 May 2013 – 30 April 2019

Stephen Ladyman has a scientific background, starting his career as a radiation biologist before moving into IT management in medical research environments. In 1997 he became the MP for South Thanet.

As an MP he founded and chaired the All Party Parliamentary Autism Group and in 2003 he was appointed as Minister for Community in the Department of Health with responsibilities that included adult social care, the health of older people and extra care housing. In 2005 he became Minister of State for Transport.

After leaving Government he chaired a number of Parliamentary Committees and was an advisor to the Learning Disability Coalition. He left Parliament in 2010 and took a two year appointment as the Chief Executive of Retirement Security Ltd, a company that manages the largest estate of private extra-care retirement property in the UK. In 2012 he left Retirement Security to set up his own company, Oak Retirement, in the same sector and he is currently also the Chair of the Retirement Housing Group, a trade body representing the retirement housing sector.

David Wood, Non-Executive Director from 1 August 2011– 31 July 2017 (Deputy Chairman from 1 January 2012 until 31 July 2017)

David is a solicitor and former partner in Bevan Brittan a large regional firm with a significant public sector client base. David was Chief Executive of the firm for a period of four years and specialised in regulatory law especially health and safety and environmental issues. He has acted for many NHS bodies over the years. Now retired from practice he continues to be involved as he has been for the last 30 years with Glastonbury Festival. He was for five years a Non-Executive Director and Vice-Chair of NHS Somerset and for the three years up until its acquisition by Somerset Partnership NHS Foundation Trust, Chair of Somerset Community Health.

Liz Simmons, Non-Executive Director from 1 March 2012 – 28 February 2019 (Senior Independent Director from 1 May 2016 and Deputy Chairman from 1 August 2017)

Liz worked in marketing within the telecommunication industry and as a social worker in a large acute hospital and within a neuro-rehabilitation unit. For the last 16 years Liz has worked in third sector development roles including a charity specialising in support to young people with physical disabilities and sensory loss and nine years as chief officer of a mental health charity.

Liz now undertakes a range of freelance work across the south west charity sector including training, interim management, organisational reviews, external evaluation, and supervision for charity chief officers. Liz was a Non-Executive Director of South Somerset PCT from April 2005 until September 2006 and of Somerset PCT from October 2006 until February 2012. She is a trustee and director of SHINE Somerset Ltd a healthy living centre based in Chard and a trustee of Somerset Advocacy.

Liz's qualifications are: MA (Hons), a Certificate of Qualification in Social Work and a Diploma in Management Studies.

David Allen, Non - Executive Director from 1 May 2016 - 30 April 2019

David undertook a number of managerial roles within the NHS and has solid experience in acute, mental health and community services, specialising in risk, governance and compliance.

Prior to his work in the NHS, David was a director and Company Secretary at a leading insurance company, with overall responsibility for Information Technology, Human Resources, Facilities, Compliance and Governance.

David is a Chartered Engineer and holds a BSc (Hons) in Engineering and he is a Member of the British Computing Society.

Philip Dolan, Non – Executive Director from 1 June 2012 – 31 May 2019

A qualified strategist, Phil completed 27 years in local government in 2010 serving as the Chief Executive at three different local authorities over a period of 11 years. Phil has extensive experience in strategy, performance enhancement, governance, financial planning and partnership delivery. He lectures in these subjects at level 7 for the Chartered Management Institute for whom he is also a senior management mentor.

Phil has served as a member of the Somerset Safeguarding Children's Board and is a former Government advisor in the field of welfare benefits. He was a national examiner with the Institute of Revenues, Rating and Valuation (IRRV) for 7 years. Currently he is Chief Executive at Age UK Somerset.

Philip's qualifications are MSc (Strategic Management), CMI Executive Diploma in Management, Diploma in Strategy, Certificate in Quality Assessment and full professional qualification with the IRRV. He is also a fellow of both the RSA and CMI.

Barbara Clift, Non - Executive Director from 1 November 2014 - 31 October 2020

Barbara previously worked for the global technology company IBM, where she gained considerable experience working in business development at a senior level both in the UK and overseas.

While this is Barbara's first NHS post, she brings extensive experience from the commercial sector which complements the skills of current Board members. Barbara also has significant experience in the voluntary sector supporting charities and not-for profit organisations in business and marketing. Barbara has also run a successful hotel/restaurant in the West Country and is an active supporter and mentor for women in business.

Judith Newman, Non-Executive Director from 1 August 2011 – 31 July 2017

Judith completed over 30 years of service in the NHS before taking early retirement in 2009. She is a former Director of Secondary Care Development for NHS Somerset, and has been a Director of Finance for a Health Authority, an NHS Trust and a

Primary Care Trust. She is experienced as a health service commissioner, financial strategist and planner and performance manager.

Judith is a founder member and Treasurer of the Friends of Dene Barton Community Hospital. Judith's qualifications are Chartered Institute of Management Accountants (CIMA), Henley Management College Senior Management Programme.

Barbara Gregory, Non-Executive Director from 1 August 2017 – 31 July 2020. (From 1 June 2017 to 1 August 2017 Associate Non-Executive Director)

Barbara Gregory has worked at senior management level in the NHS since 1993, including 15 years at Board level in a number of organisations in different parts of the health system – including as a Director of Finance in an NHS organisation that manages similar services to the Trust. She has an excellent working knowledge gained from first-hand experience of the health and social care system and has also been involved in the Strategic Transformation Programme in Cornwall.

Barbara has also worked closely with senior colleagues from the Local Authority on the integration of provision and commissioning and the opportunities for the devolution of expenditure to providers as part of the potential development of accountable care organisations/systems.

Jan Hull, Non-Executive Director from 1 August 2017 – 31 July 2020. (From 1 June 2017 to 1 August 2017 Associate Non-Executive Director)

Jan Hull has worked at senior management level in the NHS in Somerset from 1992 until very recently – most recently as Managing Director of the South, Central and West Commissioning Support Unit - and has a good level of knowledge of the services provided by the Trust, and the strategic context in which the Trust operates. Her service knowledge comes from experience of directly managing community services, when they were first transferred to Taunton Deane PCT from the acute trust, and more recently having had commissioning responsibility for mental health services.

Jan was also involved in the development of the business case for the Primary Care Trust proposing the transfer of Somerset Community Health to the Trust in 2011. Jan has worked at senior level with all of the major health and social organisations in the county, including primary care and the voluntary sector."

Executive Directors

Dr Nick Broughton, Chief Executive from February 2016 until 3 November 2017

Nick is a psychiatrist by background and has worked as a Consultant in Forensic Psychiatry since 2000. He graduated from Cambridge University in 1989 and completed his medical training at St. Thomas' Hospital Medical School. He trained in psychiatry in North West London. During the course of his consultant career he has worked in a wide variety of secure settings including a specialist remand service, an enhanced medium secure service for women, a remand prison and a young offenders' institution.

Nick held a number of managerial positions prior to joining Somerset Partnership NHS Foundation Trust as Chief Executive in February 2016 including being Clinical Director for a forensic service and Medical Director of a large specialist mental health Trust. In January 2012 he was appointed Chair of the National Clinical Reference Group for Secure and Forensic Mental Health Services, a position he held until 2014. He was joint Clinical Director and Co-Chair of London's Strategic Clinical Network for Mental Health and a Director of Imperial College Health Partners.

Nick is also a trustee of the Charlie Waller Memorial Trust, a national mental health charity.

Peter Lewis, Chief Executive from 4 November 2017 – joint appointment with Taunton and Somerset NHS Foundation Trust – voting Board member

Peter joined Taunton and Somerset NHS Foundation Trust in 2005 as Director of Finance and Performance. He became Deputy Chief Executive in 2008 and took on the responsibility of Chief Operating Officer in 2010, before becoming Chief Executive in September 2017. Prior to joining the Trust, Peter was a Director of Performance at Dorset and Somerset Strategic Health Authority and has also worked in both commissioning and provider organisations prior to that. Peter is a Fellow of the Chartered Institute of Management Accountants.

Andy Heron, Chief Operating Officer – January 2014. From 1 October 2017 Chief Operating Officer (Mental Health and community Services) – joint appointment with Taunton and Somerset NHS Foundation Trust – voting Board member

Andy joined the Trust in January 2014 after having worked in health and social care for 27 years after originally qualifying as

an Occupational Therapist (DIP.COT). He initially worked clinically in Cornwall and North Somerset and went on to manage mental health services. Andy then managed mental health services in Bristol from 1999 – 2006 where he took a central role in integrating NHS and social care services and a modernisation programme that included complete service redesign and the comprehensive re-provision of the mental health estate in the city.

Following this Andy gained a broad range of experience in London and the south west in senior commissioning and provider roles in the NHS and also in social care where he worked at the level of service director with responsibility for services to people with physical and sensory impairment, learning disabilities and mental health problems. Prior to joining the Trust in 2014 he was working as Director of Projects for a successful mental health and community foundation NHS trust in East London with portfolio responsibility for service modernisation and commercial and business development.

Andy maintains a strong interest in care pathway redesign and service integration and is also lead director for restrictive interventions.

Pippa Moger, Director of Finance and Business Development - June 2013. From 2 October 2017 Director of Finance – joint appointment with Taunton and Somerset NHS Foundation Trust – voting Board member

Pippa joined the NHS in 2002 as a management accountant at South Somerset Primary Care Trust where she remained employed until the restructuring of Primary Care Trusts in 2007 by which stage she had been promoted to Assistant Director of Finance. In 2007 Pippa joined NHS South West as Assistant Director of Finance responsible for strategic development of costing and payment by results for the south west. During her time at NHS South West a secondment opportunity arose in NHS Wiltshire to head up the Commissioning Team for 6 months.

In March 2009 Pippa joined Yeovil District Hospital NHS Foundation Trust as Assistant Director of Finance and on leaving the Trust in 2013 had been Interim Director of Finance. Pippa has a passion for ensuring that NHS resources are used in the most efficient and effective way whilst ensuring patient safety is not compromised.

Pippa's qualifications are a fellow member of Association of Chartered Certified Accountants (ACCA).

Dr Andrew Dayani, Medical Director – May 2013 until 23 June 2017 – voting Board member

Andrew has been an NHS doctor for 24 years. After initially training in hospital medicine, he switched to general practice,

training in Cornwall before moving to Somerset in 1994. As a GP Principal and Executive Partner he led many of the organisational and business aspects of the practice, whilst also maintaining interests in dermatology, cardiology and community hospital medicine.

In addition to clinical practice, Andrew was Locality Commissioner for Taunton Deane and West Somerset, working with primary and secondary care plus third sector bodies to improve patient care. He has also been a member of Somerset Local Medical Committee, where he was Lead Negotiator for PMS practices and more recently the LMC representative to the interim Somerset Clinical Commissioning Group. Andrew maintains an interest in occupational medicine and general practice.

Andrew's qualifications are MB ChB, MRCGP, D.Occ Med. He is a member of the Faculty of Medical Leadership and Management, and the Society of Occupational Medicine. He is a Fellow of the Royal College of General Practitioners.

Sarah Oke, Interim Medical Director from 23 June 2017 until 1 October 2017 – voting Board member

Sarah covered as Interim Medical Director from 23 June 2017 to 1 October 2017.

Sarah commenced in the post of Consultant in General Adult Psychiatry Inpatient and CRHT Taunton at the Trust in December 2014. Sarah's work history in the Bristol area includes Consultant in General Adult Psychiatry, Prison Inreach Consultant to Eastwood Park Prison and Consultant in the Bristol Intensive Team. Additional roles covered until 2014 include perinatal psychiatry and assertive outreach. Sarah has a longstanding interest in clinical governance and has management and teaching experience.

Stuart Walker, Chief Medical Officer from 1 October 2017 - joint appointment with Taunton and Somerset NHS Foundation Trust – voting Board member

Stuart is a Consultant Cardiologist at Musgrove Park Hospital and during his time in Taunton has also held a number of managerial roles within Trust operational line management, and in Regional roles within the wider NHS. He has for example been Clinical Director for Acute Medicine at the Trust and Clinical Director at the Southwest Regional Vascular Strategic Network. As Medical Director he is keen to enhance his experience in patient safety and quality improvement.

Sue Balcombe, Director of Nursing and Patient Safety from August 2011 until 31 October 2017 – voting Board member

Sue qualified as a state registered nurse at the Royal Devon and Exeter Hospital in 1982 and continued to work clinically for 19 years. She has wide clinical experience including neuro-rehabilitation, gynaecology and theatres, with the majority of her

clinical time spent working in accident and emergency departments where she worked for 12 years.

She commenced her Health Visitor training in 1997 and later moved into clinical management, becoming Community Service Manager and Head of Community Services before becoming Director of Nursing and Community Services at Taunton Deane Primary Care Trust in 2005.

Following the integration of four primary care trusts into one in Somerset in 2006, she was appointed Associate Director of Adult Services and then Lead Officer for Adult Services. At the time of the acquisition of Somerset Community Health she was its Deputy Chief Operating Officer and Chief Nurse. She has recently completed the Kings Fund Leadership Programme for Service Managers and is an accredited coach.

Hayley Peters, Chief Nurse from 2 October 2017 - joint appointment with Taunton and Somerset NHS Foundation Trust – voting Board member

Hayley has over 25 years of experience in the NHS and joined Taunton and Somerset NHS Foundation Trust in July 2013 as the Deputy Director of Nursing. Prior to that, Hayley worked in senior clinical leadership roles in the southwest, London and the southeast. Hayley became Acting Director of Nursing at Musgrove in September 2015, and then Director of Patient Care in December 2015.

Hayley's early professional career centred in critical care, first as an intensive care nurse and later, following a period of training at Birmingham Medical School, as one of the very first physician's assistants to practise in the UK.

As a senior nursing leader in the southwest, Hayley has developed a growing interest in nursing and enabling elderly and frail people to stay safe and reach their full potential through personalised care and service integration. Hayley is passionate about excellence in patient care and aspires at every opportunity to improve patient safety, quality and patient experience. Hayley is an active local and national patient safety champion.

Phil Brice, Director of Strategy and Corporate Affairs - January 2012. From 1 October 2017 Director of Governance and Corporate Development – joint appointment with Taunton and Somerset NHS Foundation Trust – voting Board member

Phil Brice joined the Trust in 2012, having joined the NHS in 2000, working for Somerset Heath Authority before becoming Director of Corporate Services for Taunton Deane Primary Care Trust and then Director of Corporate Services and Communications for NHS Somerset from 2006 – 2011. He

previously worked for the Treasury Solicitor's Department, the Parliamentary and Health Service Ombudsman and AXA PPP healthcare.

Phil holds a BA (Hons) in English Literature and a MSc in Comparative and General Literature and is a member of the NHS Top Leaders' programme.

Nick Macklin, Director of Workforce and Organisational Development - October 2015 until 31 October 2017

Nick Macklin joined the Trust in October 2015 and has more than 25 years' experience in Human Resources/Organisational Development. He has worked in both central and local government and with the police and probation services before joining the NHS, where he has held director posts at Taunton and Somerset NHS Foundation Trust and Royal Cornwall Hospitals NHS Trust.

Nick holds an MA in Strategic Human Resource Management and is a Chartered Member of the Chartered Institute of Personnel and Development.

Isobel Clements, Interim Director of People and Organisational Development. From 1 November 2017 - joint appointment with Taunton and Somerset NHS Foundation Trust

Isobel started her career at Musgrove Park Hospital in 1988 and held several senior human resources and organisational development management roles, including at associate and deputy level, until she became director of people for the Trust in 2014.

She has played a key role in developing the Trust's system of distributed leadership, in ensuring that the organisation's values are brought to life in everyday behaviour, and in overseeing a leadership programme in which over 900 colleagues at the hospital have now taken part.

Isobel is a member of the Chartered Institute of Personnel and Development.

David Shannon, Director of Strategic Development and Improvement from 24 October 2017 – joint appointment with Taunton and Somerset NHS Foundation Trust

David joined the Taunton and Somerset NHS Foundation Trust in August 2016.

David was previously director of operational finance at North Bristol NHS Trust, from June 2014. Before that he spent six years at Nottingham University Hospitals NHS Trust, most of them as assistant director of

finance. He originally joined the NHS in 1998 on its graduate financial management training scheme.

Matthew Bryant, Chief Operating Officer (acute hospital services) from 1 October 2017 – joint appointment with Taunton and Somerset NHS Foundation Trust

Matthew joined the Taunton and Somerset NHS Foundation Trust in 2014 as director of operations and was appointed as chief operating officer in 2015. He is responsible for the day-to-day running of the hospital and for its performance in meeting the required national standards.

Matthew has worked in the NHS in the south west since 1998, managing medical and surgical services at the Royal Devon and Exeter Hospital, and being part of the management team when that trust became one of the country's first foundation hospitals. He led the trust's delivery of new models of care for older people, which included a strong focus on integration with services outside hospital across the East Devon area.

He was involved in the planning of cancer services across Devon and Cornwall, and helped to establish the Peninsula Medical School in Exeter, of which he became an Honorary Fellow, teaching undergraduate medical students about healthcare management. He was also involved in the commissioning of specialist services and the development of joint working for health authorities across Devon and Cornwall. Matthew joined the NHS on the national general management training scheme, after graduating from Oxford University. He is also a trustee of Hospiscare, the palliative care provider for Exeter, East and Mid-Devon.

Board effectiveness

On the basis of the expertise and experience described above, the Trust is confident that the necessary range of knowledge and skills exists within the Board of Directors and that its balance, completeness and appropriateness to the requirements of the NHS Foundation Trust constitute a high performing and effective Board. No company directorships or other material interests in companies are held by any Board members where those companies or related parties are likely to do business, or are possibly seeking to do business, with the Trust. The Chairman has held no other significant commitments during 2016/17. A register of interests of Board members is available from the Secretary to the Trust and is also included in the Board papers published on the Trust's website.

An independent review of governance against NHS Improvement's Well Led Framework was undertaken during 2017/18 and an action plan has been developed to take forward those areas where further improvement is required. The implementation of the action plan will be closely monitored by the Board.

The effectiveness of the Board of Directors meetings is reviewed at the end of each meeting. Effectiveness of Board sub committees is monitored through the Board by quarterly reports and annual evaluation/review of the terms of reference.

Non-Executive Directors are subject to regular and annual appraisals by the Chairman; unsatisfactory appraisals could result in termination of their appointment. The decision to remove Non-Executive Directors rests with the Council of Governors. An annual performance review of the Chairman is undertaken by the Council of Governors' Nomination and Remuneration Committee and includes feedback from individual governors. The findings of the performance review are reported to a meeting of the Council of Governors.

The performance of Executive Directors is similarly reviewed through regular supervision and annual appraisals by the Chief Executive, whose performance is, in turn, reviewed and appraised by the Chairman, and reported to the Non-Executive Directors through the Remuneration Committee.

The Board considers that all the Non-Executive Directors, including the Non-Executive Director who has started her seventh year as a Non-Executive Director, are independent in character and judgement and there are no known circumstances or relationships which are likely to affect, or could appear to affect, the directors' judgement. The Board also considers that all Board members meet the Fit and Proper persons test.

Monitor (NHS Improvement) Foundation Trust Code of Governance

Somerset Partnership NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board can confirm that it is compliant with the Monitor Foundation Trust Code of Governance with the exception of the principles that "at least half the Board, excluding the chairperson, should comprise non-executive directors determined by the Board to be independent." The Trust's Board has equal numbers of Executive and Non-Executive Directors determined by the Board to be independent, including the Chairman. As the Chairman has a second vote this will ensure that Non-Executive Directors, at all times, will have a majority vote.

Significant interests held by directors

Interests held by directors which may conflict with their management responsibilities are declared at each Board meeting. Board papers which include these disclosures are available on the Trust's website. Transactions related to those interests are shown in page 32, note 25 to the accounts.

Directors' disclosure to auditors' statement

For each individual who is a director at the time this annual report was approved, so far as the directors are aware there is no relevant audit information of which the auditors are unaware and the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Quality and Performance Committee

The Quality and Performance Committee is a Board-level committee responsible for providing assurance on issues of legal, regulatory and standards and compliance with our legal and statutory requirements, clinical and quality objectives, effectiveness of strategies and the quality standards required by NHS Improvement and the Care Quality Commission. The Chair of the Quality and Performance Committee provides a six-monthly assurance report to the Audit Committee in respect of its compliance and governance functions.

Membership of the Quality and Performance Committee comprises six Executive Directors and four Non-Executive Directors, two of whom also sit on the Audit Committee. The Quality and Performance Committee meets on a bi-monthly basis.

There are six Governance Groups which report into meetings of the Quality and Performance Committee:

- Clinical Governance Group - oversees the organisation's clinical governance agenda by ensuring that appropriate systems and processes are in place to deliver continual improvement in the quality of our services, and by safeguarding high standards of care. The Group looks at areas such as serious untoward incidents, safeguarding, clinical audits, patient safety and medicines management. For more information about quality governance, please see the Trust's Quality Account;
- Our Partnership Group – responsible for ensuring that all workforce legislative and regulatory requirements are met;
- SIRI and Mortality Review Group – responsible for monitoring the SIRI investigation process, ensuring the dissemination of lessons learned and ensuring that all legal and regulatory requirements in relation to SIRIs and Mortality are met;
- Patient and Carer Involvement Group - responsible for collecting and reviewing information about patient and staff experience, monitoring complaints, compliments and PALS indicators, developing and monitoring the implementing

of the Patient and Public Involvement strategy as well as monitoring compliance with equality and diversity;

- Caldicott and Information Governance Group - looks at issues of risk relating to statutory compliance including Caldicott, freedom of information, records management, Data Protection Act and other subject access systems;
- Health, Safety, Security and Estates Group – responsible for ensuring that all issues relating to health, safety and security are discussed and resolved.

Attendance at Quality and Performance Committee meetings

Name	Quality and Performance Committee meetings attended	
	Possible	Actual
David Wood (Chairman) – until 1 August 2017	2	1
David Allen (Chairman from 1 August 2017	6	6
Barbara Clift	6	5
Liz Simmons	5	5
Jan Hull - from 1 August 2017	4	2
Phil Dolan	1	1
Phil Brice	6	6
Sue Balcombe – until 31 October 2017	3	2
Hayley Peters – from 2 October 2017	3	1
Nick Macklin – until 31 October 2017	3	2
Isobel Clements – from 1 November 2017	3	3
Pippa Moger	6	1
Andrew Dayani	1	1
Sarah Oke – from 23 June 2017 to 1 October 2017	0	0
Stuart Walker – from 1October 2017	3	3
Andy Heron	6	5

Finance & Investment Committee

The Committee is a Board Committee and acts in an advisory capacity. The Finance and Investment Committee met four times during the year to focus on investigating the progress made in the delivery of financial plans and carry out an in-depth analysis of the financial performance of the Trust. The Chief Executive and other executive directors have a standing invitation to attend this committee.

Attendance at Finance and Investment Committee

Name	Finance and Investment Committee meetings attended	
	Possible	Actual
Philip Dolan (Chairman)	4	4
Barbara Clift	4	4
Judith Newman – until 1 August 2017	1	0
Barbara Gregory – from 1 August 2017	3	3
Jan Hull – from 1 August 2017	3	2
David Allen	4	3
Pippa Moger	4	3
Phil Brice	3	3

Finance and performance issues are regularly addressed by the Trust Board and the Finance and Investment Committee, comprising four Non-Executive Directors, and also at the monthly Senior Management Team, which is chaired by the Chief Executive.

Audit Committee

Membership of the Audit Committee consists of four Non-Executive Directors. The Chairman of the Trust is not a member of the Audit Committee.

The role of the Audit Committee is:

- to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities;
- to review arrangements by which staff may raise in confidence, concerns about possible improprieties of financial reporting and control, clinical quality, patient safety or other matters;
- to review the annual accounts and make recommendations on the approval of the annual accounts to the Board;
- to ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance;
- to develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm;
- to make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor;

- to review the work and findings of the external auditor and consider the implications and management's responses to their work;
- to review the work and findings of the Counter Fraud Service and consider the implications and management's responses to their work; and
- to review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the integrated governance of the organisation.

Attendance at Audit Committee meetings

Name	Audit Committee meetings attended	
	Possible	Actual
Judith Newman (Chairman) – until 1 August 2017	3	3
Barbara Gregory (Chairman) – from 1 August 2017	2	2
Phil Dolan	5	4
Barbara Clift	5	4
David Allen	5	5

Directors' Responsibility for Trust Annual Report and Accounts

The directors have responsibility for preparing the annual report and accounts. They consider that the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess Somerset Partnership NHS Foundation Trust's performance, business model and strategy.

Significant Issues considered by the Audit Committee

After discussion with both management and the external auditor, the committee determined that the key risks of misstatement of the financial statements related to:

Property, Plant and Equipment – Revaluation

Property is the largest value group of assets of the Trust. The valuation of property is a judgemental area and professional judgement is required not only in assessing the value of individual property assets, but also their remaining useful economic lives. The Trust has engaged DTZ, Cushman and Wakefield to undertake this work and provide values as at the year end. Land and specialised buildings have been revalued as a desktop valuation as at 31 March 2018 in line with the RICS building cost indices.

NHS Income and NHS receivables

With the introduction of income from Sustainability and Transformation funding (STF) during 2016/17, there is an increased risk of misstatement. This is in addition to existing estimations of under or over activity against contracts and estimates of income due for delivering quality measures (CQUIN).

Furthermore, the Trust may seek to maximise its income receivable in order to deliver its controls total, whilst NHS commissioners may seek to minimise their expenditure to deliver their control total. As such, there is an increasing risk that the agreement of balances exercise will identify mismatches between NHS income/receivables for the Trust and NHS expenditure/creditors in commissioners, and that these mismatches will not be resolved by the date the Auditors sign their opinion.

Council of Governors

The Council of Governors is made up of 23 elected governors, six of whom are staff Governors. The Council has two working groups – strategy and planning and nominations and remuneration. Governors also sit on the Public and Patient Involvement Group.

The Council meets every quarter in public. Meetings are advertised on the Trust's website and at our headquarters. No business can be transacted at a meeting unless at least half of the governors are present, and of these, not less than half must be governors elected by the public and patient and carers' constituencies or appointed by non-health service bodies.

The responsibilities of the Council of Governors are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;
- to represent the interests of the members of the Trust as a whole and the interests of the public;
- to assist the Board of Directors in setting the strategic direction of the Trust and targets for the Trust's performance;
- to monitor the Trust's performance in achieving strategic objectives and performance targets that have been set;
- to act as guardians to ensure that the Trust operates in a way that is consistent with NHS and Trust principles (as set out Annex 9 of the Constitution) and the terms of the Trust's Authorisation;
- to appoint the Trust's external auditors;
- to exercise such other powers and to discharge such other duties as may be conferred on the Council of Governors under the Constitution;
- to appoint the Chairman and other Non-Executive Directors of the Trust;
- with the approval of at least three quarters of the Governors, to remove the Chairman and other Non-Executive Directors of the Trust;
- to approve the appointment of the Chief Executive by the Non-Executive Directors of the Trust, at a general meeting.

The Council of Governors is provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.

Led by the chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.

All governors are required to disclose details of company directorships or other material interests in companies where those companies or related parties are likely to do business, or are possibly seeking to do business, with the Trust. No such company directorships or other material interests in companies are held by any governors. A register of the interests of governors is published and updated at each public meeting of the Council of Governors and is available on our website at www.sompar.nhs.uk or can be obtained from the Secretary to the Trust.

Disagreements between Council of Governors and Trust Board

Where any disagreements between the Council of Governors and the Trust Board occur, the Trust policy "Policy and Procedure for Council of Governors: Raising Concerns" details the process by which these disagreements are resolved. This policy was last reviewed in 2015. A copy of the policy can be found on our website.

Nominations and Remuneration Committee (Council of Governors)

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

The role of the Committee is:

- to consider the Non-Executive Director or Chairman vacancies due in the next 12 months and make recommendations to the Council of Governors (Annex 9, para 3.1.1 of the Constitution); and

- to advise the Council of Governors as to the remuneration and allowances and of the Terms and Conditions of the office of the Chairman and other Non-Executive Directors (para 32.1 of the Constitution).

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

The Committee met once during the year on 21 August 2017 to discuss:

- the findings of the 2016/17 Chairman appraisal process, the draft Chairman's objectives for 2017/18, and the appraisal process for 2017/18;

- the findings of the 2016/17 Non-Executive Directors appraisals;

- the re-appointment process for three Non-Executive Directors;;

- Non-Executive Directors' remuneration;

The Committee's attendance is set out below:

NOMINATION AND REMUNERATION COMMITTEE MEETINGS – ATTENDANCE		
	Possible	**Actual**
Richard Porter (Chairman)	1	1
Philippa Hawkes	1	1
Richard Brown	1	1
Cathy Hackett*	0	0
Eddie Nicholas*	0	0

*These Governors became members of the Committee on 5 September 2017

The recruitment process for two new Non-Executive Directors from 1 August 2017 was approved at the Council of Governors meeting held on 8 November 2016. The recruitment process included open advertising and was managed by the Secretary to the Trust in line with the Trust's Constitution and recruitment process. The recommendations from the appointment panel were presented to and approved at the May 2017 Council of Governors meeting.

An internal re-appointment process was followed in 2017/18 for three Non-Executive Directors with effect from 1 November 2017, 1 March 2018 and 1 June 2018. One of the re-appointments was a second term of three years and two of the re-appointments were for a seventh year in view of the period of transformational change. This internal re-appointment process complied with the Trust's Constitution. The recommendations from the Nomination and Remuneration Committee were approved by the Council of Governors at their meeting held on 5 September 2017.

To market-test the remuneration levels of the chairman and other non-executive directors, the Council of Governors considers that the NHS Providers annual benchmarking for all Trusts executive and non-executive directors remuneration constitutes external advice.

Council of Governors elections

The election process for seats in the public constituencies – Taunton Deane, Mendip, Sedgemoor, South Somerset, Outside Somerset, and staff constituency commenced in February 2017.

There was competition for the public Mendip, and public Sedgemoor seats. Candidates for the public South Somerset, public Taunton Deane, Staff, were elected unopposed. No candidates came forward for the public Outside Somerset seat and seats remained vacant in the Public South Somerset (2), public Taunton Deane (1) and Staff (1) constituencies.

By-elections were held between 12 July and 14 September 2017 for the public Taunton Deane, public South Somerset, public Outside Somerset and Staff constituencies. There was competition for the Public South Somerset seats and the Public Taunton Deane seat. The candidate for the Staff constituency seat was elected unopposed but no candidates came forward for the public Outside Somerset seat.

Governor	**Constituency**	**Governor in place on 1 April 2017**	**Term of Office**		**Meetings**	
			From	**To**	**Possible**	**Actual**
Ian Aldridge	Public – West Somerset	Ian Aldridge	1 May 2016	30 April 2019	5	*2*
Peter Ernest	Public – Taunton Deane	Peter Ernest	31 October 2016	30 April 2019	5	*4*
Sigurd Reimers (until 30 April 2017)	Public – Taunton Deane	Sigurd Reimers	1 September 2014	30 April 2017	*0*	*0*
Vacancy (from 1 May 2017)	Public Taunton Deane	Sigurd Reimers	1 May 2017	8 October 2017	0	0
Sumitar Young	Public – Taunton Deane	Vacancy	9 October 2017	30 April 2020	2	2
Elaine Hodgson	Public – Taunton Deane	Elaine Hodgson	1 September 2014	*30 April 2017*	0	*0*
Elaine Hodgson	Public Taunton Deane	Elaine Hodgson	1 May 2017	30 April 2020	*5*	*3*
Philippa Hawks	Public – Taunton Deane	Philippa Hawkes	29 January 2016	30 April 2017	0	0
Philippa Hawks	Public – Taunton Deane	Philippa Hawks	1 May 2017	30 April 2020	5	5
Virginia Membrey	Public – Mendip	Virginia Membrey	1 May 2016	30 April 2017	0	0
Cathy Hackett (from 1 May 2017)	Public – Mendip	Virginia Membrey	1 May 2017	30 April 2020	5	5
Richard Brown	Public – Mendip	Richard Brown	21 January 2016	30 April 2017	0	0
Richard Brown	Public – Mendip	Richard Brown	1 May 2017	30 April 2020	5	4
Bob Champion	Public – Mendip	Bob Champion	1 May 2016	30 April 2019	5	5
Nick Phillips	Public – Mendip	Nick Phillips	1 May 2016	30 April 2019	5	2
Malcolm Turner	Public – Sedgemoor	New Seat	1 May 2017	30 April 2020	5	5
Eddie Nicolas	Public – Sedgemoor	David Allen	1 May 2016	30 April 2019	5	5
Barrie Crow (until 30 April 2017)	Public – Sedgemoor	Barrie Crow	1 May 2014	30 April 2017	0	0
Dave Gudge (from 1 May 2017)	Public – Sedgemoor	Barrie Crow	1 May 2017	30 April 2020	5	4

Governor	Constituency	Governor in place on 1 April 2017	Term of Office		Meetings	
			From	To	Possible	Actual
Richard Porter (Lead Governor)	Public – South Somerset	Richard Porter	1 May 2016	30 April 2019	5	4
Paddy Ashe	Public – South Somerset	Paddy Ashe	1 May 2014	30 April 2017	0	0
Vacancy	Public – South Somerset	Paddy Ashe	1 May 2017	8 October 2017	0	0
Paddy Ashe	Public – South Somerset	Paddy Ashe	9 October 2017	30 April 2020	5	1
Annie Adcock (until 30 April 2017)	Public – South Somerset	Annie Adcock	1 September 2014	30 April 2017	0	0
Vacancy (from 1 May 2017)	Public – South Somerset	Annie Adcock	1 May 2017	8 October 2017	0	0
Judi Morison	Public – South Somerset	Vacancy	9 October 2017	30 April 2020	2	2
Cathy Hackett (until 30 April 2017)	Public – South Somerset	Vacancy	31 October 2016	30 April 2019	0	0
Nick Beecham	Public – South Somerset	Cathy Hackett	1 May 2017	30 April 2020	5	5
Margaret Worth	Patient and Carers – Carer	Margaret Worth	1 May 2014	30 April 2017	0	0
	This seat has been removed following a review of the Council of Governors composition and an additional seat has been added to the Public Sedgemoor constituency from 1 May 2017.					
Roy Shubhabrata	Public Outside Somerset	Roy Shubhabrata	1 May 2014	30 April 2017	0	0
Vacancy	Public Outside Somerset	Roy Shubhabrata	1 May 2017	--	--	--
Claudine Brown	Staff	Claudine Brown	1 May 2016	30 April 2019	5	3
Hannah Coleman	Staff	Hannah Coleman	1 May 2016	30 April 2017	0	0
Hannah Coleman	Staff	Hannah Coleman	1 May 2017	30 April 2020	5	2
Paul Aldwinckle	Staff	Paul Aldwinckle	1 May 2016	30 April 2019	5	4
Polly Maguire	Staff	Polly Maguire	1 May 2016	30 April 2019	5	4
Bev Jones	Staff	Bev Jones	1 May 2014	30 April 2017	0	0
Nicola Price	Staff	Bev Jones	1 May 2017	30 April 2020	5	3
Abi Cundy	Staff	Abi Cundy	1 May 2014	30 April 2017	0	0
Vacancy	Staff	Abi Cundy	1 May 2017	21 August 2017	0	0

Governor	Constituency	Governor in place on 1 April 2017	Term of Office		Meetings	
			From	To	Possible	Actual
Owen Howell	Staff	Abi Cundy	22 August 2017	30 April 2020	3	2
Appointed Governors						
Cllr Nigel Woollcombe-Adams	District Councils	Cllr Nigel Woollcombe-Adams	All appointed organisations were appointed on 1 May 2008 for an unlimited period.		5	1
Cllr Terry Napper	Somerset County Council	Cllr Terry Napper			5	2
Dr Jayne Chidgey-Clark	Somerset Clinical Commissioning Group	Carolyn Moore			5	3
Anna Carey (until 30 May 2017)	Somerset Youth Volunteering Network	Anna Carey			1	0
Garth Vaughan (from 30 May 2017)	Somerset Youth Volunteering Network	Anna Carey			4	2
Ian Hawkins	Taunton Samaritans (permanently appointed from 23 May 2017)	Ian Hawkins	1 May 2014	30 April 2017	5	5
Caroline Toll	Care UK (permanently appointed from 23 May 2017)	Caroline Toll	1 May 2014	30 April 2017	5	3
Vacancy	Voluntary Sector organisation	Mary Ellen Harris	17 May 2016	22 May 2017	0	0
Melissa Hillier	We Hear You	Vacancy	23 May 2017	30 April 2020	4	4
Rose Persson	Wessex Counselling Service	Rose Persson	27 May 2014	30 April 2017	*0*	*0*
Vacancy	Voluntary Sector organisation	Rose Persson	1 May 2017	--	--	--

The process for removal from the Council of any Governor who consistently and unjustifiably fails to attend the meetings of the Council or has an actual or potential conflict of interest which prevents the proper exercise of their duties, is clearly set out in the Constitution which has been approved by the Council of Governors. Any incidence of consistent non-attendance by a governor is discussed at a Council of Governors meeting and individual circumstances are taken into account in deciding whether or not to remove a governor on the ground of consistent non-attendance.

Steps taken by Members of the Board in Understanding the Views of the Council of Governors and Membership

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

As the majority of Board members attend the Council of Governors' meetings, feedback from the meetings can be taken into account immediately. In addition, representatives from the Council of Governors also attend the public Board meetings and governors are invited to attend the joint Board/Council of Governors away day held in December each year to discuss strategic priorities. Governors also have an open invitation to attend Board Committee/Governance Group meetings.

The Chairman meets with the lead governor after each Board meeting to discuss issues arising from Board meetings and governors' concerns. The Chairman also meets with the Staff Governors on a regular basis.

The Council of Governors has a number of development days throughout the year and all Board members are invited to attend the afternoon sessions. The development day now includes a question and answer session at which a Non-Executive Director, on a rotating basis, or a new Executive Director, are given the opportunity to respond to governors' questions or concerns. Details are given below of the attendance at meetings of the Council of Governors by Trust Board members. Board members are not members of the Council, but have a standing invitation to attend Council meetings.

Board Member Attendance at Council of Governors Meetings

		Meetings	
		Possible	**Actual**
Stephen Ladyman	Chairman	5	5
Philip Dolan	Non-Executive Director	5	0
Barbara Clift	Non-Executive Director	5	4
Liz Simmons	Non-Executive Director	5	5
David Allen	Non-Executive Director	5	4
Judith Newman (until 31 July 2017)	Non-Executive Director	2	0
David Wood (until 31 July 2017)	Non-Executive Director	2	0
Jan Hull (from 1 August 2017)	Non-Executive Director	3	3
Barbara Gregory (from 1 August 2017)	Non-Executive Director	3	1

		Meetings	
		Possible	Actual
Dr Nick Broughton (until 1 November 2017)	Chief Executive	3	3
Peter Lewis (from 4 November 2017)	Chief Executive	2	2
Dr Andrew Dayani (23 June 2017)	Medical Director	1	1
Sarah Oke (from 23 June 2017 to 1 October 2017)	Interim Medical Director	2	0
Stuart Walker (from 1 October 2017)	Chief Medical Officer	2	0
Pippa Moger	Director of Finance	5	4
Phil Brice	Director of Governance and Corporate Development	5	5
Sue Balcombe (until31 October 2017)	Director of Nursing and Patient Safety	2	2
Hayley Peters (from 2 October 2017)	Chief Nurse	2	1
Andy Heron	Chief Operating Officer (Mental Health and Community Services)	5	5
Nick Macklin (until 31 October 2017)	Director of Workforce and Organisational Development	2	2
Isobel Clements (from 1 November 2017)0	Interim Director of People and Organisational Development	2	0
David Shannon (from 24 October 2017)	Director of Strategic Development and Improvement	2	1
Matthew Bryant (from 1 October 2017)	Chief Operating Officer (Acute Hospital Services)	2	0

Governor Involvement in Business Planning

Since becoming a foundation trust, we have encouraged governors and members to participate in the Trust's annual business planning process. Proposals for 2017/18 and 2018/19 service development priorities were developed taking account of the feedback received from staff across the Trust and other stakeholders.

Governors were invited to and attended a joint Board/Council of Governors Away Day on 13 December 2016 to discuss the key priorities for 2017/18.

Governors have also been involved in setting the Quality Account priorities for 2018/19 in support of the NHS Improvement Annual Plan process and governors were invited to and attended a joint Board/governors away day held on 12 December 2017 to discuss the key priorities for 2018/19 and to provide feedback from their members or appointed organisations on their priorities. The following priorities for 2018/19 were identified by Board/governors:

- improving understanding and recording of capacity and consent
- reducing the incidence of Venous Thromboembolism (VTE) in inpatients
- reducing the incidence of pressure ulceration
- increasing the skill set of staff when caring for patients with dementia / cognitive impairment
- improving incident reporting
- improved personalised care planning

Progress made in implementing the annual plan action plan is monitored by the Strategy and Planning Group who receives quarterly progress reports for discussion. The Group provides regular feedback on progress made in implementing the actions to the Council of Governors meeting.

Signed

PETER LEWIS
Chief Executive

Date: 24 May 2018

Information governance, cyber and data security

The Trust manages its information governance agenda through a number of different approaches. During the year the Trust appointed Louise Coppin as its designated Data Protection Officer, taking over from the Director of Governance and Corporate Development. The Trust's Director of Finance and Business Development is the Senior Information Risk Owner (SIRO). The Governance and Corporate Development Director chairs the Caldicott and Information Governance Group (C&IGG), which is responsible for setting the framework for information governance standards in the Trust and ensuring delivery of action plans to improve compliance. A key part of the C&IGG work is to review compliance against the Information Governance Toolkit and to ensure evidence is externally assured through audit.

In 2017/18 the Trust achieved a 66% compliance rate with the Information Governance Toolkit, including level 2 attainment for all criteria. The Trust was therefore categorised as satisfactory.

Information Governance SIRIs

There were no information governance serious incidents requiring investigation and report to the Information Commissioner's Office during 2017/18.

Cyber Security

Cyber and data security continues to be an important focus for Somerset Partnership NHS Foundation Trust and the NHS in England. Throughout 2017/18, improved processes have been implemented for the management of cyber incidents as part of our routine business processes, with the corporate IM&T security team responding to threats and reporting any Cyber Serious Incidents Requiring Investigation (CSIRI) to DH and NHS Digital where appropriate. No CSIRI were reported to NHS Digital in 2017/18.

Action Plan

During 2018/19 we will maintain compliance by completion of the new Data Security and Protection Toolkit and continuing our readiness and compliance with the new Data Protection Act and General Data Protection Regulation.

Emergency Planning and Business Continuity

The Trust was assessed as substantially compliant during the annual emergency planning, response and recovery assessment by NHS Somerset and NHS England in 2017. The organisation has a range of measures in place to ensure it can continue to operate its services during disruptive incidents which may occur in Somerset. These ensure our resilience during severe weather events this year, the national cyberattack on the NHS, utilities' failures and the 2017 Glastonbury Festival. These plans are tested through local and organisational exercises and with partner agencies. The Trust remains ready to support other organisations who may be affected by major incidents in the county and in a wider regional context.

QUALITY GOVERNANCE

New and Expanded services

Improving Mental Health and Emotional Wellbeing in Schools

The Trust was successful as one of the “test and learn” sites for this service which commenced in September 2017. This is an exciting and important project which supports teachers and young people within schools to improve their mental wellbeing.

Provision of Neurological Support Services for Mendip area

The Trust were asked to take over services that were previously provided by Sirona Healthcare in the Mendip area with the service commencing in April 2017

New and Improved Carers Service

Somerset Partnership supported the successful submission by Village Agents (Somerset Community Council) for the new and improved carers service which was commissioned by Somerset County Council.

School Immunisations – Primary and Secondary

The Trust was awarded the expanded contracts for both primary and secondary schools across Somerset. This service is provided directly into schools as well as other community settings, enabling as wide a group as possible to have access to immunisations.

Forensic CAMHS Services

The Trust has been awarded funding for three years for the provision of a regional Forensic CAMHS service.

This service will be formed by a small team based in Somerset to support local delivery as well as link with colleagues in other organisations across the south west. This service is delivered directly to young people with mental health issues who are in police custody.

Court and Custody Services

Working with Avon and Wiltshire NHS Trust, Somerset Partnership were awarded the expanded contract for this regional service which provides mental health support to people in police custody or awaiting a court attendance.

Farmers Drop in Clinic – Junction 24

Somerset Partnership was approached by The Farming Community Network, Bridgwater Agricultural Society, Weston Lions, Junction 24 Auction Centre and the Royal Agricultural Benevolent Society regarding the possibility of providing an

accessible clinic for Farmers. Following discussions, a drop in clinic, supported by volunteers has been developed which will enable farmers to have simple health checks such as blood pressure checks, advice on health matters and also sign posting to other services / support as needed.

The service will initially be funded by charitable donations from all the above organisations. The farming community is a high priority group for community and mental health services and the new walk-in service will be seen as an important step forward in helping farmers to access healthcare.

Individual Placement and Support (IPS)

The Trust is aware of the availability of potential for funding for Individual Placement and Support Services to assist clients with mental health problems get into / retain employment.

The Trust led a bid across the Somerset Sustainability and Transformation Programme to expand the currently successful IPS service which supports people with mental health issues get and remain in employment.

The Trust is seen as a “best in class” provider of this service and will be working with other partners across the county to develop a comprehensive service.

Psychiatric Liaison Services

A new Psychiatric Liaison Service has been established which aims to improve the patient journey through Musgrove Park and Yeovil District Hospitals by contributing to the holistic assessment and treatment of individuals.

The service looks to cross the boundary between physical and mental health, and aims to identify, diagnose and treat any co-morbid psychiatric conditions presenting in patients with general medical/surgical issues. The intervention aims to improve the quality of the care, dignity and quality of life that patients experience, improve skills in non-mental health professionals, and reduce adverse events and other risks to the general hospitals.

The expectation is that this service will not only improve the outcomes for individuals but also contribute to a reduction in length of stay for anyone who needs to be admitted and reduce the need for readmissions . Educating other staff will allow better management of patients with psychiatric issues on general wards, potentially reducing the need for 1:1 specials as well as giving confidence to staff and promoting excellent collegiate relationships.

Significantly redesigned services

Public Health Nursing

The decision was made by Somerset County Council to move all public health nursing into the Children’s services provided by the Council from April 2019. Notice was given to the Trust and we are working closely with the Council to ensure the

transfer will happen as smoothly as possible, aiming to minimise any impact on the services provided to patients and families as well as Trust staff who will transfer to be employees of the council.

Joint working

Somerset's Sustainability and Transformation Plan

In November 2016 the leaders of Somerset's health and social care system published their Sustainability and Transformation Plan (STP). The plan was a blueprint for delivering the national 'Five Year Forward View' strategy locally. Since then the operational and financial pressures have continued to worsen and subsequently the health and care leaders in Somerset have come together to develop a new Somerset Health and Care Strategy. The strategy builds upon the learning from the former STP but with a renewed focus upon five key service areas:

1. urgent and emergency care
2. proactive care for frail and elderly people
3. planned care such as hip replacements
4. children and maternity care
5. care for people living with mental health and learning disabilities

The strategy will address the clinical needs of local people, tackle the health inequalities that exist in our communities and ensure any proposals developed to improve services will be affordable and sustainable.

More information can be found about the development of Somerset's Health and Care Strategy at www.fitforourfuture.org.uk

Alliance with Taunton and Somerset NHS Foundation Trust

At a joint meeting of the Somerset Partnership and Taunton and Somerset NHS Foundation Trust boards on 25 May 2017, a Memorandum of Understanding (MoU) was signed formalising the trusts' respective commitments to closer collaborative working for the benefit of patients and the public in Somerset.

In support of this aim a joint executive leadership team was appointed during the autumn of 2017. Secondment arrangements have been set up for their roles to the non-employing trust. This is not an end in itself; it's very much a means to allow clear leadership and simplified decision-making for improving healthcare for people in Somerset. A single team bridging both organisations will help ease the way for service pathways to be redesigned and for services to be built around the people using them. It also gives the trusts a chance to set joint priorities, both in the very short term and in the medium term.

Some of the projects already being progressed as a result of this collaboration include discussions about joining-up stroke services and therapy services, improving rapid response, providing medical cover for community hospitals, developing a

communication strategy between the trusts and primary care and engaging with the Symphony project.

During 2017 an options appraisal was commissioned in relation to the joint working arrangements and the potential for further progression. One of the recommendations was to develop a clear vision, strategy and collective understanding of the intended benefits from the closer working arrangements. The four elements which will form the basis of the alliance vision are:

- focused on the needs of the (Somerset) population.
- supporting people to maintain their own health.
- providing safe, high quality and accessible care consistently.
- working with other stakeholders/providers to ensure that services are sustainable.

In terms of next steps, both boards have agreed that the alliance arrangements will need to progress to the next stage and the development of a strategic case for merger has commenced. To support this work a clear colleague and stakeholder communications and engagement strategy will be implemented. The development of a strategic case for merger will be undertaken in line with the broader objectives of the Somerset STP and the county-wide commissioning review of health and social care services.

Patient Safety and Quality Improvement

The Trust's quality improvement programme brings together all key improvement initiatives including the Quality Account priorities, Positive and Proactive Care, Sign Up to Safety and the application of the patient safety thermometer. Increasingly the programme looks to 'whole system' initiatives to improve patient experience and safety across the whole healthcare system.

During 2017/18 the Trust has further increased the number of staff who have undertaken the quality improvement 'launchpad' course (previously known as the patient safety officer training course) provided by the South West Academic Health Scientific Network. The total number of staff trained in this quality improvement methodology is 21 and further cohorts are planned for 2018/2019.

Directorates are engaging with local staff who have received this training to support the development of local quality improvement plans. Each directorate submits a Divisional Clinical Governance Assurance Report on a quarterly basis which details local QI plans as well as Trust priorities as stated in the Quality Account and Sign Up to Safety as well as any local issues which have been identified.

Working in alliance with Taunton & Somerset NHS Foundation Trust has also enabled development of additional improvement programmes. The Trust is looking to share quality improvement (QI) infrastructure and resources across both Trusts to ensure QI is firmly embedded in in the culture across both organisations. During 2017/18 the Trust has worked on the Northumbria Collaborative programme and has two wards that are piloting real time patient feedback.

Further collaborative work with other Trusts to bring about improvement, includes Observation and Engagement in mental health care through the national programme being hosted by NHS Improvement as well as the national collaborative being hosted by The Kings Fund on integrating physical health and mental health care. This has led to the creation of a new approach to patient safety on our Older Persons Mental Health ward which is showing signs of reducing falls and other untoward incidents whilst also using staff time more efficiently and a better patient experience through engagement rather than routine observation.

The Safe Care Programme has been implemented in all inpatient wards during 2017/18. The Safe Care Programme is software that is incorporated in the e-roster system and operates evidence based and nationally recognised tools for determining safe staffing levels on wards. The tools are based on patient acuity and dependency scores as well as any non-routine tasks occurring on a ward which may increase demand on the nursing team.

As part of our 'positive and proactive' approach to use least restrictive practices and particularly to reduce the use of restraint whenever possible, an improvement project has developed a method of undertaking post incident debriefing (safety huddles) on our Psychiatric Intensive Care Unit which whenever possible involves service users. This enables everyone involved to receive a supportive debrief following an incident involving the use of restraint and to reflect on how further incidents can be prevented. In turn this informs personalised care planning. This practice is being spread across our mental health wards.

The Trust is committed to improving the quality of care, ensuring that information is widely available to the public through our monthly detailed quality reports to the Trust board. This ensures that our performance and commitment to improvement is transparent. Measures of success include our provision of high levels of harm free care in our community hospitals and community services - with the majority consistently delivering harm free care in excess of the national average. This is testament to the expert clinical leadership and front line support for our improvement programmes.

Other key aspects of our Quality Improvement Plan and Patient Safety programme for the year ahead are:

- strengthening the Directorate triumvirate during 2018/19 through the addition of Associate Directors of Patient Care. This will further devolve quality improvement and patient safety and bring renewed focus on locally delivered care;

- launching an accreditation scheme for inpatient care within the community hospitals in two pilot areas early in the new financial year (this is a significant work stream and will be fully implemented over the next two years);

- refreshing and relaunching the Patient Safety Walk round programme in 2018/19 – this is where executive and non-executive directors and governors regularly visit inpatient areas to talk to staff and discuss their concerns about delivering safe patient care where they work.

The Trust has signed up to the Always Events ® programme and three delegates are attending an NHSI launch event in March 2018.

The Trust has continued to participate in the South of England Mental Health Patient Safety Collaborative and has both 'exported' and 'imported' initiatives. Examples include how other Trusts have been particularly interested in our Positive and Proactive Care programme to reduce the use of restraint and our work on improving communication when reporting untoward incidents ('SBAR Trek').

Quality Improvement projects are currently forming to focus on supporting patients in reducing the use of ligatures as a behavioural response to emotional distress on mental health wards, suicide reduction in the community and in preventing dehydration in hospital wards.

More staff now utilise the 'LIFE' internet based programme in order to support Quality Improvement projects. This programme has been developed by the South West Academic Health Scientific Network and through the South of England Mental Health Patient Safety Collaborative within which we are an active participant.

Research and Development 2017/18

In 2017/18, the Trust continued to increase its involvement in clinical research supported by the National Institute for Health Research (NIHR) (www.nihr.ac.uk). It actively participated in 33 research studies (compared with 23 in 2016/17) and recruited 691 participants (compared with 312 in 2016/17). Studies supported were investigating issues such as:

- seeing if there are specific genes that make people more susceptible to late-onset Alzheimer's disease;
- investigating what factors make certain individuals predisposed to adverse drug reactions;
- seeing if language outcomes and recovery can be predicted after a stroke;
- developing and testing a questionnaire designed to assess quality of life in carers of people with dementia;
- seeing if a smoking cessation intervention specifically designed for people who have had problems with their mental health is more effective than the usual Stop Smoking services;
- research into the life experiences of adults and older people on the autism spectrum;
- the effectiveness of mother and baby units versus general psychiatric inpatient wards and crisis resolution team services;

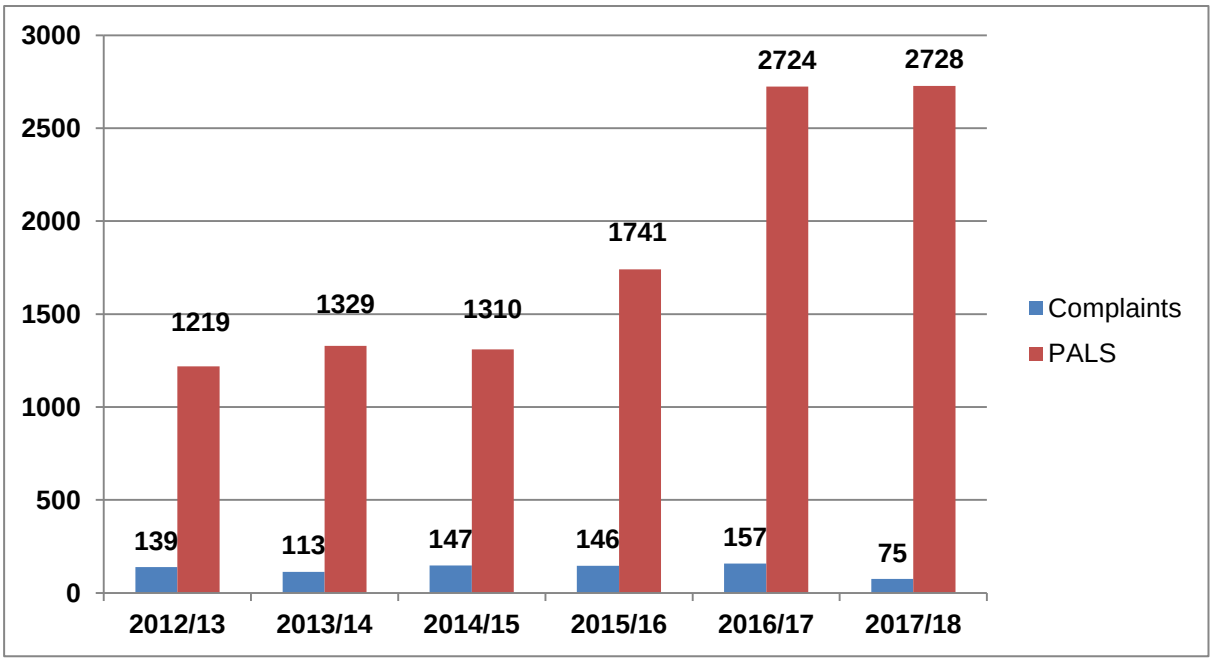
- evaluating a psychometric tool designed to identify the needs of carers looking after people with dementia;
- seeing whether text messages providing information and tips to increase safer sex, help young people adopt safer sex behaviours;
- helping to check the safety of a nasal flu vaccine for children and teenagers on behalf of a pharmaceutical company;
- evaluating the outcomes of offender liaison and diversion trial schemes;
- evaluating patient reported outcome measures for neurological conditions and stroke;
- validation of autism assessment instruments for deaf children;
- discovering the prevalence of neuronal cell surface antibodies in patients with psychotic illness;
- testing a new outcome measure of psychological interventions targeting people who hear voices;
- evaluating the tolerance, compliance and acceptability of a nutritionally complete, high energy, high protein, enteral feed in adults (a commercial trial);
- evaluating the effects of the novel GLP1 analogue, liraglutide, in patients with Alzheimer's disease;
- evaluating the most effective treatment for shoulder pain (rotator cuff disorders); and
- evaluating the effects of naloxone hydrochloride nasal spray on eating behaviours in bulimia nervosa (a commercial randomised control trial).

Complaints, Compliments and Patient Advice and Liaison Service Enquiries

The table below summarises the activity for the year for complaints, compliments and PALS enquiries.

	Complaints	PALS	MP enquiries	Compliments
2017/18	**75**	**2728**	**25**	**5077**
2016/17	**157**	**2724**	**11**	**4258**
2015/16	**146**	**1741**	**13**	**3909**
2014/15	**147**	**1310**	**33**	**4494**
2013/14	**113**	**1329**	**42**	**4833**
2012/13	**139**	**1219**	**32**	**5263**

The chart below shows the number of PALS enquiries and formal complaints by year.



Comparison to previous years

Complaints

During the year 2017/18 we received 75 recorded complaints which is a decrease of 82 (52.2%) from 2016/17.

PALS enquiries

During the year 2017/18 we received a total of 2,728 PALS enquiries registered which is an increase of 4 (0.15%) from 2016/17.

MP Enquiries

During the year 2017/18 there have been a total of 25 MPs enquiries registered, which is an increase of 14 from 2016/17.

Compliments

Compliments are available to Board members to view, should they wish, and are available outside the Chief Executive's Office at Trust Headquarters.

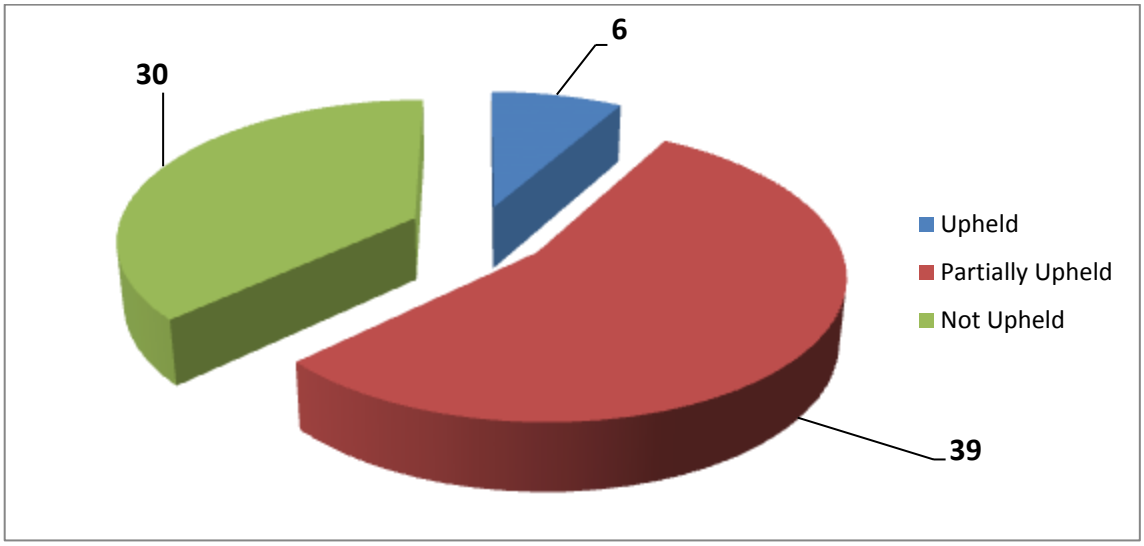
During the year 2017/18 there have been 5077 recorded compliments and letters of thanks. This is an increase of 819 from 2017/18.

Analysis of complaints and action taken

The Trust receives a comparatively small number of complaints given the significant number of patient contacts that our staff have over a year. Patient satisfaction rates from surveys and other sources remain very high but the Trust takes very seriously all formal complaints received and looks to act on areas of concern identified both in individual investigations and where trends or concerns are suggested about services.

Numbers of complaints received remained very similar this year compared to last year, despite numbers of overall PALS enquiries showing a significant increase. All complaints were subject to detailed investigation and a local and organisational level action plan was developed.

Of the 75 complaints investigated, 39 were partially upheld, 6 were fully upheld and 30 were not upheld.



The Trust received notification from the Parliamentary and Health Service Ombudsman (PHSO) that ten complainants wished to have their complaint independently reviewed. Although their requests were recorded with the PHSO in 2016/17 a number of the complaints were received by the Trust in 2015/16.
The details of the ten complaints are as follows:

Cases Still Under Investigation by the Ombudsman

The Trust received notification from the Parliamentary and Health Service Ombudsman (PHSO) that the following complainants wished to have their complaint

independently reviewed. Although their requests were recorded with the PHSO in 2017/18 the complaints were received by the Trust in 2015/16 and 2016/17.

The details of the complaints are as follows:

Cases Still Under Investigation by the Ombudsman

Mr A complained via his advocacy organisation Somerset Community Care Matters (SCCM) that he has been improperly discharged from the Trust's mental health service. SCCM say that the Trust failed to consider his Asperger's Syndrome and human rights and that he has lost 18 months of care and direct payments as a result. Mr A says he has had little care or support throughout the period. SCCM say Mr A would like an apology, an acknowledgement of failings, compensation and his care plan increased from 5 hours a week to 15 hours per week, as it was prior to his discharge. The Trust has sent all information to the Ombudsman for their investigation.

Cases Closed by the Ombudsman - Partly Upheld

Mr C, the son of a deceased patient, has complained that the Trust failed to organise and implement physiotherapy for his mother to help her regain and maintain mobility after her discharge from acute hospital; the Trust failed to work effectively with its partners, namely Somerset County Council (SCC), to ensure that there were no gaps in care offered; the Trust failed to advise that the patient could receive physiotherapy at home, and that a stay in a care home was not required; the Trust was 'petty' and evasive in its complaints response; and the Trust's record keeping was poor. A report was received from the LGO on 06.12.2017. The Ombudsman has **partly upheld** the section of the complaint that relates to the Trust and they have recommended that the Trust takes the following action:

- the Trust should review the findings of this complaint with the ILT and ensure team members are reminded of the importance of keeping accurate records in relation to patients' care and treatment relating to physiotherapy;
- the Trust should write to Mr R to apologise for any uncertainty he is left with relating to the physiotherapy service provided by the ILT. *A letter of apology letter was sent to complainant on 20 December 2017.*

Cases Closed by the Ombudsman - Not Upheld

Ms D, the mother of a young male patient, feels that the health visitors did not listen to her when she raised her concerns about her son's health and development. She feels that she was let down and unsupported by the health visitors she saw. The Trust has sent all information to the Ombudsman for their investigation. PHSO found that the actions of the Trust were consistent with relevant guidance and established good practice and so have **not upheld** any aspect of the complaint and this concludes their investigation.

Mr E, the son of an elderly female patient, complains about the overall care and treatment provided to his mother when she was an inpatient at Burnham-on- Sea Community Hospital on 19 January 2016. In addition he raises concerns about the

way his complaint was handled by the Trust and he says the Trust has lied and failed to address the concerns he raised. He says his mother was extremely upset and stressed by the events and says she could have died as a result of what happened. The Trust has sent all information to the Ombudsman for their investigation. PHSO have **not upheld** the complaint as they considered the GP's and Trust's decision was appropriate based on the information given to them and the Trust did what they would have expected of it in response to the complaint and this concludes their investigation.

Consultation, Patient and Public Involvement Activities including Scrutiny Committees

Listening to our patients and their families is at the heart of all we do. We strive to provide the best care and treatment for our patients and hearing their stories is the best way for us to learn what is going well – and what can be improved.

The Trust has a variety of approaches to listening and learning from our patients, their families and carers: through the Friends and Family Test, PALS, social media, patient and carer groups, voluntary and community groups, surveys and research, engagement events and also through compliments letters and complaints.

Consultations

The Trust has undertaken two formal consultations during the year.

Lister House Partnership: Milverton Branch Surgery

The Trust ran a formal consultation to listen to local views about the future of primary care services at Lister House Partnership, of which the Trust took on management in September 2016. The practice comprised a main surgery in Wiveliscombe and a branch surgery in Milverton. Due to a lack of GPs as well as changes in the way services are delivered, the Trust had to consider the closure of the branch surgery in Milverton.

In planning the consultation, discussions were held with local patient representatives and other local public representatives including local councillors. Consultation documents were written in plain English and explained the challenges and the preferred option and sought local views on these issues. A public meeting was held in the village hall at the start of the consultation period. This was attended by over 100 local residents.

The top three concerns about a potential closure were: transport and travel, the loss to the community, and the impact on an ageing population.

Following feedback from local patients and the public, the Trust is piloting local nurse-led clinics in the village community room for blood-pressure checks, assistance with prescriptions and hearing aid batteries. The Trust has also invested in local community transport to support patients to get to the surgery for appointments. A

Village Agent has also been established to support with health and social care needs.

Community Hospitals: Temporary Winter ward Closures / nursing staff shortages

Due to ongoing challenges with the shortage of registered nurses across Somerset, and difficulty in recruiting new staff, community hospital beds in Shepton Mallet, Chard and Dene Barton, were moved to other local community hospitals by the end of October 2017, to make sure enough staff are available for patients during winter.

The Trust held local meetings to listen to local people's views and respond to questions and concerns.

Due to the strength of feeling from local people, we undertook a formal consultation to gather views to inform the Board's review of the decision. The consultation asked for the views of the public on whether the temporary closures should continue in their current configuration if there are insufficient nurses to open the beds, what alternatives should be considered, and how the local community can be supported during the temporary closures.

331 surveys were returned and there were also submissions of correspondence from individuals and groups. Overall, respondents voiced opposition to the temporary closures and called for the closures to be reversed as soon as possible. Constructive suggestions were put forward for a renewed focus on recruitment of new staff and retention of existing staff. Local communities were consistent in supporting their local hospitals and staff as an important community asset: "local beds for local people."

Scrutiny Committees

During the year the Trust presented to the Scrutiny for Policies, Adults and Health Committee of Somerset County Council about the Sustainability Transformation Partnership, the CQC inspection, the proposals for the closure of the Milverton branch surgery and temporary ward closures in Dene Barton, Shepton Mallet and Chard community hospitals.

Engagement activity

Patient and Public Involvement (PPI)

During 2017-18 we developed our patient involvement work through our PPI action plan which encompasses the three domains which underpin our PPI Strategy: involvement at an individual, service and organisational level.

This action plan is monitored by our Patient and Public Involvement Group, which comprises Trust staff, Governors, voluntary sector representatives and representatives from Somerset Healthwatch. The PPI Group reports quarterly to the Council of Governors.

The Trust Patient and Public Involvement Best Practice Group meet quarterly and each service and division has completed a six-monthly 'PPI Workbook', compiling all

their patient feedback into one document in order to capture learning and PPI activities.

Governors
As an NHS foundation trust we also rely on our membership and our Governors to ensure that the voice of the patient and the public is heard throughout our organisation. Governors are encouraged to engage with their constituents – local people – and their feedback is reported to our Patient and Carer Involvement Group, which reports to the Board, as well as the Council of Governors. During the year, patients and carers have given talks to the Council of Governors about their experiences of our services.

The Governors' views were sought on the Quality Priorities for the year and local Healthwatch were also asked to provide comment.

League of Friends' Forum
The Friends' Forum was held twice during the year to invite all the Leagues to come together and share news and ideas: the Chief Executive addressed both meetings. Excellent work is being done with volunteers in all hospitals. New projects include reading groups, patient Wi-Fi, aromatherapy, floristry and the funding for a specialist research post. Other projects include the provision of equipment such as exercise equipment and specialist beds and updates and improvements to hospital buildings.

Engagement with Healthwatch
We have engaged with Healthwatch Somerset during the year by keeping them informed of service developments and through regular meetings to discuss progress against our quality priorities. A representative from Healthwatch Somerset also sits on our Patient and Public Involvement Group.

New Support for Patients and Carers

Home First
The Home First project has helped hundreds of people return safely home earlier from acute and community hospitals.

As soon as someone no longer needs medical support in hospital, Home First allows people to leave hospital rather than waiting on the ward for care assessments and rehabilitation planning, which can take time. Instead they receive those assessments and support at home, or in a specialist unit or care home to help them get back on their feet. Since its launch, Home First has helped over 300 patients get back home, saving them an average of five days in hospital.

Psychiatric Liaison
A new Psychiatric Liaison service was launched across Somerset, helping people who have both acute physical care needs and mental health care needs. The service provides psychiatric assessment and treatment to those patients who may be experiencing distress whilst in hospital. They help everyone consider how best to meet both the mental and physical health needs of a patient.

The new service has specialist doctors and nurses providing 24/7 care. The service operates in both A&E and hospital wards, giving patients additional mental health care to support the physical care they will be receiving in the hospital. A key additional benefit is to ensure that patients receive the right specialist mental health care that they need quicker, helping them to get home sooner and avoid admission to hospital.

Mental Health Service Users' Forum

The Trust has worked with commissioners in Public Health and the Clinical Commissioning Group to fund and establish a Mental Health Service User Forum for Somerset, via the Mental Health Hub which is a network of voluntary sector groups and charities that support mental health service users and carers. The Forum will meet during 2018-19. We hope that the Forum will be a valuable way of hearing the voices of mental health service users in relation to their experiences of our services.

Smokefree Somerset

The Trust worked towards becoming smokefree across all its sites during the year. Following concerns raised by carers of people with lived mental health experience, two carers joined the steering group that helped drive this initiative forward in order to ensure that the right support was put in place across our mental health wards. Training, support and information were put in place for staff and for patients and the Trust became Smokefree on 1 January 2018.

Expressive Movement Therapy

Expressive Movement Therapy is an 'emotional rehabilitation' group which is funded by South Petherton Community Hospital's League of Friends. The group, which meets weekly, is run by a registered dance movement psychotherapist, who is also an experienced occupational therapist. The group provides stroke patients on Mary Robertson Ward in South Petherton Community Hospital an opportunity to discuss their shared experience of stroke, and participate in creative movement to express their feelings about their experiences. As this is primarily a movement-based group, the ability to verbally communicate is not required. Feedback from patients has been positive.

SHARE Project – new service for 11 - 18 year olds

The SHARE Project is a new three-year countywide project to improve the mental health and emotional wellbeing of our young people aged 11 to 18 years across middle and secondary schools of Somerset, including children attending pupil referral units and special schools. The aim of the service is to promote good mental health and increase knowledge of tools to support those with needs, to upskill staff to identify early signs of emerging mental health conditions and to provide young people and their families seamless access to high quality evidence based interventions.

The service supports schools to develop peer mentoring champions and parent drop-ins. The service provides access to mental health liaison workers and is co-located with our child and adolescent mental health team based at Foundation House in Taunton.

Service Improvements following Patient Survey Results/Comments/CQC Results

Patient feedback is central to our service planning and service improvements. Service feedback comes via comments received by our Patient Advice and Liaison Service, the Friends and Family Test and other patient involvement work.

We also use learning from patient surveys and patient experience benchmarking, driven by national programmes and also our own audit and survey programmes. This includes our annual community mental health patient survey.

Each service has its own record of patient and public feedback and how it uses this to improve services. A few examples are described below.

Chronic Fatigue Syndrome (ME) Service

This service used feedback from patients to improve the care pathway, by ensuring that patients have a written copy of the pathway so that they do not miss the opportunity to attend the whole service. Assessments are now being provided in a variety of community settings, in order to reduce the distance patients need to travel to access the service. Follow up sessions can be arranged via telephone or Skype as well as face to face and patients can contact the service via telephone or email.

Learning Disability Service Improvements

A national mental health and learning disabilities report published by the CQC recognised the improvements the Trust made following the CQC inspection in 2015. These improvements saw the Trust's rating for learning disabilities services rise from 'Inadequate' to 'Good', with 'Excellent' for its leadership.

One of the most important areas of change has resulted in improvements in the communication between managers and frontline staff. Staff reported that this greatly lifted their morale and meant they felt empowered to suggest changes to improve care. Improvements also included a more structured team, closer monitoring of patients' care plans and recording notes electronically rather than relying on paper based notes. The service also set up a buddy system where staff skilled in particular areas could assist their colleagues and share their knowledge.

Following low responses for Friends and Family Tests, the service wrote an easy-read version for patients, which has resulted in improved response rates, positive feedback and real-time reporting of patient feedback.

Patient Led Assessment of the Care Environment (PLACE)

Patient Led Assessment of the Care Environment (PLACE) is an assessment of the care environment to demonstrate how well individual healthcare organisations are performing in key areas. The PLACE inspection process examines the following criteria within each inpatient site:

Cleaning
Ward Food
Privacy Dignity & Wellbeing
Condition Appearance & Maintenance
Dementia
Disability

Patients' representatives are key. At least 50% of the team involved in undertaking assessments must meet the definition of a 'patient' as follows 'anyone whose relationship with the hospital is as a user rather than a provider of services'.

The assessment
The assessment period was March 2017 to May 2017 when all sites comprising of ten or more beds undertook an assessment.

Overall PLACE Inspection Results 2017 table
The table below details the Trust scores across the main inspection criteria in previous year (2016) and the current year (2017) comparing the current year's results with the current national averages for 2107.

	Cleanliness %	**Ward Food % (only)**	**Privacy, Dignity and Wellbeing %**	**Condition Appearance and Maintenance %**	**Dementia %**	**Disability %**
Somerset Partnership Scores 2016	99.93	93.71	90.21	96.57	87.00	89.16
Somerset Partnership Scores 2017	99.73	95.34	90.72	97.45	87.11	90.93
National Average Scores	98.05	90.34	85.10	93.67	75.94	83.76
Variance 2017	+1.68	+5.00	+5.62	+3.78	+11.17	+7.17

Results Summary

Cleanliness

All the hospitals other than Shepton Mallet scored above the national average in this criterion, which reflects the considerable efforts of all staff that ensure a clean care environment. These scores reflect particularly positively on the work of housekeepers, assistant housekeepers and service assistants as they predominately, although not exclusively, deliver environmental cleaning.

Thirteen sites achieved 100% cleanliness score.

Food

In summary there are sixteen hospitals where the food is above the national average with only three hospitals where the food scores fell below the national average.

The inspection results are the assessment team's interpretation of the food standards at the time of inspection. The inspection process involves different groups of patient assessors for many of the hospitals and therefore the results can differ as they are subjective by nature. The vast majority of the dishes tasted were scored good and some very good. Dishes tasted during the inspection where the scores are acceptable and poor are being reviewed as part of the action plan.

All patient assessors stated when questioned that they would be more than happy to eat the food and on the assessment day they did at all the hospitals.

All the hot meals are sourced from the same contractor so therefore prepared in an identical way making it difficult to interpret the variation in scoring other than it is subjective and that a different member of staff led each inspection.

There have been no formal complaints surrounding food in the 12 months prior to the inspection and the six monthly meal observations undertaken provide positive meal time feedback.

Privacy, Dignity and Wellbeing

All hospitals other than Pyrland and Wincanton scored above the national average with one ward scoring under the National average as a result of not having all rooms with ensuite.

Condition, appearance and maintenance

All hospital results for condition, appearance and maintenance are above the national average for the Trust. Elements falling below standard have been identified in the action plan and will be rectified.

Dementia

All results for dementia other than Chard and Shepton Mallet are above the National average for the Trust in this criterion. Elements falling below standard have been identified in the action plan and will be rectified.

Disability

All results for dementia are above the national average for the Trust in this criterion.

Local Action Plans

Local action plans have been developed for estates and facilities managers, matrons and ward managers. The plans detail the improvements that are required to improve the scores for the PLACE inspection for next year.

The action plans provide details of how non-compliance issues are to be rectified. The action plans also identify who is responsible for improving the standards and rectifying the issues.

The completion of the action plans will be monitored at monthly meetings between facilities managers and estates managers who formally report to the estates and facilities governance meetings. This report will form part of the facilities managers report to the group. This report if required can be provided to other governance groups for final scrutiny and assurance purposes.

How to Become a Member of the Trust

Anyone aged 12 years or over, living anywhere in England or Wales, can join us as a Member. You can sign up online at www.sompar.nhs.uk or write, phone or email the Membership Office to have a Freepost form sent to you. There is no charge to become a member.

We welcome suggestions from members for topics which they would find of interest, or other types of event they would like us to arrange.

There are also web pages for members on the Trust's website, and governors are happy to accept invitations to talk to community groups with an interest in local health services.

Details of meetings and events can be found on the Trust's website.

Membership Office Tel: **01278 432026**
Email: foundationtrust@sompar.nhs.uk

Somerset Partnership NHS Foundation Trust
2nd Floor Mallard Court
Express Park
Bristol Road
Bridgwater
Somerset TA6 4RN

Tel: 01278 432000
Fax: 01278 432099
Email: ask@sompar.nhs.uk
Website: www.sompar.nhs.uk

Trust Board Contact Details

All Board members can be contacted at the above address.

Telephone numbers:

Chairman, Chief Executive and Non-Executive Directors	01278 432094
Chief Operating Officer (Mental Health and Community Services)	01278 432163
Chief Operating Officer (Acute Hospital Services)	01823 343411
Chief Nurse	01823 342498
Director of Finance	01823 342512
Chief Medical Officer	01823 342442 01278 432130
Director of Governance and Corporate Development	01278 432084
Director of People and Organisational Development	01278 432076
Director of Strategic Development and Improvement	01823 342527
Secretary to the Trust	01278 432073

A register of interests of the Trust Board and Council of Governors is available upon request from the Secretary to the Trust, who can also provide a copy of the Scheme of Delegation.

Council of Governors Contact Details

Governors can be contacted via the Membership Support Office:

Tel: **01278 432026**
email: governors@sompar.nhs.uk

or write care of the address above.

Somerset Partnership NHS
NHS Foundation Trust

Quality Accounts
2017 - 2018

~~~~~~

A report on the quality of the care we offer
and how we are seeking to improve
~~~~~~

Somerset Partnership NHS
NHS Foundation Trust

Quality Accounts
2017 - 2018

~~~~~~

A report on the quality of the care we offer
and how we are seeking to improve
~~~~~~

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST

QUALITY ACCOUNT
2017/18

CONTENTS

PART ONE: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Welcome to Somerset Partnership NHS Foundation Trust's Quality Account for 2017/18. This is the first account I have had the privilege to introduce since becoming Chief Executive of the Trust in November 2017. I am very pleased to report that maintaining and improving the quality of care provided by our many services has once again remained the Trust's overarching priority. This has undoubtedly proven to be challenging during the course of another year when the Trust has had to make significant efficiency savings. We believe however, that we have been successful in this regard through attempting to ensure an unrelenting focus on patient safety, clinical effectiveness and patient experience.

During the course of February and March 2017, the Trust underwent a follow up inspection by the Care Quality Commission (CQC), following our comprehensive inspection in 2015 which found the Trust's services required improvement. The outcome of that inspection was published in June 2017 and we were delighted that the CQC found our services to be rated Good overall and all of the services re-inspected to be Good as well, with the exception of community inpatient services which was rated as Requires Improvement. Overall this was a really pleasing result for the Trust and all our colleagues who have worked so hard to improve the quality of care we provide.

Effective partnership working is an essential requirement of good patient care. During 2017/18 we entered into a Memorandum of Understanding with Taunton and Somerset NHS Foundation Trust which has seen us work increasingly more closely as two organisations and, in November 2017, to appoint a joint Executive Team. We believe that this alliance will provide a platform for further improved patient care and better integrated services for all of our patients and the population we serve and in February this year we agreed, with our colleagues from Taunton and Somerset NHS Foundation Trust, to develop a Strategic Outline Case for a formal merger.

The Trust's workforce remains our most important asset and recruiting and retaining a workforce to meet the needs of our patients over the past 12 months has been our most pressing and difficult challenge. A number of innovative solutions have been introduced to assist in addressing the workforce challenges we are facing. However, vacancies in our nursing workforce in particular has meant we have had to make difficult decisions this year, including the temporary closure of some of our community hospital inpatient wards which remain closed at the time of writing this report.

We remain committed to ensuring that Somerset Partnership has a culture across the organisation which ensures that all colleagues feel valued, empowered and fully able to influence the care they help provide to our patients and service users in as constructive a manner as possible.

To the best of my knowledge, the information in this document is accurate.

PETER LEWIS
Chief Executive

PART TWO: PRIORITIES FOR IMPROVEMENT AND STATEMENT OF ASSURANCE FROM THE BOARD

PRIORITIES FOR IMPROVEMENT 2017/18

In this section we review how we performed against the key priorities we set ourselves last year.

While our aim is always to achieve the continuous quality improvement of all our services, each year we focus on a number of particularly key issues where we think improved quality would make the most difference to our patients. We then agree ways to measure how we have improved these aspects of our care delivery and we ask teams, wards and services to develop plans to make improvements in these areas at a local level.

Here is how we have done.

IMPROVING PERSONALISED CARE PLANNING

Improving Personalised Care Planning was one of our Quality Account priorities in 2016/17 as well as 2017/18, and remains an area that those individuals and organisations consulted felt most strongly about.

We continue to monitor the number of patients with care plans and those whose care has been reviewed. Care planning remains a core task carried out to support the delivery of effective care. Feedback through patient and carer groups indicates that effective involvement in personalised care planning is important to them and remains a key focus of concerns.

Feedback from the Care Quality Commission, including Mental Health Act visits, continues to indicate that across many services, while care plans were comprehensive, they were not always personalised to or understandable by the patient and their carers.

As at 31 March 2018, 94% of all recovery care plans had been reviewed at least annually, based on care co-ordinator contacts (against a target of 90%). Amongst work which we have undertaken to improve our arrangements, we have approached the NHS Benchmarking Network membership to seek examples of good practice in relation to measuring personalised care planning effectively.

During 2017/18, we updated and improved the personalised care plan template which we use, and we also developed and implemented a further range of care planning templates, specifically in relation to escalation / crisis plans.

We also undertook an audit in relation to personalised care planning in January 2018, the results of which have been reviewed by our Integrated Care Planning Group. The group has made recommendations for further improvements to our arrangements for personalised care planning.

INCREASING CARER INVOLVEMENT AND SUPPORT

This also remains an important area for the Trust and particularly Trust governors.

We continue to be an active and leading participant in the Triangle of Care programme supported by the Carers Trust which seeks to ensure that patients, carers and health care professionals are all appropriately involved in information and decision-making about a person's care.

During 2017/18 our community hospitals Triangle of Care baseline report was presented to peers at a South West Triangle of Care meeting during 2017/18, and was favourably received. We have subsequently been working on self assessment audits for other core community services to form the final submission for a potential third 'star' – one of only a handful of Trusts in the country to be doing this.

During the year, we also trialled a revised one-day Triangle of Care training package for mental health wards, and this will be repeated twice annually.

Our Mental Health Carers service is working closely with the new Somerset Community Council service (Village Agents) to provide a seamless Carers' Service for the people of Somerset. We have developed a joint website and Somerset Partnership carers' assessment workers are contributing actively to the new Carers' Helpline. Early carer feedback on the new service is very positive.

During the year we undertook a carers survey as part of the Triangle of Care initiative and to mark Carers' Week. We worked with Governors and Trust volunteers to meet with patients and carers on the wards and to obtain feedback.

Formal surveys were distributed in all community hospital and mental health inpatient wards but only a limited number were completed and only from community hospitals. We also gathered verbal feedback. Generally the carers who responded felt involved in the care and the treatment of the patients however only half of the carers felt they had enough information about medication and treatment. We also identified that issues around confidentiality and information sharing are not being provided consistently to all carers.

Feedback about the staff and the support they provide was extremely positive. However it appears that carers were not always informed of the names and roles of staff caring for their friend or relative. Carers were generally included in discharge plans and / or transfer arrangements where appropriate. We are using the feedback from this survey to develop better support for carers and reviewing our approach to information sharing with our Triangle of Care Steering Group.

We are also part of the Patient Experience Collaborative with Northumbria Trust and we are currently undertaking pilot reviews in a community hospital and an adult mental health inpatient site. One-day Triangle of Care training workshops were delivered to Home Treatment teams in February and March 2018 and feedback has been extremely positive.

CAPACITY AND CONSENT

The challenges of effectively assessing and recording capacity and consent for patients across community health and mental health services was identified by the Care Quality Commission as an area for development for us when in their report on the comprehensive inspection of our services and remained an area for improvement as part of the follow up inspection in 2017.

A further aim this year has been to improve our compliance standards with the internal audits. Our audits of compliance with the Mental Capacity Act, completed in 2017 and early in 2018 continue to demonstrate a clear need for improvement in some staff's understanding of the Capacity Act, how to record their assessments of capacity and how to demonstrate that any intervention (or non-intervention) is in an incapacitated person's best interests.

As a consequence, during the year we have further reviewed our training support for staff across all services. We have developed plans for three levels of Mental Capacity Act training, aligned to our safeguarding training programmes, and have agreed eligibility criteria for staff to undertake the training. This programme is being rolled out in 2018 to all eligible staff.

Alongside the training programme a proposal has also been developed, to offer additional advice and support (via the safeguarding team) to frontline clinicians with complex consent and capacity decision making is under consideration.

We have made improvements in understanding and information about consent to share information and, as at 31 March 2018, compliance in respect of consent to share information was 82.8%, compared to a target of 75%.

INVESTIGATING AND LEARNING FROM UNEXPECTED DEATHS AND SERIOUS INCIDENTS REQUIRING INVESTIGATION (SIRIs)

The national focus on effective investigation of unexpected deaths has continued and this has been supported by the Care Quality Commission and our commissioners, alongside the Learning from Deaths requirements which we discuss later in this report.

Following significant review in 2016/17, we have revised our Serious Incident policies and procedures during 2017/18, taking forward a range of actions arising from a Serious Incident internal audit which found that incidents lacked timely review and investigation and limitations in the learning we were able to share following investigations.

The Trust has developed and started implementation of a Serious Incident Improvement Plan – based on Care Quality Commission findings and reviewed in light of the internal audit findings. The actions arising from this plan were completed in full and have resulted in improvement in:

- the timeliness of completion of investigations

- support for investigations
- follow up of actions undertaken and learning identified
- better involvement of families and carers

However, we recognise that there is more work to do and we will continue to focus on this as a priority for 2018/19.

IMPROVING THE UNDERSTANDING AND RECORDING OF RESTRAINT

We identified improving the understanding and recording or restraint as a priority for our 'Sign Up to Safety' campaign and our Quality Improvement Plan. We already have a low level of incidents of restraint and we have moved away from simply counting numbers of restraint episodes, towards seeking assurance about the necessity and proportionality of interventions.

Our aim has been to improve the reporting of incidents and to reduce the number of incidents involving harm to patients or staff and to move to eliminate prone restraint wherever possible.

Our Positive and Proactive Care Group monitors restraint incidents in conjunction with a balancing metric of the incidence of violence and aggression. The changes which we made to our Datix (incident reporting) system during 2017/18 enable us to monitor necessity and proportionality in the use of restraint. Information which we are now collecting in Datix includes:

- the use of prone restraint to breakaway safely / exit seclusion from the use of prone positioning as a form of restraint
- the duration of the restraint
- whether post restraint debrief has taken place

We are also making changes to our training for the Prevention and Management of Violence and Aggression (PMVA), to enable staff to position patients in a lateral position for administering intramuscular injections in the gluteal muscle, as part of rapid tranquilisation. Whilst this position does not necessarily always enable the safe control of the patient's legs if they are actively fighting, it is safe to use in some circumstances and, as we have learned from other Trusts, can help in reducing the incidence of prone restraint during rapid tranquilisation.

Sometimes prone positioning happens unintendedly and in recognition of this, our staff will now be trained on a turning technique, to roll someone safely from prone to supine, when to let go and potentially re-establish holds once someone is no longer prone. Training on these techniques will become part of PMVA training from April 2018.

The overall incidence of restraint across the Trust reduced during the year, from 15.38 incidents per 1,000 bed days in February 2017, to 9.99 incidents per 1,000 bed days in January 2018. In 2018/19 attention is being focused on a further reduction in the use of prone restraint.

REDUCING THE INCIDENCE OF VENOUS THROMBOEMBOLISM (VTE) IN INPATIENTS

We are committed to providing harm free care to all its patients in line with the NHS 'Patient Safety Thermometer'. In previous Quality Accounts, we have focused on falls and pressure ulcers and reducing the incidence of venous thromboembolism (VTE) in inpatients is a further element of harm free care upon which we feel it is appropriate to focus this year, particularly as there was a cluster of incidents during 2016/17 in our inpatient units.

During the early months of 2017/18, we again experienced a cluster of VTE incidents. In order to address this, we worked during the year with the Royal United Hospitals Bath NHS Foundation Trust, to undertake a collaborative investigation to identify an issues contributing to the occurrence of these incidence and to share learning and good practice. As a result of this work, we have jointly developed an improvement plan to address the identified issues.

As at 28 February 2018, the latest data available, there had been no reported incidents of venous thromboembolism since August 2017. During 2017/18, 96.7% of patients admitted to our community hospitals were assessed for risk of VTE within 24 hours of admission.

PRIORITIES FOR IMPROVEMENT 2018/19

This section sets out how we decided our priorities for improvement for 2018/19.

During 2017/18, we consulted with staff, governors and patient representative groups on our proposals for priorities for quality improvement for 2018/19, based on a review of our quality performance and the identification of areas for improvement. This included sharing the priorities with the Council of Governors, members, with Healthwatch Somerset and with staff through the Trust's newsletter *What'sOn@Sompar*.

Following the consultation exercise the general feedback has been supportive of the overarching approach and of the issues and priorities identified. For 2018/19 these are:

- improving the understanding and recording of capacity and consent;
- enhancing procedures for reducing Venous Thromboembolism (VTE) in inpatients;
- reducing the incidence of pressure ulceration;
- increasing the skill set of staff when caring for patients with dementia/cognitive impairment;
- improved incident reporting;
- improved personalised care planning.

The Trust will monitor performance against these priorities through its Quality Report and other reports to the board and Council of Governors and through the Clinical

Governance Group and the Serious Incident Requiring Investigation (SIRI) and Mortality Group.

QUALITY ACCOUNT PRIORITIES 2018/19

	Priority Area	Rationale	Performance Improvement Measures	Monitoring
1.	Improving understanding and recording of capacity and consent	This has been a priority for the previous two years of our Quality Accounts and was identified by the Care Quality Commission as an area for development for us when in their report on the comprehensive inspection of our services and in their follow up inspection report in 2017. During 2017/18 we undertook clinical audits of compliance with our standards for recording capacity and consent. These audits demonstrated some limited progress in the recording of assessments of capacity, particularly within community services but also identified further training and support needs which we are prioritising this year.	Improve compliance standards with the internal audit to be re-taken during 2018/19 Ensure all eligible staff have completed the appropriate level of training and competency in the Mental Capacity Act	Internal Audit report to be monitored through the Audit Committee Training uptake and compliance monitored through Mental Health Legislation Committee
2.	Reducing the incidence of Venous Thromboembolism (VTE) in inpatients	Somerset Partnership NHS Foundation Trust is committed to providing harm free care to all its patients in line with the NHS 'Patient Safety Thermometer'. In previous Quality Accounts we have focused on falls and pressure ulcers and this is a further element of harm free care upon which we feel it is appropriate to focus this year, particularly as there was a cluster of incidents during the past year in our inpatient units.	Zero tolerance of avoidable Venous Thromboembolism incidents.	Monitored through monthly performance reports and quarterly through the Quality Assurance Group and Quality and Performance Committee. Reported to the Board through the Quality and Performance Report.

	Priority Area	Rationale	Performance Improvement Measures	Monitoring
3.	Reducing the incidence of pressure ulceration	As for priority number 2, Somerset Partnership NHS Foundation Trust is committed to providing harm free care to all its patients in line with the NHS 'Patient Safety Thermometer'. The effective provision of care in relation to the prevention of Trust-acquired pressure ulcers is a key aspect of demonstrating our commitment to the delivery of harm free care for all of our patients. We recognise that with the nurse staff challenges we have experienced this year, areas such as the management of pressure ulceration can be a key indicator of effective patient care and we wish to focus on this for 2018/19 as a consequence.	Reduce the number of Trust-acquired pressure ulcers in our community hospitals, per 1000 occupied bed days Reduce the number of Trust-acquired pressure ulcers on our district nursing caseload, per 1000 district nursing contacts Other measures to be specified, consistent with the 2018/19 CQUIN relating to wound care.	Monitored through monthly performance reports and quarterly through the Quality Assurance Group and Quality and Performance Committee. Reported to the Board through the Quality and Performance Report.
4.	Increasing the skill set of staff when caring for patients with dementia / cognitive impairment	Dementia and cognitive impairment are increasingly prevalent as our population ages, and we need to ensure that all of our staff who provide care for patients are appropriately trained and have the necessary skills to deliver the best quality of care to patients with dementia or cognitive impairment.	Increase the percentage of our clinical staff who have Dementia Awareness training. Increase the percentage of our clinical staff who have Enhanced Dementia Awareness training.	Monitored quarterly through the Quality Assurance Group and Quality and Performance Committee. Reported to the Board through the Quality and Performance Report.
5.	Improving incident reporting	The Trust has been identified as a comparatively low reporter of incidents when benchmarked against similar organisations. We are looking to improve the reporting of incidents but reduce the number of incidents involving harm	Increase the rate of incidents reported per 1000 bed days, for inpatient services, and per 1000 contacts for non-inpatient services.	Monitored via compliance with standards through internal audit report to Audit Committee Monitored quarterly through

	Priority Area	Rationale	Performance Improvement Measures	Monitoring
		to patients or staff to ensure we learn when things go wrong while focusing on patient safety and harm free care.	For both measures, reduce the proportion of reported incidents which result in harm.	the Quality Assurance Group and Quality and Performance Committee. Reported to the Board through the Quality and Performance Report
6.	Improved personalised care planning	Feedback through patient and carer groups indicates that effective involvement in personalised care planning is important to them and remains a key focus of concerns. Feedback from the Care Quality Commission, including Mental Health Act visits, continues to indicate that across many services, while care plans are comprehensive, they are not always personalised to or understandable by the patient and their carers. We consider this continues to be a priority in our desire to ensure we deliver genuinely patient-centred care	Monthly monitoring of the percentage of patients with care plans (for mental health services these will be measured in line with the Recovery Care Programme Approach), and the percentage of patients whose care plans have been reviewed. Audits of care plans across services Patient survey results on involvement in care planning and decision-making	Monitored quarterly through the Quality Assurance Group and Quality and Performance Committee. Reported to the Board through the Quality and Performance Report Annual reports on patient and carer experience to Patient and Public Involvement Group, Board and Council of Governors

STATEMENTS OF ASSURANCE FROM THE BOARD

In this following section we report on statements relating to the quality of NHS services provided as stipulated in the regulations.

The content is common to all providers so that the accounts can be compared between organisations and provides assurance that Somerset Partnership NHS Foundation Trust Board has reviewed and engaged in national initiatives which link strongly to quality improvement.

The board has received monthly information on quality indicators as part of the Quality Report, the Finance Report and the Performance Report. In addition, the board has received reports on patient experience and workforce issues. The board is satisfied with the assurances it has received.

The board has discussed the priorities for 2018/19 and has agreed those described above.

Services provided by the Trust

During 2017/18 Somerset Partnership NHS Foundation Trust provided and/or sub-contracted 75 relevant services, including the following:

- **Acute services** (including community hospitals; minor injury units; surgical operations; diagnostics, termination of pregnancy clinics; psychiatric liaison)
- **Long-term conditions services**
- **Hospital services for people with mental health needs, and/or learning disabilities, and/or problems with substance misuse**
- **Rehabilitation services**
- **Community healthcare services** (including district nursing; integrated therapy services; health visiting; school health nurses; family planning and sexual health services)
- **Dental services**
- **Community based services for people with a learning disability**
- **Community based services for people with mental health needs** (including community mental health teams; assertive outreach; early intervention teams; court assessment services; crisis resolution home treatment teams)

The Somerset Partnership NHS Foundation Trust Board has reviewed all the data available on the quality of care in all 75 of these relevant health services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Somerset Partnership NHS Foundation Trust for 2017/18.

The data reviewed aimed to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. The types of data reviewed included targeted measures and patient experience. The Trust considers that the amount of data did not impede these objectives.

CLINICAL AUDIT/RESEARCH ACTIVITY

During 2017/18 eleven national clinical audits (Prescribing Observatory for Mental Health – Side Effects of Depots was postponed by the providers to 2018/2019 leaving a balance of ten national audits) and two national confidential enquiries covered relevant health services that Somerset Partnership NHS Foundation Trust provides.

During 2017/18 Somerset Partnership NHS Foundation Trust participated in all ten (100%) national clinical audits and both of the national confidential enquiries (100%) in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Somerset Partnership NHS Foundation Trust was eligible to participate in (*and for which data collection took place during 2017/18*) are listed below alongside the number of cases submitted as a percentage of the number of registered cases required by the terms of that audit or enquiry:

1. Sentinel Stroke National Audit Project (SSNAP) (ongoing data collection) **100%**
2. National Diabetes Foot Care Audit **100%** (n=186)
3. UK Parkinson's Audit **100%** (Physiotherapy n=10, Occupational Therapy n=10)
4. National Clinical Audit of Psychosis **100%** (n=100)
5. Prescribing Observatory for Mental Health–UK:
    - High Dose and Combination Antipsychotics **100%** (n=84)
    - Use of Sodium Valproate **100%** (n=180)
    - Use of Depots/Long Acting Antipsychotics for relapse prevention **100%** (n=148)
6. Early Intervention in Psychosis **100%** (n=119)
7. National Confidential Enquiry into Young People and Young Adults Mental Health **100%** (*organisational questionnaire n=2, case note review n=7*)
8. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) **100%** *(Suicide n=24, Homicide n=0)*

Two national audits, although started during 2017/2018, have data collection scheduled to commence/running into 2018/19:

1. Prescribing Observatory for Mental Health-UK: Rapid Tranquilisation
2. National Audit of Anxiety and Depression

There were a total of 39 audits on the Trust Clinical Audit Plan for 2017/18. The status of these is as follows:

Fully completed	Awaiting finalised report	National, ongoing into 2018/19	Not proceeded with	Total
9	21	8	1	39

The audit not undertaken was in relation to corporate record keeping which was superseded by work undertaken in relation to the implementation of the General Data Protection Regulations (GDPR).

All completed Trust audits (including results and actions) are reported to the Clinical Governance Group via a quarterly report.

In addition to this, there are 44 audit projects registered which sit outside the 2017/18 Trust Clinical Audit Plan, being carried out by individual clinicians and/or teams, and registered between 01/04/2017 and 31/03/2018:

Fully completed	Ongoing	Reporting	Not proceeded with	Total
12	26	4	2	44

The number of patients receiving relevant health services provided or sub-contracted by Somerset Partnership NHS Foundation Trust in 2017/18, plus their carers and Trust staff that were recruited during that period to participate in national portfolio research studies approved by a research ethics committee was 691 (including those recruited to the NCISH which is included on the NIHR portfolio) – see table below:

Study ID	Study Title	Participants
16735	FADES	1
8630	MOLEGEN	1
30510	Lots2Care	26
31785	Lots2Care – process evaluation	2
35499	Delivery of Patient Reported Health Status Questions in Stroke	46
15511	PLORAS	2
3808	AD GENETICS	32
31632	DECIDE	17
14887	ELAD	5
20146	MAS - evaluation of Memory Assessment Services	4
18481	ASC-UK	44
33002	everybody Plus	1
20641	CATCH-uS	1
32191	Survey of mindfulness and self-compassion	25
8647	DPIM – bi polar	12
34784	Patient preferences for psychological help	22
18451	PPiP2	30

Study ID	Study Title	Participants
19695	REACT	5
34768	SCENE – WP1	52
17573	ESMI - effectiveness of perinatal mental health services	3
32779	Voice Impact Scale (VIS)	28
32962	DAWN-SMI	34
5655	NCISH - Suicide	24
34920	The assessment of risk and safety in mental health services	2
31938	Liaison & diversion trial schemes in England	55
34363	Patient Reported Outcome Measures for Neurological Conditions	130
32935	Patient-centred practice within physiotherapy	16
31551	The GRASP Trial	2
33087	ADAPT	6
33853	Assessment of Tennis Elbow outcome measures	21
35542	Fluenz	6
33327	Improving healthcare for probationers: mapping the landscape	1
34281	Nutricia Enteral Feed	4
20710	SafetTXT	31
	TOTAL:	**691**

Of the ten national audits in which the Trust participated, two have been completed, and the remaining audits will carry over into next year.

The recommendations and actions of the two completed national audits are as follows:

Audit 266: Rapid Tranquilisation (POMH-UK 2017)
Audit Lead: Head of Inpatient and Urgent Care Services, Adult Mental Health and Learning Disabilities
Sample: All patients occupying a bed on an acute adult, psychiatric intensive care, or low, medium or high secure ward, who received medication (in addition to their regularly prescribed medication) for the management of an episode of acutely-disturbed behaviour from 1st September 2016 – 16th November 2016 inclusive (n=62).

No	Recommendation	Action required
1	Report to be discussed at IQIS Group	Add to agenda
2	Share results Trust wide	Send to editors of What's On and publish on intranet
		Ward Managers to cascade results to all inpatient staff
		Present results and discuss at Medical Audit
		Discuss findings at the Positive and Proactive Care Group
3	Improve staff knowledge with regards to RT, in particular to the requirement for monitoring	Consider adding RT and monitoring to the 'clinicians pocket booklet' currently being designed as part of the recommendations agreed in the Violence and Aggression audit
		Include RT and monitoring in the Patient Deterioration Workshop
		Ensure RT Induction training for medical staff includes monitoring requirements by emailing Dr Hoare
		Ensure the Trust RT e-learning covers all the standards in this audit, and also includes definitions of RT
4	Clinical Leads to review ALL instances of RT in their ward, to ensure standards are followed	Email to be sent to Ward Managers and Clinical Leads setting out requirements, including the standards to be followed

Audit 278: High Dose and Combination Antipsychotics (POMH-UK)
Audit Lead: CT3 Psychiatry Doctor, Adult People Mental Health
Sample: All patients occupying a bed and prescribed antipsychotics were included, and were audited during the period 1/02/2017 – 28/02/2017 (n=84).

Recommendation		Action required
1	Report to be shared with medical staff	Medical Director to share with Medical staff
		Present at Medical Audit
2	Report to be shared with Improving Quality of Inpatient Services Group	Add to IQIS Agenda. Dr Emma Salter to attend meeting to discuss if possible
3	Report to be shared with Adult Mental Health Divisional Governance Group	Add to Divisional Governance Group agenda
4	Report to be discussed at Medicines Oversight Group	Report to be added to agenda for discussion
5	Share results Trust wide	Send to editors of staff newsletter and add to the intranet
6	Discuss at Proactive Care Group	Report to be added to agenda for discussion
7	ECGs should be **scanned** into documents on RiO, and not just typed up into progress notes	Present at Medical Audit
		Further discussion to take place to clarify scanning process
8	Reduce the number of PRN prescriptions being written	Investigate how long the expiry date of STAT doses can be entered for on RiO EP
		Include use of PRN, STAT doses and RT in PGME meetings
9	All high dose antipsychotic prescribing should be recorded within the care plan, making specific mention of high dose	Discussion at PGME meetings

Of the remaining audits on the Trust audit plan that are not national audits, a total of 7 have been fully completed. We have set out in the next few pages some examples from these completed audits, detailing the actions that the Trust intends to take to improve the quality of healthcare provided:

Audit 318: Quality of Early Help Assessment Level 3 and 4 Referrals to Children's Social Care
Audit Lead: Named Nurse Safeguarding Children
Sample: All Early Help Assessment referral forms completed during April, May and June 2017 (n=71)

No	Recommendation	Action required
1	Report to be discussed and agree recommendations at the Safeguarding Children Best Practice Group	Add to agenda, discuss results and agree recommendations
2	Report to be discussed at the Safeguarding Steering Group	Add to the agenda and discuss the final report
3	Share results Trust wide	Send to editors of What's On and publish on intranet
4	Re-audit in 2018/19	Add to the Trust Clinical Audit Plan to carry out a full re-audit in 2018/19.
5	Report to be discussed at the appropriate Divisional Governance Groups	Add to the agenda and discuss the final report
6	All Early Help Assessment (EHA) referral forms to be fully completed (where the information is available at the time of completing the form)	The Safeguarding Children Nurses who quality assures the referral forms need to increase their scrutiny of key demographic information to ensure there are no gaps in recording known information. This needs to be followed up with the person who completed the form to fill in the gaps.
7	The referral form must be sent to the relevant professionals in line with Trust policy	When checking the EHA form, the Safeguarding Children Nurses must remind staff of their need to share referral information with relevant professionals in line with Trust policy
8	Compare the number of completed EHA forms against the number of referrals received by Children's Social Care (CSC)	Obtain a list from CSC of all referrals received for Quarter 2 and compare against the number of forms received by the Safeguarding Team. Identify if the higher number of referrals received by CSC is because there is more than one child on the referral form, or because SomPar staff are sending the EHA form directly to CSC without contacting the Safeguarding Team.
9	Dental Service to document the patient's GP and School as routine practice at the first point of contact	At the first point of contact details of the patient's GP and School should be recorded within the 'Medical History' section of the form.

Audit 282: Provision of information to patients on Section 132 of the Mental Health Act
Audit Lead: MHA Coordination Lead
Sample: All inpatients subject to the MHA (n=95) and all patients in the community subject to a CTO or conditional discharge (n=22) as at 30th April 2017

	Recommendation	**Action Required**
1	Report to be shared with wards/teams involved in the audit, for feedback prior to agreement of recommendations by the MHA Legislation Committee	Send report to teams for feedback
2	Report to be discussed and recommendations agreed at the MHA Legislation Committee	Send report to chair of meeting
		Discuss and agree recommendations
3	Share results Trust wide	Send to editors of What's On and add to the intranet
4	Develop and publish a S132 Trust policy	Write and publish policy
5	Develop a factsheet for patients who change to informal status to explain that the MHA is no longer applicable and what that means	Develop a factsheet
6	Ensure that the current standards are comparable to existing best practice	Review current standards and suggest following changes to be agreed: • Information to be provided at: - *Commencement of detention under the MHA* - *On a daily basis if patient does not understand/lacks capacity at point of commencement* - *Following any significant deterioration in mental health presentation* - *Following extension/renewal of detention* - *When changing to informal status* - *At point of discharge to a CTO or conditional discharge* Remove remaining standards and replace with: • "At frequency, agreed with patient/carer, as determined in care plan"
		Send new standards to all relevant teams via memo and share at IQIS
7	Review current MHA training & establish if it should include information on s132 policy	Review training

Audit 322: Obesity
Audit Lead: Dietetics Service Manager and Professional Lead
Sample: All Inpatients occupying a bed (community hospitals and mental health wards) plus random selection of 10 patients from community teams who fulfilled the inclusion criteria. Total sample = 555.

Recommendation		Action required
1	Report to be shared with managers of teams included in the audit for feedback	Send report. Collate feedback and update report to be sent for agreement at Nutrition Best Practice Group
2	Report to be discussed at Nutrition and Hydration Best Practice Group (BPG)	Discuss and agree recommendations
3	Report to be added to agendas of relevant BPGs	Send a copy of the report to meeting chair and request that results are shared with teams
		Yvonne Barclay and Sue Chant to attend Improving Quality of Inpatient Services Group (IQIS)
4	Report to be discussed at East, West, Countywide, and Adult MH Divisional Governance Groups	Send a copy of the report to meeting chair
5	Share results Trust wide	Send to editors of the staff newsletter and add to the intranet
6	Support wards and teams to improve the management of obese patients and the subsequent recording on RiO/paper records	**Inpatient:** Share this report with all adult and older adult mental health wards and community hospitals and highlight the areas of improvement required.
		Audit lead to liaise with Head of Mental Health Nursing and Head of Inpatient and Urgent Care to establish if and how obesity can be included in the physical health strategy for mental health patients. Audit lead to attend AIMS meeting
		Community: Develop a factsheet that includes at least the following information: ▪ To use clinical judgement to decide when to measure height, weight and BMI ▪ What to do if the patient is obese e.g., informing patient, signposting, etc

Recommendation		Action required
		Audit lead to liaise with head of District Nursing (DN) to discuss how to improve the recording of weight, height and BMI for DN patients
		Community and Inpatient: Promote the Making Every Contact Count training via What's On
		Add information on how to manage obesity to the Trust Nutrition policy – to include standards included in this audit and also make clear any exceptions to standards and the use of clinical judgement to assess patient engagement with losing weight
7	Clarify who is responsible for discussing bariatric surgery with inpatients – ward staff, GPs or other	Clarify process and inform inpatient staff
8	Simplify the process of recording height, weight and BMI on RiO	Review where this can be recorded on RiO and reduce the number of locations if possible. Share any changes with staff.
9	Establish if training on obesity management can be offered	Discuss with Head of L&D the possibility of developing obesity management training

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

A proportion of Somerset Partnership NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Somerset Partnership NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following twelve month period are available electronically at
http://www.sompar.nhs.uk/about_us/our_performance

The value of CQUINs for 2017/18 was 3,175,493. In 2016/17, Somerset Partnership NHS Foundation Trust received 3,037,555 in income for achieving the CQUIN goals set by Somerset Clinical Commissioning Group. In 2015/16 the Trust received 3,086,425.

REGISTRATION WITH THE CARE QUALITY COMMISSION (CQC) AND PERIODIC/SPECIAL REVIEWS

Somerset Partnership NHS Foundation Trust is required to register with the CQC and its current registration status is compliant for the 24 registered locations. Somerset Partnership NHS Foundation Trust has no conditions on its registration.

Somerset Partnership NHS Foundation Trust has participated in the following reviews and inspections undertaken by the CQC relating to the following areas during 2017/18:

Care Quality Commission (CQC) Inspections

In February and March 2017 the CQC undertook a re-inspection of some of the Trust's core services that had been inspected in September 2015, including our Community Learning Disability Services for Adults.

The CQC inspected the following services:

- acute wards for adults of working age (including our Psychiatric Intensive Care Unit);
- forensic inpatient/secure wards;
- older people MH inpatient wards;
- community based mental health services for adults of working age;
- community Learning Disability Services;
- community Sexual Health Services;
- community Health inpatient services;
- urgent care services;
- community health services for adults.

CQC inspectors also conducted a Well Led inspection of the Trust's governance on 8 and 9 March 2017 during which they interviewed executive and non-executive members of the Board, Clinical Directors and senior managers.

CQC published its report of this inspection in June 2017.

The Trust achieved an overall rating of 'good" after an 18 month programme of improvement across all of our services. This included improvements in the services originally of concern to the CQC when it undertook its comprehensive inspection of our services in September 2015: community services for adults with learning disabilities and the Trust's district nursing services which are now both rated as good.

The CQC re-inspected nine of the Trust's core services of which eight were rated as 'good' and one as 'requires improvement'.

This means that 15 of the Trust's 17 core services are now rated as 'good'. The CQC also rated the quality of care across all services as good or outstanding and one service, community services for adults with learning disabilities, had their rating for the quality of leadership move from the lowest rating to outstanding, the highest possible CQC rating.

	Safe	Effective	Caring	Responsive	Well-led
Somerset Partnership NHS Trust CHS	Requires Improvement	Good	Good	Good	Requires Improvement
Somerset Patnership NHS Foundation Trust MH	Good	Good	Good	Good	Good

Overall provider ratings (based on the summary above).

	Safe	Effective	Caring	Responsive	Well-led
Trust by key question	Requires Improvement	Good	Good	Good	Good

Deviated from principle. See below for details.

Overall trust rating	Good

A full copy of the current reports and ratings from CQC can be found on our website at www.sompar.nhs.uk and on the CQC website at www.cqc.org.uk

Care Quality Commission Mental Health Act Assessment

During 2017/18, CQC also undertook Mental Health Act Assessment visits of all our inpatient mental health wards, including as part of the re-inspection in February 2017. CQC identified some areas where we needed to improve our compliance with the Act and the new Code of Practice published in 2015.

We provided the CQC with responses to all the areas highlighted and CQC has not asked for any further information.

Key areas for improvement identified in the visits included:

- Patient and carer involvement in care planning (this continues to be one of our priorities for 2018/19)
- Recording of advanced wishes statements (we will be working with patients to identify and record these better)
- Recording of patients' rights under section 132
- Recording of sharing s17 plans with carers and relatives

The Trust monitors its actions against these plans and wider compliance through our Mental Health Legislation Committee.

DATA QUALITY

Somerset Partnership NHS Foundation Trust recognises the important role of data quality in providing confidence in the accuracy of information used to inform decisions relating to service improvement. Data quality indicators relating to the timeliness and accuracy of coding are routinely reported to the Trust's Finance and Performance and Audit Committees. Additional measures which permit the regular monitoring of data quality include:

- the use of the NHS number
- the clinical coding completion rate
- the use of GP medical practice
- the Information Quality and Records Management score

Somerset Partnership NHS Foundation Trust submitted records in 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS Number was:
  - 99.9% for admitted patient care;
  - 100.0% for outpatient care; and
  - 99.0% for accident and emergency care.
- which included a valid general practice code was:
  - 100.0% for admitted patient care;

- 100.0% for outpatient care; and
- 100.0% for accident and emergency care

The Somerset Partnership NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 for data quality was 98.5% and was graded as GREEN. The Trust achieved a minimum of level 2 compliance against all criteria of the Information Governance Toolkit version 14 and 66% compliance overall.

Somerset Partnership NHS Foundation Trust will be taking the following actions to improve data quality:

- Continue to monitor quality of individual data items on the Trust's clinical systems, providing exception reports to staff to enable then to improve the quality of the clinical data. Currently the information team carry out approximately 100 data quality tasks which are continuing to expand.
- Regular meeting with Clinical staff outlining any data quality issues and discussing solutions.
- Regular working groups within the IT division to review local data submission reports to see if any data quality issues can be resolved technically or if any potential data quality issues can be addressed before they become a problem.
- The continued rollout of a clinician based clinical self reporting portal to all staff members which will include a number of reports enable them to monitor their own data quality.

Somerset Partnership NHS Foundation Trust utilised the Terminology Reference-data Update Distribution Service (TRUD) to ensure the local Electronic Patient Record contains update reference data.

Somerset Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period.

PERFORMANCE AGAINST CORE INDICATORS

Single Oversight Framework targets

These indicators form part of appendices 1 and 3 of the Single Oversight Framework:

Target	Threshold	Performance			
		Q1	Q2	Q3	Q4
Referral to Treatment Waiting Times: percentage of patients waiting within 18 weeks: (Incomplete pathways)	92%	98.9%	99.5%	99.3%	99.6%
Percentage of Minor Injury Unit patients waiting under four hours from arrival to admission, transfer or discharge	95%	99.7%	99.8%	99.8%	99.7%
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	90%	96.8%	97.5%	97.2%	96.4%
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	76.2%	73.7%	57.1%	55.6%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a. inpatient wards b. early intervention in psychosis services c. community mental health services (people on CPA1 a) Internal mental health provider sample submitted to national audit provider for the CQUIN b) Early intervention: Internal mental health provider sample submitted to the Royal College of Psychiatrists CCQI EIP Network	90% 90%				Results awaited Results awaited

Target	Threshold	Performance			
		Q1	Q2	Q3	Q4
Improving Access to Psychological Therapies (IAPT)/talking therapies: Percentage of people completing a course of IAPT treatment moving to recovery	50%	41.9%	40.8%	37.9%	38.2%
Improving access to psychological therapies (IAPT): • people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	87.1%	92.9%	93.5%	94.1%
• people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	99.2%	99.9%	99.3%	99.3%
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	95%	97.3%	95.8%	97.2%	99.0%
Admissions to adult facilities of patients under 16 years old	0	0	0	0	0
Inappropriate out-of-area placements for adult mental health services	0	2	4	1	2

National and Local Performance Indicators

	Definition	2013-14	2014-15	2015-16	2016-17	2017-18	Bench Mark (national averages) - where available	Highest performing Trust – where available	Lowest Performing Trust – where available
1. Seven day follow up Percentage of people receiving face to face or telephone contact within 7 days of inpatient discharge	National (target 95%)	97%	97.5%	96.5%	97.1%	97.3%	96.9%[1]	Not available[2]	Not available[2]
2. Recording of risk Percentage of clients under our care who have had a formal assessment of risk and safety recorded	Local (target 95%)	98.4%	97.25%	99.5%	98.6%	98.9%	Not available[2]	Not available[2]	Not available[2]
3. Patient Safety Incidents Reported Patient safety incidents reported to the National Reporting and Learning Services (NRLS)	National	2,809[4]	3,148	3,215	2,591	4,180	Not available[5]	Not available[5]	Not available[5]
4. Safety Incidents involving severe harm or death Percentage of patient safety incidents reported to the NRLS where degree of harm is recorded as 'severe harm' or 'death'	National	1%	1%	1%	1%	1.4%	1%[4]	Not available[5]	Not available[5]
5. Gatekept Admissions Admissions to inpatient services had access to crisis resolution home treatment teams	National (95%)	97%	98.1%	98.2%	98.2%	98.8%	Not available[6]	Not available[6]	Not available[6]
6. Emergency Readmissions The percentage of patients aged (i) 0-15 and (ii) 16 and over readmitted to a hospital which forms part of the trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period.	National	(i) 25% (ii) 9.1%	(i)… .0% (ii)11.2%	(i)… .0% (ii)10.6%	(i)… .0% (ii)10.9%	(i)… 0% (ii) 0.5%	Not available[8]	Not available[8]	Not available[8]

	Definition	2013-14	2014-15	2015-16	2016-17	2017-18	Bench Mark (national averages) - where available	Highest performing Trust – where available	Lowest Performing Trust – where available
7. Complaints Number of complaints received by the Trust	Local	139~	113~	146	157	75	Not available[7]	Not available[7]	Not available[7]
8. Patient Advice and Liaison Service (PALS) Number of enquiries received by the Trust Patient Advice and Liaison Service Officer	Local	1,219~	1,329~	1,741	2,724	2,728	Not available[6]	Not available[6]	Not available[6]
9. Compliments Number of compliments received by the Trust	Local	5,263~	4,833~	3,909	4,258	5,077	Not available[2]	Not available[2]	Not available[2]
10. Community Mental Health Patient Survey The trust's 'Patient Experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	National	New indicator	6.9	6.9	7.0	7.0	Not available[9]	7.5[9]	6.1[9]
11. Staff Friends and Family The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	National	63	68	82	84	88[10]	Not available[6]	Not available[6]	Not available[6]

- [1.] 2016-17 Q3 HSCIC website
- [2.] Local target not collated nationally or regionally
- [3.] Information on the number of falls is not collated nationally or regionally but data on falls resulting in harm is collected through the HSCIC Patient Safety Thermometer Report at http://www.hscic.gov.uk/thermometer

- [4] NHS Commissioning Board Special Health Authority Organisation Patient Safety Incident Report March 2015
- [5] Information on number of incidents is not collated nationally or regionally but the Commissioning Board Special Health Authority Organisation Patient Safety Incident Report September 2015 benchmarks the reporting rate of incidents per 1,000 bed days. Somerset Partnership NHS Foundation Trust has a reporting rate of 23.08 incidents per 1,000 bed days compared to a median of 38.62
- [6] Information not collated nationally or regionally
- [7] Information not collated nationally or regionally but The NHS Benchmarking Network is including areas of corporate governance as part of its benchmarked information in the 2013-14 programmes. This covered complaints and reported in 2014/15.
- [8] Information not collated nationally or regionally
- [9] CQC national patient survey information at http://www.cqc.org.uk/content/community-mental-health-survey
- [10] Based on a 13% response rate
- * change of definition to include those care managed by others
- ~ figure for the integrated Trust for the full year. Previous years' reports relate only to mental health inpatient services)

1. **Seven day follow up** Somerset Partnership considers that this data is as described for the following reasons: This was defined in the NHS Improvement Single Oversight Framework and the former Monitor 2016/17 Risk Assessment Framework. Data is sourced from the electronic patient record. Performance is monitored monthly through a balanced scorecard presented to the Trust's Senior Managers' Operational Group Meeting which identifies discharges and follow ups, and enables our Heads of Division to alert clinicians and take focused, informed action. There is a CPA Policy to support this operationally, and the business rules are published and shared across the Trust to ensure we are acting on and recording this information correctly.

The Trust continues to undertake actions to improve this percentage, and so the quality of its services: by continuing the level of monitoring at service and locality level through the coming year.

2. **Recording of Risk** Somerset Partnership considers that this data is as described for the following reasons: This is defined locally as the percentage of clients who have a risk assessment recorded in the electronic patient record as a proportion of those over 18, open to services, and placed on a CPA level. All relevant records are checked each month as part of an automated report. This process has been subject to a previous internal audit review. A clear record of an assessment of risk is an important component in the process of managing risk and of communicating patient safety factors in a structured, easy to find, manner.
The Trust has taken the following actions to improve this percentage, and so the quality of its services: by monthly reporting on performance in this area and notifying individual health care professionals of cases requiring a record of the risk assessment when performance falls below a threshold in that service area.

3. **Patient Safety Incidents Reported** Somerset Partnership NHS Foundation Trust considers that this data is as described for the following reasons: the total number of patient safety incidents is exported directly from the Trust's Risk Management System, DATIX to the National Reporting and Learning System (NRLS). All untoward events, including patient safety incidents, are reviewed daily by the Risk Management Team. This centralised function enables the team to accurately record patient safety incidents that require reporting onto the NRLS.

The Trust has taken the following actions to improve this number, and so the quality of its services: by promoting risk management within the organisation and undertaking a detailed review of levels of incidents reported, following identification of this risk through CQC reports and liaison meetings. The review continues to inform the reconfiguration in the mapping of the DATIX system to improve reporting levels and additional training and support for practitioners and teams.

4. **Patient Safety Incidents involving Severe Harm or Death** Somerset Partnership NHS Foundation Trust considers that this data is as described for the following reasons: the percentage of patient safety incidents recorded as major or catastrophic consisted of Somerset Acquired pressure ulcers graded 3 or 4, sudden unexpected deaths and other reportable Serious Incidents Requiring Investigation (SIRI). Within this 1% are also significant incidents where a full Root Cause Analysis (RCA) was not required from the Commissioner. The Trust receives a bi-annual report from the NHS Commissioning Board Special Health Authority which uses data submitted to the NRLS to benchmark Somerset Partnership NHS Foundation Trust against similar neighbouring NHS Trusts. Within these reports Somerset Partnership NHS Foundation Trust is within the bottom 25th percentile of reporters.

The Trust has taken the following actions to improve this percentage and so the quality of its services: by developing strategies to reduce significant harm to patients and actively learning from experiences. The Trust has reviewed its suicide prevention strategy during the year and continued to undertake a range of measures to reduce the instances of falls and pressure ulcers and the position is monitored monthly by the Board through the Quality Report.

All incidents are reviewed by the risk management team. Significant incidents are followed up by a 72 hour review which, if necessary will inform the level of RCA investigation required. SIRIs and other significant incidents are reviewed at the SIRI review group, where full investigations are considered, and learning outcomes and action plans are monitored. We have again reviewed the Trust's processes around serious incident investigation and the role and functions of the SI Review Group.

5. **Gate-kept admissions** Somerset Partnership considers that these percentages are as described for the following reasons: This was defined in the Monitor 2013/14 Risk Assessment Framework and includes for the Trust gate-kept admissions via Psychiatric Liaison Teams as part of Crisis Services as recorded in the electronic patient record. Performance is monitored monthly through a balanced scorecard presented to the Trust's Senior Managers' Operational Group Meeting which identifies admissions and gate-keeping which informs actions as required. The Crisis Resolution Team policy and business rules are published and shared with all staff via our intranet to ensure we are acting on and recording this information correctly.

The Trust has taken the following actions to improve this number, and so the quality of its services: by reporting compliance rates each month in the relevant divisional dashboards.

6. **Emergency Readmissions**: Somerset Partnership considers that these percentages are as described for the following reasons: emergency readmissions are reported directly from the electronic patient record and monitored through the Trust's performance management systems.

The Trust has taken the following actions to improve this number, and so the quality of its services: by reporting emergency readmissions rates each month in the relevant divisional dashboards and undertaking regular reviews of cases to establish underlying themes and implement actions to minimise risk of re-admissions. .

7. **Complaints** Somerset Partnership considers that these percentages are as described for the following reasons: complaints are recorded on the Trust's Risk Management System, DATIX and reported monthly to the Trust's Clinical Governance Group for review. The number of complaints, information on response times and analysis of themes, lessons learned and actions taken are reported quarterly to the Patient and Carer Involvement Group and as part of the Trust's Quality Report to the Board. The report is also presented in the public meetings of the Council of Governors. A quarterly return on complaints (K041a) is submitted to the Department of Health and validated as part of the national reporting system.

The Trust has taken the following actions to improve this number, and so the quality of its services: by reviewing its Complaints and PALS policy and systems following further feedback from the CQC follow up inspection.

8. **PALS** Somerset Partnership considers that these percentages are as described for the following reasons: PALS enquiries are recorded on the Trust's Risk Management System, DATIX and reported monthly to the Trust's Clinical Governance Group for review. The number of PALS enquiries, analysis of themes, lessons learned and actions taken are reported quarterly to the Patient and Public Involvement Group and as part of the Trust's Quality Report to the Board.

The Trust has taken the following actions to improve this number, and so the quality of its services: by reviewing its Complaints and PALS policy and systems following feedback from the CQC follow up inspection team and introducing a workbook for teams to provide a structured systems for feedback of lessons learned across the Trust. The PALS team also leads on the follow up of issues identified from the Friends and Family Test.

9. **Compliments** Somerset Partnership considers that these percentages are as described for the following reasons: Compliments are collected from all Trust sites and services and reported monthly to the Trust's Clinical Governance Group for review. The number of compliments and areas of best practice are reported quarterly to the Patient and Public Involvement Group.

The Trust has taken the following actions to improve this number, and so the quality of its services: by establishing a Patient and Public Involvement Best Practice Group which looks at best practice identified through compliments and ways to disseminate these.

10. **Community Mental Health Patient Survey** Somerset Partnership considers that this figure is as described for the following reasons: The national patient survey for community mental health is conducted independently on behalf of the Trust by Quality Health and submitted to the Care Quality Commission. The results are published on the CQC website. The Trust has taken the following actions to improve this number, and so the quality of its services: by producing an action plan addressing all areas within the patient survey where the Trust scored below national averages or where performance was less favourable than the previous year. The action plan is monitored through the Trust Patient and Public Involvement Group which includes staff, governors, patient and voluntary sector representatives and commissioners.

11. **Staff Friends and Family** Somerset Partnership considers that this figure is as described for the following reasons: The national staff survey is conducted independently on behalf of the Trust and submitted to the Department of Health. The results are published on the website and openly available.

The Trust has taken the following actions to improve this number, and so the quality of its services: by undertaking a full staff survey during 2017/18together with staff engagement events across the Trust. The Trust has also introduced service level 'PULSE' surveys to gain a greater detail of local feedback from staff.

As part of its programme for external assurance, the Trust identified three performance indicators for detailed audit by our external auditors.

Under the guidance issued by NHS Improvement, as a provider of both community health services and mental health services, the mandated indicators for the Trust are those for the service which forms the majority of income for the organisation. These are community health services. However, only one of the mandated indicators is relevant to the Trust. This is:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

In line with NHS Improvement guidance, the Trust's governors agreed with our external auditors a further indicator and it was decided this would relate to mental health services. This indicator was:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral

The final indicator is a local indicator chosen by the governors and this is:

- Patient Safety Incidents reported

The definitions of these indicators are set out in Appendix 3.

PART THREE: OTHER INFORMATION

The NHS (Quality Accounts) Amendment Regulations 2012 requires Trusts to identify three performance indicators against each of the quality criteria:

- patient safety
- clinical effectiveness
- patient experience

We have set these out in Part Two (see pages 2 – 32) together with the additional key indicators that we have identified as priorities for the Trust. We also continue to improve quality across other essential areas of our services. Some examples include:

Patient Safety and Quality Improvement

The Trust's quality improvement programme brings together all key improvement initiatives including the Quality Account priorities, Positive and Proactive Care, Sign Up to Safety and the application of the patient safety thermometer. Increasingly the programme looks to 'whole system' initiatives to improve patient experience and safety across the whole healthcare system.

During 2017/18 the Trust has further increased the number of staff who have under taken the Quality Improvement 'Launchpad' course (previously known as the Patient Safety Officer training course) provided by the South West Academic Health Scientific Network. The total number of staff trained in this quality improvement methodology is 21 and further cohorts are planned for 2018/2019.

Directorates are engaging with local staff who have received this training to support the development of local Quality Improvement (QI) Plans. Each directorate submits a Divisional Clinical Governance Assurance Report on a quarterly basis which details local QI plans as well as Trust priorities as stated in the Quality Account and Sign Up to Safety as well as any local issues which have been identified.

Working in alliance with Taunton & Somerset NHS Foundation Trust has also enabled development of additional improvement programmes. The Trust is looking to share Quality Improvement infrastructure and resources across both Trusts to ensure QI is firmly embedded in in the culture across both organisations. During 2017/18 the Trust has worked on the Northumbria Collaborative programme and has two wards that are piloting real time patient feedback.

Further collaborative work with other Trusts to bring about improvement, includes Observation and Engagement in mental health care through the national programme being hosted by NHS Improvement as well as the national collaborative being hosted by The Kings Fund on integrating physical health and mental health care. This has led to the creation of a new approach to patient safety on our Older Persons Mental Health ward which is showing signs of reducing falls and other untoward incidents whilst also using staff time more efficiently and a better patient experience through engagement rather than routine observation.

The Safe Care Programme has been implemented in all inpatient wards during 2017/18. The Safe Care Programme is software that is incorporated in the e-roster system and operates evidence based and nationally recognised tools for determining safe staffing levels on wards. The tools are based on patient acuity and dependency scores as well as any non-routine tasks occurring on a ward which may increase demand on the nursing team.

As part of our 'positive and proactive' approach to use least restrictive practices and particularly to reduce the use of restraint whenever possible an improvement project has developed a method of undertaking post incident debriefing ('Safety Huddles') on our PICU ward which whenever possible involves service users, this enables everyone involves to receive a supportive debrief following an incident involving the use of restraint and to reflect on how further incidents can be prevented. In turn this informs personalised care planning. This practice is being spread across our mental health wards.

The Trust is committed to improving the quality of care, ensuring that information is widely available to the public through our monthly detailed quality reports to the Trust Board. This ensures that our performance and commitment to improvement is transparent. Measures of success include our provision of high levels of harm free care in our community hospitals and community services - with the majority consistently delivering harm free care in excess of the national average. This is testament to the expert clinical leadership and front line support for our improvement programmes.

Other key aspects of our Quality Improvement Plan and Patient Safety programme for the year ahead are:

- Strengthening of the Directorate triumvirate during 2018/19 through the addition of Associate Directors of Patient Care. This will further devolve quality improvement and patient safety and bring renewed focus on locally delivered care

- An accreditation scheme for inpatient care within the community hospitals is being developed and will be launched in two pilot areas early in the new financial year. This is a significant work stream and will be fully implemented over the next two years

- The Patient Safety Walk Round programme will be refreshed and relaunched in 2018/19 – this is where executive and non-executive directors and governors regularly visit inpatient areas to talk to staff and discuss their concerns about delivering safe patient care where they work.

- The Trust has signed up to the Always Events ® programme and three delegates are attending an NHSI launch event in March 2018.

- The Trust has continued to participate in the South of England Mental Health Patient Safety Collaborative and has both 'exported' and 'imported' initiatives. Examples include how other Trusts have been particularly interested in our Positive and Proactive Care programme to reduce the use of restraint and our

work on improving communication when reporting untoward incidents ('SBAR Trek').

- Quality Improvement projects are currently forming to focus on supporting patients in reducing the use of ligatures as a behavioural response to emotional distress on mental health wards, suicide reduction in the community and in preventing dehydration in hospital wards.

- More staff now utilise the 'LIFE' internet based programme in order to support Quality Improvement projects. This programme has been developed by the South West Academic Health Scientific Network and through the South of England Mental Health Patient Safety Collaborative within which we are an active participant.

Learning from Deaths

During 2017/18 a total of 5,341 patients who were known to Somerset Partnership NHS Foundation Trust services died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 1243 in the first quarter;
- 1267 in the second quarter;
- 1440 in the third quarter;
- 1391 in the fourth quarter.

The range of services provided by the Trust means that a significant number of these deaths will have been expected as part of a patient's end of life or other care pathway.

The Trust has always maintained a robust process of investigating unexpected deaths. However, in line with national guidelines, from September 2017, a process of case record review has been started to look at a greater number of deaths.

In the period from 1 September to 31 December 2017, 24 case record reviews and 10 investigations were carried out in relation to deaths occurring during that period. These investigations were commenced as a result of the death being reported as a serious incident. Of these our investigations indicated that two cases (0.1%) were more likely than not to have been due to problems in the care provided to the patient.

The number of case record reviews and investigations undertaken on the period from 1 January to 31 March 2018 has not been finalised at the time of writing this report.

The deaths during this period relate to patients open to both mental health and community patients who died whilst under the care of the trust or within six months of their last contact. We are testing what is known as the 'structured judgement' review method for these investigations.

The case record review used a scale of harm in relation to problems during phases of patient care. The review of these cases has identified learning for our practice in relation to better end of life planning and prescribing of end of life medication.

Investigations undertaken into serious incidents that resulted in death has provided learning for the Trust relating to:

- better ways of including families and carers when agreeing plans of care for patients
- improving the process for GPs to raise urgent concerns, by simplifying the communication pathway for referral, and
- improving access to services from an attendance at NHS Emergency Departments when a patient is assessed as needing further mental health support.

Learning from any death is disseminated through Trust governance processes and includes local governance meetings, the Serious Incident Review Group and the Mortality Surveillance Group. Any identified changes to practice are agreed and escalated to be implemented Trustwide. We are using the information to support services and improve communication especially where there is multi-agency provision of care. Due to the recent testing of the case record review process we expect the quality of the information to improve even further but at the time of writing the actions and their impact on individual patient care or for service improvement is not yet fully clear for the individual cases.

No case record reviews or investigations have been completed during this reporting period which related to deaths which took place before the start of the reporting period as the process for case record reviews has been introduced only in this reporting period.

Medical Revalidation

Dr Andrew Dayani was Responsible Officer (RO) until he left the Trust in June 2017. Dr Dayani was succeeded on an interim basis by Dr Sarah Oke before Dr Stuart Walker took over as Chief Medical Officer in October 2017. Dr Walker was already RO for Taunton and Somerset NHS Foundation Trust (TSFT) and also took on the RO role for Somerset Partnership. Dr Sarah Oke continued as Deputy RO for Mental Health and performed the majority of RO duties for Somerset Partnership doctors on behalf of the RO. Dr Walker and Dr Oke regularly participated in regional RO Network events. Since Dr Walker became RO for both trusts, the revalidation teams from TSFT and Somerset Partnership have had regular meetings to begin to align practice.

Each RO has been supported by the Lead Appraiser, Dr Reenee Barton, and a team of six medical appraisers (Consultants and Specialty Doctors from a range of disciplines). Three of the appraisers were new to the team in 2017-2018.

Appraisers attended quarterly peer group supervision. Half the appraisal portfolios were formally audited in May 2017 and established appraisers had a 1:1 with the Lead Appraiser for quality assurance and professional development. Additional appraiser capacity has been established by the appointment of three new appraisers (subject to completion of training and job plan reviews). The number of appraisals completed by each appraiser in 2017-18 ranged between 8 and 11, which is within the recommended range of between 5 and 20 appraisals per appraiser.

Out of 71 appraisals due in 2017-2018, a total of 64 appraisals were undertaken and signed off. Two appraisals are awaiting sign-off, four appraisals have been postponed until 2018-19 due to long-term sickness absence and one new starter is having their 2017-18 appraisal at the start of the 2018-19 year, with their 2018-19 appraisal following in early 2019. The former CEO and Deputy RO both undertook external appraisals.

The RO made two positive revalidation recommendations to the General Medical Council (GMC) during 2017-18. Both were submitted on time. There was one request for a deferral to allow a newly appointed doctor time to gather more evidence.

Oversight of medical revalidation is the responsibility of the Medical Revalidation Steering Group. An annual report on Medical Appraisal and Revalidation was submitted to the Trust Board in July 2017. The Board subsequently made the required declaration of compliance to NHS England by the deadline of August 2017.

STAFF ENGAGEMENT

Engagement

We use a variety of methods to provide colleagues with information about the Trust, the NHS and any changes which may affect them and we have revised these as part of our joint work with Taunton and Somerset NHS Foundation Trust. This includes:

- Staff News – a weekly electronic newsletter which updates staff on activities across both Somerset and T&S Trusts and sharing lessons learned from incidents, complaints and audits;
- Senior Managers and Leaders' Away Days and cascade briefings to all teams;
- Chief Executive's Video Blog;
- Facebook and social media sites.

We have also reviewed our intranet this year, working with colleagues to ensure we provide information more effectively.

As part of our work around engagement we have introduced regular PULSE surveys for all teams and directorates to gain more detailed feedback linked to the national staff survey and Friends and Family Test.

Senior Managers continue to meet regularly with the Joint Executive Team members to discuss financial, performance, operational and other issues of importance at the Senior Managers Team meeting. Operational and Professional managers meet with the Chief Executive and the Executive Directors two to three times per year, to hear and discuss updates in relation to partnership working, our financial and clinical performance and any other relevant national and local issues. These meetings are also used to engage managers in the Trust's annual business planning process, particularly in identifying priorities for the future together with a range of consultative activity.

The Trust has formal mechanisms for engaging with staff. These include the Joint Management and Staff Side Committee (JMSSC), and individual supervision and appraisal. The JMSSC plays a key role in discussing issues which affect staff, and in formal consultation and negotiation with the Trust.

As we take forward our proposals for closer working with Taunton and Somerset NHS Foundation Trust we are establishing a joint communications team and will be reviewing our resource to support better engagement as the alliance and proposals towards merger proceed.

Staff Survey

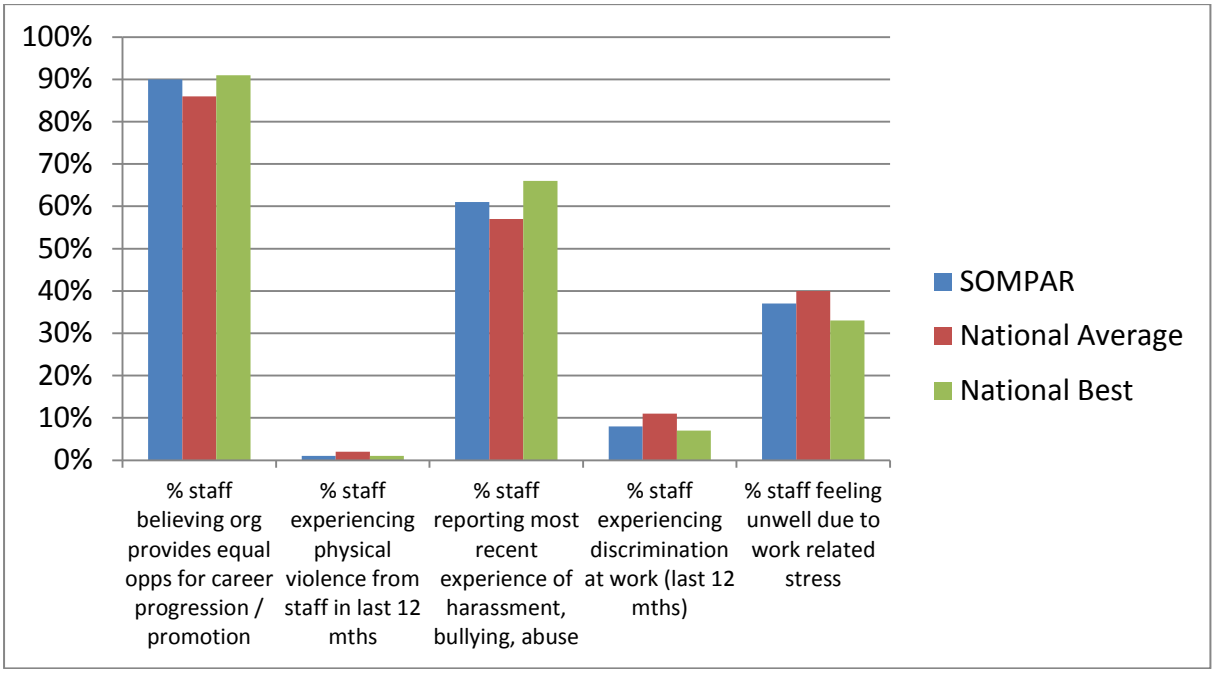
The 2017 staff survey was completed between September and December 2017 with a 40% response rate equating to feedback from 1471 colleagues, which was a decrease on the response rate of 46% in 2016 but is an above average response in respect of comparable Trusts.

The Trust's overall Staff Engagement score for 2017 was 3.79, which ranks Somerset Partnership NHS Foundation Trust at 15th position in a field of 29 combined Community and Trusts nationally. This score has improved from 3.77 in 2016 and this indicates a positive improvement in staff engagement.

TOP FIVE KFs

The top five areas where the Trust compares most favourably with similar Trusts are:

- % staff believing the organisation provides equal opportunities for career progression / promotion;
- % staff experiencing physical violence from staff in last 12 months;
- % staff reporting most recent experience of harassment, bullying, abuse;
- % staff experiencing discrimination in last 12 months;
- % staff feeling unwell due to work related stress.



BOTTOM FIVE KFs

The bottom five areas where the trust compares least favourably with similar trusts (Fig. 2, Fig. 3) are:

- effective use of patient / service user feedback;
- quality of appraisals;
- % staff working extra hours;
- % staff experiencing harassment, bullying and abuse from patients, relatives and the public;
- % staff reporting good communication between senior management and staff.

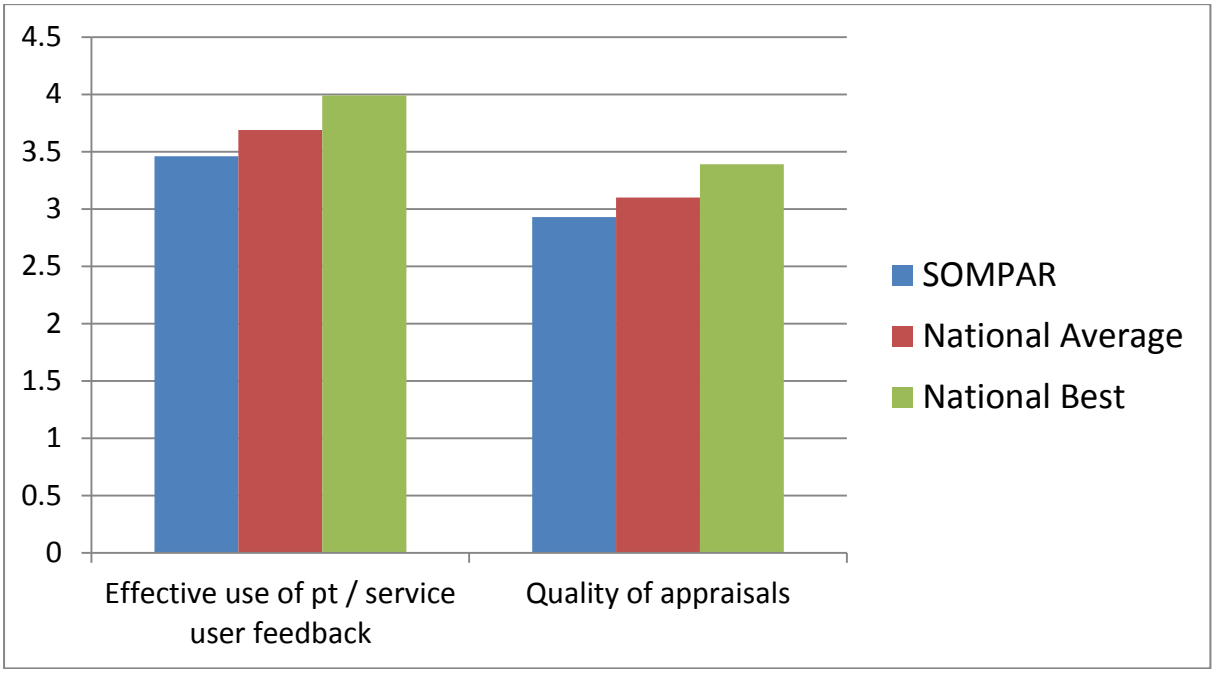
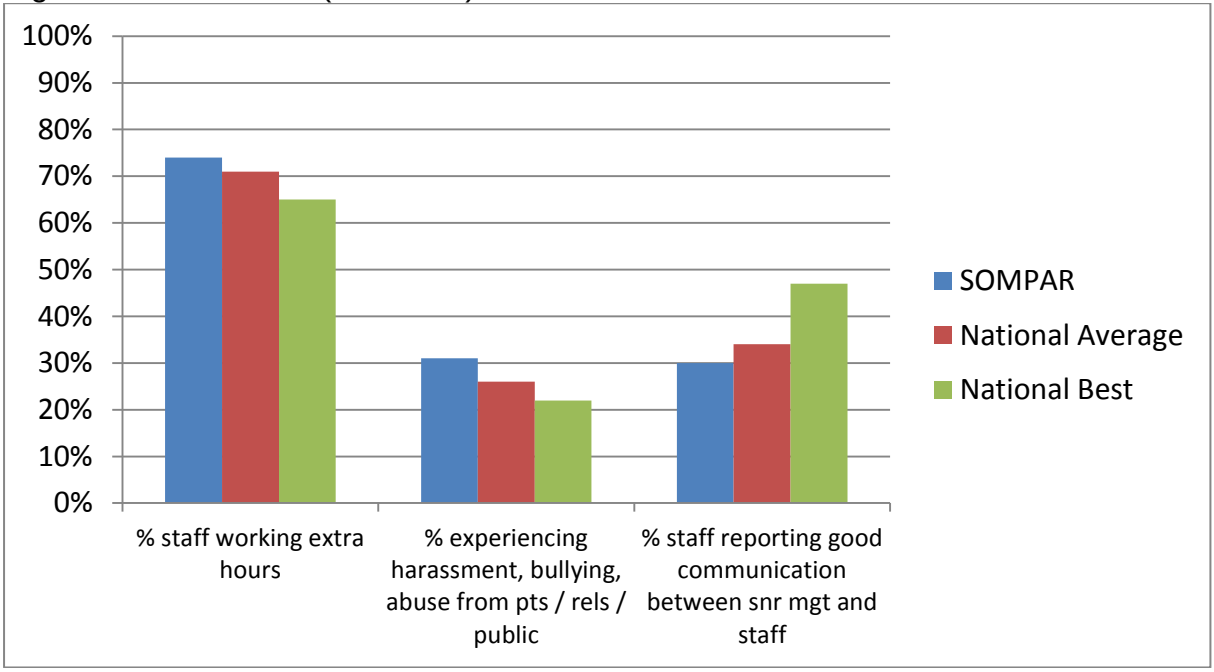


Fig. 2. Bottom five KF (1-5 score)



WHERE STAFF EXPERIENCE HAS IMPROVED

There has been statistically significant improvement in 3 KFs (Fig 4):

- staff confidence and security in reporting unsafe clinical practice;
- effective team working;
- fairness and effectiveness of procedures for reporting errors, near misses and incidents.

Fig. 4. KFs where staff experience has improved

WHERE STAFF EXPERIENCE HAS DETERIORATED

There is only one KF where staff experience has shown a statistically significant deterioration (Fig. 5, overleaf):

- Percentage of staff appraised in last 12 months.

.

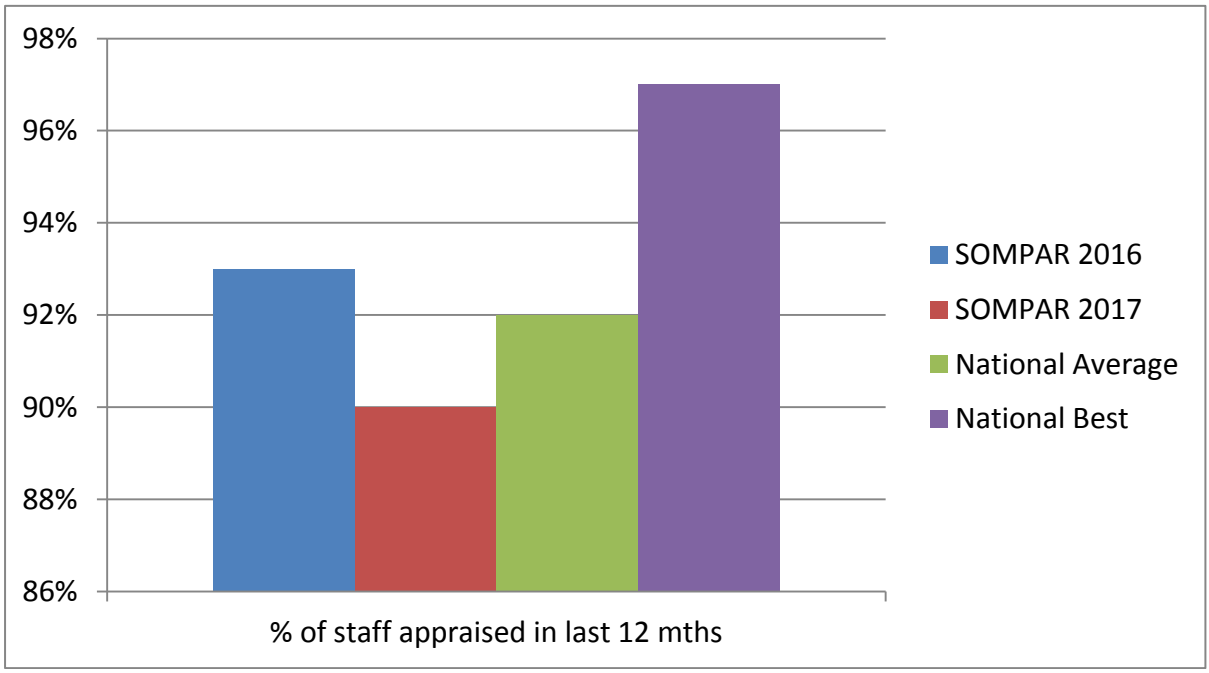


Fig. 5. Where staff experience has deteriorated.

In addressing these areas we have developed a People Strategy which is a joint strategy with Taunton and Somerset NHS Foundation Trust. The key themes

identified in the staff survey will inform actions to be delivered as part of that strategy:

1. THEME 1: APPRAISALS AND SUPPORT FOR DEVELOPMENT

- 90% of Somerset Partnership respondents reported having been appraised in the last 12 months. This has deteriorated since 2016. Appraisal quality and quality of non-mandatory training are unchanged since 2016, with the Trust scores being worse than the national averages for each KF.

People Strategy actions:

- **Review and align the Appraisal and Performance Review policies to introduce a consistent approach to appraisal**

2. THEME 2: EQUALITY AND DIVERSITY

- Somerset Partnership scored better than the national average for both of the KFs that contribute to this theme. In both cases, the score is very close to the national best.

People Strategy actions:

- Establish unified Leadership Development programme with opportunities open to all those who have management responsibilities for others

3. THEME 3: ERRORS AND INCIDENTS

- Results for witnessing incidents, errors and near misses are in line with the national average. Reporting of incidents was in line with the national average. Fairness and Effectiveness of reporting procedures was worse than the national average and staff confidence and security in reporting unsafe practice was average.

People Strategy actions

- **Introduction of the Freedom to Speak Up portal providing a completely confidential platform for colleagues to raise issues of concern. Training in having difficult conversations**

4. THEME 4: HEALTH AND WELLBEING

- Somerset Partnership has achieved average scores for KF18 (% attending work in last 3 months despite feeling unwell because they felt pressure) and KF19 (Org and management interest in and action on health and wellbeing). Somerset Partnership scored better than average for the percentage of staff feeling unwell due to work-related stress.

People Strategy actions:

- **The scores for wellbeing are reassuring. Roll-out of the Wellbeing Strategy and initiatives such as Wellbeing Month and the Wellbeing Conference will further raise awareness of this issue.**

5. THEME 5: WORKING PATTERNS

- The SOMPAR score for KF 15 (% satisfied with opportunities for flexible working patterns) is broadly in line with the national average. The percentage of staff working extra hours is worse than average. Neither score has changed significantly since 2016.

People Strategy actions:

- **The Wellbeing Strategy sets out actions to improve work- life balance issues**

6. THEME 6: JOB SATISFACTION

- Of six KFs, Somerset Partnership scores were average for four and worse than average for two (percentage of staff able to contribute towards improvements at work, satisfaction with level of responsibility and involvement).

People Strategy Actions:

- **Improvement of engagement through Questback and other communications mechanisms and developing skills of leaders in supporting high performance in teams.**

7. THEME 7: MANAGERS

- Somerset Partnership scores are worse than the national average in each of the three KFs. The score for each KF remains unchanged since 2016.

People Strategy Actions:

- **Leadership and management development. Roll-out of a web based tool for staff engagement using Questback portals. This will facilitate two-way communication between senior management and staff as well as facilitating communication across the entire staff cohort and within focussed staff groups.**

8. THEME 8: PATIENT CARE AND EXPERIENCE

- Somerset Partnership scored worse than the national average for each of the contributing KFs; with scores unchanged from 2016.

People Strategy actions

- **The reasons for lower scores in each of these areas are not immediately apparent, although there is considerable variance in scoring between different professional groups. More work will be required to better understand the underlying reasons. Since February 2018, groups of staff are undertaking 'Pulse Check' diagnostic surveys. It is intended that this will enable better understanding of staff concerns in specific areas.**

9. THEME 9: VIOLENCE HARASSMENT AND BULLYING

- Somerset Partnership results for all KFs have not changed since 2016, with 2 KFs scoring better than average, 2 KFs scoring average and 2 KFs scoring worse than average.

People Strategy Actions:

- **Work will need to be undertaken to reduce incidents of harassment, bullying and abuse from patients, relatives and public and to reinforce the need to report violence. Although direct comparisons with Acute Trusts are not necessarily beneficial, SOMPAR scored better than TST in this area, which may provide an opportunity to share examples of good practice / best practice to raise the standard across the Alliance.**

Future Priorities

Our principal priorities for 2018/19 are embedded within the Alliance People Strategy. The Alliance between Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust involves closer working between organisations with a combined substantive workforce of over 7,500 colleagues and a transient bank/temporary workforce of around 1,500 colleagues at any one time.

As the two organisations work closer together, ensuring that all of our colleagues delivering high class services to the people of Somerset are helped by a strategy that supports, engages, and develops them is critical. This People Strategy sets out how the Alliance will meet its strategic objectives that include:

• Recruit, retain and support an empowered workforce with a shared, collaborative and positive culture, to deliver high quality, cost effective care
• Work with partners to deliver a joined up workforce resourcing and skills strategy, to increase sustainability, reduce reliance on temporary staffing, and ensure that we recruit and retain the right staff

Our diverse workforce is paramount to delivering high quality care for the people of Somerset and this People Strategy sets out our ambitions and also the key challenges facing us during the next five years. Importantly it details the changes that need to be made to enable the organisation to move forward and adapt to the

changing environment of the NHS. It provides a long term strategic framework under which a number of more detailed projects will be developed to address specific challenges or development priorities. The ambitions within this strategy are scalable; therefore as further work progresses within the Somerset system, the strategy will evolve to support it.

The strategy is comprehensive and realistic, covering all the significant people aspects by taking advantage of the opportunities afforded by collaborative working between the two trusts and in forging a common culture. It is supported by more detailed department-led plans which have ownership within the different areas of both Trusts. Its development has been overseen by the Joint Executive Team, and the actions contained within it will be subject to regular review. A copy of the strategy can be found at http://www.sompar.nhs.uk/media/5823/alliance-people-strategy-2018-2021-v16-public.doc

PATIENT EXPERIENCE AND PUBLIC ENGAGEMENT

Engagement, Consultation, Patient and Public Involvement Activities, including Scrutiny Committees

Listening to our patients and their families is at the heart of all we do. We strive to provide the best care and treatment for our patients and hearing their stories is the best way for us to learn what is going well – and what can be improved.

The Trust has a variety of approaches to listening and learning from our patients, their families and carers: through the Friends and Family Test, PALS, social media, patient and carer groups, voluntary and community groups, surveys and research, engagement events and also through compliments letters and complaints.

Consultations

The Trust has undertaken two formal consultations during the year.

Lister House Partnership: Milverton Branch Surgery

The Trust ran a formal consultation to listen to local views about the future of primary care services at Lister House Partnership, which the Trust took on management of in September 2016. The practice comprised a main surgery Wiveliscombe and a branch surgery in Milverton. Due to a lack of GPs as well as changes in the way services are delivered, the Trust had to consider the closure of the branch surgery in Milverton.

In planning the consultation, discussions were held with local patient representatives and other local public representatives including local councillors. Consultation documents were written in plain English and explained the challenges and the preferred option and sought local views on these issues. A public meeting was held in the village hall at the start of the consultation period. This was attended by over 100 local residents.

The top three concerns about a potential closure were: transport and travel, the loss to the community, and the impact on an ageing population.

Following feedback from local patients and the public, the Trust is piloting local nurse-led clinics in the village community room for blood-pressure checks, assistance with prescriptions and hearing aid batteries. The Trust has also invested in local community transport to support patients to get to the surgery for appointments. A Village Agent has also been established to support with health and social care needs.

Community Hospitals: Temporary Winter ward Closures / nursing staff shortages

Due to ongoing challenges with the shortage of registered nurses across Somerset, and difficulty in recruiting new staff, community hospital beds in Shepton Mallet,

Chard and Dene Barton, were moved to other local community hospitals by the end of October 2017, to make sure enough staff are available for patients during winter.

The Trust held local meetings to listen to local people's views and respond to questions and concerns.

Due to the strength of feeling from local people, we undertook a formal consultation to gather views to inform the Board's review of the decision. The consultation asked for the views of the public on whether the temporary closures should continue in their current configuration if there are insufficient nurses to open the beds, what alternatives should be considered, and how the local community can be supported during the temporary closures.

331 surveys were returned and there were also submissions of correspondence from individuals and groups. Overall, respondents voiced opposition to the temporary closures and called for the closures to be reversed as soon as possible. Constructive suggestions were put forward for a renewed focus on recruitment of new staff and retention of existing staff. Local communities were consistent in supporting their local hospitals and staff as an important community asset: "local beds for local people."

Scrutiny Committees

During the year the Trust presented to the Scrutiny for Polices, Adults and Health Committee of Somerset County Council about the Sustainability Transformation Partnership, the CQC inspection, the proposals for the closure of the Milverton branch surgery and temporary ward closures in Dene Barton, Shepton Mallet and Chard community hospitals.

Engagement activity

Patient and Public Involvement (PPI)

During 2017-18 we developed our patient involvement work through our PPI Action Plan which encompasses the three domains which underpin our PPI Strategy: involvement at an individual, service and organisational level.

This Action Plan is monitored by our Patient and Public Involvement Group, which comprises Trust staff, Governors, voluntary sector representatives and representatives from Somerset Healthwatch. The PPI Group reports quarterly to the Council of Governors.

The Trust Patient and Public Involvement Best Practice Group meet quarterly and each service and division has completed a six-monthly 'PPI Workbook', compiling all their patient feedback into one document in order to capture learning and PPI activities.

Governors

As an NHS foundation trust we also rely on our membership and our Governors to ensure that the voice of the patient and the public is heard throughout our

organisation. Governors are encouraged to engage with their constituents – local people – and their feedback is reported to our Patient and Carer Involvement Group, which reports to the Board, as well as the Council of Governors. During the year, patients and carers have given talks to the Council of Governors about their experiences of our services.

The Governors' views were sought on the Quality Priorities for the year and local Healthwatch were also asked to provide comment.

League of Friends' Forum

The Friends' Forum was held twice during the year to invite all the Leagues to come together and share news and ideas: the Chief Executive addressed both meetings.

Excellent work is being done with volunteers in all hospitals. New projects include reading groups, patient wifi, aromatherapy, floristry and the funding for a specialist research post. Other projects include the provision of equipment such as exercise equipment and specialist beds and updates and improvements to hospital buildings.

Engagement with Healthwatch

We have engaged with Healthwatch Somerset during the year by keeping them informed of service developments and through regular meetings to discuss progress against our quality priorities. A representative from Healthwatch Somerset also sits on our Patient and Public Involvement Group.

New Support for Patients and Carers

Home First

The Home First project has helped hundreds of people return safely home earlier from acute and community hospitals.

As soon as someone no longer needs medical support in hospital, Home First allows people to leave hospital rather than waiting on the ward for care assessments and rehabilitation planning, which can take time. Instead they receive those assessments and support at home, or in a specialist unit or care home to help them get back on their feet. Since its launch, Home First has helped over 300 patients get back home, saving them an average of five days in hospital.

Psychiatric Liaison

A new Psychiatric Liaison service was launched across Somerset, helping people who have both acute physical care needs and mental health care needs. The service provides psychiatric assessment and treatment to those patients who may be experiencing distress whilst in hospital. They help everyone consider how best to meet both the mental and physical health needs of a patient.

The new service has specialist doctors and nurses providing 24/7 care. The service operates in both A&E and hospital wards, giving patients additional mental health

care to support the physical care they will be receiving in the hospital. A key additional benefit is to ensure that patients receive the right specialist mental health care that they need quicker, helping them to get home sooner and avoid admission to hospital.

Mental Health Service Users' Forum

The Trust has worked with commissioners in Public Health and the Clinical Commissioning Group to fund and establish a Mental Health Service User Forum for Somerset, via the Mental Health Hub which is a network of voluntary sector groups and charities that support mental health service users and carers. The Forum will meet during 2018-19. We hope that the Forum will be a valuable way of hearing the voices of mental health service users in relation to their experiences of our services.

Smokefree Somerset

The Trust worked towards becoming Smokefree across all its sites during the year. Following concerns raised by carers of people with lived mental health experience, two carers joined the Steering Group that helped drive this initiative forward in order to ensure that the right support was put in place across our mental health wards. Training, support and information were put in place for staff and for patients and the Trust became Smokefree on 1 January 2018.

Expressive Movement Therapy

Expressive Movement Therapy is an 'emotional rehabilitation' group which is funded by South Petherton Community Hospital's League of Friends. The group, which meets weekly, is run by a registered dance movement psychotherapist, who is also an experienced occupational therapist. The group provides stroke patients on Mary Robertson Ward in South Petherton Community Hospital an opportunity to discuss their shared experience of stroke, and participate in creative movement to express their feelings about their experiences. As this is primarily a movement-based group, the ability to verbally communicate is not required. Feedback from patients has been positive.

SHARE Project – new service for 11 - 18 year olds

The SHARE Project is a new three-year countywide project to improve the mental health and emotional wellbeing of our young people aged 11 to 18 years across middle and secondary schools of Somerset, including children attending Pupil Referral Units and Special Schools. The aim of the service is to promote good mental health and increase knowledge of tools to support those with needs, to upskill staff to identify early signs of emerging mental health conditions and to provide young people and their families seamless access to high quality evidence based interventions.

The service supports schools to develop Peer Mentoring Champions and parent drop-ins. The service provides access to Mental Health Liaison Workers and is co-located with our Child and Adolescent Mental Health team based at Foundation House in Taunton.

Service Improvements following Patient Survey Results/Comments/CQC Results

Patient feedback is central to our service planning and service improvements. Service feedback comes via comments received by our Patient Advice and Liaison Service, the Friends and Family Test and other patient involvement work.

We also use learning from patient surveys and patient experience benchmarking, driven by national programmes and also our own audit and survey programmes. This includes our annual community mental health patient survey.

Each service has its own record of patient and public feedback and how it uses this to improve services. A few examples are described below.

Chronic Fatigue Syndrome (ME) Service

This service used feedback from patients to improve the care pathway, by ensuring that patients have a written copy of the pathway so that they do not miss the opportunity to attend the whole service. Assessments are now being provided in a variety of community settings, in order to reduce the distance patients need to travel to access the service. Follow up sessions can be arranged via telephone or Skype as well as face to face and patients can contact the service via telephone or email.

Learning Disability Service Improvements

A national mental health and learning disabilities report published by the CQC recognised the improvements the Trust made following the CQC inspection in 2015. These improvements saw the Trust's rating for learning disabilities services rise from 'Inadequate' to 'Good', with 'Excellent' for its leadership.

One of the most important areas of change has resulted in improvements in the communication between managers and frontline staff. Staff reported that this greatly lifted their morale and meant they felt empowered to suggest changes to improve care. Improvements also included a more structured team, closer monitoring of patients' care plans and recording notes electronically rather than relying on a paper based notes. The service also set up a buddy system where staff skilled in particular areas could assist their colleagues and share their knowledge.

Following low responses for Friends and Family Tests, the service wrote an easy-read version for patients, which has resulted in improved response rates, positive feedback and real-time reporting of patient feedback.

Complaints

During the year 2017/18 we received 75 recorded complaints which is a decrease of 82 (52.2%) from 2016/17. Numbers of complaints received were significantly lower this year compared to last year, but this compared to an increase in enquiries dealt with through PALS registered as concerns. We have ensured that the complaints &

PALS processes have been widely advertised across the Trust by way of posters and leaflets.

Of the 75 complaints investigated, 8 were fully upheld, 36 were partially upheld, and 24 were not upheld. Out of the seven remaining complaints, three are still open (as Q4), one is out for external review, one is now being investigated as a SIRI, one complaint pending as waiting to hear from the complainant as to whether they would like to move forward, and the final one was withdrawn.

PALS enquiries

During the year 2017/18 we received a total of 2,728 PALS enquiries registered which is an increase of 4 (0.15%) from 2016/17.

The key themes that have emerged from PALS & complaints in the last year are summarised here and were:

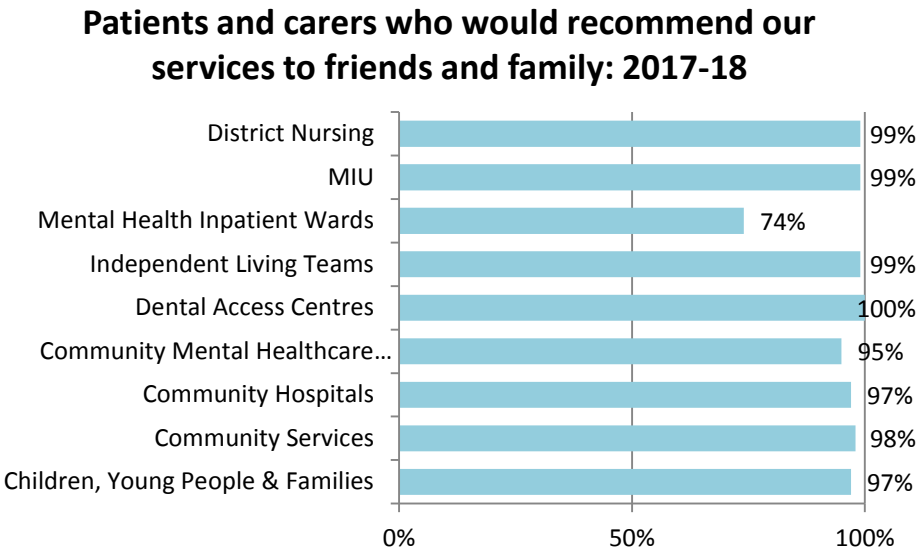
- Communication
- Service access and waiting times especially in relation to Talking Therapies (mostly via PALS)
- All Aspects of clinical care and treatment
- Attitude of staff

Key findings and actions have been shared with teams and colleagues across the Trust to improve the way we do things and we will monitor progress in these areas during the year by way of the Clinical Governance Group.

Friends and Family Test

The Trust receives over 700 Friends and Family test responses each month and these have provided a wide range of views and comments from patients and their carers about our services.

During 2017-18, 98% of respondents would be likely or extremely likely to recommend Trust services to their friends and family members. The chart below shows the results by service.



The word cloud below shows the most commonly used words in the comments provided by patients and carers returning the survey:

Real-time Surveys

This year we have joined with several other Foundation Trusts piloting the use of real-time patient surveys in two of our wards: mental health inpatient ward (Rydon Ward) and the community hospital inpatient ward at Minehead. By asking patients about their experience of our care, we have been able to listen to the experiences of the patients that we are looking after, and feeding back almost instantly to the staff members who are caring for them. Up to date patient feedback is also published and displayed on the ward itself.

Learning Disability Service Improvements

A national mental health and learning disabilities report published by the CQC recognised the improvements the Trust made following the CQC inspection in 2015. These improvements saw the Trust's rating for learning disabilities services rise from 'Inadequate' to 'Good', with 'Excellent' for its leadership.

One of the most important areas of change has resulted in improvements in the communication between managers and frontline staff. Staff reported that this greatly lifted their morale and meant they felt empowered to suggest changes to improve care. Improvements also included a more structured team, closer monitoring of patients' care plans and recording notes electronically rather than relying on a paper based notes. The service also set up a buddy system where staff skilled in particular areas could assist their colleagues and share their knowledge.

Following low responses for Friends and Family Tests, the service wrote an easy-read version for patients, which has resulted in improved response rates, positive feedback and real-time reporting of patient feedback.

Appendix 1

Statements from External Agencies

Healthwatch Somerset's Response to Somerset Partnership NHS Foundation Trust Quality Account 2017-18

Introduction

Healthwatch Somerset welcomes the opportunity to comment on the draft Somerset Partnership NHS Foundation Trust Quality Account for 2017-18. Somerset Healthwatch exists to promote the voice of patients and the wider public with respect to health and social care services. As of 1st October 2017, Healthwatch Somerset came under new management and are therefore are unable to comment on the previous year's activity as it relates to work carried out under the previous Healthwatch Somerset contract.

Although Somerset Healthwatch has not been directly involved in the development of quality priorities this year, we were invited to comment on a "long list" of potential priorities for 2018-19. We note that the topics were developed through wide consultation with staff, governors and patient representative groups. As in previous years the priorities were based on the Trust's review of quality performance and the identification of areas for improvement.

Priority Areas

Our comments on the six quality improvement priorities for 2018-19 are:

Improving the understanding and recording of capacity and consent

The challenges of effectively assessing and recording capacity and consent for patients across community health and mental health services has been highlighted as a national priority and was identified by the Care Quality Commission as an area for development following an inspection of the Trust services. We note that clinical audits of compliance for recording capacity and consent demonstrated some limited progress in the recording of assessments of capacity and a clear need for improved staff understanding of the Mental Capacity Act. We would support any action to increase the uptake of training and competency of Trust staff in the Capacity Act.

Reducing the incidence of Venous Thromboembolism (VTE) in inpatients

In previous Quality Accounts the Trust has focussed on falls and pressure ulcers and this is a further element of harm free care upon which we feel it is appropriate to focus this year. The focus this year is on reducing the incidence of venous thromboembolism (VTE) in inpatients, particularly as there has been a

cluster of VTE incidents during the past year in the Trust's inpatient units. This priority relates to the quality of nursing care and an understanding of how to prevent VTE occurring or awareness of where it is likely.

Reducing the incidence of pressure ulceration

Reducing the incidence of avoidable pressure ulcers when in hospital and community settings must be a priority for the Trust. Feedback from patients and carers has indicated continuing concerns about patients in care suffering from avoidable pressure damage. We note that the intention is to reduce the number of Trust acquired pressure ulcers, but it would be useful if targets were agreed in order to measure compliance with this important area of care.

Increasing the skill set of staff when caring for patients with dementia/cognitive impairment

We note that a priority for the Trust is to increase the capability of staff to recognise and respond to those patients with dementia/cognitive impairment. The Trust needs to ensure that all staff who care for patients are given appropriate training and the necessary skills to deliver the best possible care for those with dementia or cognitive impairment. Again, it would be helpful to agree targets to show the increase in the percentage of staff who are given this training.

Improved incident reporting

We commend action by the Trust to improve the reporting of incidents, and to reduce the number of incidence involving harm to patients or staff.

Improved personalised care planning

Personalised care planning remains a core task carried out to support the delivery of effective care. Feedback from the Care Quality Commission indicates that while care plans were in place they were not always personalised or understandable by patients and carers. We are also aware that feedback from patients and their carers indicates that effective involvement in personal care plans is important to them and remains a key focus of concerns. We commend action proposed by the Trust to monitor the number of patients with care plans and those whose care has been reviewed.

Summary

Overall, we feel that this is a balanced report covering both past performance and proposals for future priorities. We look forward to working with the Trust over the coming year to ensure that the experiences of patients, their families and carers are heard and taken seriously.

2 May 2018

Our Ref: SC/DR/HW/jf/725
Your Ref: PB/dg/qa

NHS
Somerset
Clinical Commissioning Group

18 May 2018

Wynford House
Lufton Way
Lufton
Yeovil
Somerset
BA22 8HR

Tel: 01935 384000
Fax: 01935 384079

Email: somccg.enquiries@nhs.net

Phil Brice
Director of Governance and Corporate Development
Somerset Partnership NHS Foundation Trust
2nd Floor, Mallard Court
Express Park
Bristol Road
BRIDGWATER TA6 4RN

Dear Phil

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST QUALITY ACCOUNT 2017/18

I am writing in response to your letter dated 23 April 2018 and the enclosed copy of the draft Quality Account 2017/18 for Somerset Partnership NHS Foundation Trust (the Trust).

During 2017/18 NHS Somerset Clinical Commissioning Group has monitored the safety, effectiveness and patient experience of health services that we commission from Somerset Partnership NHS Foundation Trust. We have welcomed the Trust's engagement in this process as part of quality contract monitoring. This provides a strong position for NHS Somerset CCG to comment on the Quality Account and the Trust's performance against quality improvement priorities.

Given that a number of the priorities have been carried forward to a second or third year the CCG would like the document to provide more detail so as to better understand what additional actions and measures will be put in place to support improvement in these areas during 2018/19. The CCG would like to better understand progress so far and in particular the challenges faced. The CCG also notes that a number of the performance measures and monitoring also appear to be the same and the CCG questions whether some review of these are necessary given the ongoing challenges in meeting the priorities.

NHS Somerset Clinical Commissioning Group Commissioner Statement

This is the sixth Quality Account integrating both community and mental health services and reflects the ongoing commitment by the Trust to provide high quality care across all commissioned services. As lead commissioner, NHS Somerset Clinical Commissioning Group (CCG) has monitored the safety, effectiveness and patient experience of health services at the Trust during 2017/18.

The Trust's engagement in the quality contract monitoring process provides the basis for the CCG to comment on the Quality Account including performance against quality

improvement priorities and the quality of the data included. The Quality Account document is well presented, easily accessible and demonstrates, alongside the Trust's report to Board (Quality Account Priorities 2018/19, March 2018) some consultation with local people and service users about priorities for 2018/19. We can confirm that the Quality Account provides a balanced view of the Trusts' achievements and as such is an accurate reflection of the quality of services provided.

The CCG regularly reviews the quality and safety of the services provided by the Partnership using a broad range of quality indicators and these are reported to the CCG at the Clinical Quality Review meetings (CQRM). These include the quality improvement priorities identified for 2017/18 as part of the Commissioning Quality and Innovation (CQUIN) framework agreed with the Trust.

The staff engagement section is detailed though would welcome reference to the Workforce Race Equality Scheme (WRES) findings within the NHS Staff Survey 2017. The CCG would also welcome reference to the survey's findings in relation to 'Violence, harassment and bullying' for employees with disabilities alongside those who have chosen 'prefer not to say' when asked to identify with a protected characteristic group. This is particular so, given the forthcoming Workforce Disability Equality Standard (WDES) due to come into force Autumn 2018.

The Trust has faced a number of challenges following the findings from the CQC inspection undertaken in September 2015. The CCG wishes to note the Trust's continual willingness to learn and improve services and this is reflected in: the outcome of the CQC's inspection of February / March 2017 (published June 2017) which rated Trust services as 'Good' overall with all services rated as 'Good' apart from Community Dental Services and Community Health Inpatient Services, both of which are rated as 'Requires Improvement'; the Trust's Community Mental Health Services for People with Learning Disabilities or Autism services moving from 'inadequate' (publication date: December 2015) to 'good' (publication date: June 2017) with leadership as 'outstanding'; and the Trust featuring as a case study in the CQC's March 2018 publication, 'Driving Improvements: Case studies from seven mental health trusts.' Our view is that the Trust provides, overall, good quality care for patients.

1 PATIENT EXPERIENCE

1.1 The Trust continues to demonstrate commitment to patient engagement and experience demonstrating a diverse range of engagement activities within the Quality Account. The CCG notes the decrease in complaints received but that data shows little change in Patient Advice and Liaison Service (PALS) activity. The CCG notes the work the Trust has undertaken during 17/18 in increasing carer involvement and support and particular the positive work that continues to take place in the Triangle of Care programme. The CCG also looks forward to receiving updates on the Trust's work in the Patient Experience Collaborative (in partnership with Northumbria Trust)

1.2 The Trust's approach to patient experience sets out the various conduits through which patients and carers are engaged, including PALS, surveys, social media and the Friends and Family Test and Patient groups. Although FFT feedback remains positive with 98% of respondents being likely or extremely likely to recommend Trust services to their friends and family members, the CCG notes the low response rate to the Community FFT when compared to peer average (Community Indicators Scorecard, March 2018). In

light of this the CCG would encourage the Trust to continue to look at ways to improve FFT response rates.

1.3 A further comment the CCG wishes to make is in relation to the Staff Survey 2017 where a key finding (KF32) noted that a lower proportion of staff, compared to peer group average, felt the organisation made effective use of patient / service user feedback. The CCG welcomes updates in the coming year about staff engagement and how staff members can be better engaged in how patient feedback is acted upon to support ongoing improvement in quality of services.

2 PATIENT SAFETY

2.1 The CCG acknowledges the challenges the Trust has faced this year with regards to nursing staff in community in-patient services and the decision to temporarily consolidate beds on the grounds of patient safety. The CCG continues to work with the Trust to monitor the situation, patient experience and impact on staff. The CCG also wishes to highlight the work the Trust has been undertaking in collaboration with Taunton and Somerset NHS Foundation Trust and the development of the Alliance's People Strategy to support staff recruitment, retention and skill development across the two organisations.

2.2 The CCG notes the increased reporting of patient safety incidents on the National Reporting and Learning Services (NRLS) compared to previous years. The latest report from NRLS shows significant change in the Trust's reporting rate per 1,000 bed days between April 2017 – September 2017 (32.86) compared to the same period in 2016 (18.90), with incidents being reported more timely with 5% of incidents being reported after 38 days during April 2017 – September 2017, compared to 96 days for the same period in 2016. This is a positive start ahead of the focus on incident reporting as one of the Trust's quality priorities for 2018/19.

3 CLINICAL EFFECTIVENESS

3.1 The Trust continues to display a strong audit function that has supported many of the quality improvement initiatives and identified areas for action over the year, with participation in all ten national clinical audits and all two national confidential enquiries relevant to the services they provide.

3.2 The CCG acknowledges that the format and content of the section comparing performance with national and trust averages is required as part of the NHS Improvement requirements for Quality Accounts. However, such information does not reflect the wider quality improvement work that is undertaken within the Trust. For example, the Trust has seen a changing nature in patient acuity over the year especially with the opening of re-ablement beds to support 'Discharge to Assess' patients. In response to this the Trust's Falls Best Practice Group reviews all incidents and learning from falls and shares organisational learning when identified. Where local learning is identified this is shared through the Falls Local Action Groups (FLAGs). In addition, local FLAGs consider local learning and have devised a number of small local quality improvement initiatives (Plan-Do-Study-Act cycles), which is then shared across sites. The Trust has also continued to develop the Activity Co-

ordinator role in wards, which has further supported falls reduction work in addition to supporting patients overall health and wellbeing.

3.3 The CCG wishes to highlight the positive work the Trust has undertaken in the 'Personalised Care and Support Planning' indicator within the Commissioning for Quality and Innovation (CQUIN) programme for 2017/18, which will complement the ongoing 'Improving Personalised Care Planning' quality priority. The Trust's work has demonstrated collaborative working across services within the Trust culminating in a Trust-wide event to share learning in April this year. Such collaboration continues throughout 2018/19 as both Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust join the Trust in developing this work both in-house and across the Somerset health system.

4 QUALITY IMPROVEMENT PRIORITIES FOR 2018/19

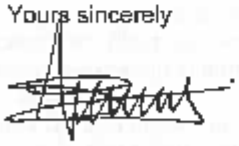
4.1 Somerset CCG supports the quality improvement priorities identified by the Trust for 2018/19. The Trust has selected a number of relevant quality priorities for the coming year accompanying this with a clear rationale as to why such priorities are applicable to the Trust, whilst incorporating both patient and CQC feedback. The CCG notes that one of the six priorities is a continuation from the previous year and a further two are continuations from the previous two years, with Performance Improvement Measures remaining the same.

4.2 The CCG welcomed the Quality Priority for 17/18 to 'Improve the understanding and recording of restraint.' The CCG continues to have concerns over the use of restraint, particularly prone restraint, and will continue to work with the Trust to better understand the measures being put in place to reduce use alongside increased, more detailed reporting.

4.3 The CCG further welcomes the Quality Priority for 2018/19: Reducing the incidence of pressure ulceration. The Trust has undertaken related work in relation to wound assessments as part of its Service Development Improvement work during 17/18 and the CCG looks forward to seeing how this quality priority progresses following this work and alongside the 2018/19 CQUIN developed in collaboration with the Trust around wound assessments.

Please contact me at the above address if you wish to discuss any of the above comments further.

Yours sincerely



Sandra Corry
Director of Quality, Safety and Engagement, Somerset CCG

Copy: Debbie Rigby, Deputy Director of Quality, Safety and Engagement, Somerset CCG
Nick Robinson, Chief Officer, Somerset CCG
Alison Henly, Chief Finance Officer and Director of Performance, Somerset CCG
Helen Weldon, Quality Improvement Manager (Quality Assurance)

APPENDIX 2

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

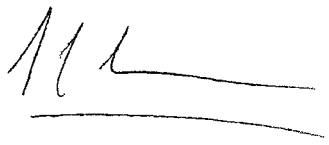
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017-18
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to March 2018
    - papers relating to quality reported to the Board over the period April 2017 to March 2018
    - feedback from the commissioners dated 18 May 2018
    - feedback from governors
    - feedback from Healthwatch Somerset dated 2 May 2018
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the National Patient Survey September 2017
    - the 2017 National Staff Survey
    - the Head of Internal Audit's annual opinion over the Trust's control environment presented at the Trust Audit Committee on 24 May 2018
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the

Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board 24 May 2018



Chairman

Chief Executive

APPENDIX 3

Performance Indicators Subject to External Audit

All information is taken from the Trust Electronic Patient Record.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Source of indicator definition and detailed guidance

The indicator is defined within the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring referral to treatment (RTT) standards can be found at http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Detailed descriptor

E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator

The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

Denominator

The total number of patients on an incomplete pathway at the end of the reporting period

Accountability

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-21content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format

Reported as a percentage

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care

Indicator description
The access and waiting time standard for early intervention in psychosis (EIP) services requires that, from 1 April 2016 more than 50% of people experiencing first episode psychosis will be treated with a NICE-approved care packagea within two weeks of referral. The standard is targeted at people aged 14-65. Detailed guidance can be found at:
https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf

Numerator
The number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.

Denominator
The number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package in the reporting period.

Indicator
Numerator divided by the denominator expressed as a percentage.

Patient Safety Incidents reported

Indicator description
Patient safety incidents reported to the National Reporting and Learning Service (NRLS).

Indicator construction
The number of incidents as described above.

A patient safety incident (PSI) is defined as ‘any unintended or unexpected incident(s) that could or did lead to harm for one or more person(s) receiving NHS funded healthcare’

Indicator format
Whole number

Safety Incidents involving severe harm or death

Indicator description
Patient safety incidents reported to the NRLS where degree of harm is recorded as ‘severe harm’ or ‘death’, as a percentage of all patients safety incidents (PSIs) reported

Indicator construction

Numerator: The number of patient safety incidents recorded as causing severe harm/death as described above

The degree of harm for PSIs is defined as follows:

‘severe’ – the patient has been permanently harmed as a result of the PSI, and ‘death’ – the PSI has resulted in the death of the patient

Denominator: The number of patient safety incidents reported to the NRLS

Indicator format
Standard percentage

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Somerset Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in aplace in Somerset Partnership NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Somerset Partnership NHS Foundation Trust is committed to providing high quality services in environments which are safe and secure for patients, visitors and staff.

The Board and I are committed to providing the resources and support systems necessary to deliver the Risk Management Strategy and Policy and to ensure that action is taken to address all identified risks which are assessed as unacceptable to the organisation.

In September 2016 the Trust established a Quality and Performance Committee. The Director of Strategy and Corporate Affairs has held executive level responsibility for risk management and is a member of the Quality and Performance Committee and attends all Audit Committee meetings.

The Trust's Risk and Compliance Manager has operational lead for developing the Risk Management Strategy and Policy, working with the Head of Corporate Business, and undertakes training and support sessions for managers, teams and staff in relation to risk assessment and risk management.

Risk management awareness training is available to the Trust Board and senior managers and the Trust's Risk Management Strategy and Policy is published on the Trust's website which is available to all staff.

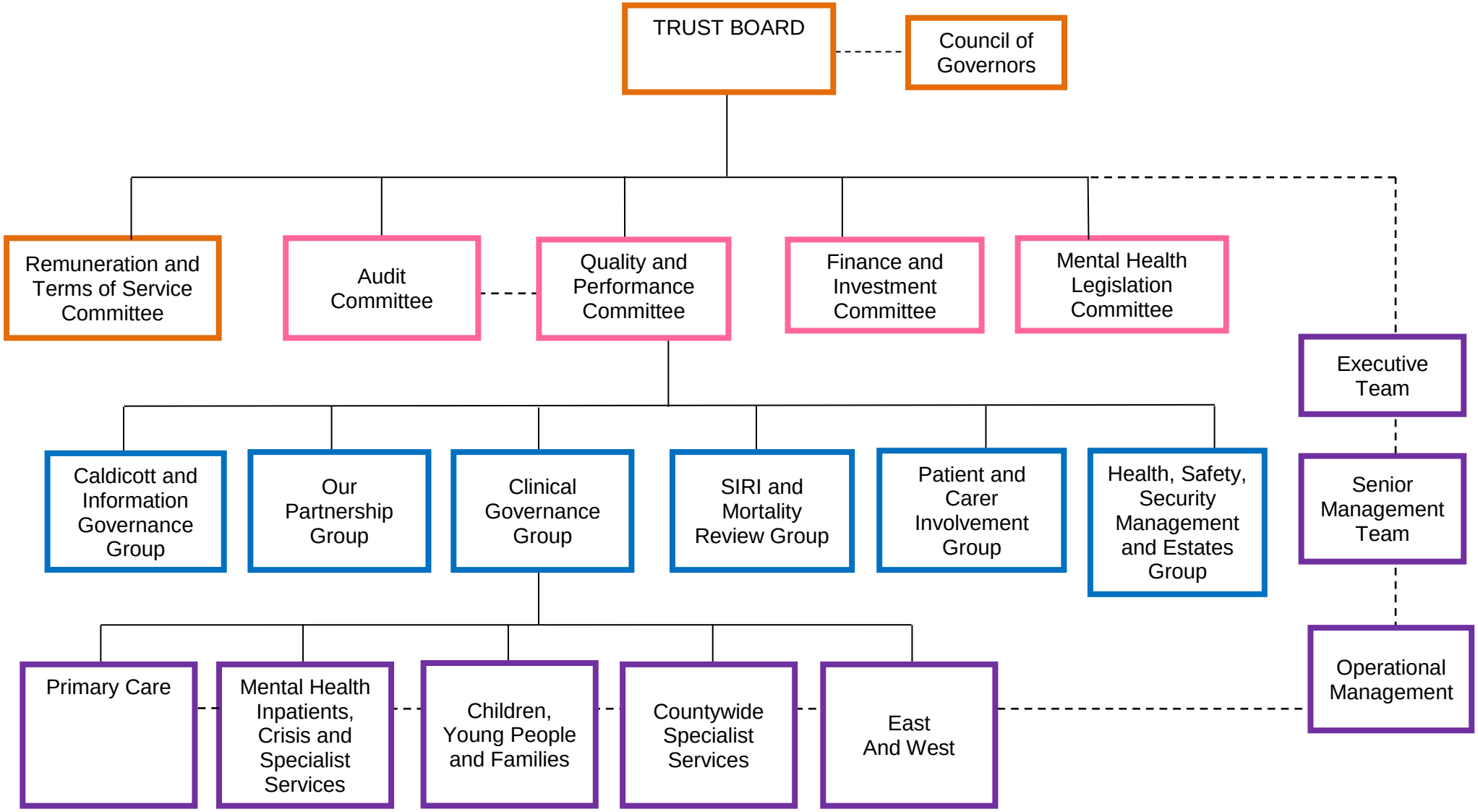
The Trust is committed to the sharing of good practice and learning from incidents, complaints and patient feedback and it does this through:

- individual appraisal and personal development planning for all staff;
- policies that encourage reporting and investigation of adverse incidents, near misses and complaints;
- root cause analysis of incidents;
- clinical and non-clinical audit;
- feedback on learning and good practice through a range of communications media, including the Trust newsletter What'sOn@sompar, the Trust intranet, Best Practice Groups, Away Days and team and service meetings

The risk and control framework

The idea of 'integrated governance' in the NHS combines the principles of corporate and financial accountability with clinical and management accountability and it moves towards a single risk management process which covers all the Trust's objectives, supported by a co-ordinated approach to collecting and analysing information about performance and risk.

For Somerset Partnership NHS Foundation Trust, the Board of Directors is responsible for overseeing the Trust's integrated governance programme. It delegates key duties and functions to its sub-committees. The diagram overleaf gives an overview of the integrated governance structure that operated within the Trust during 2017/18.


TRUST BOARD
Council of Governors
Remuneration and Terms of Service Committee
Audit Committee
Quality and Performance Committee
Finance and Investment Committee
Mental Health Legislation Committee
Executive Team
Caldicott and Information Governance Group
Our Partnership Group
Clinical Governance Group
SIRI and Mortality Review Group
Patient and Carer Involvement Group
Health, Safety, Security Management and Estates Group
Senior Management Team
Primary Care
Mental Health Inpatients, Crisis and Specialist Services
Children, Young People and Families
Countywide Specialist Services
East And West
Operational Management

There are four key committees within the structure that provide assurance to the Board of Directors. These are:

- Audit Committee;
- Quality and Performance Committee;
- Finance and Investment Committee;
- Mental Health Legislation Committee.

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

The Board of Directors receives regular reports from its sub committees on business covered, risks identified and actions taken. The minutes of each committee meeting are presented to the Board and reporting to the Board is based on the principle of exception reporting.

The **Audit Committee** provides objective assurance to the Board and management as to the adequacy and effectiveness of the organisation's risk management. The Committee is required to discharge a number of statutory duties and assists the Board with its responsibilities to strengthen and improve the risk management and controls framework. The Audit Committee considers the findings and recommendations of internal and external audit reports, counter fraud reports and monitors the Trust's Assurance Framework.

Membership of the Audit Committee comprises four Non Executive Directors.

The **Quality and Performance Committee** co-ordinates the individual operational strategies of the Trust to provide assurance to the Board in relation to the quality of the services it provides. The Committee receives reports covering three areas:

- risk, performance and quality assurance (including the Corporate Risk Register and Assurance Framework and quality and performance dashboards);
- external reports and reviews (including CQC, PHSO, internal and external audit, relevant national and regional reports);
- exception reporting from governance groups in relation to quality performance, based on identified key performance indicators.

The Quality and Performance Committee triangulates performance information with clinical governance (patient safety, clinical effectiveness and patient experience) and workforce data to provide oversight of the quality of trust services. The Committee oversees the Trust's Corporate Risk Register and will monitor progress against action plans to mitigate identified risks upon the register.

Membership of the Quality and Performance Committee comprises four Non Executive Directors, two of which are also members of the Audit Committee, together with all Executive Directors of the Trust.

There are six governance groups that report to the Quality and Performance Committee. They are:

- **Clinical Governance Group** which oversees the organisation's clinical governance agenda by ensuring that appropriate systems and processes are in place to provide evidence of continual improvement in the quality of services, and by safeguarding high standards of care through creating an environment in which excellence in clinical care will flourish. The group looks at areas such as serious incidents requiring investigation, safeguarding, clinical effectiveness, patient safety, patient experience, infection control and medicines management.

- **Patient and Public Involvement** which is responsible for the development and implementation of the Communications and Patient and Public Involvement Strategy, the Membership Strategy and the Equality Delivery System and will identify key annual performance indicators and risks relating to the delivery of those strategies and arising from patient and carer experience and public feedback.

- **SIRI and Mortality Review Group** which is responsible for the review and oversight of SIRI investigations and mortality reviews across the Trust and identifying risks and lessons learned from incidents within the Trust.

- **Our Partnership Group** which is responsible for staff and staff experience and oversees the development and implementation of an Organisational Development Strategy, workforce planning information, learning and development and staff experience, including the staff survey. This Group did not meet during the year and the Trust made the decision in year to establish a People Committee as a Board sub-committee in common with Taunton & Somerset NHS Foundation Trust which will oversee implementation of the People Strategy and identify key annual performance indicators and risks relating to the delivery of that strategy and arising from staff experience and feedback.

- **Caldicott and Information Governance Group** which is responsible for the Trust's compliance with areas such as data protection, freedom of information, Caldicott principles, records management and data quality.

- **Health, Safety, Security Management and Estates Group** which is responsible for overseeing the development and implementation of the Estates Strategy, the Health and Safety Strategy and the Security Management Strategy and will identify key annual performance indicators and risks relating to the delivery of those strategies.

The Quality and Performance Committee receives quarterly reports from the first four of these groups setting out areas of risk identified, actions being taken to address

and mitigate the risks and determines areas for which further assurance is required, together with exception reports from the Caldicott and Information Governance Group and the health, Safety, Security Management and Estates Group. These may be referred to the Audit Committee to request additional external assurance. The Quality and Performance Committee monitors all reports on Care Quality Commission inspections of the Trust services and the new Care Quality Commission Intelligent Monitoring Reports and any action plans arising from them; all reports of investigations undertaken by the Parliamentary and Health Service Ombudsman, the Information Commissioner, HM Coroner and the Health and Safety Executive and all action plans arising from them.

The **Finance and Investment Committee** acts in an advisory capacity to the Board. It comprises four Non-Executive Directors, the Director of Finance and Business Development, the Director of Strategy and Corporate Affairs, Deputy Director of Finance, the Head of Estates and Facilities and the Head of IM&T. The Committee focuses on the delivery by the Trust of its key financial targets, its management of capital and investment, including the IM&T and Estates strategies.

The **Mental Health Legislation Committee** was established in May 2016 to focus on compliance and monitoring of the Trust's approach to Mental Health Legislation, including the Mental Health Act, Mental Capacity Act and Deprivation. The Committee comprises two Non Executive Directors, the Medical Director, theChief Operating Officer, the Director of Strategy and Corporate Affairs, the Head of Division for Mental Health Inpatient, Crisis and Specialist Services and the Mental Health Legislation Co-ordinator.

The Trust's Risk Management Strategy and the Risk Management Policy set out responsibilities for all staff in relation to risk identification, risk assessment, risk management and risk handling.

The Trust's overall risk identification and management process represents a four stranded approach:

- a top down process, beginning with the Trust's strategic objectives and the Annual Operating Plan, which identifies the strategic risks to the Trust in achieving its plans and in remaining a viable organisation;

- a subjective process, emanating from the Board, its Committees and the supporting Governance Groups, in which process risks are identified and fed into the Business Assurance Framework if organisationally threatening;

- an objective process, emanating from internal and external audit of our processes and procedures; and

- a bottom up process, initiated by staff and team meetings, in which local risks are identified and recorded within directorate risk registers and escalated to the Corporate Risk Register in line with the Risk Management Policy.

All risks are assessed using a 5x5 likelihood v consequence matrix.

The Trust has developed a risk appetite that ensures that risks are considered in terms of both opportunities and threats. It is also influenced by the strategic objectives set by the Trust, individual programmes of work and the delivery of operational, quality and performance objectives across divisions, as well as the organisational and system changes identified above.

In line with the Trust's Risk Management Policy, we will, where necessary, tolerate overall levels of risk that are classified as moderate (12 or lower on the risk assessment matrix) where action is not cost effective or reasonably practicable.

The Trust will not normally accept levels of risk rated high (red) which are scored between 15 and 25, using the Trust's risk assessment matrix. The Trust ensures that plans are put into place to lower the level of risk whenever a high risk has been identified and the target risk (risk appetite) for each risk is recorded on risk registers and will regularly monitor the effectiveness of actions to achieve this.

Risks assessed as 'low' represent the lowest levels of threat and actions are limited to contingency planning rather than active risk management action. Such risks were recorded on local risk registers and their level monitored as part of local risk register review activities such as team and directorate meetings.

Risks assessed as 'moderate' represent moderate levels of opportunity/threat which may have a short-term impact on organisational objectives. Risks in this category are recorded onto directorate/divisional risk registers along with supporting action plans for risk treatment. All risks have been subject to ongoing review and monitoring via directorate and specific governance group meetings together with the status of controls in place and risk treatment.

A significant risk is defined as any risk which has been identified as being potentially damaging to the organisation's objectives. Significant risks are those assessed as having a risk rating of 15 or above. Risks rated at 15 and above are incorporated within the Trust's Corporate Risk Register and were subject to review and scrutiny at the bi-monthly meetings of the Quality and Performance Committee.

The Trust has had an Assurance Framework in place throughout 2017/18. The Assurance Framework is designed to provide the Trust with a method for the effective and focused management of the principal risks which may impact on the achievement of objectives.

The Trust's Assurance Framework sets out:

- strategic objectives;
- principal risks;
- mitigating controls;
- assurances on controls, including Board reports;
- gaps in control;

- gaps in assurance;

- action plans.

The Assurance Framework is linked to the Trust's strategic aims and objectives.

The highest risks to the Trust were cross-referenced with the Assurance Framework. The Assurance Framework was reviewed by the Quality and Performance Committee and Audit Committee at every meeting and issues of concern escalated to the Board.

The highest risks to the Trust are available for detailed scrutiny to both internal and external auditors. Action plans for the management of risks have been developed and monitored through the Governance Groups.

The Quality and Performance Committee reviews quarterly the levels of risk identified and the controls in place to manage them. During 2017/18the Quality and Performance Committee has undertaken a regular detailed review of all risks on the Corporate Risk Register and a 'deep dive' into individual risks which is recorded in the minutes of the meetings and submitted to the Board.

The Audit Committee reviews quarterly the levels of assurance that the Trust has that the systems of control are effective. A summary of significant risks (managed in year) is provided below:

- **Staffing Pressures** - The Trust has continued to identify risks in a number of services around staffing pressures arising from vacancies, sickness absence and increasing levels of demand. This has led to the temporary closure or reduction of some services during the year and the extension of waiting times (with agreement of the Trust's commissioners) in other services. In particular, we had to temporarily close Magnolia Ward, the Trust's dementia ward for older people in Yeovil, due to significant and sustained staffing pressures and have established a community based Independent Dementia Support Service (IDSS) to maintain services for these highly vulnerable patients. It was also necessary to temporarily close three community hospital inpatient wards at Dene Barton, Chard and Shepton Mallet, to ensure sustained provision of community hospital beds over the winter period in the face of significant staffing issues. An extensive recruitment campaign was maintained during the year, including continued overseas recruitment, but was not sufficiently successful and significant pressures remain. Detailed reports on staffing issues were presented to the Board during the year and a public consultation was undertaken in December 2017-January 2018 in relation to the temporary closure of the community hospital inpatient wards. These steps and the consultation has had an impact on the reputation of the Trust with significant public protest, a series of high profile media campaigns and legal challenges, all of which were managed in year.

- **Sustainability and Transformation Plan (STP)** – the difficult progress of the development and implementation of the Somerset STP has continued to present a number of risks for the Trust in terms of its impact on existing

strategic plans, capacity within the Trust to support the STP while maintaining focus on our core services, and the financial sustainability of the Trust within the wider Somerset health and social care system. The detail of the proposals for the STP have not yet been developed and much of its work has been superseded by the Somerset Clinical Commissioning Group's (CCG) development of a Health and Care Strategy which will be subject to widespread engagement and consultation over the next 18 months. Senior members of the Trust, including the Chief Executive, continue to occupy central roles in the STP Programme and during the year the Trust's Chairman has taken over the role of Chair of the STP Programme Executive Group. The delay in development of plans has had an impact on the Trust delivering some of its plans, particularly for mental health services, and this is being taken forward with the CCG. We will continue to ensure that the proposals align with our objectives for the delivery and sustainability of high quality, effective community health, mental health and learning disability services.

Finance

- Although the Trust achieved its control total this year, the system-wide risks in relation to the financial position have also been significant during the year and the Trust has worked with the CCG, Somerset County Council and partner organisations to manage these risks during the year. The year end position has been testament to the significant hard work of staff across the organisation to manage these pressures during the year.

The Quality and Performance Committee is responsible for monitoring the Corporate Risk Register and Assurance Framework. The Audit Committee is responsible for seeking assurance from key external agencies to ensure that the risk management processes and systems of internal control are being followed.

NHS Resolution handles negligence claims made against the Trust and works to improve risk management practices in the NHS.

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting, and the investigation of Serious Incidents. The Trust Board, through the risk management policy and incident reporting policy, promotes open and honest reporting of incidents, risks and hazards.

The Trust has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the Trust. All patient related incidents which have resulted in harm as well as 'near miss' incidents are reported onto the National Reporting & Learning System (NRLS) to aid national trend analysis of incident data. Twice yearly, the Trust receives a summary of activity benchmarked against that of other, similar organisations. Significant issues are escalated to the Quality and Performance Committee.

Care Quality Commission

The Trust is registered with the Care Quality Commission (CQC) for the provision of all of its services. During February and March 2017the Trust was subject to a follow up CQC inspection to assess progress against the action plan to address recommendations from the comprehensive inspection undertaken in 2015.

In addition, all the Trust's adult, children and young people's and older people's mental health inpatient wards were subject to Mental Health Act compliance reviews during the year.

The CQC inspected the following services:

- acute wards for adults of working age (including our Psychiatric Intensive Care Unit);
- forensic inpatient/secure wards;
- older people MH inpatient wards;
- community based mental health services for adults of working age;
- community Learning Disability Services;
- community Sexual Health Services;
- community Health inpatient services;
- urgent care services;
- community health services for adults.

CQC inspectors also conducted a Well Led inspection of the Trust's governance on 8 and 9 March 2017 during which they interviewed executive and non-executive members of the Board, Clinical Directors and senior managers.

CQC published its report of this inspection in June 2017.

The Trust achieved an overall rating of 'good" after an 18 month programme of improvement across all of our services. This included improvements in the services originally of concern to the CQC when it undertook its comprehensive inspection of our services in September 2015: community services for adults with learning disabilities and the Trust's district nursing services which are now both rated as good. The Trust is rated 'good' for the 'effective', 'caring', responsive' and 'well led' domains and 'requires improvement' for 'safe'
Of the nine of the Trust's core services that the CQC inspected, eight were rated as 'good' and one, community health inpatient services, as 'requires improvement'.

This means that 15 of the Trust's 17 core services are now rated as 'good'. The CQC also rated the quality of care across all services as good or outstanding and one service, community services for adults with learning disabilities, had their rating

for the quality of leadership move from the lowest rating to outstanding, the highest possible CQC rating.

As a consequence of the lifting of the current ratings arising from the 2017 inspection, the foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

Public engagement with risk management

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

- engagement with HealthWatch Somerset;
- the Council of Governors and Trust members are consulted on key issues and risks as part of the annual operating plan;
- Annual members' meeting;
- engagement with patient and carer representative groups, including the voluntary sector and Leagues of Friends;
- involvement with local Health Forums and Patient Participation Groups.

The Trust has an integrated Patient and Carer Involvement Group, which is chaired by the Director of Strategy and Corporate Affairs and comprises governors, operational staff, voluntary sector representatives and HealthWatch representatives. The PCI Group provides a quarterly report, including assessment of risks and issues, to the Board – as part of its Quality Report – and to the Council of Governors. During 2017/18 the Trust undertook public consultations on the proposed closure of a branch surgery at Milverton and on the temporary closures of three inpatient community hospital wards.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure all organisations' obligations under equality, diversity and human rights legislation are complied with. The Trust adopted the Equality Delivery System (EDS) when it was first published as its preferred way or reporting its equality information and objectives.

During 2017/18 the Trust reviewed its achievement against EDS2 and submitted a report to the Board on compliance. The Trust's delivery of its equality objectives for 2017/18 was monitored through its Patient and Public Involvement Group and the Board.

All Trust policies are impact assessed in respect of the nine protected characteristics and a tenth characteristic – Learning Disabilities – which the Trust has identified as part of its own strategy.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Quality Governance is a key element of the overall governance arrangements of the Trust. At the heart of the Trust's commitment to quality is a clearly defined quality strategy, a system of quality performance management, and a clear risk management process.

A Quality and Performance Report is presented to the Board on a monthly basis which highlights the key issues and trends, in relation to the provision of high quality care and patient experience.

The Chief Executive is ultimately accountable for the clinical governance processes in the Trust. During the year, this responsibility was delegated to the Director of Nursing and Patient Safety.

The Executive Directors are experienced in NHS settings and the Non-Executive Directors provide independent challenge and bring a range of senior level experience from the commercial and public sectors. They receive independent appraisals conducted by the Chief Executive and Chairman.

The Trust has an integrated structure for monitoring quality and safety including a committee structure which has executive and non-executive representation.

The Board monitors quality through the following processes:

- the monthly quality and performance report, including a quarterly report on complaints and patient experience;

- the reporting of serious incidents and learning;

- an in-depth review of quality is undertaken on a monthly basis by the Clinical Governance Group with key risks and issues reported to the Quality and Performance Committee and Trust Board.

The Trust has a comprehensive clinical audit work plan covering both national and local audits. Regular updates on clinical audit are reported to the Clinical Governance Group and Quality and Performance Committee.

A framework exists for the management and accountability of data quality.

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

The following key processes are in place to ensure that resources are used economically, efficiently and effectively:

- Scheme of Delegation and Reservation of Powers approved by the Board;
- Standing Financial Instructions;
- the monitoring of spend in year using budgets and variance analysis against actuals, with regular monthly financial monitoring reports produced for each operational unit or segment. An organisational report is produced monthly and reported to the Board, and discussed and reviewed in detail at the Finance and Investment Committee;
- robust competitive processes used for procuring non-staff expenditure items;
- cost improvement schemes, which are assessed for their impact on quality with local clinical ownership and accountability;
- strict controls on vacancy management and recruitment; and
- contract monitoring arrangements with key commissioners which provide evidence that key requirements have been delivered.

Staff have a responsibility to identify and assess risk and to take action to ensure controls are in place to reduce and or mitigate risks whilst acknowledging need for economy, efficiency and effectiveness of the use of resources. All budget managers have a responsibility to manage their budgets and systems of internal control effectively and efficiently. These processes are not only reviewed on an ongoing basis by managers themselves but are also examined by internal and external audit as part on their annual plans.

A local counter fraud specialist and procedures are in place for work related to fraud and corruption as required by NHS Protect.

The Trust Board gains assurance from the Finance and Investment Committee in respect of financial and budgetary management across the organisation and the Audit Committee, which receives reports regarding Losses and Special payments and the Write-Off of Bad Debts.

There are a range of internal and external audits that provide further assurance on economy, efficiency and effectiveness, including internal audit reports on creditors, financial reporting and budgetary control and cost improvement programmes.

The Audit Committee receives reports from directors of the Trust as well as internal audit, external audit and the Counter Fraud service on the work undertaken to review the Trust's systems of control including economy, efficiency and effectiveness of the use of resources. Action plans are agreed from these reports to improve controls where necessary.

Information Governance

Maintaining the security of the information that the Trust holds provides confidence to patients and employees. To ensure that security is maintained an Executive Director has been identified to undertake the role of Senior Information Risk Owner (SIRO). The SIRO has overseen the implementation of a wide range of measures to protect the data we hold and a review of information flows to underpin the Foundation Trust's information governance assurance statements and its assessment against the information governance toolkit. The review against the information governance toolkit provides assurance that these aspects are being managed and identified weaknesses addressed.

In March 2018 the Trust submitted its return for the 2016/17 Information Governance Toolkit v14.1 with an achievement of664% compliance with the minimum level 2 compliance against each standard.

In November 2017 the Trust commissioned an internal audit of the Trust's evidence of readiness for the implementation of the General Data Protection Regulations (GDPR) which delivered moderate assurance with some recommendations about the sufficiency and timeliness of evidence.

During 2017/18, the Trust reported no Level 2 incidents NHS Digital and the Information Commissioner.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The following steps were put in place during the year to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

- the information provided is subject to robust checking and scrutiny through the Trust's governance groups and the Senior Management Team meetings. The information is further integrated and tested by the Quality and Performance Committee and by the Board itself;

- the Trust ensures key areas of performance are included within the annual internal audit programme.

- data quality and information governance are reviewed through regular quarterly reports to the Caldicott and Information Governance Group and through Board monitoring of the Information Governance Toolkit;

- the priorities for the Quality Account were drawn from the Trust's own review of its quality performance and the identification of areas for improvement -

whether continuing existing areas or developing new themes from quality issues or feedback. These priorities were discussed with a wide range of people, including representatives of patients and carers and voluntary sector organisations, governors and members of the Trust, senior managers, staff and clinical teams and commissioners;

- this review took into account:

  - National patient safety and patient experience initiatives
  - Patient, carer and public feedback on Trust services
  - Learning from complaints, PALS, incidents and quality reviews
  - Patient surveys and patient satisfaction questionnaires
  - Feedback from Patient Safety Walkrounds and staff listening events
  - Feedback from external reviews of Trust services
  - Progress on last year's Quality Improvement Plans
  - Feedback on last year's Quality Account
  - Trust strategic objectives and service development plans

- performance against the priorities is monitored through the Trust's Quality Account Priorities which is reviewed quarterly and reported to the Quality and Performance Committee;

- performance is also reviewed quarterly with a representative from Healthwatch Somerset.

Governance and leadership

The Trust's integrated governance model uses a full range of corporate, clinical, and information governance assurances to inform the Board in relation to operations and compliance.

The board sub-committees are supported in this process by the six principal governance groups. In addition, under the revised governance arrangements, each of the five operational divisions within the Trust has their own devolved governance responsibilities and governance groups which report to the Clinical Governance Group. There are also sub groups dedicated to specific topics, such as the Best Practice Groups, which act as a vital part of the clinical audit cycle by bringing together clinical experts and leaders within the Trust to look at setting practice standards, which are informed by quality and best practice sources and advice, such as NICE guidance etc.

The various professions have a system of professional heads who are either Executive Directors (as in the case of medicine and nursing) or who are members of the Trust's senior management (therapies, social work etc.). Each of the professions has a professional forum (Senior Medical Staffing Group, Professional Nurse Advisory Group etc.).

The Trust monitors agreed performance and quality targets in a number of ways.

This information is scrutinised by the Board on a monthly basis as part of the Trust's Performance and Quality Reports, and the Finance and Investment Committee and Quality and Performance Committee of the Board scrutinise this information in significant detail, including the triangulation of data.

The Trust monitors quality issues alongside performance through the use of a Trust dashboard which is examined in detail at the Senior Management Team. This examines quality information including performance against CQUIN and local and national quality measures, across the Trust's services. This information is then disseminated to directorate, ward and team level.

The Trust works collaboratively with Somerset Clinical Commissioning Group as the main commissioner of Trust services to set effective and meaningful quality and performance targets and these are regularly monitored in joint quality contract meetings.

The Trust believes that these various levels and methods of leadership and governance relating to governance and quality are effective.

The Trust also consults broadly on the content of its Quality Accounts.

At a corporate level the various audits and quality reports feed into the Trust's assurance framework as forms of assurance against significant risks.

Policies

The Trust has a well-developed system for the formulation, updating, management and dissemination of policies. This process is managed by the Trust's Corporate Governance Team.

Policies go through a clear process. The formulation and update process is led by a named senior manager or senior clinician, who consults with appropriate governance, specialty, managerial and other groups.

In terms of dissemination, all Trust employees are advised to familiarise themselves with all policies and alerts to new or reviewed policies are published fortnightly in 'what's-on@sompar'. However, there are specific policies which are defined as essential for particular occupational and professional groups. The decision on which policies are allocated to which group is reached between the professional head and the Corporate Governance Team.

People and skills

The Trust utilises a number of systems to ensure that it has effective staff and skills capability but this has remained an area of challenge for the Trust during the year.

The Trust has a matrix of mandatory and recommended training, and attendance is closely monitored and reported to the Board. This matrix is updated regularly.

During 2017/18 the Trust has established an integrated People and OD function collaboratively with Taunton and Somerset NHS Foundation Trust and worked to develop a People Strategy, building on the Organisational Development Strategy developed by Somerset Partnership in 2016/17.

The Trust has a system in place for appraisal and the development of Personal Development Plans, which not only identifies learning and development needs related to the Knowledge and Skills Framework for individuals, but on a wider organisational scale, has supported the development of the People Strategy.

The Trust works closely with the universities and professional training bodies to ensure that the correct skills and development are in place for professionals in training who will come to work in the Trust, and those who currently work for the Trust but will require further development. These institutions include the Severn Medical Deanery, Bristol University, the University of the West of England, Plymouth University, Bournemouth University and the Royal College of Psychiatrists and the Royal College of Nursing.

Practice standards are used to identify expected practice and competence requirements for clinicians and those in support roles.

The Trust has identified staffing and staff engagement as key risk areas during the year and implemented a series of measures to address these. Actions included:

- regular safer staffing level reports;

- six monthly safer staffing establishment reviews;
- development of the People Strategy;
- development of a Health and Wellbeing Strategy;
- recruitment and retention plans;
- further review of skill mix and development of new roles;
- full staff survey published in February 2018;
- introduction of regular PULSE surveys for all staff to support greater interactive staff engagement.

Data use and reporting

Internal audit provides independent validation.

There are documented data quality procedures and policies, and weekly data quality meetings. Data quality issues are reported to the Caldicott and Information Governance Group, and to the Quality and Performance Committee and Trust Board as appropriate.

The Board has approved the content and derivation of performance dashboard items. The Quality and Performance Committee and the Board regularly reviews how each dashboard item is calculated and inclusions/exclusions from the calculations to assist with the triangulation of data.

Reports are provided to operational managers at ward and team level for validation.

Data quality was subject to internal audit during 2017/18 which identified areas for improvement. This included the establishment of a Data Quality Group to ensure that the Trust and its Board are receiving accurate and high quality data on which to base its assessment of performance.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and

Quality and Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- NHS Improvement Single Oversight Framework;
- Care Quality Commission inspection reports;
- Internal Audit reports;
- External Audit reports;
- CQC Intelligent Monitoring Reports;
- NHSLA assessments;
- Clinical audits;
- Patient and staff surveys; and
- Benchmarking information.

The Board is supported by the Quality and Performance Committee, Finance and Investment Committee, Mental Health Legislation Committee and Audit Committee who routinely review the Trust's system of internal control and governance framework, together with the Trust's integrated approach to achieving compliance with the Care Quality Commission essential safety and quality standards.

The Assurance Framework provides the Board with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. The Assurance Framework was subject to review and scrutiny at each meeting of the Quality and Performance Committee and Audit Committee, with a quarterly update provided to the Trust Board. The Assurance Framework and Corporate Risk Register were also subject to a positive internal audit review.

The Finance and Investment Committee focus on investigating the progress made in the delivery of financial plans and to undertake an in-depth analysis of financial information.

Clinical Audit is given a high importance. The annual clinical audit plan was agreed by the Clinical Governance Group and Quality and Performance Committee and reflects the priorities of the Board of Directors and national best practice, for example, NICE clinical guidelines, national confidential enquiries, NHS frameworks, high level enquiries and other nationally agreed guidance is taken onto account in the context of clinical services provided by the organisation. A quarterly review of progress against the plan is reported to the Clinical Governance Group. Any significant issues that emerge are reported to the Board of Directors and a service improvement plan or trust wide quality improvement plan is approved.

Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit Committee. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

Internal audit identified one area of critical risk and two areas of high risk for the Trust during the year. The area of critical risk related to agency staffing, particularly in relation to the Trust being unable to provide evidence of framework agreements or individual contracts being in place to agencies. This has been addressed since the year end. The high risk audit findings related to:

- the timeliness of completion and reporting of serious incident investigations;

- the monitoring on some wards of drug usage.

The Head of Internal Audit Opinion was issued for 2017/18 was issued as Major Improvement Required. The opinion states:

“Our opinion is based on:

- All audits undertaken during the year.
- Any follow up action taken in respect of audits from previous periods.
- Any significant recommendations not accepted by management and the resulting risks.
- The effects of any significant changes in the organisation’s objectives or systems.
- Any limitations which may have been placed on the scope or resources of internal audit.
- What proportion of the organisation’s audit needs have been covered to date.

Major improvements are required to improve the adequacy and effectiveness of governance, risk management and control relating to agency staffing processes. Since the year end, we have been provided with evidence which shows that the Trust is taking action in response to this risk. At the date of this report, based on the evidence provided, the critical risk identified has been reduced. Had this action been taken during the year we would have concluded that the control environment was generally satisfactory with some improvements required.”

Conclusion

The Annual Governance review has identified significant control issues in respect of the Head of Internal Audit opinion in relation to the critical risk rated report in relation to agency staffing.

Signed.....

Chief Executive Date: 24 May 2018

KPMG

External Audit Report

(Quality Report)

Somerset Partnership NHS Foundation Trust

—

24 May 2018

I confirm that this is the final version of our ISA 260 Audit Memorandum relating to our audit of the 2017/18 quality report and quality accounts for Somerset Partnership NHS Foundation Trust. This document was discussed and approved by the Trust's Audit Committee on 24 May 2018.

.....

Jonathan Brown

Senior statutory auditor,

for and on behalf of KPMG LLP,
Chartered Accountants
66 Queen Square, Bristol, BS1 4BE

24 May 2018

Our audit opinions and conclusions:	
Quality Reports (content): clean	Quality Report (indicators): clean

Content

The contacts at KPMG in connection with this report are:

Jon Brown
Partner

Tel: 0117 905 4362
jonathan.brown@kpmg.co.uk

Duncan Laird
Senior Manager

Tel: 0117 905 4253
duncan.laird@kpmg.co.uk

James Woolway
Assistant Manager

Tel: 0117 905 4283
james.woolway@kpmg.co.uk

Important Notice

This report is presented under the terms of our audit engagement letter. Circulation of this report is restricted. The content of this report is based solely on the procedures necessary for our audit. This report is addressed to Somerset Partnership NHS Foundation Trust (the Trust) and has been prepared for your use only. We accept no responsibility towards any member of staff acting on their own, or to any third parties. The National Audit Office (NAO) has issued a document entitled Code of Audit Practice (the Code). This summarises where the responsibilities of auditors begin and end and what is expected from the Trust. External auditors do not act as a substitute for the Trust's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Basis of preparation: We have prepared this External Audit Report (Report) in accordance with our engagement letter dated 08 May 2017.

Purpose of this report: This Report is made to the Trust's Audit Committee (and for the quality report work we will share the findings with governors) in order to communicate matters as required by International Audit Standards (ISAs) (UK and Ireland), and other matters coming to our attention during our audit work that we consider might be of interest, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone (beyond that which we may have as auditors) for this Report, or for the opinions we have formed in respect of this Report.

Restrictions on distribution: This Report is subject to disclosure restrictions as set out in our Engagement Letter.

Limitations on work performed: This Report is separate from our long form audit report and does not provide an additional opinion on the Trust's financial statements, nor does it add to or extend or alter our duties and responsibilities as auditors. We have not designed or performed procedures outside those required of us as auditors for the purpose of identifying or communicating any of the matters covered by this Report. The matters reported are based on the knowledge gained as a result of being your auditors. We have not verified the accuracy or completeness of any such information other than in connection with and to the extent required for the purposes of our audit.

Status of our audit: Our audit is substantially complete, however matters communicated in this Report may change prior to signing of our audit report. We will provide an oral update on the status of our audit at the Audit Committee meeting but would highlight the following work is still outstanding:

- Quality Accounts - Final review of the quality accounts/ report

KPMG

Quality Report

Quality Report

Conclusion on content of quality report

Subject to carrying out our final checks to ensure you have reflected our comments in the quality report and reviewing changes made by the Trust after the date of this report, we are satisfied that there is sufficient evidence to provide a limited assurance opinion on the content of the quality report.

Work performed and findings

We consider two criteria:

- Review of content to ensures it addresses the requirements set out in the Detailed Requirements for Quality Reports for Foundation Trusts in 2017/18 issued by NHSI; and
- Review of content in the quality report for consistency with other information specified by NHSI.

Our findings are set out below:

Issue considered	Findings
Inclusion of all mandated content	The content of the quality report presented for audit was accurately reported in line with the quality report regulations.
Are significant matters in the specified information sources reflected in the quality report and significant assertions in the quality report supported by the specified information sources?	We identified that the Trust's quality report reflected its significant matters, relevant to the selected priorities from the specified information sources. • Significant assertions in the quality report are supported by the relevant information sources; and • Significant assertions in the draft of the quality report were supported by the specified information sources.

Quality Report

Audit of indicators within the quality report

We carried out work on two mandated indicators, which require a public opinion, chosen by the Trust from a list of three available indicators as specified by NHSI in its guidance:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral

In addition, we carried out work on a locally selected indicator chosen by your Council of Governors. The indicator selected was the Patient Safety Incidents Reported by the Trust. This indicator is not subject to a limited assurance opinion.

Conclusion

Our work on the two mandated indicators has concluded that there is sufficient evidence to provide a limited assurance opinion in respect of Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period and Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral. For the local indicator, Patient Safety Incidents Reported, we have concluded that if required we would be in a position to provide a limited assurance opinion.

Please note that the extent of the procedures performed is reduced for limited assurance. The nature of the procedures may be different and less challenging that those used for reasonable assurance. Therefore, our work was not a reasonable assurance audit of either the performance indicators or the processes used to collate and report them.

Results of our work

We have set out overleaf the key findings from our work as described above in relation to the two mandated indicators and the locally selected indicator. In reaching our conclusions we required to have assessed the design and operational of the systems of control over the data against the six data quality dimensions defined by the NAO. In reaching our conclusion we have assessed these arrangements to consider whether they can be graded as:

- **Green**: No improvement to achieve compliance with the dimensions of data quality noted.
- **Amber**: Opportunities to achieve great efficiency or better control in compliance with the dimensions of data quality noted.
- **Red**: Concern that systems will not achieve compliance with one or more aspects of the dimensions of data quality and therefore a limited assurance opinion cannot be provided.

Quality Report

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Mandated Indicator: Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways Performance target: 92% Performance recorded in Quality Account: 99.3%					
Accuracy	●	●	The data collected is in line with the NHSI guidance.	The clock starts on the day that a referral from a patient's GP or dentist is received by the Trust. It ends on the day of treatment, or discharge where patients are discharged without treatment. The date of first treatment is the date on which the clock stops, and any follow up treatment or subsequent appointments are not included within the 18 weeks. As the Trust reported that performance for the year exceeded the target, we selected a sample of 25 items to test. Each patient's details were traced back to the RiO system. We identified the date that the patient had been referred. Further inspection was then made to identify if that patient had undertaken their procedures at year end. If not, we identified if they were included in the 'patients on open pathways at year end Metric' in the quality accounts. No issues were noted with the testing performed above.	We have not come across any indications that data for this indicator is not produced in line with national guidance.
Completeness	●	●	No issues over completeness of data were noticed. We obtained the data set for each month which was consistent with the system and with the overall quality account metric recorded.		
Relevance	●	●	The data used is in line with the NHSI guidance.		
Reliability	●	●	The data is reviewed by a team of data validators before the report is created each month. In addition, the Trust is providing ongoing training to all those who are responsible for inputting data into the system, encouraging them to make use of on-going validation, so that errors in the data be picked up as soon as possible.		
Timeliness	●	●	The clock start and stop points are clearly defined, and sufficient training has been given to those who use the system. Periodic review of PAS data is conducted by the information department, during which any discrepancies over discharge or readmission dates would be discovered. Performance is reported in each Performance Report to the Board.		
Validity	●	●	A team of validators review the data before the report is drawn from RiO, linking it back to the data on patient records and investigating any discrepancies.		
Overall	●	●	The information provided was complete and assessed as accurate.		

Quality Report

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Mandated Indicator: Early intervention in psychosis (EIP) Performance target: 50% Performance recorded in Quality Accounts: 65.7%					
Accuracy	●	●	The data collected is in line with the government guidelines however, due to the limitations with Rio and its inability to maintain a historic record of each patient, the process is very manual which consequently increases the risk of inaccuracy within the data.	Once psychosis is first recognised in a patient, the relevant staff members fill out the EIP checklist on RiO. This includes a checklist detailing which NICE-approved care packages the patient has received. These data entries produce a report which looks at waiting times for EIP patients and their relevant NICE-approved packages to check against the two week required metric. As the Trust reported that performance for the year exceeded the target, we selected a sample of 25 items to test. We followed each patient number from the monthly data downloads to the cumulative report and compared the details with Rio. No issues were noted in the testing performed.	We have not come across any indications that data for this indicator is not produced in line with national guidance.
Completeness	●	●	As per operational rules, all hospital staff are required to document indicators of Psychosis on a checklist within RiO. This includes a checklist for NICE-approved healthcare packages. As this information is downloaded straight from RIO, we have assurance on its completeness.		
Relevance	●	●	The data used is in line with the requirements laid out by NHSI guidance and for the required reporting to UNIFY.		
Reliability	●	●	Standard reports are used to extract the data.		
Timeliness	●	●	The main cumulative report is updated every 24 hours. Performance is reported to the Board on a monthly basis by the team.		
Validity	●	●	Information team staff get adequate training on the RiO system. Data is recorded and double-checked with relevant clinicians which gives an extra layer of validity.		
Overall	●	●	We did not identify any issues relating to the six specified dimensions of data quality in relation to this indicator that would impact our overall opinion.		

Quality Report

Design of system and processes and operation				Results of our sample testing	Conclusion reached
Data quality dimension	**Design**	**Operation**	**Commentary on ratings**		
Local Indicator: Patient Safety Incidents reported Performance target: N/A - Total Quantity Performance recorded in Quality Account: 4,180					
Accuracy	●	●	Data is collected through clinicians and healthcare assistants through the DATIX system. (In addition to this, anyone can submit a DATIX form). The data received from the Trust was agreed to the DATIX system in full.	Data is collected through various sources at the Trust and is passed electronically or in paper copy to the Risk team who monitor the DATIX inbox and system. Forms are investigated depending on their level of consequence/ recurrence and forwarded to relevant levels of senior management. Any serious incidents would be recorded on the NHS England serious incident reporting and monitoring system. We selected a sample of 25 items due to the recurring nature of the data collection. The testing involved reviewing the incident cases, ensuring that relevant documentation had been filled out, appropriate investigation had taken place if needed, and that the incident had been logged accurately on the DATIX system and feeds through accurately to the Quality accounts. No issues were noted in the testing performed.	We have not come across any indications that data for this indicator is not produced in line with the Trust's definition and local guidance. If we had been asked to provide a limited assurance opinion over the local indicator, we would have been able to do so.
Completeness	●	●	There is inherent subjectivity regarding total completeness of all incidents on Trust sites due to the nature of what is being reported. The DATIX system ensures that all reported incidents are summarised and reported monthly to NRLS. All serious incidents which are inherently included in the total list of incidents are captured by Doctors/ Coroners who communicate directly with the Risk team.		
Relevance	●	●	The data is relevant for the reporting measure.		
Reliability	●	●	The data is reliable as all incidents included within the year in the breakdown total to the incidents reported in the QAs. The risk team have the relevant, appropriate knowledge to perform investigations into cases and summarise a complete data set for reporting to NRLS.		
Timeliness	●	●	Data is reviewed on a daily basis by members of the risk team.		
Validity	●	●	More than one person is trained to review cases and to request/ complete data from DATIX. This reduces the risk of inaccurate/ incomplete reporting.		
Overall	●	●	We did not identify any issues relating to the six specified dimensions of data quality in relation to this indicator that would impact our overall opinion.		

kpmg.com/socialmedia

kpmg.com/app

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

We have been engaged by the Council of Governors of Somerset Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of Somerset Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated May 2018;
- feedback from governors, dated May 2018;
- feedback from local Healthwatch organisations, dated 02 May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated September 2017;

- the latest national staff survey, dated December 2017;
- Care Quality Commission Inspection, dated 01 June 2017;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated March 2018; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Somerset Partnership NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Somerset Partnership NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may

change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Somerset Partnership NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
Bristol
BS1 4BE

24 May 2018

Somerset Partnership NHS
NHS Foundation Trust

ANNUAL ACCOUNTS

2017/18

Somerset Partnership

CONTENTS

FOREWORD TO THE ACCOUNTS

Independent auditor's report

TO THE COUNCIL OF GOVERNORS OF SOMERSET PARTNERSHIP NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion on the financial statements is unmodified

We have audited the financial statements of Somerset Partnership NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Tax Payers' Equity, Statement of Cash flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of the Trust's income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

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

.

Overview		
Materiality: Trust financial statements as a whole	£3.4m (2016/17:£3.3m) 2% of total revenue (2016/17: 2%)	
Risks of material misstatement		**vs 2016/17**
Recurring risks	Valuation of Land and Buildings	◀▶
	NHS Income and NHS receivables	◀▶

Key

◀▶ Risk level unchanged from prior year

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the key audit matters, in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion . These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon , and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

	The risk	Our response
Land and Buildings (£115.6 million; 2017: £109.8m) *Refer to page XX (Annual report), page X (accounting policy) and page XX (financial disclosures).*	**Valuation of Land and Buildings:** Land and buildings are initially recognised at cost. Non-specialised property assets in operational use are subsequently recognised at current value in existing use (EUV). Specialised assets, where a market value is not readily ascertainable, are subsequently recognised at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property (MEAV). An impairment review is carried out each year to ensure that the carrying amounts of assets are not materially different from their fair/current values, with a full valuation every five years and an interim desktop valuation after three years, performed by an independent valuer. Desktop reviews were performed as at 31 March 2017 and 01 April 2017, with a full revaluation performed as at 1 April 2016. There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation of the asset. In particular the DRC basis of valuation requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site.	**Our procedures included:** • **Assessing Valuer's credentials**: We assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the information provided to the Trust in 2017/18, to inform its assessment of market value movements, for consistency with the requirements of the NHS Group Accounting Manual; • **Test of detail:** Agreeing the information provided to the valuer by the Trust to underlying records of the estate held; • **Benchmarking assumptions:** Critically assessing the calculation of market value indices movements completed by the Trust, including a re-performance of this calculation to confirm that no material movements in the value of the land and buildings assets are indicated; • **Test of detail:** Critically assessing the Trust's formal consideration of indications of impairment and surplus assets within its estate, including the process undertaken and the adequacy of the decision outcomes as a result of the process; and **Our findings** • We found the resulting valuation of land and buildings to be balanced

2. Key audit matters: our assessment of risks of material misstatement (cont.)

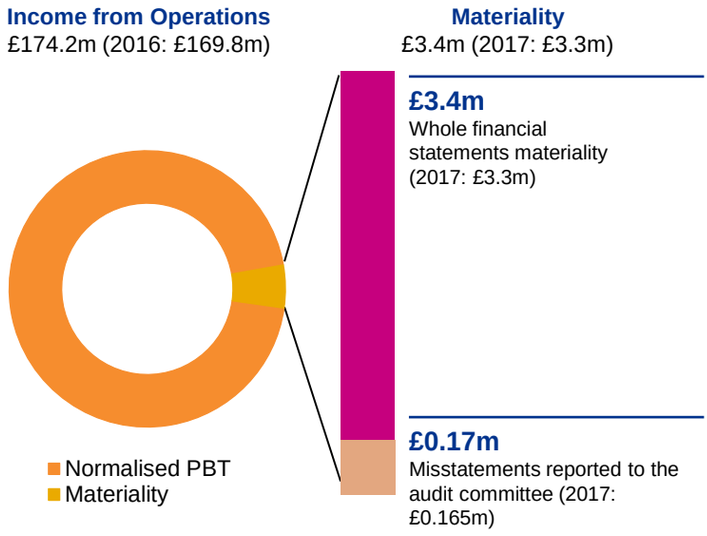
	The risk	Our response
NHS income and NHS receivables NHS income (including STF Income): (£158.9 million; 2017: £155.6m) NHS Receivables: (£4.6 million; 2017: £3.1m) *Refer to page XX (Annual report), page X (accounting policy) and page XX (financial disclosures).*	**Subjective estimate** Of the Trust's reported total income, £148.4 million (2016/17, £146.2m) came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). Income from CCGs and NHS England makes up 91% of the Trust's income. The majority of this income is contracted on an annual basis, but actual income is based on completing the planned level of activity and achieving key performance indicators (KPIs). An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £0.3m are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. **Accounting judgment** In 2017/18, the Trust received strategic transformation funding (STF) from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Trust was allocated £2.87m of transformation funding. This includes a year-end incentive payment of £1.23m.	**Our procedures included:** • **Test of detail:** We agreed commissioner income to the signed contracts and selected a sample of the largest balances to agree that they had been invoiced in line with the contract agreements and payment had been received. • **Test of detail:** We inspected invoices for material income, in the month p rior to and following 31 March 2018 to determine whether income w as recognised in the correct accounting period, in accordance with the amounts billed to corresponding parties; • **Test of detail:** We agreed that the levels of over and under performance reported were consistent with contract variations and challenged the Trust's assessment of the level of income where these were not in place by considering our own expectation of the income based on our knowledge of the client and experience of the industry. • **Test of detail:** We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers and compared the values they are disclosing within their financial statements to the value of income captured in the financial statements. We sought explanations for any variances over £0.3m, and all balances in dispute, and challenged the Trust's assessment of the level of income they were entitled to and the receipts that could be collected. • **Test of detail:** We re-performed the Trust's calculation of performance against the financial and operational targets used in determining receipt of transformation funding to determine the amount the Trust w a s qualified to receive. We agreed the amounts recorded in the accounts to our calculation. • **Our findings:** We found the resulting estimates and judgments made by the Trust in relation to NHS income to be balanced.

3. Our application of materiality and an overview of the scope of our audit

Materiality for the Trust's financial statements as a whole was set at £3.4m (2017: £3.3m), determined with reference to a benchmark of Income from Operations, of which it represents 2% (2017: 1.9%).

We reported to the Audit Committee any corrected or uncorrected identified misstatements exceeding £170k (2016: £165k), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was performed at the Trust's head office in Bridgwater



4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

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

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

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

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

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

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

We did not identify any significant risks to the Trust.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Somerset Partnership NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Jonathan Brown

Jonathan Brown
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

24 May 2018

KPMG

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

	NOTE		2017/18 £000		2016/17 £000
Operating Income from patient care activities	3		**162,846**		159,508
Other Operating income	4		**11,366**		10,336
Operating expenses	5, 6		**(161,955)**		(161,060)
Operating surplus from continuing operations			**12,257**		8,784
Finance costs					
Finance income	8	**43**		22	
Finance costs	9	**(49)**		(53)	
Public dividend capital - dividends payable		**(3,587)**		(3,556)	
Net finance costs			**(3,593)**		(3,587)
Other losses			**(2)**		0
Surplus for the year from continuing operations			**8,662**		5,197
Other comprehensive income					
Revaluations	13		**2,525**		888
Total comprehensive income for the period			**11,187**		6,085

The accompanying notes form part of the financial statements

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	12	**1,868**	988
Property, plant and equipment	13	**115,580**	109,768
Total non-current assets		**117,448**	110,756
Current assets			
Inventories	14	**429**	413
Trade and other receivables	15	**9,261**	7,655
Cash and cash equivalents	20	**14,895**	9,959
Total current assets		**24,585**	18,027
Current liabilities			
Trade and other payables	16	**(14,184)**	(12,150)
Other liabilities	17	**(298)**	(55)
Borrowings	18	**(232)**	(218)
Provisions	19	**(100)**	(107)
Total current liabilities		**(14,814)**	(12,530)
Total assets less current liabilities		**127,219**	116,253
Non-current liabilities			
Borrowings	18	**(1,142)**	(1,351)
Provisions	19	**(52)**	(64)
Total non-current liabilities		**(1,194)**	(1,415)
Total assets employed		**126,025**	114,838
Financed by Taxpayers' equity:			
Taxpayers' equity			
Public dividend capital		**32,763**	32,763
Revaluation reserve		**19,946**	17,421
Income and expenditure reserve		**73,316**	64,654
Total taxpayers' equity		**126,025**	114,838

The notes on pages 5 to 37 form part of these accounts.

The financial statements on pages 1 to 37 were approved by the Board on 24th May 2018 and signed on its behalf by:

Signed:  Date: 24/5/18

The accompanying notes form part of the financial accounts

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	TOTAL	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
		£000	£000	£000	£000
Taxpayers' and other 's equity at 1 April 2017		**114,838**	32,763	17,421	64,654
Surplus for the year		**8,662**	0	0	8,662
Revaluations		**2,525**	0	2,525	0
Taxpayers' and other 's equity at 1 April 2018		**126,025**	**32,763**	**19,946**	**73,316**

	TOTAL	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' and other 's equity at 1 April 2016	**108,753**	32,763	16,533	59,457
Surplus for the year	**5,197**	0	0	5,197
Revaluation	**888**	0	888	0
Taxpayers' and other 's equity at 1 April 2017	**114,838**	**32,763**	**17,421**	**64,654**

The accompanying notes form part of the financial accounts

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	2017/18 £000	2017/18 £000	2016/17 £000	2016/17 £000
Cash flows from operating activities					
Operating surplus			**12,257**		8,784
Non-cash income and expense:					
Depreciation and amortisation	5	**4,160**		3,874	
Net impairments	5	**(4,620)**		(1,857)	
Income recognised in respect of capital donations	4	**(102)**		(115)	
Decrease/(increase) in receivables and other assets		**(1,606)**		1,062	
(Increase) in inventories		**(16)**		(87)	
(Decrease) in payables and other liabilities		**2,323**		(623)	
(Increase) in provisions		**(18)**		(41)	
Other movements in operating cash flows		**20**		0	
			141		2,213
Net cash generated from operating activities			**12,398**		10,997
Cash flows from investing activities					
Interest received		**43**		22	
Purchase of intangible assets		**(1,244)**		(230)	
Purchase of property, plant and equipment		**(2,372)**		(2,476)	
Net cash generated (used in) investing activities			**(3,573)**		(2,684)
Cash flows from financing activities					
Movement on loans from the Department of Health		**(200)**		(200)	
Capital element of finance lease rental payments		**(15)**		(15)	
Interest paid		**(29)**		(33)	
Interest element of finance leases		**(21)**		(21)	
PDC Dividend paid:					
Net dividends payable at 1 April B/F		**(42)**	**167**		
Dividends payable for year		**(3,587)**	**(3,556)**		
Dividends payable/(receivable) at 31 March C/F		**5**	**(3,624)**	**42**	(3,347)
Net cash generated from/(used in) financing activities			**(3,889)**		(3,616)
Increase in cash and cash equivalents			**4,936**		4,697
Cash and cash equivalents at 1 April	20		**9,959**		5,262
Cash and cash equivalents at 31 March	20		**14,895**		9,959

The accompanying notes form part of the financial statements

NOTES TO THE ACCOUNTS

1 Reporting Entity

Somerset Partnership NHS Foundation Trust ("The Trust") is a public benefit corporation authorised under the National Health Service Act 2006, on 1 May 2008. It is licensed by NHS Improvement as an NHS provider under the Health and Social Care Act 2012 (as amended).

The primary objective of the Trust is to provide community and mental health services to the population of Somerset and increasingly to a wider community.

The financial statements of the Trust are for the year ended 31 March 2018 as approved by the Trust Board.

1.1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern

In the preparation of the year end accounts the Board is required to undertake an assessment confirming the Trust will continue as a going concern (i.e. that it will continue in the business of healthcare provision for the foreseeable future).

The Trust has prepared its financial plans and cash flow forecasts on the assumption that funding will be received from the Department of Health. Discussions to date indicate this funding will be forthcoming. These funds are expected to be sufficient to enable the Trust to meet its obligations as they fall due. These funds will be accessed through the nationally agreed process published by NHS Improvement and the Department of Health.

The Directors have concluded that there is a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the next 12 months.

NOTES TO THE ACCOUNTS

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

NOTES TO THE ACCOUNTS

1.3 Expenditure on employee benefits (cont-d)

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Consolidation

The Trust exercises control of a Primary Care GP Pratice. This has not been consolidated on the grounds of materiality to the Accounts of 2017/18

NOTES TO THE ACCOUNTS

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are subsequently measured at fair value.

Basis for assessing fair values

Operational land, buildings and dwellings are valued on a three and five yearly valuation cycle on the basis described below. The carrying values of revalued items are reviewed at each balance sheet date to ensure that those values are not materially different to fair value.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. During 2017/18, a desktop exercise to update the latest carrying values as at 31 March 2018 was undertaken by Cushman & Wakefield DTZ.

The valuations are carried out primarily on the basis of depreciated replacement cost on a modern equivalent asset (MEA) basis for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value. The Trust has valued its land and specialised buildings to reflect the fact that a modern equivalent asset need not be built in the current location (in a predominantly residential area) but could perform the same function located on the edge of town in a commercial area.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the valuation processes when they are brought into use.

Operational equipment:

Operational equipment is valued at net current replacement cost, based on depreciated historical cost, as a proxy for current value. Equipment surplus to requirements is valued at net recoverable amount. Under normal circumstances operational equipment is not revalued. Where equipment is acquired second hand, it will be revalued at its fair value based on age and intended purpose.

NOTES TO THE ACCOUNTS

1.6 Property, plant and equipment (continued)

Accounting for revaluations:
The Trust accounts for revaluations of property, plant and equipment on an asset by asset basis.

Reductions in value are charged to an asset revaluation reserve for that class of asset; where no revaluation reserve exists the reduction in value is charged directly to the Statement of Comprehensive Income. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the Statement of Comprehensive Income will be recognised first in the Statement of Comprehensive Income up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

For impairments expensed directly to the Statement of Comprehensive Income, the balance on any revaluation reserve (up to the level of impairment) to which the impairment would have been charged under IAS 36 is transferred to the income and expenditure reserve.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Buildings and Dwellings	20 to 100 years (1% - 5%)
Plant and Machinery	5 to 20 years (5% - 20%)
Information Technology	5 years (20%)
Furniture and Fittings	5 to 10 years (10% - 20%)

Property, plant and equipment which has been reclassified as 'non-current assets held for resale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

NOTES TO THE ACCOUNTS

1.6 Property, plant and equipment (continued)

Impairments
In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of "other impairments" are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value' less costs to sell. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘non-current assets held for resale’ and instead is retained as an operational asset. The asset is reviewed for impairment and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets
Donated and grant funded property, plant and and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

NOTES TO THE ACCOUNTS

1.7 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust, where the cost of the asset can be measured reliably and the value is £5,000 or greater.

Internally generated intangible assets:
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Development expenditure	3 to 5 years (20% - 33%)
Software	5 to 8 years (12% - 20%) or the terms of the licence, if shorter

NOTES TO THE ACCOUNTS

1.8 Non-current assets held for resale

Non-current assets held for resale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction, not through continuing use. Non-current assets held for resale are measured at the lower of their carrying amount and fair value less costs of sale.

Non-current assets held for resale have been determined by the Trust to be assets where there is an intention to sell confirmed by the Board for property or land, with an initial anticipation that the sale will occur within 12 months. Where the Board determines that property or land asset sales should not continue the assets will be reclassified as an operating or investment asset.

Non-current assets (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale. Interest and other expenses attributable to the liabilities of a disposal group classified as held for sale continue to be recognised.

1.9 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expenses is also recognised at the point of recognition for the benefit.

1.10 Impairment of non-financial assets

Non-financial assets that have an indefinite useful life are not subject to amortisation and are tested annually for impairment. Assets that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the entity would, if deprived of the asset, replace it's remaining future economic benefits or service potential.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.12 Trade and other receivables

Trade and other receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

A provision for impairment of receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of receivables. The amount of the provision is the difference between the asset's carrying amount and the expected value of the collectible debt.

NOTES TO THE ACCOUNTS

1.13 Cash and cash equivalents

Cash and cash equivalents includes cash in hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients (see "third party assets" below).

Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within borrowings. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

Bank overdrafts are shown within borrowings in current liabilities in the Statement of Financial Position.

1.14 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as 'Loans and receivables'.

Financial liabilities are classified as 'Other financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

NOTES TO THE ACCOUNTS

1.14 Financial Instruments (continued)

Other financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision. Impairments are only accounted for directly when occurring in year. Impairments are charged against the bad debt provision when a risk is identified of non-payment. The amount charged is the probable reduction in the recoverable asset.

1.15 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The initial value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability is derecognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

NOTES TO THE ACCOUNTS

1.16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that there will be a future outflow of cash or other resources and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.42% in real terms (2016/17 2.7%), except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 0.1% (2016/17 0.24%) in real terms.

Clinical negligence costs

The NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Foundation Trust is disclosed at Note 19, but is not recognised in the Foundation Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

1.18 Critical judgements in applying the Trust's accounting policies

Management has exercised the following critical judgements in applying the Trust's accounting policies for the year ended 31 March 2018:

Property, plant and equipment

All land and buildings are revalued using professional valuations in accordance with IAS 16 every three and five years, with desktop exercises carried out in subsequent years. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. During 2017/18, the Trust had a desktop exercise undertaken to update the latest carrying values as at 31 March 2018 using the appropriate BCIS (Building Cost Information Service) indices. The carrying values of revalued items are reviewed at each Statement of Financial Position date to ensure that those values are not materially different to fair value.

Specialised assets are valued on the basis of depreciated replacement cost for a modern equivalent asset. The Trust has valued the assets to reflect the fact that a modern equivalent asset need not be built in the current location (in a predominantly residential area) but could perform the same function located on the edge of town in a commercial area. To ensure a consistent basis the valuer has adopted commercial, rather than residential land values.

As part of the valuation process, the valuer also reassesses the remaining useful economic lives of the assets. This judgement affects the future levels of depreciation charges recorded in the accounts.

NOTES TO THE ACCOUNTS

1.18 Critical judgements in applying the Trust's accounting policies (cont.)

Land and property assets which the Board decide to make available for sale within 12 months will be classified as non-current assets for resale. The Board will need to agree that these assets are no longer to be resold for them to be reclassified as an operational or investment asset.

1.19 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Third party assets

Assets belonging to third parties - money held on behalf of patients are not recognised in the accounts since the trust has no beneficial interest in them. This is disclosed in note 21 to the accounts.

1.21 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an actuals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the losses and special payments note (note 27) is compiled directly from the losses and compensations register which reports on a cash basis with the exception of provisions for future losses.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

1.24 Accounting standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following standards and interpretations to be applied in 2017/18. The application of the standards as revised would not be expected to have a material impact on the accounts for 2017/18, were they applied in that year:

IFRS 16 Leases, effective date 1 January 2019

NOTES TO THE ACCOUNTS

2. Segmental analysis

All income and activities are for the provision of health and health related services in the UK.

The Trust is managed by the Board of Directors, which is made up of executive and non-executive directors. The non executive directors bring expertise to the Trust and provide advice and challenge to the executive directors. The executive directors have responsibility for the day to day running of the Trust.

The Board is therefore considered to be the Chief Operating Decision Maker (CODM) of the Trust for 2017/18 and 2016/17.

Due to the nature of the block contract with Somerset Clinical Commissioning Group for services the Trust is unable to fully report the income by directorates (segments), although it does report the expenditure by service area reflecting the current operational management structure. All assets are managed as one central pool.

The monthly financial information presented to the Board includes a corporate level Statement of Comprehensive Income, a Statement of Financial Position, a Statement of Cash Flow and a number of other financial indicators including capital expenditure, performance against cost improvement plans, debt analysis and risk rating.

The segmental expenditure data is included by way of a separate note reporting achievement against planned expenditure inclusive of any directorate specific income and highlighting any variances. It is acknowledged that the analysis of figures included below is different to that used for the remainder of the financial statements.

The table below summarises details reported to the Board during 2017/18 and 2016/17.

	2017/18 £000	*Restated (Note 1)* 2016/17 £000
Total corporate income less that attributable to operational budgets	**159,285**	156,707
Expenditure less non specific income:		
Community Services	**71,439**	72,383
Children & Young People & Dental	**23,301**	22,510
Mental Health and Learning Disabilities	**33,661**	32,560
Central Operations	**2,737**	3,060
TOTAL DIVISIONS	**131,138**	130,513
Medical	**1,169**	1,000
Pharmacy	**2,221**	2,168
Central Services	**13,062**	12,360
TOTAL OTHER SERVICES	**16,452**	15,528
Total operating expenditure net of specific income	**147,590**	146,041
Operational EBITDA before the effect on non-recurring items, as reported to the Board[1]	**11,695**	10,665
Other adjustments	**102**	115
Net profit/(loss) on disposal of assets	**(2)**	0
Trust EBITDA[1]	**11,795**	10,780
Depreciation and amortisation	**(4,160)**	(3,874)
Interest receivable	**43**	22
Finance charges	**(49)**	(32)
PDC dividend payable	**(3,587)**	(3,556)
Retained operational (deficit)/surplus	**4,042**	3,340
Retained surplus arising from operations after exceptional items	**4,042**	3,340
Revaluation exceptional items (note 2)	**4,620**	1,857
(Deficit)/surplus for year per Statement of Comprehensive Income	**8,662**	5,197

[1]Earnings before Interest, Tax, Depreciation and Amortisation

Note 1
In 2017/18, there was a change to service directorate information presented to the Board, 2016/17 restated to reflect these changes

Note 2
The revaluation exceptional items arise from impairments to the Valuer's assessment of the carrying values of the Trust's estate

NOTES TO THE ACCOUNTS

3. Operating income from patient care activities

3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Cost and volume contract income from commissioners	**5,486**	5,269
Mental health block contract income from commissioners	**56,500**	53,691
Clinical partnerships providing mandatory services (including S75 agreements)	**1,287**	1,637
Other clinical income from mandatory services	**106**	131
Community services income from CCGs and NHS England	**86,991**	87,847
Community services income from other commissioners	**12,476**	10,933
Total income from activities	**162,846**	159,508

3.2 Income from patient care activities (by source)	2017/18 £000	2016/17 £000
Income from patient care activities received from:		
NHS foundation trusts	**230**	157
NHS trusts	**57**	46
CCGs and NHS England	**148,401**	146,207
Local authorities	**11,957**	12,854
Department of Health - other	**282**	0
NHS Other	**41**	0
NHS Injury Scheme (was RTA)	**467**	249
Non NHS: other	**1,411**	(5)
Total income from activities	**162,846**	159,508
Of which:		
Related to continuing operations	**162,846**	159,508

NOTES TO THE ACCOUNTS

4. Other Operating income

	2017/18 £000	2016/17 £000
Research and development	**291**	304
Education and training	**1,797**	1,577
Receipt of capital grants and donations	**102**	115
Non-patient care services to other bodies	**543**	32
Sustainability and Transformation Fund income	**2,868**	2,616
Income in respect of staff costs where accounted on gross basis	**1,063**	1,186
Car parking		
Estate recharges and property rentals	**3,793**	3,869
Pharmacy sales	**9**	8
Catering	**128**	129
Other	**772**	500
Total other operating income	**11,366**	10,336
Of which:		
Related to continuing operations	**11,366**	10,336

4.1 Income from activities arising from commissioner requested services

Under the terms of its trust license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the trust license and are services that commissioners believe would need to be protected in the event of trust failure. This information is provided in the table below:

	2017/18 £000	2016/17 £000
Income from services designated (or grandfathered) as commissioner requested services	161,893	159,164
Income from services not designated as commissioner requested services	953	344
Total	**162,846**	159,508

NOTES TO THE ACCOUNTS

5. Operating expenses

	2017/18 £000	*Restated* 2016/17 £000
Services from NHS foundation trusts	**1,935**	1,680
Services from NHS trusts	**175**	146
Services from CCGs and NHS England	**694**	0
Purchase of healthcare from non NHS bodies	**4,642**	4,322
Employee costs - executive directors (Note 1)	**1,021**	1,092
Employee costs - non-executive directors (Note 1)	**142**	137
Employee costs - staff	**122,580**	120,894
Supplies and services - clinical (excluding drug costs)	**4,403**	4,618
Supplies and services - general	**2,670**	2,830
Establishment	**4,605**	4,429
Research and development	**25**	21
Transport	**356**	253
Premises	**7,683**	7,566
Increase in provision for impairment of receivables	**21**	0
Drug costs	**2,674**	3,068
Drugs inventories consumed	**1,139**	972
Rentals under operating leases - minimum lease payments	**3,827**	4,258
Depreciation on property, plant and equipment	**3,796**	3,518
Amortisation on intangible assets	**364**	355
Impairments of property, plant and equipment	**(4,620)**	(1,857)
Audit fees payable to the external auditor (Note 2)		
audit services - statutory audit	**72**	72
other auditor remuneration (external auditor only)	**11**	11
Clinical negligence - premiums paid to the NHSR	**214**	158
Legal fees	**121**	193
Consultancy costs	**328**	340
Training, courses and conferences	**611**	364
Patient travel	**245**	252
Car parking and security	**138**	154
Redundancy	**173**	63
Insurance	**96**	139
Internal audit costs (includes counter fraud)	**55**	59
Losses, ex gratia and special payments	**40**	1
Other (Note 2)	**1,719**	952
	161,955	161,060
Of which:		
Related to continuing operations	**161,955**	161,060

Note 1

Employee expenses for executive and non-executive directors exclude benefits in kind, but include social security costs. Total remuneration including these benefits is £1,021,165 (2016/17: £1,093,646) for executive directors and £141,758 (2016/17: £136,819) for non-executive directors.

Note 2

Re-allignment of prior year irrecoverable vat between other expenditure and audit services - statutory audit

NOTES TO THE ACCOUNTS

6. Operating leases

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	**3,827**	4,258
Total	**3,827**	4,258

	2017/18 £000	2016/17 £000
Future minimum lease payments due:		
- not later than one year;	**3,635**	3,972
- later than one year and not later than five years;	**6,124**	7,794
- later than five years.	**5,815**	7,204
Total	**15,574**	18,970

7.1 Other auditor remuneration

	2017/18 £000	*Restated* Note 1 2016/17 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	**11**	11
Total	**11**	11

Note 1
Re-allignment of prior year irrecoverable vat between other expenditure and audit services - statutory audit

7.2 Limitation on auditors' liability

The limitation on the auditor's liability for external audit work for 2017/18 is £1m (2016/17 £1m)

NOTES TO THE ACCOUNTS

8. Finance income

Finance income represents interest received on assets and investments in the period

	2017/18 £000	2016/17 £000
Interest on bank accounts	**43**	22
Total	**43**	22

9. Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health	**28**	32
Finance leases	**21**	21
Total	**49**	53

10. The late payment of commercial debts (interest) Act 1998

The Trust has not incurred any interest arising from claims made under this legislation or paid any compensation to cover debt recovery costs in 2017/18 or 2016/17.

11. Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus/(deficit) resulting from:		
Changes in market price	**(4,620)**	(1,857)
Total Impairments included in operating surplus/(deficit)	**(4,620)**	(1,857)

NOTES TO THE ACCOUNTS

12. Intangible assets

	Software Licences £000	Total £000
Gross cost at 1 April 2017	**2,042**	**2,042**
Additions	**1,244**	**1,244**
Gross cost at 31 March 2018	**3,286**	**3,286**
Amortisation at 1 April 2017	**1,054**	**1,054**
Provided during the year	**364**	**364**
Amortisation at 31 March 2018	**1,418**	**1,418**
Net book value at 31 March 2018	**1,868**	**1,868**

	Software Licences £000	Total £000
Gross cost at 1 April 2016	1,868	1,868
Additions - purchased	230	230
Disposals	(56)	(56)
Gross cost at 31 March 2017	**2,042**	**2,042**
Amortisation at 1 April 2016	755	755
Provided during the year	355	355
Disposals	(56)	(56)
Amortisation at 31 March 2017	**1,054**	**1,054**
Net book value at 31 March 2017	**988**	**988**

NOTES TO THE ACCOUNTS

13.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport Equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	15,166	85,354	945	0	6,619	24	7,300	4,596	120,004
Additions	0	860	0	0	336	0	973	193	2,362
Additions - donations of physical assets (non-cash)	0	0	0	0	57	0	12	33	102
Impairments	0	(3,818)	0	0	0	0	0	0	(3,818)
Reversal of impairments	0	6,792	4	0	0	0	0	0	6,796
Revaluations	0	2,525	0	0	0	0	0	0	2,525
Transfers to/from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	(23)	(624)	(647)
Cost or valuation at 31 March 2018	**15,166**	**91,713**	**949**	**0**	**7,012**	**24**	**8,262**	**4,198**	**127,324**
Accumulated depreciation at 1 April 2017	0	44	0	0	4,075	4	3,228	2,885	10,236
Provided during the year	0	1,593	12	0	359	3	1,273	556	3,796
Impairments	0	(239)	0	0	0	0	0	0	(239)
Reversal of impairments	0	(1,392)	(12)	0	0	0	0	0	(1,404)
Disposals	0	0	0	0	0	0	(21)	(624)	(645)
Accumulated depreciation at 31 March 2018	**0**	**6**	**0**	**0**	**4,434**	**7**	**4,480**	**2,817**	**11,744**
Net book value at 31 March 2018									
- Owned	15,166	88,639	949	0	2,119	16	3,750	1,111	111,750
- Finance leased	0	0	0	0	51	0	0	0	51
- Government granted	0	1,901	0	0	0	0	0	0	1,901
- Donated	0	1,168	0	0	408	0	32	270	1,878
Total at 31 March 2018	**15,166**	**91,708**	**949**	**0**	**2,578**	**16**	**3,782**	**1,381**	**115,580**

NOTES TO THE ACCOUNTS

13.1a Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport Equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	15,166	82,595	915	609	6,410	24	6,055	4,372	116,146
Additions	0	841	32	37	98	0	1,232	219	2,459
Additions - donations of physical assets (non-cash)	0	0	0	0	115	0	0	0	115
Impairments	0	(495)	0	(401)	0	0	0	0	(896)
Reversal of impairments	0	1,295	(3)	0	0	0	0	0	1,292
Revaluations	0	891	1	0	(4)	0	0	0	888
Reclassifications	0	227	0	(245)	0	0	13	5	0
Cost or valuation at 31 March 2017	**15,166**	**85,354**	**945**	**0**	**6,619**	**24**	**7,300**	**4,596**	**120,004**
Accumulated depreciation at 1 April 2016	0	4	0	0	3,727	1	2,149	2,297	8,178
Provided during the year	0	1,489	11	0	348	3	1,079	588	3,518
Impairments	0	(177)	0	0	0	0	0	0	(177)
Reversal of impairments	0	(1,272)	(11)	0	0	0	0	0	(1,283)
Accumulated depreciation at 31 March 2017	**0**	**44**	**0**	**0**	**4,075**	**4**	**3,228**	**2,885**	**10,236**
Net book value at 31 March 2017									
- Owned	15,166	82,293	945	0	2,016	20	4,046	1,397	105,883
- Finance leased	0	0	0	0	66	0	0	0	66
- Government granted	0	1,924	0	0	0	0	0	0	1,924
- Donated	0	1,093	0	0	462	0	26	314	1,895
Total at 31 March 2017	**15,166**	**85,310**	**945**	**0**	**2,544**	**20**	**4,072**	**1,711**	**109,768**

NOTES TO THE ACCOUNTS

13.2 Impairments and revaluations

Cushman & Wakefield, DTZ undertook an interim valuation of the estate at the 31st March 2018 in accordance with the 3 year cyclical valuations.

During 2017/18, the total net increase in the value of buildings and dwellings due to revaluations and impairments was £7,144,243 (2016/17: £2,750,576).

Of the net increase in valuation of £7,144,243, £2,977,493 relates to reversal of impairments and £1,642,225 relates to depreciation on impairment charged to the Statement of Comprehensive Income. The remaining £2,524,525 relates to impairment write backs credited to the Statement of Comprehensive Income.

13.3 Net book value of assets held under finance leases

The Trust held £74,572 (2016.17: £66,476) of assets under finance leases during the financial year. These relate to franking machines.

13.4 Donated assets

During 2017/18, donations of £102,000 were donated to the Trust (2016/17: £115,000). There were no restrictions on the use of donated assets.

13.5 Asset reclassification

During the year there was no reclassification of any asset.

NOTES TO THE ACCOUNTS

14. Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	**111**	122
Consumables	**292**	264
Energy	**26**	27
TOTAL	**429**	413

Inventories recognised in expenses for the year were £2,796,000 (2016/17: £2,745,000. There were no write down of inventories (2016/17: £0).

15.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables due from NHS bodies	**4,562**	3,078
Other receivables due from related parties	**229**	100
Provision for impaired receivables	**(178)**	(157)
Prepayments (non-PFI)	**2,026**	2,454
Accrued income	**788**	652
VAT receivable	**184**	332
Other receivables	**1,650**	1,196
Total current trade and other receivables	**9,261**	7,655

All trade and non trade receivables are current.

15.2 Provision for impairment of receivables

	31 March 2018 £000	2016/17 £000
At 1 April	**157**	700
Increase in provision	**21**	0
Amounts utilised	**0**	(543)
At 31 March	**178**	157

NOTES TO THE ACCOUNTS

15.3 Analysis of impaired receivables

	31 March 2018 £000	31 March 2017 £000
Over 180 days	**178**	157
Total	**178**	157

15.4 Analysis of financial assets

	31 March 2018 £000	31 March 2017 £000
Ageing of non-impaired financial assets past their due date		
0 - 30 days	**1,442**	1,221
30 - 60 days	**151**	134
60 - 90 days	**29**	110
90 - 180 days	**69**	7
over 180 days	**90**	121
Total	**1,781**	1,593

16. Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	**2,594**	1,336
Amounts due to other related parties	**4,001**	1,721
Capital payables	**0**	9
Other payables	**2,169**	3,212
Social security costs	**1,644**	2,141
Accruals	**3,771**	3,689
PDC dividend payable	**5**	42
Total current trade and other payables	**14,184**	12,150

All trade and non trade payables are current.

17. Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Other deferred income	**298**	55
Total current other liabilities	**298**	55

NOTES TO THE ACCOUNTS

18. Borrowings

	31 March 2018 £000	31 March 2017 £000
18.1 Current		
Loans from the Department of Health	**200**	200
Obligations under finance leases	**32**	18
Total current borrowings	**232**	218
18.2 Non-current		
Loans from the Independent Trust Financing Facility	**1,100**	1,300
Obligations under finance leases	**42**	51
Total non-current borrowings	**1,142**	1,351

The Trust has one loan from the Department of Health which is payable by instalments over a 10 year period, and has a final repayment date of 15 June 2024, and a fixed interest rate of 2%.

18.3 Finance lease obligations: future minimum lease payments due

Lease liabilities are effectively secured as the rights to the leased asset revert to the lessor in the event of default.

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	**32**	18
- later than one year and not later than five years;	**42**	51
Finance charges allocated to future periods	**(19)**	(38)
Total minimum lease payments due	**55**	31

NOTES TO THE ACCOUNTS

19. Provisions for liabilities and charges analysis

	Pensions relating to staff	Legal claims	Total
	£000	£000	£000
At 1 April 2017	122	49	**171**
Arising during the year	41	17	**58**
Utilised during the year	(14)	(1)	**(15)**
Unwinding of discount	(41)	(21)	**(62)**
At 31 March 2018	**108**	**44**	**152**
	£000	**£000**	**£000**
At 1 April 2016	182	30	**212**
Change in the Discount Rate	0	1	**1**
Arising during the year	0	41	**41**
Utilised during the year	(60)	(22)	**(82)**
Unwinding of discount	0	(1)	**(1)**
At 31 March 2017	**122**	**49**	**171**
Expected timing of cash flows:			
- not later than one year;	56	44	**100**
- later than one year and not later than five years;	52	0	**52**
At 31 March 2018	**108**	**44**	**152**
- not later than one year;	58	49	**107**
- later than one year and not later than five years;	64	0	**64**
At 31 March 2017	122	49	**171**

Pensions

Pension provisions relate to early retirements in lieu of redundancy for periods prior to 1997/98 where the costs were "capitalised" as required by accounting standards. Some of the original provisions have been exhausted and so during the current period the Trust has made additional provisions to reflect ongoing payments. Quarterly payments are made to the NHS Pensions Agency and a significant amount of the payments are expected to be due after one year.

Legal claims

The provisions are based on the expected values and probabilities quantified by the NHS Litigation Authority (NHSR). The outcome of these cases are inherently uncertain and the timing of payments is dependant on the progression of each case. The figures included in the summary are based purely on the Trust's excess reflecting the fact that the NHSR makes the majority of payments direct. See also note 24.

Clinical negligence liabilities

£315,481 is included in the provisions of the NHS Resolution at 31 March 2018 in respect of potential clinical negligence liabilities of the Trust (31 March 2017: £676,788).

NOTES TO THE ACCOUNTS

20. Cash and cash equivalents movements

	2017/18 £000	2016/17 £000
At 1 April	**9,959**	5,262
Net change in the year	**4,936**	4,697
At 31 March	**14,895**	9,959
Broken down into:		
Cash at commercial banks and in hand	**148**	822
Cash with the Government Banking Service	**14,747**	9,137
Total cash and cash equivalents as in Statement of Financial Position and Statement of Cash Flows	**14,895**	9,959

21. Third party assets

The Trust held £272,855 cash at bank and in hand at 31 March 2018 (£735,000 at 31 March 2017) which relates to monies held on behalf of clients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

22.1 Contractual capital commitments

There were no commitments under capital expenditure contracts at 31 March 2018 (31 March 2017:£0).

22.2 Other financial commitments

The Trust has no financial committments during 2017/18 and 2016/17.

23. Events after the reporting year

There have been no exceptional events identified after the reporting year.

24. Contingent liabilities

In addition to provisions disclosed in note 19 there were £14,842 potential contingent liabilities in 2017/18 (2016/17: £33,575). There are no amounts identified as recoverable against these liabilities.

NOTES TO THE ACCOUNTS

25. Related party transactions

During the year details of transactions with board members or members of the key management staff or parties related to them are detailed below:

	Payments to related party 2017/18 £000	Receipts from related party 2017/18 £000	Amounts owed to related party 31/03/2018 £000	Amounts due from related party 31/03/2018 £000
Taunton & Somerset NHS Foundation Trust The Director of Nursing and Patient Safety, Sue Balcombe is a stakeholder member of the Council of Governors of Taunton and Somerset NHS Foundation Trust.	4,390	2,912	421	533

The equivalent disclosures for 2016/17 were as follows:

	2016/17 £000	2016/17 £000	31/03/2017 £000	31/03/2017 £000
Taunton & Somerset NHS Foundation Trust The Director of Nursing and Patient Safety, Sue Balcombe is a stakeholder member of the Council of Governors of Taunton and Somerset NHS Foundation Trust.	4,224	2,826	537	100

The Trust entered into an Alliance with Taunton & Somerset NHS Foundation Trust during 2017/18. As a result, a single Executive/Management Team was formed. The table of Salary and Pension entitlements of senior managers for 2017/18 includes the full entitlements paid to senior managers during the year. This is not the amount chargeable to the Trust. Recharges between the two organisations are shown separately in the table. All director disclosures are shown in the Remuneration Report.

NOTES TO THE ACCOUNTS

25. Related party transactions (continued)

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are summarised below:

	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
	2017/18 £000	2017/18 £000	31/03/2018 £000	31/03/2018 £000
Department of Health	0	282	0	0
NHS England	4	16,629	0	3,118
Health Education England	0	2,359	0	2
NHS Bath and North East Somerset CCG	0	212	0	38
NHS Bristol CCG	0	43	5	4
NHS Dorset CCG	0	206	0	28
NHS Kernow CCG	0	159	0	7
NHS North, East, West Devon CCG	0	406	0	69
NHS North Somerset CCG	0	61	0	5
NHS Somerset CCG	1,450	132,722	762	403
NHS Wiltshire CCG	0	395	0	43
Dorset County Hospitals NHS Foundation Trust	510	0	54	**0**
Dorset Healthcare University NHS Foundation Trust	149	1	1	0
Gloucester Hospitals NHS Foundation Trust	422	0	31	0
Great Western Hospitals NHS Foundation Trust	293	0	2	2
Royal Devon & Exeter NHS Foundation Trust	5	170	1	15
South Staffordshire Healthcare NHS Foundation Trust	0	124	0	37
Taunton and Somerset NHS Foundation Trust	4,390	2,912	421	533
University Hospital Bristol NHS Foundation Trust	25	7	8	2
Yeovil District Hospital NHS Foundation Trust	2,968	755	910	156
Devon Partnership NHS Trust	20	5	20	0
Isle of Wight NHS Trust	127	0	146	0
North Bristol NHS Trust	1	9	0	0
Plymouth Hospitals NHS Trust	19	0	10	0
Royal United Hospital Bath NHS Trust	232	363	26	0
Weston Area Health NHS Trust	49	0	0	13
NHS Resolution (formerly NHS Litigation Authority)	293	0	0	0
NHS Property Services	1,518	0	133	0
Other NHS bodies	419	566	63	86

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

NHS Pension Scheme	12,233	0	0	0
Somerset County Council	761	12,443	0	176
Other central and local government bodies	10,043	0	3,798	237

Other related parties

Lister House GP Surgery	3	57	0	565

NOTES TO THE ACCOUNTS

25. Related party transactions (continued)

The equivalent disclosures made for 2016/17 were as follows:

	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
	2016/17	2016/17	31/03/2017	31/03/2017
	£000	£000	£000	£000
Department of Health	4	0	42	0
NHS England	0	15,478	0	2,337
Health Education England	0	1,748	0	48
NHS Bath and North East Somerset CCG	0	267	0	54
NHS Bristol CCG	0	55	0	8
NHS Dorset CCG	0	230	0	27
NHS Kernow CCG	0	17	0	1
NHS North, East, West Devon CCG	0	625	0	248
NHS North Somerset CCG	0	62	0	8
NHS Somerset CCG	0	131,988	105	13
NHS Wiltshire CCG	0	277	0	25
Devon Partnership NHS Trust	13	8	0	0
North Bristol NHS Trust	2	11	0	0
Royal United Hospital Bath NHS Trust	212	380	5	0
Weston Area Health NHS Trust	82	0	0	0
Dorset Healthcare University NHS Foundation Trust	167	7	72	0
Gloucester Hospitals NHS Foundation Trust	358	0	0	0
Great Western Hospitals NHS Foundation Trust	389	0	96	0
Royal Devon & Exeter NHS Foundation Trust	9	158	0	13
South Staffordshire Healthcare NHS Foundation Trust	0	109	0	23
University Hospital Bristol NHS Foundation Trust	24	7	0	6
Yeovil District Hospital NHS Foundation Trust	2,520	627	381	68
NHS Resolution	285	0	0	0
NHS Property Services	1,671	0	70	0
Other NHS bodies	1,018	601	71	99
In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.				
NHS Pension Scheme	12,250	0	1,721	0
Somerset County Council	3	13,076	0	622
Other central and local government bodies	8,182	116	2,141	354
Other related parties				
Lister House GP Surgery	4	25	1	0

NOTES TO THE ACCOUNTS

26. Financial Instruments

Financial risk management

IFRS 7, dealing with financial instruments, require disclosure of the role that financial instruments have had during the year in creating or changing the risks the Trust faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which these standards mainly apply.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest-rate risk
The Trust has the power to borrow for capital expenditure subject to affordability as confirmed by NHS Improvement, the independent regulator. In 2014/15 the Trust took out a £2 million loan from the Department of Health to fund capital expenditure at a fixed rate of 2% p.a. over 10 years.

Some of the financial instruments have a fixed interest rate which means the Trust is exposed to interest rate risk. If the interest rate moves interest paid could be higher than the market rates, and/or interest received could be lower than the market rates.

Credit risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Cash deposited with financial institutions outside the Government Banking Service at 31 March 2018 was £148,000 (2017: £822,000). The credit risk on this is negligible.

Liquidity risk
The Trust's net operating costs are incurred under contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from retained surpluses and funds obtained from the Independent Trust Financing Facility or central funding from the Department of Health in the form of Public Dividend Capital. The Trust has undertaken a going concern review involving a year's future cash flow assessment. Following this review, the Trust has concluded that it is not exposed to significant liquidity risks.

Investment risk
The Trust has the ability to invest surplus cash; the risks resulting from transactions of this nature are mitigated by the Trust's treasury and investment policies and protocols and by the reporting of performance against financial targets to NHS Improvement.

NOTES TO THE ACCOUNTS

26.1 Financial assets by category

Assets as per Statement of Financial Position as at 31 March 2018	Loans and receivables
	£000
Trade and other receivables excluding non financial assets	**7,048**
Cash and cash equivalents at bank and in hand	**14,895**
Total at 31 March 2018	**21,943**

Assets as per Statement of Financial Position as at 31 March 2017	£000
Trade and other receivables excluding non financial assets	4,339
Cash and cash equivalents at bank and in hand	9,959
Total at 31 March 2017	14,298

26.2 Financial liabilities by category

Liabilities as per Statement of Financial Position as at 31 March 2018	Other financial liabilities measured at amortised cost
	£000
Borrowings excluding finance leases and PFI liabilities	**1,300**
Obligations under finance leases	**74**
Trade and other payables excluding non financial liabilities	**12,536**
Total at 31 March 2018	**13,910**

Liabilities as per Statement of Financial Position as at 31 March 2017	£000
Borrowings excluding finance leases and PFI liabilities	1,500
Obligations under finance leases	69
Trade and other payables excluding non financial liabilities	12,152
Total at 31 March 2017	13,721

NOTES TO THE ACCOUNTS

26.3 Fair values

There is no significant difference between the book values and fair values of the Trust's financial assets and liabilities at 31 March 2018.

27. Losses and special payments

The following losses and special payments were recognised. These amounts are reported on a payments basis but exclude any provision for future losses. Of the total, there were no claims for 2017/18 and 2016/17 relating to claims via NHS Resolution, formerly the NHS Litigation Authority, that were below the excess limits and had been included within provisions at the end of the previous year. There were no cases exceeding £300,000.

	31 March 2018		**31 March 2017**	
	Number of cases	**Value £000**	**Number of cases**	**Value £000**
Losses				
Losses of cash (including overpayment and theft)	**21**	**8**	2	0
Bad debts and claims abandoned	**88**	**8**	95	7
Total losses	**109**	**16**	97	7
Special payments				
Compensation payments	**5**	**22**	0	0
Ex gratia payments	**2**	**2**	0	0
Special severance payments	**1**	**88**	1	13
Total special payments	**8**	**112**	1	13
Total losses and special payments	**117**	**128**	98	20
Compensation payments received		**3**		3

KPMG

External Audit Report

(Financial statements & VFM)

Somerset Partnership NHS Foundation Trust

—

24 May 2018

I confirm that this is the final version of our ISA 260 Audit Memorandum relating to our audit of the 2017/18 financial statements for Somerset Partnership NHS Foundation Trust. This document was discussed and approved by the Trust's Audit Committee on 24 May 2018.

.....Jonathan Brown.....

Jonathan Brown

Senior statutory auditor,

for and on behalf of KPMG LLP,
Chartered Accountants
66 Queen Square, Bristol, BS1 4BE

24 May 2018

Our audit opinions and conclusions:	
Financial Statements: unqualified	Use of resources: clean

Content

The contacts at KPMG in connection with this report are:

Jon Brown
Partner

Tel: 0117 905 4362
jonathan.brown@kpmg.co.uk

Duncan Laird
Senior Manager

Tel: 0117 905 4253
duncan.laird@kpmg.co.uk

James Woolway
Assistant Manager

Tel: 0117 905 4283
james.woolway@kpmg.co.uk

Important Notice

This report is presented under the terms of our audit engagement letter. Circulation of this report is restricted. The content of this report is based solely on the procedures necessary for our audit. This report is addressed to Somerset Partnership NHS Foundation Trust (the Trust) and has been prepared for your use only. We accept no responsibility towards any member of staff acting on their own, or to any third parties. The National Audit Office (NAO) has issued a document entitled Code of Audit Practice (the Code). This summarises where the responsibilities of auditors begin and end and what is expected from the Trust. External auditors do not act as a substitute for the Trust's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Basis of preparation: We have prepared this External Audit Report (Report) in accordance with our engagement letter dated 29 May 2015.

Purpose of this report: This Report is made to the Trust's Audit Committee (and for the quality report work we will share the findings with governors) in order to communicate matters as required by International Audit Standards (ISAs) (UK and Ireland), and other matters coming to our attention during our audit work that we consider might be of interest, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone (beyond that which we may have as auditors) for this Report, or for the opinions we have formed in respect of this Report.

Restrictions on distribution: This Report is subject to disclosure restrictions as set out in our Engagement Letter.

Limitations on work performed: This Report is separate from our long form audit report and does not provide an additional opinion on the Trust's financial statements, nor does it add to or extend or alter our duties and responsibilities as auditors. We have not designed or performed procedures outside those required of us as auditors for the purpose of identifying or communicating any of the matters covered by this Report. The matters reported are based on the knowledge gained as a result of being your auditors. We have not verified the accuracy or completeness of any such information other than in connection with and to the extent required for the purposes of our audit.

Status of our audit: Our audit is substantially complete, however matters communicated in this Report may change prior to signing our audit report. We will provide an oral update on the status of our audit at the Audit Committee meeting but would highlight the following work is still outstanding:

- Final consistency check between the summarisation schedules and the accounts.

KPMG

Summary

Section One

Summary

Financial Statements Audit

We intend to issue an unqualified audit opinion on the accounts following the Audit Committee adopting them and receipt of the management representations letter.

We have completed our audit of the financial statements. We have also read the content of the Annual Report (including the Remuneration Report) and reviewed the Annual Governance Statement (AGS). Our key findings are:

- There are no unadjusted audit differences, explained in Appendix 2.
- We have agreed minor presentational changes to the accounts with Finance, mainly related to compliance with the Group Accounting Manual (GAM).
- We have reviewed the annual report and have no matters to raise with you.

Total comprehensive income for the period was £11.2m (2016: £6.1m), an increase of 84%. Underlying total assets employed were £126m (2016: £114.8), an increase of 10%.

Value for money and audit certificate

Based on the findings of our work, we have concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources.

Sufficient action plans were deemed to be in place for Trust-identified risks, along with no CQC visits in the year.

We are required to certify that we have completed the audit of the Trust financial statements in accordance with the requirements of the Code. If there are any circumstances under which we cannot issue a certificate, then we must report this to those charged with governance.

There are no issues that would cause us to delay the issue of our certificate of completion of the audit.

Other Matters

We intend to issue an unqualified Group Audit Assurance Certificate to the NAO regarding the Whole of Government Accounts submission, made through the submission of the summarisation schedules to NHS Improvement (NHSI).

We are satisfied that the Trust has addressed the recommendations raised in our ISA260 and Quality Report work in 2016/17. We have made one recommendation as a result of our 2017/18 work. Please see page 7 and appendix 1.

In auditing the accounts of an NHS body auditors must consider whether, in the public interest, they should make a report on any matters coming to their notice in the course of the audit, in order for it to be considered by Trust members or bought to the attention of the public; and whether the public interest requires any such matter to be made the subject of an immediate report rather than at completion of the audit. There are no matters that we wish to report.

KPMG

Financial Statements Audit

Section Two

Financial Statements Audit

We audit your financial statements by undertaking the following tasks:

Work Performed	Accounts production stage		
	Before	During	After
1. Business Understanding: review your operations	✓	✓	–
2. Controls: assess the control framework	✓	–	–
3. Prepared by Client Request (PBC): issue our prepared by client request	✓	–	–
4. Accounting standards: agree the impact of any new accounting standards	✓	✓	–
5. Accounts Production: review the accounts production process	✓	✓	✓
6. Testing: test and confirm material or significant balances and disclosures	–	✓	✓
7. Representations and opinions: seek and provide representations before issuing our opinions	✓	✓	✓

We have completed the first six stages shown above and report our key findings below:

1. Business Understanding	In our 2017/18 audit plan we highlighted the key risks related to your financial statements. We confirmed this risk assessment as part of our audit work. We have provided an update on each of the risks identified later in this section.
2. Assessment of the control environment	We have assessed the effectiveness of your key financial system controls that prevent and detect material fraud and error. We found that the financial controls on which we seek to place reliance are operating effectively. We have made one recommendation which relates to journal authorisation. We believe that these recommendations (which are shown in appendix 1) will strengthen your control environment. We have reviewed the work undertaken by PricewaterhouseCoopers, your internal auditor, in accordance with ISA 610 and used the findings to inform our planning and audit approach.
3. Prepared by client request	We produced this document to summarise the working papers and evidence we ask you to collate as part of the preparation of the financial statements. We discussed and tailored our request with Chris Upham and this was issued as a final document to the finance team. The team was forthcoming with all requests and efficient in responding to queries.
4. Accounting standards	We work with you to understand the changes to accounting standard and other technical issues. For 2017/18 these changes have related to: • Updates to the content of the annual report – Updates to how the median pay disclosure and highest paid director disclosures are calculated after re-charges are taken into account; and • The inclusion of mandated headings for number of the prime financial statements and notes.

Section Two

Financial Statements Audit

5. Accounts Production	We received complete draft accounts by 24 April 2018 in accordance with NHSI's deadline. The accounting policies, accounting estimates and financial statement disclosures are in line with the requirements of ARM and GAM. We will debrief with the Finance team to share views on the final accounts audit. Hopefully this will lead to further efficiencies in the 2018/19 audit process. In particularly we would like to commend Trust finance staff who were available throughout the audit visit to answer our queries. We thank the finance team for their co-operation throughout the visit which allowed the audit to progress and complete within the allocated timeframe.
6. Testing	We have summarised the findings from our testing of significant risks and areas of judgement within the financial statements on the following pages. During the audit we identified only presentational issues which have been adjusted as they have no material effect on the financial statements
7. Represent-ations	You are required to provide us with representations on specific matters such as your going concern assertion and whether the transactions in the accounts are legal and unaffected by fraud. We provided a draft of this representation letter to the Director of Finance on 11 May 2018. We draw your attention to the requirement in our representation letter for you to confirm to us that you have disclosed all relevant related parties to us.

We are required under ISA 260 to communicate to you any matters specifically required by other auditing standards to be communicated to those charged with governance; and any other audit matters of governance interest. As the Trust is required to comply with elements of the UK Corporate Governance Code through the Foundation Trust Code of Governance, ISA 260 also requires us to communicate to you any information that we believe is relevant to understanding our rationale and the supporting evidence for the exercise of our professional judgement. This includes our view of: business risks relevant to the financial reporting objectives, the application of materiality and the impact of our judgements on these areas for the overall audit strategy and audit plan; significant accounting policies; management's valuations of the Trust's material asset and liabilities and the related disclosures; the quality of management's assessment of the effectiveness of the system of internal control included in the AGS; and any other matters identified during the course of the audit. We have not identified any other matters to specifically report.

To ensure that we have provided a comprehensive summary of our work, we have over the next pages set out:

- The results of the procedures we performed over valuation of land and buildings, recognition of NHS and non-NHS income, and NHS receivables which were identified as significant risks within our audit plan and which will form a part of our audit opinion;
- The results of our procedures to review the required risks of the fraudulent risk of revenue recognition and management override of control; and
- Our view of the level of prudence you have applied to key balances within your financial statements.

Financial Statements Audit

SIGNIFICANT audit risk	Account balances effected	Summary of findings
Valuation of land and buildings	Property, plant & equipment: (£115.6m 2017: £109.8m)	In 2017/18 the Trust engaged Cushman & Wakefield to undertake an interim review valuation as at 31 March 2018. The 2017/18 financial statements include £2.5 million of revaluation gains (2016/17: £0.9m). This has primarily been driven by increases in building cost indices in the year. Our audit procedures over the valuation of PPE included: • Assessing the competence, capability, objectivity and independence of the external valuator (Cushman & Wakefield) who performed the valuation; • Critically assessing the calculation of market value indices movements completed by the Trust, including a re-performance of this calculation to confirm that no material movement in the value of the land and buildings assets are indicated. • Critically assessing the Trust's formal consideration of indications of impairment and surplus assets within its estate, including the process undertaken and the adequacy of the decision outcomes as a result of the process • Agreeing the information provided to the valuer by the Trust to underlying records of the estate held; Our review of external building and land indices was materially in line with the Cushman & Wakefield valuation report as at 31 March 2018. We found that the group's valuation to be balanced, resulting in appropriate carrying value of land and buildings, with proportionate disclosure of the related assumptions and sensitivities.

Financial Statements Audit

SIGNIFICANT audit risk	Account balances effected	Summary of findings
NHS income and NHS receivables	Income from activities: (£162.8 million; 2017: £159.5m) NHS Receivables: (£4.6 million; 2017: £3.1m)	Of the Trust's reported total income, £148.4 million (2016/17, £146.2m) came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). Income from CCGs and NHS England therefore represented 91% of the Trust's income. The majority of this income is contracted on an annual basis, but actual income is based on completion of the planned level of activity and achieving key performance indicators (KPIs). In 2017/18, the Trust received transformation funding from NHS Improvement. This was received on the basis of the Trust achieving defined financial and operational targets on a quarterly basis. The Trust was allocated £2.87m of transformation funding. This includes a year-end 'incentive payment' of £1.23m. This was included in the income levels reported above. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £0.3m are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. Our audit procedures over NHS income and NHS receivables were as follows: • We agreed commissioner income to the signed contracts and selected a sample of the largest balances to agree that they had been invoiced in line with the contract agreements and payment had been received. • We agreed that the levels of over- and under-performance reported were consistent with contract variations and challenged the Trust's assessment of the level of income where these were not in place by considering our own expectation of the income based on our knowledge of the client and experience of the industry. • We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers and compared the values they are disclosing within their financial statements to the value of income captured in the financial statements. We sought explanations for any variances over £0.3m, and all balances in dispute, and challenged the Trust's assessment of the level of income they were entitled to and the receipts that could be collected. • We re-performed the Trust's calculation of performance against the financial and operational targets used in determining receipt of transformation funding to determine the amount the Trust was qualified to receive. We agreed the amounts recorded in the accounts to our calculation. From the above procedures, no material issues were noted. In particular, our re-calculation of STF financial and performance-based measures did not indicate any material deviations from the amounts recorded.

Financial Statements Audit

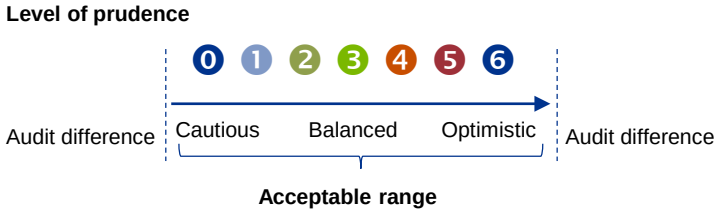
Risks that ISAs require us to assess in all cases	Why	Our findings from the audit
Fraud risk from revenue recognition	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial covenants, rather than broader financial reporting or share based management concerns.	We have classified recognition of NHS and non-NHS income as a significant audit risk for 2017/18 and have outlined above the audit work we undertook fulfil our responsibilities for this objective. Our procedures included: • reviewing the outcome of the Agreement of Balances exercise; • agreeing income reported in the financial statements back to signed contracts with key commissioners; • analytical procedures over other income; and • cut off testing to provide assurance over the completeness of income recorded in the financial statements. • Review and re-performance of calculations behind the STF funding received in the year. We have not identified any issues as a result of the work performed. The risk is lower for Somerset Partnership due to the predominantly block nature of the main contracts.
Fraud risk from management override of controls	Professional standards require us to communicate the fraud risk from management override of controls as significant because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We have not identified any specific additional risks of management override relating to this audit.	Our procedures, including testing of journal entries, accounting estimates and significant transaction outside the normal course of business, no instances of fraud were identified.

Section Two

Financial Statements Audit

Judgements in your financial statements

We consider the level of prudence within key judgements in your financial statements. We have summarised our view below using the following range of judgement:



Assessment of subjective areas				
Asset/liability class	**Current year**	**Prior year**	**Balance (£m)**	**KPMG comment**
Provisions	3	3	£0.15m (PY:£0.17m)	The balance was immaterial for our audit purposes. We consider the related disclosures to be appropriate.
Accruals	3	3	£3.8m (PY:£3.7m)	The accruals balance is made up of a variety of immaterial accrual balances such as divisional and agency accruals. We performed testing over the breakdown of accruals and based on the testing performed, we did not identify any significant variances and thus consider the related disclosure to be adequate and appropriate in the annual accounts.
Deferred income	3	3	£0.3m (PY:£0.1m)	The balance was immaterial for our audit purposes. We consider the related disclosures to be appropriate.
Debtors provisioning	3	3	£0.2m (PY:£0.2m)	The balance was immaterial for our audit purposes. We consider the related disclosures to be appropriate. The balance has remained consistent on the prior year.
Assets (lives, VAT and valuations)	3	3	£115.6m (PY:£109 m)	An assessment was made whether the remaining useful lives of revalued assets were appropriate at year end. Other applicable guidelines set in the GAM indicate that Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. When performing our testing of fixed asset additions we confirmed that the Trust had appropriately accounted for VAT. We also performed detailed testing over the interim valuation performed by Cushman & Wakefield and assessed the competence and capabilities of the valuers. No issues were noted in the testing performed. The related disclosure was deemed to be appropriate and in line with the ARM.

Section Two

Financial Statements Audit

Annual report

We have read the contents of the Annual Report (including the Accountability Report, Performance Report and Annual Governance Statement) and audited the relevant parts of the Remuneration Report. We have checked compliance with the NHS Foundation Trust Annual Reporting Manual (ARM) issued by NHSI. Based on the work performed:

- We have not identified any inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements.
- We have not identified any material inconsistencies between the knowledge acquired during our audit and the director's statements. As Directors you confirm that you consider that the annual report and accounts taken as a whole are fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.
- The parts of the Remuneration Report that are required to be audited were all found to be materially accurate;
- The Annual Governance Statement is consistent with the financial statements and complies with relevant guidance subject to updates as outlined within section three; and
- The report of the Audit Committee included in the Annual Report is currently being reviewed by management to ensure that it appropriately addresses matters communicated by us to the Audit Committee, and meets guidance as set out in the ARM.

Independence and Objectivity

ISA 260 also requires us to make an annual declaration that we are in a position of sufficient independence and objectivity to act as your auditors, which we completed at planning and no further work or matters have arisen since then.

Audit Fees

Our fee for the audit was £69,000 plus VAT, in line with our initial audit proposal and highlighted within our audit plan agreed by the Audit Committee in January 2018. This included our fee for the external assurance on the quality report. We have not completed any other non-audit work at the Trust during the year.

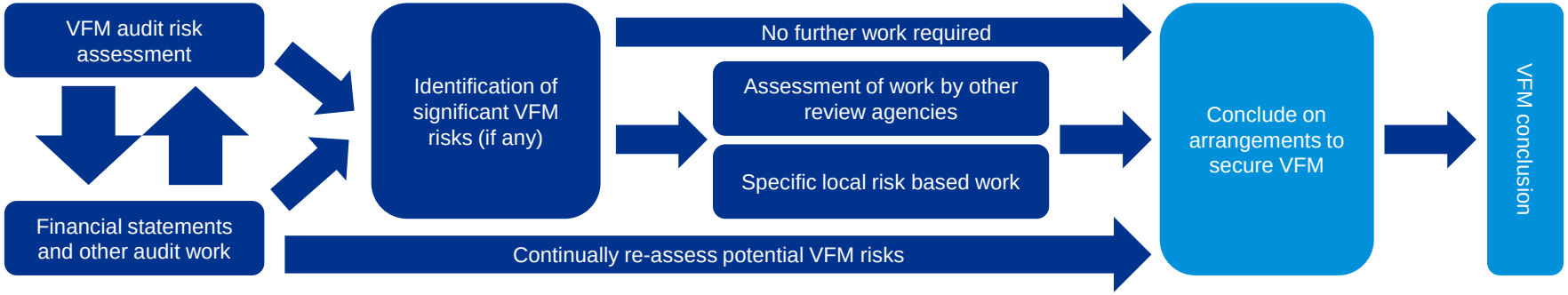
KPMG

Value for Money

Section Three

Value for Money

For 2017/18 our value for money (VFM) work follows the NAO's guidance. It is risk based and targets audit effort on the areas of greatest audit risk. Our methodology is summarised below. We did not identify any significant VFM risks and provide a summary below of the routine work required to issue our VFM conclusion, which is that we are satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2018, based upon the criteria of informed decision making, sustainable resource deployment and working with partners and third parties.



AGS review	Regulatory review	Other matters considered in risk assessment
We reviewed the 2017/18 AGS and took into consideration the work of internal audit. We confirm that the AGS reflects our understanding of the Trust's operations and risk management arrangements	We considered the outcomes of relevant regulatory reviews (NHS Improvement, CQC, etc.) in reaching our conclusion. The latest CQC review was undertaken in February/March 2017, the findings were published in June 2017. The Trust was rated 'Good' in 4 out of 5 key areas, with sufficient action plans in place for the remaining area which was highlighted as 'requiring improvement'.	As part of our risk assessment we reviewed various matters, including: • Internal audit findings: the final internal audit report highlighted various risk areas. We reviewed the action plans in place as a result of the review findings. The result of this review supported our VFM conclusion. • The work of inspectorates and review agencies: the CQC report from June 2017 highlighted limited areas which required improvement. We reviewed progress against action plans, noting that appropriate measures had been put in place to improve key service areas mentioned in the report. • Relevant findings from the financial statements audit work, including understanding the entity and work on key systems and controls: the Trust has a robust system of control, with a strong emphasis on value for money, evidenced by the receipt of Sustainability Transformation Funding in the year of £2.87m. • current operational performance and commissioner relationships: both deemed to be at an acceptable level, supporting our VFM conclusion.

KPMG

Appendices

Appendix 1

Recommendations raised and followed up

The recommendations raised as a result of our work in the current year are as follows:

Priority rating for recommendations					
1	Priority one: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2	Priority two: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3	Priority three: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
Financial Statements			
1	2	Journals Authorisation- It should be noted that all journals should be reviewed and authorised as per the Trust's policy. Two sample items from a sample of 50 were found to be lacking authorisation.	Accepted- management have rectified the inherent issue.

Appendix 2

Audit Differences

We are required to report any inconsistencies greater than £300,000 between the signed audited accounts and the consolidation data and details of any unadjusted errors or uncertainties in the data provided for intra-group and intra-government balances and transactions regardless of whether a Trust is a sampled or non-sampled component. We have provided details of the inconsistencies that we are reporting to the NAO as follows:

Counter party	Type of balance/ transaction to SomPar	Balance as per Trust (£'000)	Balance as per counter party (£'000)	Difference (£'000)	Comments on Difference
FRA4-Yeovil District Hospital NHS Foundation Trust	Expenditure	3,398	2,968	-430	Yeovil have included income from 16/17 in their figure and therefore the figure is skewed from the accurate 17/18 figure. Somerset Partnership have followed up with Yeovil on this inaccuracy with no response.
NPS033-NHS Property Services	Expenditure	1,518	22	1,496	No revenue notification has been included. Invoices received by Somerset Partnership have not been recognised by NHS Property Services. On inquiry by the Trust into the balance, NHS Property Services confirmed that Somerset Partnership's position was an accurate reflection and they would be amending their position in due course.

Appendix 3

Audit Independence

The purpose of this Appendix is to communicate all significant facts and matters that bear on KPMG LLP's independence and objectivity and to inform you of the requirements of *ISA 260 (UK and Ireland) Communication of Audit Matters to Those Charged with Governance.*

Integrity, objectivity and independence

We are required to communicate to you in writing at least annually all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place that, in our professional judgement, may reasonably be thought to bear on KPMG LLP's independence and the objectivity of the Engagement Lead and the audit team.

We have considered the fees paid to us by the Trust for professional services provided by us during the reporting period. We are satisfied that our general procedures support our independence and objectivity.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP Audit Partners and staff annually confirm their compliance with our Ethics and Independence Manual including in particular that they have no prohibited shareholdings.

Our Ethics and Independence Manual is fully consistent with the requirements of the Ethical Standards issued by the UK Auditing Practices Board. As a result we have underlying safeguards in place to maintain independence through: Instilling professional values, Communications, Internal accountability, Risk management and Independent reviews.

We would be happy to discuss any of these aspects of our procedures in more detail. There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the Board of Governors.

Audit matters

We are required to comply with *ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance* when carrying out the audit of the accounts.

ISA 260 requires that we consider the following audit matters and formally communicate them to those charged with governance:

- Relationships that may bear on the firm's independence and the integrity and objectivity of the audit engagement lead and audit staff.
- The general approach and overall scope of the audit, including any expected limitations thereon, or any additional requirements.
- The selection of, or changes in, significant accounting policies and practices that have, or could have, a material effect on the Trust's financial statements.
- The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements.
- Audit adjustments, whether or not recorded by the entity that have, or could have, a material effect on the Trust's financial statements.

Appendix 3

Audit Independence

- Material uncertainties related to event and conditions that may cast significant doubt on the Trust's ability to continue as a going concern.
- Disagreements with management about matters that, individually or in aggregate, could be significant to the Trust's financial statements or the auditor's report. These communications include consideration of whether the matter has, or has not, been resolved and the significance of the matter.
- Expected modifications to the auditor's report.
- Other matters warranting attention by those charged with governance, such as material weaknesses in internal control, questions regarding management integrity, and fraud involving management.
- Any other matters agreed upon in the terms of the audit engagement.

We continue to discharge these responsibilities through our attendance at Audit Committees, commentary and reporting and, in the case of uncorrected misstatements, through our request for management representations.

Auditor Declaration

In relation to the audit of the financial statements of the Trust for the financial year ending 31 March 2018, we confirm that there were no relationships between KPMG LLP and the Trust, its directors and senior management and its affiliates that we consider may reasonably be thought to bear on the objectivity and independence of the audit engagement lead and audit staff. We also confirm that we have complied with Ethical Standards in relation to independence and objectivity.

Appendix 4

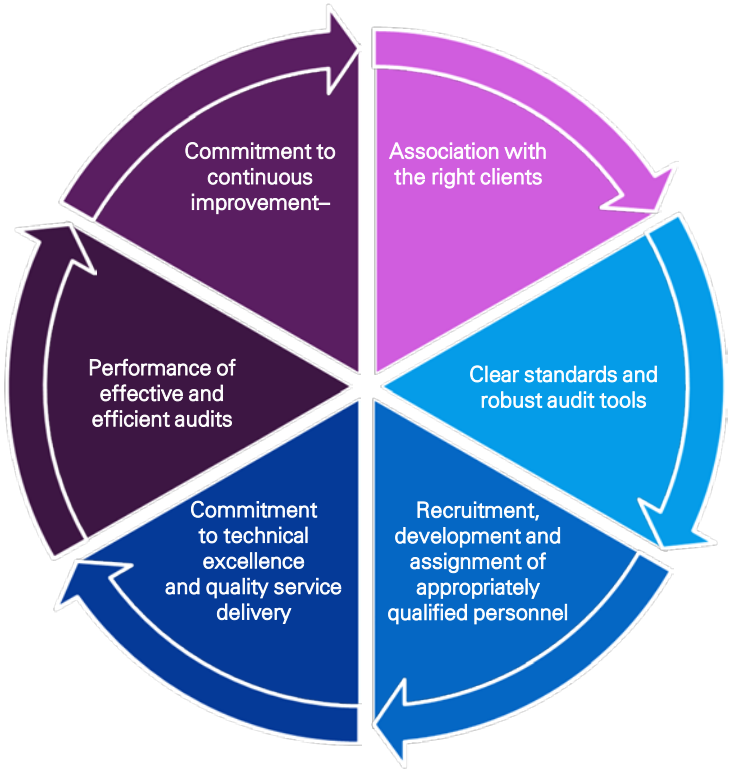
KPMG's Audit quality framework

Audit quality is at the core of everything we do at KPMG and we believe that it is not just about reaching the right opinion, but how we reach that opinion. To ensure that every partner and employee concentrates on the fundamental skills and behaviours required to deliver an appropriate and independent opinion, we have developed our global Audit Quality Framework

- Comprehensive effective monitoring processes
- Proactive identification of emerging risks and opportunities to improve quality and provide insights
- Obtain feedback from key stakeholders
- Evaluate and appropriately respond to feedback and findings

- Professional judgement and scepticism
- Direction, supervision and review
- Ongoing mentoring and on the job coaching
- Critical assessment of audit evidence
- Appropriately supported and documented conclusions
- Relationships built on mutual respect
- Insightful, open and honest two way communications

- Technical training and support
- Accreditation and licensing
- Access to specialist networks
- Consultation processes
- Business understanding and industry knowledge
- Capacity to deliver valued insights



- Select clients within risk tolerance
- Manage audit responses to risk
- Robust client and engagement acceptance and continuance processes
- Client portfolio management

- KPMG Audit and Risk Management Manuals
- Audit technology tools, templates and guidance
- Independence policies

- Recruitment, promotion, retention
- Development of core competencies, skills and personal qualities
- Recognition and reward for quality work
- Capacity and resource management
- Assignment of team members and specialists

kpmg.com/socialmedia

kpmg.com/app